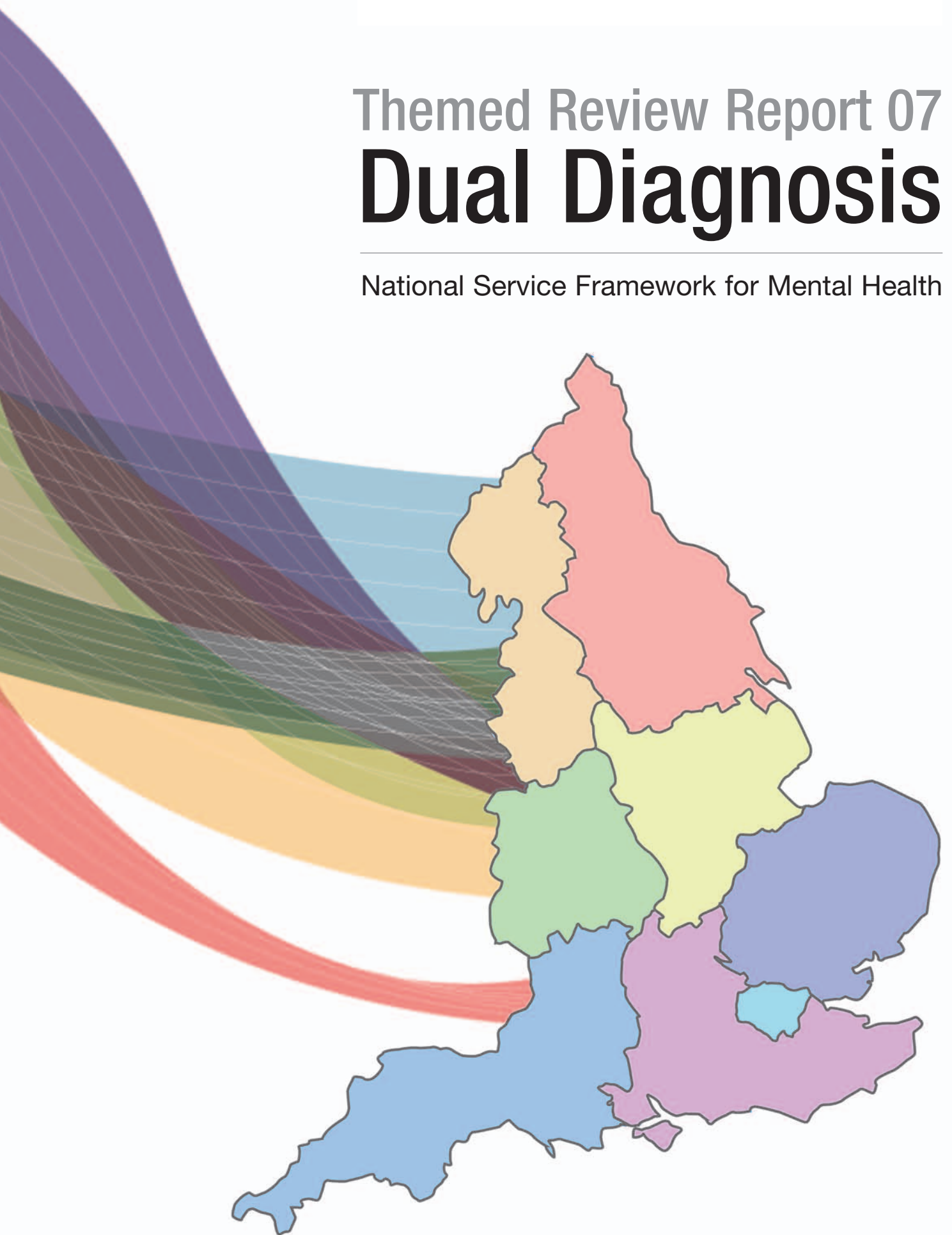


# Themed Review Report 07

# Dual Diagnosis

National Service Framework for Mental Health



**DH INFORMATION READER BOX**

<b>Policy</b>	Estates
HR / Workforce	Commissioning
Management	IM & T
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**Description** The Autumn Assessment of Mental Health services has been an annual event since the NSF launch in 1999. Four main strands include a 'themed review' on a key topic; Dual Diagnosis in 2006/7. Local Implementation Teams (LITs) were asked to respond on behalf of their mental health communities and submit an online report. This report summarises the the key findings in the following areas: strategic planning, service delivery, health promotion and training & practice development.

**Cross Ref** Department of Health (2002) Mental health policy implementation guide: Dual diagnosis good practice guide, London.  
  
Department of Health (2006) Dual diagnosis in mental health inpatient and day hospital settings, London.

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**For Recipient's Use**

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# Foreword



It is everyone's business to provide good quality services for people with mental health and substance misuse difficulties. The management of people with dual diagnosis (DD) remains an area of concern and one of high priority for mental health policy and within clinical practice. This was highlighted in the National Service Framework for Mental Health – 5 Years On document (DH 2004) where I restated that dual diagnosis remained one of the biggest challenges for mental health service providers.

Providing appropriate information and support for carers, family members and friends of service users is an important aspect of the services we provide, and must be given the priority it deserves. Due to the complexity of physical, social, psychological and other issues associated with this condition, it makes detection, assessment, treatment and the provision of good quality care even more challenging.

The information in this report has been collected from across the country, and thanks to the high response rate, we now have a much clearer picture of areas around the country where service users, carers, commissioners and providers are working together and driving up the quality of care locally. We are also aware of areas that may require more support and guidance so as to improve local dual diagnosis services.

It is clear that there is a long way to go to genuinely meet the complex and changing needs of people with dual diagnosis. But I commend this report as a valuable step on the road to achieving choice and real quality of life improvements for service users, carers and their families, and a way forward for service providers to be more confident and competent in providing these services.

A handwritten signature in black ink that reads "Louis Appleby". The signature is written in a cursive, flowing style.

Louis Appleby, *National Director for Mental Health*

# Executive Summary with recommendations

## The review process

This review is the first national assessment of progress towards the good practice set out in the Dual Diagnosis Good Practice Guide (May 2002).

In late 2006-7 mental health Local Implementation Teams (LITs) were asked to respond to review questions structured around the requirements of the Good Practice Guide. A response rate of about 80% was achieved – 131 LITs. However many responses were incomplete and not all questions yielded data that could be comprehensively analysed.

## Definitions and integration of services

Nearly all LITs reported having a local definition of dual diagnosis. For around 80% of LITs this definition was already in operation.

However many LITs (40%) did not have a dual diagnosis strategy agreed with local stakeholders such as Drug and Alcohol Action teams (DAATs) and mental health commissioners. This shortfall needs to be urgently addressed.

There was evidence of progress towards better integration with mainstream mental health services in the majority of LIT areas. But local leadership or championing of dual diagnosis seems lacking in many patches, with only 20% of LITs using this as a measure to achieve integration.

## Resourcing and planning

Two thirds of LITs reported that users with dual diagnosis problems were having either a quite severe or very severe resource impact on mental health services and only two per cent reported little impact.

Despite this, fundamental requirements for planning services such as monitoring service use and carrying out local needs assessments had been achieved only patchily. Less than two thirds of LITs were able to report that a needs assessment had been completed. In two SHAs no LITs could report that needs assessment data were available.

## User satisfaction and user outcomes

Only two fifths of LITs had collated evidence on user satisfaction with services.

It is of interest however that the treatment outcomes profile (TOPs) developed by the National Treatment Agency is now being used by drug treatment agencies to monitor user outcomes (see p. 34 in the Appendix).

## Public awareness

Promotion and dissemination of information to the public on the impact of substance abuse, and for practitioners on the availability of relevant services was reported by many LITs using a wide range of approaches. A quarterly bulletin and website run by a local DAAT was one such approach.

## Skills and capabilities of staff

There is a mixed picture on training and the existing skills and capabilities of staff. Fewer than half the LITs had made an assessment of training needs. Variation between SHAs was extreme. 83% of LITs in the East Midlands reported that an assessment had been made compared to only 14% in the South West.

Specific competencies for staff working in assertive outreach and acute inpatient wards where there is a high or very high incidence of substance abuse problems are recommended in the Dual Diagnosis Practice Guide. But a wide variation is reported in the level of competencies achieved by staff in these services.

As described in p 47 of the Appendix, the North West SHA has examples of lead nurses with specific dual diagnosis skills in inpatient wards and cross fertilisation of capabilities between substance misuse services and mental health inpatient services via a specialist dual diagnosis worker based in substance misuse services.

Development of the recommended competencies remains a priority need across much of the country.

## Recommendations

**Modern, effective provision for people experiencing dual diagnosis benefits from the following features:**

- 1) There is clear designated local responsibility for the strategic development of dual diagnosis services. Ideally this should be a named individual who supports a forum for decision making.
- 2) The Joint Strategic Needs Assessment can be a useful process to help raise dual diagnosis issues. Data can contribute to the development of a clear local definition of the target population for services.

If the local definition covers only those with severe mental illness plus substance abuse, then the needs of those with less severe mental illness also need to be considered. Clinical and Needs Assessments across the whole age range (including the needs of older people) will provide a more comprehensive service response.

- 3) Sensitive and appropriate collection of the views of users as part of needs assessment, strategy development and quality monitoring, to understand satisfaction with services and unmet needs.
- 4) Workforce capabilities are strengthened through employing resources such as The Dual Diagnosis Capability Framework and the 10 ESC Dual Diagnosis module.
- 5) Joint stakeholder ownership of local strategies, in which the development and training needs (including local health promotion activities) of staff working with dual diagnosis service users are addressed.
- 6) Assessment and care coordination includes substance misuse problems and physical health care needs.
- 7) The effective recording of user defined outcomes leading to a local outcomes framework for dual diagnosis.

# Introduction

## Background on Dual Diagnosis

### What is dual diagnosis?

There is no formal definition of dual diagnosis. The World Health Organisation (WHO 1994) and the United Nations Office on Drugs and Crime (UNODC) suggest it applies to a 'person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric such as mood disorder or schizophrenia'.

However policy guidance for mental health services in England has made it clear that services need to provide for a wider group – those that have a mental disorder and have problematic substance misuse. Many of these people do not fit the criteria for a formal substance misuse diagnosis. It is this wider group which this review has covered.

### Dual diagnosis statistics

Research suggests that between 22% and 44% of adult psychiatric inpatients also have problematic drug or alcohol use, up to half being drug dependent. Urban patient populations have higher prevalence figures than those in rural services. In high secure hospitals between 60% and 80% of patients have a history of substance use prior to admission. It has been suggested that fewer than 20% of psychiatric inpatients receive treatment for their substance use.

### Policy context

The statistics above highlight the fact that the management of people with dual diagnosis remains an area of concern and one of high priority for mental health policy and in clinical practice. In the “National Service Framework for Mental Health – 5 years on” the National Director for Mental Health, Professor Louis Appleby, emphasised that dual diagnosis was one of the most pressing problems facing mental health services from day to day, and highlighted:

- the importance of assertive outreach teams and dedicated services for dual diagnosis
- the need for better collaboration between community drug and alcohol teams and mental health teams
- training for mental health staff in the assessment and clinical management of substance misuse
- the need for intensive efforts to prevent drug misuse, including cannabis use, in people with severe mental illness, and
- the prevention of drug misuse in in-patient units.

## The Autumn Assessment

The autumn assessment of mental health has been an annual event since the National Service Framework (NSF) for the mental health of working age adults was launched in 1999. Its purpose is to provide an in depth assessment of the progress of services towards full implementation of the NSF. It comprises of four main strands:

- a self assessment process on local services carried out by Local Implementation Teams (LITs)
- a themed review on a key topic
- finance mapping, and
- mapping of adult mental health services.

The review and the detailed local and national reports that result from it are designed to help evaluate local progress, both on specific targets and on developing the breadth of mental health services. The themed review key topic for the autumn assessment of mental health in 2006-7 was 'Dual diagnosis'.

## The Dual Diagnosis Themed Review

### Aims and objectives

The review's aim was to encourage integration of drug and alcohol expertise and related training into mental health provision to provide a standard service plan. The review also wanted to investigate what quantitative and qualitative information was available about dual diagnosis services for people of all ages who have both mental health and substance use needs.

This review encompassed local strategic plans, service delivery, health promotion and the staff and training needs of the workforce.

The information provided in the review will be used to:

- a) Inform future national policy and strategy
- b) Provide a national picture of the delivery of dual diagnosis services as specified in Policy Implementation Guidance for DD
- c) Inform local service providers and commissioners by identifying and describing good practice and identifying gaps in services

### Review Process and Methodology

Local Implementation Teams (LITs) co-ordinated the review process and where necessary Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) were asked to assist where LITs vary in their area coverage.

Taking part in the review was optional and not intended to be exhaustive but rather to identify key issues in relation to the provision of care for people with 'dual diagnosis'. The review authors collated 131 responses nationally. This equates to a response rate of approximately 80% from the LITs.

Consideration should be given to the variation in numbers of contributors from each geographical area. The review questions are given in full on pages 61-62 within the appendix. The set questions were grouped under four main headings:

- Strategic Planning. Evidence of integration of mental health services and strategic development to deliver through mainstream services
- Service Delivery. To clarify the range of service user need that is catered for and the impact is this having on the mainstream mental health services. Are users satisfied with care they have received in the last 6 months?
- Health promotion. How do local mental health services provide information on drug and alcohol misuse?
- Training and practice development. What steps are being taken to assess training needs and are these monitored for the future to deliver patient care?

### Data Collection process

For the first time the 'themed review' was developed as an online tool. End users could log into the website to:

- 1) View guidance
- 2) Download relevant documents
- 3) Submit responses.

The data presented across this report is representative of the original submissions made by the individual Local Implementation Teams in early 2007. Throughout the report the data is presented by geographical Strategic Health Authority areas and by national percentage figures.

# Results and Commentary

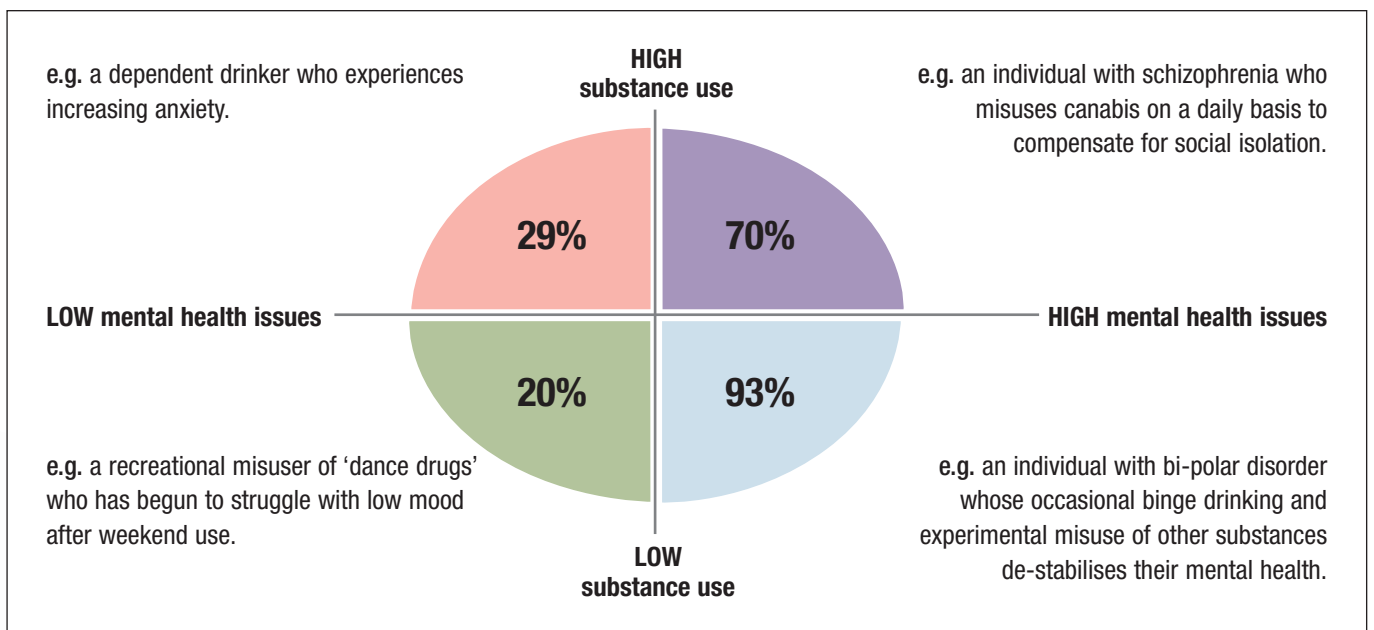
## Strategic Planning

### Question 1 Is there a local definition of dual diagnosis, which clarifies the treatment population for services?

90% of LITs reported that they had a local definition. There was substantial variation in definitions when mapped onto the axes of severity of a) mental illness and b) substance abuse (see below).

The majority of definitions related to the severe end of mental illness.

Overall four fifths of LITs reported the definition as in operation. However there was substantial variation between SHAs. Two SHAs reported 100% of LITs with operational definitions, while at the lower end three SHAs had only 60% of LITs in this position.



### Question 2 Is any local definition agreed between agencies and drug and alcohol teams/ mental health commissioners?

Four fifths of LITs reported that a local definition was agreed between agencies (Drug and Alcohol Action Teams (DAATs), mental health commissioners etc). There was a similar level of variation between SHAs as on the operational status.

### Question 3: Is there an agreed local strategy? Which key stakeholders have this been agreed with?

Nationally 60% of LITs reported there was an agreed strategy and a further 28% said this was in development. There was considerable SHA variation – 80% of LITs in Yorkshire & Humber reported an agreed strategy while only 29% did in the West Midlands. DAATs and PCTs were the two stakeholder organisations most commonly

referred to, while the Criminal Justice System was included in only 9% of responses.

#### **Question 4 What indicators are used to see if dual diagnosis interventions and service provision are well integrated across LIT and the Drug and Alcohol Action Teams to meet patients' needs as per the 'Dual Diagnosis Good Practice Guidance 2002'?**

Nationally 54% of responses said that indicators on integration were in place while a further 18% reported they were being developed. SHAs varied from 21% in place (South West) to 81% (London).

Markers for integration included:

- (i) Overlap in membership between the membership of the LIT and the DAAT
- (ii) DAAT and MH teams actively working together (joint care plans and risk assessments)
- (iii) Integrated training (mainstreaming)
- (iv) A sizeable minority of LITs (up to 40% in three SHAs) used care pathways as an indicator of integration.

#### **Question 5 And if not well integrated, what measures are being taken to integrate DD into the mainstream MH services, (including primary care mental health services and GPs) to deliver effective patient assessment and care for people who require both MH and substance use interventions?**

Two of the most common responses to this were:

- (i) By reviewing current care pathways or employing effective pathways – 27% of returns
- (ii) By ensuring the embedding of dual diagnosis workers or champions within mainstream mental health services

Overall the majority of LITs were able to report positive steps towards integration.

<sup>1</sup> The question would have benefitted from referring to specialist substance misuse services rather than community DATs; respondents appear to have treated the terms interchangeably

#### **Question 6 To what extent are the physical health problems like HIV, CHD or diabetes, etc, associated with substance use addressed within local MH service provision?**

The most commonly cited approach was “through effective physical health assessments/screening” (39% of returns). Also common (28% each) were: “through CPA processes” and “through effective blood borne virus services”. Other points frequently made included the QOF requirement for a register and a physical health check, wellbeing clinics in place within secondary care, needle exchange programmes, and general medical health checks on admission to acute care units.

#### **Question 7 What service provision is there for less severe MH problems i.e. individuals accessing community DATs<sup>1</sup> with moderate MH needs?**

The analysis of the data was difficult because of the large amount of textual information. Responses were assessed in detail for only three SHAs: East Midlands, East of England and London. There was a strong reliance on the drug services managing these problems either directly e.g. by qualified team members or by referral to Primary Care. An example of good practice was a county which was served by four complex needs workers providing groups/ workshops for substance abuse and minor mental ill health problems. Two workers were in the substance misuse service and two in a substance misuse charity.

#### **Strategic Planning Commentary**

The variation in defining ‘dual diagnosis’ is reflected in the broad populations to whom mental health services are provided. Where a broader definition is used (inclusive of lower severity mental ill health and/or substance abuse), the resulting spread of service provision may indicate some replication of service (where there is overlap with DAAT responsibilities), or may indicate co-operative

working over broader client groups (such as those experiencing less problematic substance use and less severe mental ill health). However, it is important that some resource remains available for cooperative and joint working with DAAT's, and third sector providers, to co-work where appropriate.

In some areas, there are high rates of operational agreements for defining dual diagnosis, but much lower rates in developing a strategy (for example, the West Midlands has a 93% rate of agreeing definitions, but only a 29% rate of successfully developing strategy). This may indicate a definition being implemented without a strategy, and/or that the strategy is still in development. (57% of LITs in West Midlands reported strategy in development).

The development of effective strategies across all areas of the country will take some time to achieve. There are examples of effective strategies that have taken up to three years to negotiate and implement (in Durham for example). However, with 88% of LITs with a strategy in place or in development, the remaining 12% need to urgently commence the process.

Developing indicators for integration may help to encourage strategy development; evidence of integrated care pathways, joint working and integrated training support the mainstreaming agenda. In two SHA's (South East and East of England), there are 60% rates of no indicators or indicators in development, and also 60% rates of no strategy or strategy in development.

The returns show there are a number of areas where local strategic groups and joint commissioning is working well across substance misuse and mental health providers and within Primary Care settings. It is crucial that local commissioners draw on expertise from service users, carers and providers to deliver high quality integrated services. Only 22% of the returns to Q5 identified having a local champion/lead within local mental health services as a measure to achieve integration, as recommended in the DD Good Practice Guidance (DH2002).

The responses to Q6 suggest a number of opportunities along the care pathway and at access points to primary and secondary care

services where the physical health needs of this group can be assessed and treated. The Care Programme Approach (CPA) is highlighted as a process within secondary mental health services that can be helpful in recording and agreeing a plan of physical care. Responding to the sometimes complex physical health needs of this client group is a third dimension for commissioning, alongside substance use and mental health care.

## Service Delivery

### Question 8 What are the criteria for accessing MH services and substance use services?

Two of the most common responses (21% each) were: a) Tiered models of care criteria<sup>2</sup> and b) Open Access self referral. 18% of returns referred to locally agreed protocols on inclusion and exclusion. Other frequent responses included access via criminal justice routes and 24 hour access via crisis services.

### Question 9a Is there a system in place to measure how many people used the services in the past six months?

Nationally 61% of returns reported that there was a system in place – varying from 50% in two SHAs (West Midlands and South West) to 80% (Yorkshire and Humber). There was wide variation in systems used – some organisations used the National Drug Treatment Monitoring System (NDTMS) and others locally developed systems.

### Question 9b Has there been any local needs assessment? Is this information available?

Nationally 63% reported there was a needs assessment, 21% replied there was no assessment. The balance of 16% either did not respond to the question or said an assessment was being developed. Of those LITs reporting that

<sup>2</sup> The tiered classification ranges from Tier 1 Interventions (provision of drug related information and advice, screening and referral by generic providers to more specialised drug treatment) to Tier 4 (Interventions include provision of residential specialised drug treatment which is care planned and care coordinated to ensure continuity of care and aftercare). [www.nta.nhs.uk/](http://www.nta.nhs.uk/)

an assessment had been made only around half said that information from the assessment was readily available. In two SHAs, no LITs reported needs assessment information as available.

### **Question 10 Are there any age restrictions on dual diagnosis services?**

69% reported no age restrictions varying from 40% in Yorkshire and Humber to 100% in East of England.

### **Question 11 Are there any specialist dual diagnosis provisions for older people with mental health, including provisions for alcohol-related cognitive impairment?**

Only 26% of LIT areas reported that there were specialist services for older people. Again there was wide inter SHA variation with London and South Central at 52% and 60% respectively while no LITs in either East Midlands or South West had such services.

### **Question 12 What financial impact on mental health services are people with dual diagnosis having?**

This question was graded on a four point scale from 1: very severe to 4: little impact.

Only 2% of replies reported little impact, 33% some impact and 65% reporting either quite severe or very severe impact. In 9 SHAs a majority of LITs reported either quite severe or very severe impact indicating a relatively high degree of consensus on this point.

### **Question 13 What resources are available for assisted withdrawal/detoxification within mental health services?**

Responses were wide ranging and complex to summarise. Some important points reported frequently were:

- dedicated beds within acute care for detoxification
- community detoxification programmes
- alcohol detoxification within primary care
- no appropriate pathways in place, and
- spot purchase beds out of county.

### **Question 14 Is evidence being collated to show that dual diagnosis users are satisfied with service provision?**

Only 42% of all LITs responded “Yes” to this question. As often in this survey, there was wide SHA variation; three SHAs at 60% or more and five SHAs between 20% and 25%.

### **Question 15 Do risk assessment tools in the care plan pick up the additional risks of substance misuse? Are their appropriate steps to address the risks in this context?**

Overall 93% confirmed that substance misuse risks were picked up with a further 5% saying that developmental work was being done. No LIT gave a definite “no” to this question. There was good consistency across SHAs with 5 SHAs on a 100% positive response and the lowest (London) on 85%.

## **Service Delivery Commentary**

The obligation to develop a Joint Strategic Needs Assessment (JSNA) provides an opportunity to describe the current and future healthcare and well-being needs of the population, and the strategic direction of service delivery to meet those needs. JSNA plans typically extend over a time frame of 3-5 years and should include the strategic development of services for those with a dual diagnosis. The responses to Q9 suggest that less than two thirds of LITs have a needs assessment in place and nearly 40% have no system in place to measure service use. There are clearly needs assessments in place in some patches without information on service use, and patches with service monitoring but no needs assessment. Both

needs assessments and service use measurement are clearly key components for planning services.

Less than half the LITs reported collecting evidence on user satisfaction and 5 SHAs had a quarter or less of their LITs doing this. This is important in informing service development and it is noteworthy that SHAs with better than average responses on user satisfaction tend also to do better on needs assessment

Although age is not reported to be a barrier to access services in most regions, JSNA may also need to consider the needs of an aging population, and the implications for dual diagnosis treatment provision, particularly in relation to alcohol. – There are usually no age restrictions, but little specific service provision for older age clients.

There are examples of ways that providers are improving access to local services, and overcoming some of the obstacles and barriers for this client group. However only 18% of the returns have locally agreed protocols on inclusion and exclusion. These agreements between key stakeholders and service providers are essential to any developing strategy.

Although the majority of LITs reported the financial impact of people with dual diagnosis on services as quite severe or very severe, there is a paradox when this result is compared with responses to earlier questions. For example, 85% of LITs in the North West assessed impact as quite severe or very severe but only half that number (43%) had a needs assessment in place.

Further analysis of the financial impact of dual diagnosis may also help understand the minority of LITs who returned 'little impact' through the review. One area (South West) had the lowest rates of defining dual diagnosis or measuring service use locally, but high rates of agreeing a local strategy. The perception of impact are possibly influenced by local funding arrangements where joint commissioning frameworks help to offset the financial burden in any one domain.

Regional data concerning the 'Out of Area' treatments or contracting with the private sector for detoxification services would be helpful in determining the local viability of services. The development of assertive outreach teams and primary mental health teams could increase the

availability of community detoxification closer to home, where appropriate.

The returns on Q15 suggest widespread early detection and recognition of substance use issues through routine assessment processes. However, this seems somewhat at odds with a general view that substance misuse in those with mental ill health is often not assessed and responded to adequately. Further data on service capability in managing risks associated with substance use would be helpful in assessing training needs.

## Health Promotion

**Question 16** **Locally, how is information on the impact of drug and alcohol use for those with mental health problems promoted? What types of outlets are used to disseminate information on dual diagnosis? What types of information are provided?**

Responses were wide-ranging and difficult to summarise. Some categorisation was made into a) Resources, b) Activities c) Settings.

Resources cited included the Cannabis Toolkit, 24 hour help lines, local leaflet campaigns and local service directories. Activities included Alcohol Anonymous meetings on acute wards, health and well being nurses on acute wards and harm minimisation programmes.

Settings included nightclubs, schools, youth groups, pharmacies, GP premises, district council offices, community centres, prisons and A&E.

**Question 17** **How do mental health services make sure that staff ask questions on substance use that are consistent with 'good practice guidance' as set out in the 'MH policy implementation guide: dual diagnosis good practice guide'?**

This question seems to have been not widely understood. Answers were wide ranging. The most relevant responses related to supervision and comprehensive training.

### **Question 18a How do practitioners know about the availability of services for people with dual diagnosis?**

The routes of dissemination of information most commonly quoted were:

- Websites and service directories
- Meetings, forums and networking events
- Close links between services
- Induction, training, bulletins, newsletters and leaflets were also frequent, and
- A notable example was a regular quarterly bulletin and a website with service details set up by the DAAT.

### **Question 18b Who in the organisation is responsible for DD?**

A wide range of roles were described in the returns, including joint funded senior practitioner posts in dual diagnosis, senior management, practitioners and commissioners. Other LIT's have highlighted steering groups, strategy groups or joint commissioning/ provider groups as holding responsibility for dual diagnosis.

### **Health Promotion Commentary**

There is a wide range of settings and locations that are appropriate environments for health promotion activities for dual diagnosis as demonstrated by the responses from LITs. Assessment should lead to appropriate health promotion activities and resources that adopt a harm reduction approach. Health promotion should be considered an integral part of the treatment process.

The returns describe a range of nationally and locally available resources and activities, with cooperative and joint working central to most pursuits. Activity appears to span not only mental health and substance use services, but across into primary care, public health, pharmacy services, education and local communities.

Responses to 18 b. suggest that practice in assigning responsibility for dual diagnosis is very

variable with some LITs pointing to strategy or joint commissioning groups as opposed to specific posts. This coupled with the responses to Q5 indicate that a lack of clarity in leadership responsibility may be a wide spread issue.

## **Training and Practice Development**

### **Question 19a What training is in place and what is the nature of that training?**

There was wide variation in responses and only snapshots of the responses from LITs within each SHA have been compiled. These indicate that some form of formal training related to substance abuse/dual diagnosis is in place at least locally within each of the 10 SHAs. This is by a range of types of provider: academic institutions, the Sainsbury Centre, the Royal College of Psychiatrists, specialist services (e.g. DD teams) etc. The subjects the training covers include drug awareness, motivational interviewing, prescribing, Cognitive Behavioural Therapy and risk management.

It was not possible to quantify provision or make very meaningful comparisons between SHAs.

### **Question 19b Has an assessment been made of training needs?**

Overall 47% of LITs confirmed that an assessment had been made. A further 10% said that this issue was under development with the balance either not answering or saying that no assessment had been made. There was wide SHA variation on this question. One SHA (South West) had only a 14% positive response (although 43% of LITs in the SHA did not answer). At the other extreme the East Midlands had an 83% positive response with the remaining 17% in the 'under development' category.

### **Question 19c Are training needs monitored for the future?**

60% said, "yes" with SHAs varying from 20% to 90%. 17% said this was under development and 8% giving a definite "no".

**Question 20 Does a training strategy exist to equip staff with the capabilities required to deliver care and treatment to people with dual diagnosis?**

41% of LITs reported they had a strategy and 32% were developing one with the balance of 27% saying no. Variation was quite extreme – 0% of LITs in the South East had a strategy compared to London with 67% at the high end.

**Question 21a What specific skills/capabilities have been acquired within generic or specialist mental health services e.g. crisis teams etc. for dealing with dual diagnosis patients?**

A wide range of responses were elicited. Two widely reported skills were:

- (i) Motivational interviewing skills (23%) and
- (ii) Harm reduction/risk assessment (11%).

Others included drugs awareness, screening, medication management, DANOS competencies, specialist detoxification skills, family involvement, relapse prevention and care planning. [www.nta.nhs.uk/areas/workforce/initiatives/danos.aspx](http://www.nta.nhs.uk/areas/workforce/initiatives/danos.aspx)

**Question 21b Do assertive outreach teams have evidence-based skills/capabilities for working with dual diagnosis?**

The data were not comprehensively analysed and returns indicated a wide variation. Some teams claimed to meet DANOS competencies. Other comments included: “to be addressed”, or “training strategy under development.”

**Question 21c Do psychiatric in-patient services have evidence-based skills/capabilities for working with dual diagnosis?**

A snapshot of responses from three SHAs (NW, SE and WM) was looked at. Availability of DD skills was patchy within all three SHAs and appears to

be weaker in the South East than in the other two SHAs. Development of greater capability mainly through training was acknowledged in each SHA.

**Training and Practice Development Commentary**

Training needs assessment and training strategies for dual diagnosis were each reported in less than half of the LIT's nationally. The assessment of training needs was the question most unanswered in the review (31%).

There is a wide and varied provision of dual diagnosis, substance misuse and mental health awareness training across the country, with provision of some type in every region.

It is of concern that so many LITs did not report a training needs assessment and/or a training strategy. The pronounced inter SHA variation (0% to 67% on training strategy) suggests that this is probably a question of local/regional prioritisation.

Recommendations have been made in previous guidance and reports concerning Assertive Outreach Teams and staff working in psychiatric acute inpatient settings. These settings (along with Early Intervention Teams) report a high incidence of people with a dual diagnosis, and staff require increased capabilities to work effectively. The returns describe some capabilities in line with recommendations, transferred through joint working, experiential learning and in some areas, led by a dual diagnosis practitioner.

# Appendix 1: Detailed reports and assessment of responses

## Strategic planning

**Question 1** Is there a local definition of dual diagnosis, which clarifies the treatment population for services?

To achieve mainstreaming, 'local services must develop focused definitions of dual diagnosis which reflect local patterns of need and clarify the target group for services' (DH 2002). A fundamental problem in achieving this aim is a lack of clear operational definition of dual diagnosis. In many areas a significant proportion of people with severe mental

health problems also misuse substances, whether as self-medication, episodically, or continuously. Equally, many people who require help with substance misuse may suffer from a common mental health problem such as depression or anxiety. Sweeping up all these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues. Integrating services therefore requires a clear and locally agreed definition of dual diagnosis supported by clear care pathways and care coordination protocols.

AREA	YES% (Number of LITs)	NO%
North East Yorkshire and Humber	93% (14)	7%
North West	85% (17)	15%
North East	80% (8)	20%
East Midlands	83% (5)	17%
West Midlands	93% (13)	7%
East of England	100%(10)	0
South Central	100%(10)	0
South East	100% (5)	0
South West	79% (11)	21%
London	96% (26)	4%

National Data	YES% (Number of LITs)	NO%
	90%	10%

## Defining dual diagnosis

The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently.

The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- a primary psychiatric illness precipitating or leading to substance misuse
- substance misuse worsening or altering the course of a psychiatric illness
- intoxication and/or substance dependence leading to psychological symptoms and/ or
- substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses (DH 2002)

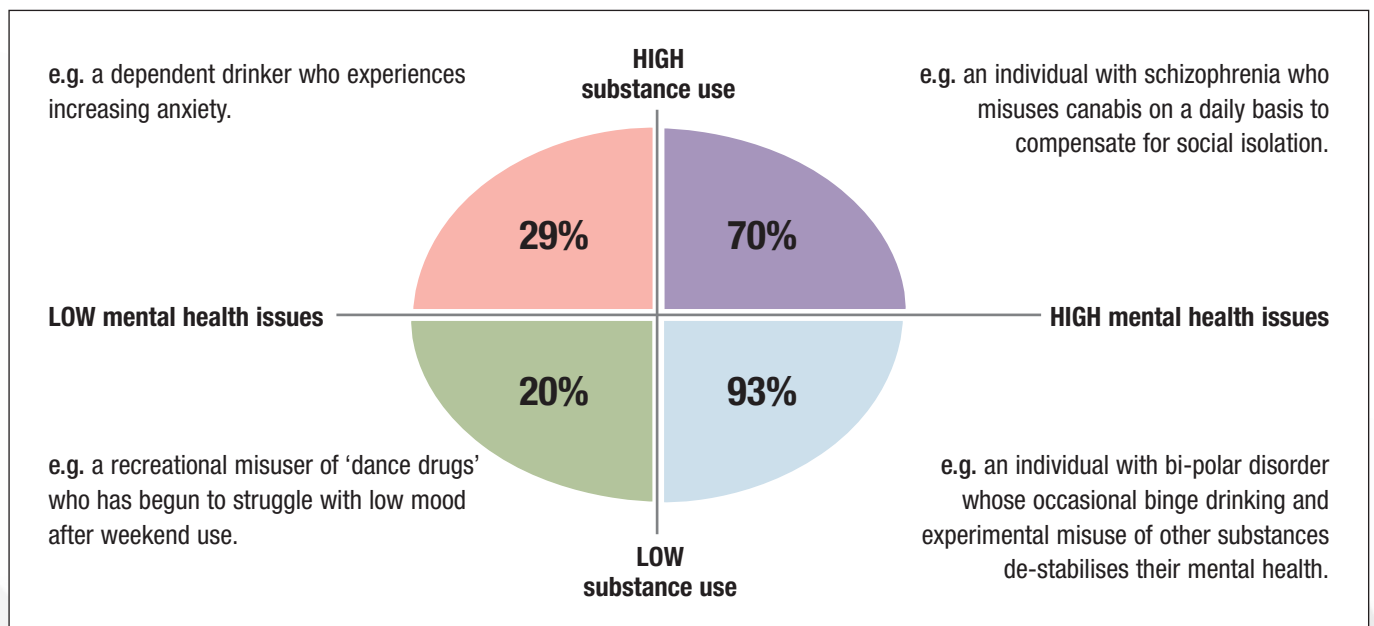
The World Health Organisation (WHO 1994) and the United Nations Office on Drugs and Crime (UNODC) define dual diagnosis as a 'person diagnosed as having an alcohol or drug abuse

problem in addition to some other diagnosis, usually psychiatric such as mood disorder or schizophrenia'. The European Monitoring Centre in Drug Dependence and Alcohol (EMCDDA 2004) refers to co-morbidity or dual diagnosis as a situation when there is a 'temporal co-existence of two or more psychiatric or personality disorders as defined by the International Classification Diagnostic System (ICD), one of which is problematic substance use' (Scottish Executive 2006).

## What is the definition?

Responses to this question have been mapped onto the diagram below (DH 2002) and indicate the national overview of all responses.

N.B: Where a submitted response could map against a number of the quadrants this has been reflected within the statistical information provided below. For example a returned definition may be able to map against both High Right and Low Right. This definition would contribute to the percentages in each of these two quadrants.



NO DATA = 9%

## Is it in place or being implemented?

### Results

AREA	In place/ Being implemented	Under consultation/ Review/ Further development	Neither
North East Yorkshire and Humber	100% (15)	0	0
North West	60% (12)	20%	20%
North East	100% (10)	0	0
East Midlands	83% (5)	17%	0
West Midlands	93% (13)	0	7%
East of England	90% (9)	0	10%
South Central	60% (6)	30%	10%
South East	60% (3)	40%	0
South West	64% (9)	21%	15%
London	81% (22)	13%	8%

AREA	In place	Consultation/ Dev	Neither
	79%	12.5%	8.5%

### Question 2 Is any local definition agreed between agencies and drug and alcohol teams/ mental health commissioners?

To achieve 'mainstreaming', these definitions must be agreed between relevant agencies (DH 2002). It is important to include all key stakeholders in this process in particular service users, carers, service providers from all sectors, and commissioners for mental health and drug and alcohol services. The interface between substance misuse and mental health and social care is vital to provide appropriate interventions for this client group across the broad spectrum of dual diagnosis.

## Results

AREA	YES%	NO%
North East Yorkshire and Humber	80% (12)	20%
North West	75% (15)	25%
North East	70% (7)	30%
East Midlands	67% (4)	33%
West Midlands	93% (13)	7%
East of England	80% (8)	20%
South Central	60% (6)	40%
South East	80% (4)	20%
South West	71% (10)	29%
London	93% (25)	8%

National Data	YES%	NO%
	79%	21%

### Question 3 Is there an agreed local strategy? Which key stakeholders have this been agreed with?

Small and time limited local project teams including mental health and substance misuse specialists working to the LIT should prepare the focused definition together with care pathways and clinical governance guidelines.

Formulating the basic strategy – This will need to be very simple and might consist of say three points.

Examples might be:

- construct agreed local care pathways by a certain date;
- train all assertive outreach staff in substance misuse by a certain date and

- produce information for users and carers, including an easily comprehensible guide to services.

The strategy should emerge from the planning information and stakeholder group. All strategies will have to include the agreed local definition of dual diagnosis and other necessary agreed documentation;

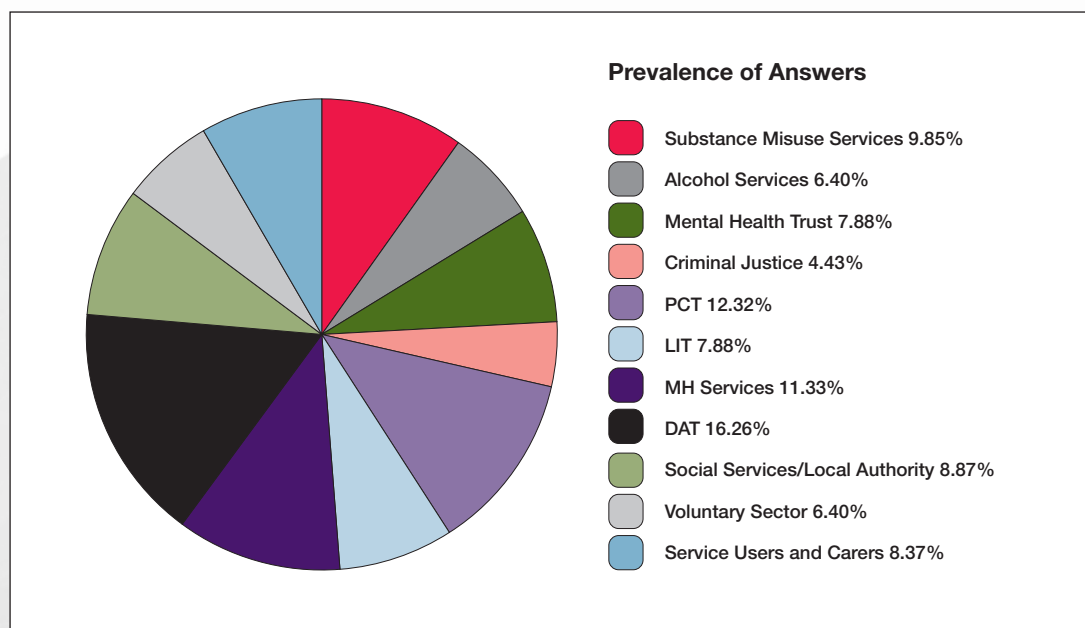
- operationalising the strategy by producing a short written plan identifying the philosophy and values of the service, service goals and concrete steps to be taken to deliver the strategy. The plan must be produced by the project team which will feed back the draft to the wider stakeholder audience getting the strategy signed off by the relevant agencies/boards (DH 2002)

## Results

AREA	YES%	NO%	In development/Consultation/ Draft form
North East Yorkshire and Humber	80% (12)	20%	0
North West	75% (15)	5%	20%
North East	60% (6)	0	40%
East Midlands	67% (4)	33%	0
West Midlands	29% (4)	14%	57%
East of England	40% (4)	40%	20%
South Central	50% (5)	0	50%
South East	40% (2)	0	60%
South West	71% (10)	7%	22%
London	59% (16)	13%	28%

National Data	YES%	NO%	Development/Consultation/ Draft
	60%	12%	28%

The following table illustrates the prevalence of answers indicating which key stakeholders the local strategy has been agreed with.



We can correlate the information above directly with data collected from the 2005 self-assessment paper (2005 Mental Health Strategies), which indicated that:

## Results

	Answer	No of LIT's	Percentage of LIT's
<b>RED</b>	There is no local dual diagnosis strategy and action plan	15	9%
<b>AMBER</b>	There is a local strategy and action plan but links between treatment and criminal justice services are inadequate or ineffective	68	39%
<b>GREEN</b>	There is a local strategy and action plan with effective links between treatment and criminal justice services	90	52%

A listing of relevant stakeholders can be found on page 29 of the DDGPG and are listed for your reference below:

Core	Those with an interest
Users/clients	Housing authorities
Carers	Housing providers
Strategic health authorities	The Benefits Agency
Primary care trusts	Police
NHS trusts providing mental health or substance misuse services	Probation services
Independent sector	Employment services
Social services	Local politicians and community leaders
Clinicians (includes GPs) and clinician's groups	The local media
DATs	Educational institutions
LITs	
Addiction/drug and alcohol teams	
Prisons	
Support services for vulnerable people	

## Commentary

The national data is encouraging, although there remain a number of LIT areas that will need to clearly articulate distinctions between target groups. Developing definitions and strategies with key stakeholders will help to introduce 'a clearer way of working across drug and alcohol agencies and mental health agencies involving the definition of clear care pathways so that:

- drug and alcohol services provide specialist support, consultancy, and training to mental health services to support mainstreaming of clients with severe mental health problems (*top right hand quadrant of Figure 1, page 17*) without which people will continue to receive poorly integrated or episodic care, and
- mental health services offer the same sort of packages of support to drug and alcohol services so that they can deal effectively with people with less severe mental health problems (*top left hand quadrant of Figure 1*).’ (DH 2002)

The National Treatment Agency (NTA) is responsible for implementing the treatment target of the Government's national drug strategy to:

- double the number of people in effective, well-managed treatment from 100,000 in 1998 to 200,000 in 2008, and
- increase the proportion of people who successfully complete or, if appropriate, continue treatment.

The NTA achieves this through Drug and Alcohol Action Teams (DAATs) which mirror the function of the LITs, in commissioning services that include working with people with less disabling mental health problems. DAATs are local consortiums that bring together representatives of all the local agencies involved in tackling substance misuse, including primary care trusts, local authorities, police, probation services. There are 149 DAATs in England covering all local authorities. ([www.nta.nhs.uk](http://www.nta.nhs.uk))

Most substance misuse clients do not have sufficient mental health problems for eligibility to access community mental health teams, which prioritise those with severe and enduring mental illness. It is recommended that the majority with mild and moderate mental health problems should be managed by primary care and counseling services and/or by

specialist substance misuse services. For people with severe and enduring mental illness, there is likely to be the need for joint working between mental health and substance misuse services, led by mental health teams and in line with Models of Care (Strathdee 2002).

Reference: *Dual diagnosis in a primary care group (PCG) A step-by-step epidemiological needs assessment and design of a training and service response model* (Strathdee et al, 2002)

The LIT returns suggest that some teams are working to a wide remit (and possibly a less restricted definition of the client group). The data may indicate some replication of delivery, although it may also point to co-operative working between mental health services and substance misuse providers.

**Question 4 What indicators are used to see if dual diagnosis interventions and service provision are well integrated across LIT and the drug and alcohol action teams to meet patients needs as per the ‘Dual Diagnosis good practice guidance 2002’?**

Responses to this question listed ‘self expressed’ indicators that reflected integration. The assumption is that integration can be defined by exhibiting evidence that substance misuse and mental health services are working effectively together.

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care. This should be delivered within mental health services.

This policy is referred to as mainstreaming. Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services, which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively. (DDGPG)

LITs reported a range of ways in which they were moving towards working with increased effect across services. We have categorised the returns into the following headings listed below:

## Processes

- 1) evidence that a strategy group is active and that it reflects integration in its membership
- 2) LIT membership overlapping "There is some overlap in the membership of the DAAT and the LIT"
- 3) services have developed or are developing integrated care pathways
- 4) SLAs (indicators are shown to be built into current or proposed Service Level Agreements)
- 5) monitoring meetings are held between commissioners and providers
- 6) joint commissioning

- 7) locally agreed patterns of need "Dual Diagnosis Leads are able to collect data relating to current need and this information supports the assessment of future need and identifies service gaps", and
- 8) joint working protocols are in place.

## Infrastructure/Organisation of resources

- 1) DAAT and mental health teams are actively working together (joint care plans and risk assessments)
- 2) local forums and multi disciplinary networks are in place
- 3) multi disciplinary teams are in place, and
- 4) co-location of teams: "Co-location and shared operations by both the Mental Health and Substance Misuse services."

## Training

- 1) staff development work, and
- 2) integrated training (mainstreaming).

## Performance

- 1) common feedback tools are in place for service users and carers across services.
- 2) formal audits are in place
- 3) SLAs (indicators are shown to be built into current or proposed Service Level Agreements)
- 4) NTA linked outcomes for treatment (substance misuse performance indicators) "NTA key performance indicators. The steering group has overall responsibility for this and regular reports are made via this forum, looking at outcome based on (MHPIG 2002) benchmarks".

## Regional overview

AREA	Indicators in place	No indicators	Currently being developed
North East Yorkshire and Humber	60%	20%	20%
North West	57%	29%	14%
North East	60%	30%	10%
East Midlands	33%	33%	33%
West Midlands	57%	21%	22%
East of England	40%	40%	20%
South Central	40%	20%	40%
South East	40%	60%	0
South West	21%	58%	21%
London	81%	7%	12%

Indicators in place	No indicators	Currently being developed
54%	28%	18%

Finally, we can look at the prevalence of the number of answers that referred to using care pathways as a source of indicator.

AREA	Care Pathway indicators mentioned
North East Yorkshire and Humber	40%
North West	14%
North East	40%
East Midlands	17%
West Midlands	29%
East of England	20%
South Central	0
South East	40%
South West	7%
London	26%

**Question 5** And if not well integrated, what measures are being taken to integrate DD into the mainstream MH services, (including primary care mental health services and GPs) to deliver effective patient assessment and care for people who require both MH and substance use interventions?

Answers to this question have been categorised using the following headings.

**Processes**

- 1) integrated care pathway development
- 2) information strategies
- 3) implementation plans
- 4) formation of local dual diagnosis boards (including primary care)
- 5) development of referral pathways that include primary care and voluntary sector services “A dual diagnosis brief assessment and referral/ intervention pathway is currently being piloted. If successful this could be rolled out to other agencies, including primary care and voluntary sector mental health organisations”
- 6) service mapping processes
- 7) primary care using referral forms for models of care

- 8) considering exclusion criteria in order to adopt an inclusive approach “No exclusion criteria is included within mainstream mental health services that would disadvantage people with dual diagnosis”
- 9) local borough collaborative: “The liaison model facilitates a collaborative and joined up way of working at a local borough level between all local services for the better outcomes of clients and to ensure the principles of best practice are applied for clients with dual diagnosis.”

**Infrastructure**

- 1) regular practitioner meetings and multi agency meetings
- 2) identifying dual diagnosis champions that link across teams
- 3) shared care services in place
- 4) local enhanced services for alcohol and drugs

**Performance**

- 1) audits

The following table illustrates a snapshot of the prevalence of answers indicating what measures are being taken to ensure the greater integration of dual diagnosis into mainstream mental health service.

By reviewing current or by employing effective care pathways	By ensuring that specialist DD workers/ champions/link workers are embedded within local mental health services/teams	Through the developing local strategy
27%	22%	16%
34 returns	28 returns	20 returns

## Commentary

There are positive examples of integration across mental health and substance misuse systems from the LIT returns, with many areas reporting indicators in place or at the developmental stage. For integration between mental health and substance misuse systems to be successful it should be evident at both strategic and operational levels.

Delivering appropriate interventions for this client group at an operational level has been demonstrated by reports of local joint protocols and integrated, effective care pathways being developed. These should be linked in and disseminated across all relevant structures and integrated within clinical governance frameworks, training and development programmes and local strategies (DH 2002)

The returns also show there are a number of areas where local strategic groups and joint commissioning is working well across substance misuse and mental health and within primary care settings. It is crucial that local commissioners draw on expertise from service users, carers and providers to deliver high quality integrated services. 22% of the returns identified having a local champion/lead within local mental health services, as recommended in Mental Health Policy Implementation Guide (DH2002).

### **Question 6 To what extent are the physical health problems like HIV, CHD or diabetes etc associated with substance use addressed within local MH service provisions?**

There are a number of physical health problems associated with use and abuse of substances .as well as increased incidence of respiratory complications, diabetes, Hepatitis C, HIV, amongst other conditions for people diagnosed with a severe mental illness (Burns & Cohen 1998).

Drug users in particular are one of the 'high risk'

groups in relation to contracting HIV, hepatitis and septicaemia, due to methods of use, i.e. sharing injecting equipment and other paraphernalia.

It is imperative that whatever services clients are engaged with or in are able to address these issues and wherever possible be pro-active in prevention. (Burns, T & Cohen, A.1998. Item of service payments for general practitioner severely mentally ill patients: Does the money matter? 48, 1425-1516).

NHS Organisations and Local Authorities were asked to use the framework of 'Standards for Better Health' (DH 2006c) in planning services. In particular Standard C23 is applicable which states 'health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the NSF and national plans with regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

#### **An example of good practice around this area would be:**

*"Ensuring health education leaflets on BBV, safer injecting, overdose risk, effects of alcohol on the body are available in inpatient units and community settings".*

The following points were commonly cited throughout many of the returns to this question:

- 1) the QOF requires firstly that there is:
  - a register, and that secondly
  - a physical health care check is carried out
- 2) well being clinics in place within secondary care
- 3) screening evident through care programme approach
- 4) blood borne viruses services – educational services and treatment services
- 5) needle exchange programmes: "Needle

- exchange services are available”
- 6) ensuring registration with primary care
  - 7) general medical health checks on admission to acute care units
  - 8) vaccination schemes
  - 9) developing a clinical standards and procedures framework: “A trust wide physical healthcare policy was released during March 2006. This

- sets out detailed clinical standards, ward and CPA physical health maps for CHD, diabetes and sexual health (including HIV)”
- 10) sexual health assessments
  - 11) harm reduction activities: “BBV and harm reduction prevention activities across all substance misuse services”
  - 12) health promotion projects.

Through the assessment process/ CPA processes	Through effective Blood Borne virus services	Through effective physical health assessments/ screening
<b>28%</b>	<b>28%</b>	<b>39%</b>
37 returns	37 returns	51 returns

The following table illustrates an overview of the prevalence of a number of answers:

### Commentary

For many years substance misuse services have, for many years, been pro-active in collecting information, providing help, support and advice around physical health issues related to substance misuse. This has developed from the harm reduction approach used to engage and treat clients with substance problems. The NTA have routine assessment items relating to this within The National Drug Treatment Monitoring System (NDTMS) and the Treatment Outcomes Profile (TOP).

Mental health services are reporting a variety of strategies and approaches to raising awareness of physical health risks associated with drug use, and there has been some investment in treatment and educational programmes. There are opportunities to jointly commission and provide such services across not only substance misuse services and

mental health providers, but within primary care and other community provision.

Harm reduction aims to prevent or reduce negative health or other consequences associated with drug misuse, whether to the drug-using individual or to the wider society. With such approaches it is not essential for there to be a reduction in the drug use itself (although, of course, this may be one of the methods of reducing harm). For instance, needle and syringe exchange services aim to reduce transmission of blood-borne viruses through the promotion of safer drug injecting behaviour (NICE 2007).

For other information and evidence please see: The NTAs 2005 survey of needle exchanges in England (April 2007) Dima Abdulrahim, Dawn Gordon, David Best et al. found at [www.nta.nhs.uk/publications/publications.aspx?CategoryID=37](http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=37)

**Question 7 What service provision is there for less severe MH problems i.e. individuals accessing community DATs with moderate MH needs?**

Mental health problems are fairly common within the general population. It is estimated that around 20% of the population has a mental health problem of some kind. There are a range of less severe common mental health problems which can affect individuals who use and abuse drugs and alcohol, but do not require specialist intervention from mental health services. Around

one third of heavy drinkers and half of dependent drug users are reported as having associated mental health problems. The majority of mental health disorders are treated within primary care and there are many positive examples of ‘shared care’ working with clients who have substance misuse and mild to moderate mental health problems.

In the COSMIC Study (2002), Weaver and others found that some 74.5% of patients from drug services and 85.5% from alcohol services were assessed to have experienced one or more of the disorders listed below:

	Prevalence estimates	
	% Drug treatment population	% Alcohol treatmentpopulation
Psychotic disorder	7.9%	19.4%
Personality disorder	37%	53.2%
Depression and/or anxiety disorder	67.6%	80.6%
Severe depression	26.9%	46.8%
Mild depression	40.3%	33.9%
Severe anxiety	19%	32.3%

**Reference:** Co-morbidity of substance misuse and mental illness collaborative study (COSMIC) A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations (Weaver et al, 2002). Found at [www.nta.nhs.uk/publications/publications.aspx?CategoryID=37](http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=37)

Due to the nature of this question and the free text answers that were supplied we chose to look at a snapshot from three of the areas: London (as one of the larger contributors), the East of England and the East Midlands.

**An example of positive practice around this area can be found below:**

*“There are four complex needs workers in the county, two based within a substance misuse charity and two within the substance misuse service. These workers run anxiety management groups and are planning to run depression workshops”.*

## East Midlands

- services are limited and vary across areas. Some consultancy is available to support tier 2 and primary care as part of the integrated care pathways [www.nta.nhs.uk](http://www.nta.nhs.uk)
- the drug team manages secondary mental health issues. Minor and common mental health problems are referred back to the GP who can then onward refer to the common mental health problem service (which provides therapeutic interventions in primary care settings including to service users with substance and/or alcohol problems)
- the DD team liaises and offers support and advice to non-statutory agencies that have contact with such individuals. Assessments are undertaken as necessary by the specialist service and appropriate care plans are put in place. Similarly, primary care providers are able to access this support
- there are four complex needs workers in the county, two based within a substance misuse charity and two within the substance misuse service. These workers run anxiety management groups and are planning to run depression workshops. Currently we are experiencing a lack of data; co-ordination and strategic ownership for people with less severe mental health problems and,
- through primary care mental health service based on NICE stepped care guidance.

## East of England

- through community drug services and shared care provision (including community prescribing)
- all of the DAT (Drug and Alcohol Teams) teams are staffed with RMN's who are capable and confident in dealing with mental health problems, as well as having robust links to the local community mental health teams. There are also DD champions in the mental health and substance misuse teams, who act as resources for patients, staff and carers

There are also strong links with primary care through the GP shared care scheme and the inclusion of GP's within some of the drug team's core activities

- through open access for the full range of tier two services for those with mild to moderate mental health needs
- open access for the full range of basic DD services for mild to moderate mental health needs and,
- tier two and tier three services are open access. All services have referral pathways. Some mental health provision is currently being met by the pilot primary health care MH gateway workers.

## London

- clinicians liaise closely with GPs; particularly where the nature of the patient's mental health needs do not warrant community mental health team involvement. A guide is available to all staff and clients with contact numbers for emergency situations. People with mild to moderate mental health problems (who do not meet the criteria for secondary services) are able to access services through their primary care team. This can include counselling and psychosocial therapy in some areas. Graduate primary care mental health workers who are able to provide referral facilitation to a range of services/ organisations
- through treatment via GP as part of the shared care scheme and implementation of agreed guidelines. In addition there are a number of other commissioned services
- all substance misuse providers use an agreed common assessment tool. This tool covers physical and mental health issues. As a result all service users presenting to services will be screened for both mental and physical health issues. If more formalised mental health support is required they can be referred to the primary care solutions project which offers formal mental health support within the primary care setting

- there is a range of tiered interventions and services for those with less severe mental health problems or people with moderate mental health needs. The DAT has published details of the established service provision and this also addresses access and equality issues for these groups, and
- for those with less severe mental health problems, the community substance misuse service manage their care, and with support from mental health services as and when required.

## Commentary

There are many areas across the country where people with less severe mental health problems receive appropriate interventions within substance misuse services. In order to provide robust, comprehensive service provision and achieve integrated care there should be:

- links between substance misuse and psychiatric services and,
- training and supervision in substance misuse for staff working in psychiatry and equivalent training in mental health issues for substance misuse workers (DH 2002).

This can be provided in a variety of ways and should be at the centre of any agreed local strategy and demonstrated within local integrated clinical care pathway (ICCP). In some areas there are specified 'link workers' who have received additional training or have appropriate experience to provide the support and intervention required. Other areas have arrangements for 'specialist workers' to provide support and consultancy to the substance misuse team and there are some good examples of joint working in operation.

The COSMIC study reiterates that substance misuse services should work more collaboratively with local psychotherapy services and GPs to improve management of co-morbid patients who do not meet the criteria for access to community mental health services (i.e. those with anxiety and depression in particular).

## Service Delivery

### Question 8 What are the criteria for accessing MH services and substance use services?

This question was included so that we could look in greater detail at the issues of exclusion, which may cut across services and remains one of the key factors regarding service development. The Social Exclusion Unit published its report 'Mental Health and Social Exclusion' in June 2004. The report's immediate impact is directed at improving the lives of people with mental health problems by reducing or eliminating barriers to employment and wider social participation. However it has great potential also to impact significantly across service areas, client populations and on the health, engagement and economic position of wider communities.

The following points were commonly cited throughout many of the returns to this question:

- 1) tier 2, 3 and 4 models of care criteria in use ([www.nta.nhs.uk](http://www.nta.nhs.uk))
- 2) open referrals evident
- 3) via criminal justice routes
- 4) 24 hour via crisis services in place
- 5) joint protocols between Mental Health Services and Drug and Alcohol Action Teams
- 6) complex needs matrixes in use
- 7) supported through robust service level agreements
- 8) choose and Book via a single point of access
- 9) criteria based on risk analysis and assessment tools, and
- 10) Models of care and health advisory service standards (HAS).

The following table illustrates an overview of the prevalence of a number of answers outlined above (where the answer was explicit to the table headings):

Locally agreed protocol on inclusion and exclusion	Models of Care criteria applies (Tiered interventions)	Open Access (Self Referral)
18%	21%	21%
23 (of the total amount of returns)	28 (of the total amount of returns)	27 (of the total amount of returns)

## Commentary

There have been significant improvements in access to and choice of mental health services for service users and carer's in recent years. People want more life choices; a choice of how to contact mental health services; choices when having an assessment, and a choice of care options. (Our Choices in Mental Health; CSIP 2006)

There are many examples cited above, of ways that providers are improving access to local services, and overcoming some of the obstacles and barriers often in the way of effective treatment. However only 18% of the returns have locally agreed protocols on inclusion and exclusion. Developing such protocols and involving all key stakeholders in the process would be a positive way forward.

## Question 9 Is there a system in place to measure how many people used the services in the past six months?

Of those reporting 'yes – a system is in place', the systems listed may differ greatly. A number of organisations used the National Drug Treatment Monitoring System (NDTMS), others utilised systems that had been developed locally.

A number of returning organisations also acknowledged the use of separate information harvesting using more than one database and having to 'cross reference' entered data.

## Results

AREA	YES%	NO%
North East Yorkshire and Humber	80% (12)	20%
North West	60% (12)	40%
North East	60% (6)	40%
East Midlands	67% (4)	33%
West Midlands	50% (7)	50%
East of England	60% (6)	40%
South Central	70% (7)	30%
South East	60% (3)	40%
South West	50% (7)	50%
London	74% (20)	26%

National Data	YES%	NO%
	61%	39%

## Has there been any local needs assessment? Is this information available?

### Results

AREA	YES%	NO%	Under Development	No Data
North East Yorkshire and Humber	74%	13%	13%	0
North West	43%	33%	19%	5%
North East	70%	20%	10%	0
East Midlands	83%	17%	0	0
West Midlands	71%	21%	0	8%
East of England	50%	30%	0	20%
South Central	50%	30%	10%	10%
South East	60%	0	0	40%
South West	57%	21%	7%	15%
London	74%	15%	11%	0

National Data	YES%	NO%	Under Development	No Data
	63%	21%	8%	8%

Of those answering YES (*A local needs assessment has been made*), the following table indicates strategic health authority areas where documentation to support the assessment was entered as being readily available.

AREA	Data Collected	Data Available
North East Yorkshire and Humber	74% (11)	82%
North West	43% (9)	33%
North East	70% (7)	0
East Midlands	83% (5)	0
West Midlands	71% (10)	100%
East of England	50% (5)	40%
South Central	50% (5)	60%
South East	60% (3)	67%
South West	57% (8)	50%
London	74% (20)	22%

## Commentary

From April 2007 the treatment outcomes profile (TOPS) developed by the NTA and used across all drug treatment agencies will collect some limited data on physical and psychological health status at the point of assessment to treatment.

Developed by the NTA in partnership with Dr John Marsden and Dr Michael Farrell, leading researchers in outcomes monitoring in substance misuse, the TOP is a series of twenty simple questions asked by the keyworker and answered by the client, to measure outcomes in a meaningful way that is sensitive to change over time. (*rugbyhouse.org.uk*)

During the development and validation process, the NTA worked very closely with drug treatment service users and providers, testing the questionnaire with nearly 1,000 service users in a wide range of structured drug treatment services. Results and feedback were then used to amend the TOP, ensuring that the tool is quick and simple to complete, while at the same time providing accurate and sufficiently detailed data.

(*rugbyhouse.org.uk*)

### Question 10 Are there any age restrictions on dual diagnosis services?

The evidence suggests that many young people begin to experiment with drugs and alcohol at an early age due to peer pressure, curiosity and many other reasons. There is also a growing population of older adults who are using or are dependant on substances, in particular alcohol. (Rassool, 2006)

Young Minds reiterate that 'the division between drug and alcohol services and mental health services creates widespread problems throughout the mental health system. As the majority of young people with serious drug and alcohol misuse has significant mental health problems, it is essential that there is the capacity for close liaison and joint work between the specialist CAMHS and the young people's substance abuse service.' (Young Minds)

### Results

AREA	YES%	NO%
North East Yorkshire and Humber	60% (9)	40%
North West	25% (5)	75%
North East	40% (4)	60%
East Midlands	33% (2)	67%
West Midlands	50% (7)	50%
East of England	0	100%
South Central	20% (2)	80%
South East	40% (2)	60%
South West	7% (1)	93%
London	33% (9)	66%

National Data	YES%	NO%
	31%	69%

## Question 11 Are there any specialist dual diagnosis provisions for older people with mental health, including provisions for alcohol-related cognitive impairment?

### Results

AREA	YES%	NO%
North East Yorkshire and Humber	13% (2)	87%
North West	25% (5)	75%
North East	20% (2)	80%
East Midlands	0	100%
West Midlands	14% (2)	86%
East of England	10% (1)	90%
South Central	60% (6)	40%
South East	40% (2)	60%
South West	0	100%
London	52% (14)	48%

National Data	YES%	NO%
	26%	74%

### Commentary

The data reports that in the majority of areas across the country there are no age restrictions in place with regard to dual diagnosis services. The data shows a clear lack of specialist dual diagnosis provision for older people with 75% of areas reporting this and only 25% of areas reporting specialist dual diagnosis provision for older adults in place.

With regard to alcohol related cognitive impairment, people with this presentation tend to be passed around services with little or no clear ownership and responsibility for their needs. However more specific diagnosis of Wernicke's and Korsakoff's syndrome often leads to placement with old age psychiatry services. (McCabe, 2006)

## Question 12 What financial impact on mental health services are people with dual diagnosis having?

(Scale from 1 to 4)

- 1 = very severe
- 2 = quite severe
- 3 = some impact
- 4 = little impact

People with mental health and substance misuse problems are a vulnerable group with complex needs, often with a combination of physical, psychological and social needs. In addition they may have problems with regard to accessing housing, welfare, and increased involvement with the criminal justice system. They are more likely to

have a poor prognosis with high levels of service use, including accident and emergency services through to in-patient admissions. (McCrone et al, 2000)

This high level of service use and demand for resource will impact on providers across a number of domains.

## Results

AREA	Very Severe	Quite Severe	Some Impact	Little Impact
North East Yorkshire and Humber	13%	40%	47%	0
North West	45%	40%	15%	0
North East	20%	30%	50%	0
East Midlands	50%	50%	0	0
West Midlands	43%	36%	2%	0
East of England	0	30%	70%	0
South Central	0	60%	30%	10%
South East	0	60%	40%	0
South West	7%	57%	29%	7%
London	23%	55%	21%	1%

National Data	Very Severe	Quite Severe	Some Impact	Little Impact
	22%	43%	33%	2%

## Commentary

The data does not allow for any specific commentary concerning financial modelling in this area; 65% of the LIT returns report that the financial impact of dual diagnosis on mental health services is significant. Due to the complex nature of this condition, and sometimes complicated funding arrangements, the demand on a variety of services and clinicians is perceived as substantial.

### Question 13 What resources are available for assisted withdrawal/detoxification within mental health services?

Detoxification is the withdrawal of a substance from the body. In the majority of cases this is carried out in a variety of settings, using a number of different pharmaceutical preparations – dependant on the original drug source, which is being withdrawn. This process can be potentially harmful and should be carried out under appropriate supervision. These can include in the community, in an acute medical

ward, or in an appropriate mental health service (statutory, voluntary or private sector provider)

Ideal settings to provide inpatient drug detoxification and stabilisation are specialised dedicated inpatient or residential substance misuse units or wards. Inpatient provision in the context of general psychiatric wards may only be suitable for some patients with co-morbid severe and enduring mental illness, but many such patients will benefit from a dedicated addiction specialist inpatient unit'. (Models of Care for Treatment of Adult Drug Misusers: Update 2006, National Treatment Agency)

The following points were commonly cited throughout many of the returns to this question:

- dedicated beds within mental health acute care for detoxification
- community detoxification programmes
- spot purchase beds out of county
- economic evaluation of costs incurred
- community mental health teams, assertive outreach , crisis intervention/ home treatment teams managed programmes
- alcohol detoxification is in place within primary care
- non exclusive beds available at times (access to general MH beds)
- no appropriate treatment pathways are currently in place
- tier 4 detoxification services, and
- dual diagnosis practitioners in place within acute ward environments.

## Commentary

There are a variety of approaches and services provided for detoxification within mental health services across the country as listed above. This is the first step towards treatment and recovery from substance misuse and allows the individual an opportunity to reflect upon some of the negative symptoms associated with their substance misuse and gives them an opportunity to move onto a more active treatment process within the cycle of change. (Reference[DN??]) In recent years there has been a shift from traditional in-patient detoxification towards a variety of community-based alternatives, offering a wider range of choice for service users.

Many areas across the country that do not have any specialist workers or dedicated detoxification facilities will have to purchase this care out of area. This may cause difficulties for service users and carers and needs to be given careful consideration.

NIHCE Guidance – Opiate detoxification  
[guidance.nice.org.uk/CG52/?c=91523](http://guidance.nice.org.uk/CG52/?c=91523)

### Question 14 Is evidence being collated to show that dual diagnosis users are satisfied with service provision?

*“Choice listens to me, involves me, responds to me, values me, and supports me on my road to recovery. If we are serious about putting service users at the heart of modern mental health services, providing choice is essential.”*

#### Our Choices in Mental Health: 2006

Service User involvement should be at the centre of all service provision, and it is imperative that feedback is given at every step along the client journey. Otherwise providers and commissioners will not know if they are providing appropriate services to meet the complex needs of this client group.

## Results

AREA	YES%	NO%
North East Yorkshire and Humber	60% (9)	40%
North West	25% (5)	75%
North East	70% (7)	30%
East Midlands	50% (3)	50%
West Midlands	21% (3)	79%
East of England	20% (2)	80%
South Central	20% (2)	80%
South East	20% (1)	80%
South West	36% (5)	64%
London	67% (18)	33%

National Data	YES%	NO%
	424%	58%

We can now look at correlating this data with the information gathered from part 2 of question 9, which asked: "Has there been any local needs assessment?" The percentage of YES answers from that question have been tabled below alongside positive responses from question 14.

AREA	YES – A needs assessment has taken place	Evidence on user satisfaction is being collated
North East Yorkshire and Humber	74%	60%
North West	43%	25%
North East	70%	70%
East Midlands	83%	50%
West Midlands	71%	21%
East of England	50%	20%
South Central	50%	20%
South East	60%	20%
South West	57%	36%
London	74%	67%

## Commentary

The NTAs service user survey in 2005 found that 'More satisfaction was expressed by clients who had shorter waiting times for treatment and had up-to-date care plans' (NTA 2005). An increased effort on finding out how service users can be more satisfied with services will lead to a focus for service improvements.

The making a real difference website has a range of tools and guidance for engaging meaningfully with service users.

For additional information, please visit:  
[www.nimhe.csip.org.uk/~mard](http://www.nimhe.csip.org.uk/~mard)

**Question 15** Do risk assessment tools in the care plan pick up the additional risks of substance misuse? Are their appropriate steps to address the risks in this context?

Substance misuse is usual rather than the exception among those with mental health problems. Within the assessment process there are three important component which should be considered:

- detection and screening
- specialised assessment, and
- risk assessment.

Risk assessment tools and protocols should address factors relevant to individuals with dual diagnosis. This should include information on the severity and combination of substances – which is often related to increased overdose and/or suicide risk. Exploration of any possible links between substance use and increased risk of anti-social or violent behaviour should be an integral part of the risk assessment and be documented in detail. (DH 2002)

## Results

AREA	YES%	In Development	Unsure/ Unanswered	NO%
North East Yorkshire and Humber	100% (15)	0	0	0
North West	90% (18)	5%	5%	0
North East	90% (9)	0	10%	0
East Midlands	100% (6)	0	0	0
West Midlands	86% (12)	0	14%	0
East of England	100% (10)	0	0	0
South Central	100% (10)	0	0	0
South East	100% (5)	0	0	0
South West	100% (14)	0	0	0
London	85% (23)	15%	0	0

National Data	YES%	In Development	Unsure/ Unanswered	NO%
	93%	5%	2%	0%

## Commentary

There are a range of robust risk assessment procedures and tools in operation, with only a few exceptions. This highlights the priority given and the understanding and awareness of the increased risks associated with this client group. Some of these risks include:

- increased likelihood of self-harm
- increased risk of violence
- homelessness
- poor compliance with medication and treatment programmes, and
- increased risk of physical problems, particularly blood borne viruses.

(Rassool, 2006)

In order to minimise and manage risk, service providers need to use a variety of tools to ensure that this vital part of the overall care plan, is given the attention and priority needed.

## Health Promotion

**Question 16** Locally, how is information on the impact of drug and alcohol use for those with mental health problems promoted? What types of outlets are used to disseminate information on dual diagnosis? What types of information are provided?

*“Information is available in community settings in hard copy and through information kiosks. Healthy living initiatives include the detrimental effects of alcohol and drugs on general health and social wellbeing”*

**Oldham**

We have categorised the returns into the following headings:

## Current campaigns

- 1) FRANK ([www.talktofrank.com/home\\_html.aspx](http://www.talktofrank.com/home_html.aspx))
- 2) Cannabis Toolkit
- 3) World Mental Health Day
- 4) World Aids Day, and
- 5) NICE Guidance: Available from ([www.nice.org.uk/page.aspx?o=418956](http://www.nice.org.uk/page.aspx?o=418956)).

## Resources

- 1) local leaflet campaigns
- 2) national leaflets
- 3) 24 hour help-lines
- 4) local Service Directories
- 5) Drug alcohol team website ([www.drugs.gov.uk/dat/directory](http://www.drugs.gov.uk/dat/directory))
- 6) local websites/ intranets
- 7) local libraries
- 8) information kiosks
- 9) healthy living kits
- 10) multi language leaflets, and
- 11) video and audio resources.

## Activities

- 1) dual diagnosis leads in reach within in patient unit environments
- 2) health and wellbeing nurses within in patient wards
- 3) alcohol anonymous meetings held on acute wards
- 4) harm minimisation programmes
- 5) graduate workers within primary care settings
- 6) formal staff training available, and
- 7) county-wide dual diagnosis training available via the DAAT for all providers from Tiers 1 upwards, inclusive of primary care, housing and criminal justice, and
- 8) pan London five day dual diagnosis training course.

## Settings

- 1) resources available through local nightclub initiatives
- 2) schools (Via Early Intervention services)
- 3) youth groups
- 4) community pharmacy outlets
- 5) GP practices
- 6) district council offices
- 7) community centres
- 8) prison settings, and
- 9) accident and emergency.

## Commentary

There are a number of national and local campaigns and programmes, which help promote the impact of drug and alcohol issues and mental health awareness to inform local communities and signpost people who require help and support.

It is essential that substance misuse and mental health promotion is a key consideration at each stage of the care pathway. Minimising the harm caused by substances, (harm reduction) both drugs and alcohol, is an approach, which has been developed successfully with in substance misuse services. Promoting mental health awareness is vital so as to raise awareness of mental health issues and promote health across health communities.

For additional information and links to the dual diagnosis CD Rom Resource Library – proper reference please], please access the link below: [www.eastmidlands.csip.org.uk/dd/dd.zip](http://www.eastmidlands.csip.org.uk/dd/dd.zip)

## Question 17 How do mental health services make sure that staff ask questions on substance use that are consistent with ‘good practice guidance’ as set out in the ‘MH policy implementation guide, dual diagnosis good practice guide’?

Engagement is concerned with the development and maintenance of a therapeutic alliance between staff and client. The strength of this alliance will depend, in part, on the value a client attributes to the service. This can be enhanced by the style of interaction, which should be non-confrontational, empathic and respectful of the client’s subjective experiences of substance misuse. The therapeutic alliance will also benefit from meeting a client’s immediate needs rather than focusing on the cessation of substance misuse. Typically, individuals who misuse substances may have deficits in basic living requirements such as food, housing, shelter, clothing and physical health. (DH 2002)

The following points were commonly cited throughout many of the returns to this question.

Assessment tools, including:

- risk assessment
- outcome measurements
- common assessments
- substance specific assessments
- initial screening
- care programme approach
  - dual diagnosis forums
  - link staff are in place within community mental health teams
  - audit of care plans
  - established protocols
  - QOF indicators
  - supervision & personal development plans (comprehensive training).

The tools listed above do not equate to the fact that the staff are using them in a skilful way. Important attention needs to be given on staff skills in utilising these tools in a sensitive and appropriate manner.

**Question 18a How do practitioners know about the availability of services for people with dual diagnosis?**

We know there are areas of good practice around the country where local/regional forums are established and running well on a regular basis. *(For further information, please contact your regional lead. Details can be found on page 71)* These groups provide an opportunity for service users, carers, providers and commissioners to meet on a regular basis to receive up to date information, network, share good practice and develop local services in line with national guidance.

The following points were commonly cited throughout many of the returns to this question.

- clinical supervision and case discussion
- local directories of services developed by commissioners
- local support groups and forums

- carers support groups and phone lines
- a quarterly bulletin for practitioners “The DAT produces regular quarterly bulletins for practitioners and has set up a website with service details to keep the existing directory of substance misuse services regularly updated”.
- The ‘choosing health training programme’
- joint working
- countywide training on information sharing “County wide training is available for multi agency/ disciplinary groups to help networking and information sharing across sectors”
- developed communications strategies
- local training packages
- dual diagnosis Practitioners that attend mental health ward rounds/ care programme approach reviews

The following table illustrates the prevalence of answers indicating what measures are being taken to ensure that practitioners are aware of the

Via website/service directory	Induction/training	Meetings/forums/networking events	Bulletins/ Newsletters/leaflets	Close links between services
39%	21%	35%	26%	33%
51	28	46	33	42

availability of services.

*“Individuals who attend the Choosing Health training program meet other providers and are informed of services, which include all areas of substance misuse and mental health”*

**London Region**

## Question 18b Who in the organisation is responsible for DD?

Dual Diagnosis is everyone's business. However, there are often issues around organisations taking ownership and acceptance of this. It is helpful to have a champion or lead in each area/locality/service that has appropriate knowledge and skills working in this complex area, and is committed to encourage full service involvement when appropriate.

"In addition, all mental health provider agencies should designate a lead clinician for dual diagnosis issues and all health and social care economies should designate a lead commissioner" (DH 2002)

There are some positive examples of good practice across the country in relation to joint funded senior practitioner posts in dual diagnosis.

Submitters quoted a range of senior management, practitioners and commissioners across organisations.

Other organisations have highlighted steering groups, strategy groups or joint commissioning/provider groups.

## Training and practice development

### Question 19a What training is in place and what is the nature of that training?

The following types of training were commonly cited throughout the responses as models by which training is regionally delivered. Due to the number and the variation of these responses we have compiled a snapshot of available training that details five responses from each of the regions.

#### North East Yorkshire and Humber

- 1) Risk assessment and CPA training
- 2) training includes basic drug awareness,

motivational interviewing and prescribing etc

- 3) Post basic training is available within the organisation; a rolling programme consisting of a ten-day course is delivered to a multi-professional audience
- 4) Short in house training sessions over the past 2 years have been provided to CMHT staff, substance misuse services, voluntary sector services, social services and inpatient staff
- 5) The training department within the addictions service provides a portfolio of long and short courses

#### North West

- 1) Contract exists with external provider to deliver DD training across all services
- 2) The dual diagnosis team provide awareness training (mental Health) and provide input into diploma and post graduate courses
- 3) In mental health specialist services there is a joint health and social care training group and plan. There has been training on brief interventions, problem solving etc. The mental health trust have commissioned 10 places for substance misuse training at our local university
- 4) Currently, there is a specific joint dual diagnosis training session available to staff of mental health and substance misuse service. Staff also attend joint conferences on issues relating to Dual Diagnosis. In-house substance misuse training is also provided to mental health services and voluntary sectors, by the substance misuse service
- 5) All staff have received a weeks comprehensive training programme on various topics such as motivational interviewing, harm reduction etc

#### North East

- 1) Extensive formal training is in place locally. 1 day dual diagnosis awareness training exists for all staff working with clients with dual needs in

mental health and substance misuse services; statutory or independent sector. Over 600 staff have been trained at awareness level

- 2) The DD training aimed to provide baseline theory and skills in the care and treatment of people experiencing drug and alcohol problems alongside severe and enduring mental health problems. The training provider was Sainsbury Centre for Mental Health
- 3) The training includes understanding dual diagnosis, POVA (protection of vulnerable adults), CBT (cognitive behavioural therapy) and risk management
- 4) Individual training on drugs awareness has been provided to a range of mental health staff by the DAT training function
- 5) There is a degree level module at Teesside University in dual diagnosis. This is jointly delivered to substance use and mental health staff

### **East Midlands**

- 1) The five day dual diagnosis training meets the level 2 standards as outlined in the dual diagnosis capabilities framework (Hughes 2006). Link workers receive 5 day training followed by ? day every two months for update and continued education
- 2) Capability framework being developed by CSIP which will integrate DANOS standards. Training for substance misuse use available on an 'as and when' basis but this is basis awareness only and does not include specific dual diagnosis training. Training is offered to all agencies both statutory and non-statutory. Training has been delivered to student nurses and junior doctors via Nottingham University
- 3) The specialist team have involvement with the development and delivery of a degree level module which is accredited to Nottingham University x2
- 4) Local universities offer diploma and certificate courses e.g. at the Universities of Leicester,

Northampton and Nottingham

### **West Midlands**

- 1) Training focuses on mental health issues for substance workers and substance misuse for mental health workers to enable them to work with clients in their own settings, without the need to refer to specialist provision. Training from the Royal College of Psychiatrists was commissioned and delivered to a group of mental health staff on Training the Trainers
- 2) Drug awareness Levels 1 and 2 together with other relevant training is available e.g. CPA; mental health; harm reduction; risk assessment and management. DAT commissioned dual diagnosis training for substance misuse team
- 3) There is a well established approach on joint training. This is based on co-location of training teams for social care and PCT's, plus a specialist function for substance misuse. Through this, there is provision for free multi-disciplinary drug and alcohol training in partnership for CSMS and MH staff
- 4) The dual diagnosis(Co-morbidity) service provides training in:  
Assessment and identification of need  
Motivational interviewing.  
Relapse prevention. Initial discussions have taken place, involving DAAT and training provider representatives, regarding the development of more comprehensive arrangements, building on the above foundations
- 5) Via DAAT  
Protected learning time  
Health – Knowledge Skills Framework  
SSD – Continuing personal development  
Interagency social care & health training

### **East of England**

- 1) Service runs drug awareness central training programme, which is available to all MH staff and is well publicised. Dual diagnosis workers within

the CMHTs will act as a specialist resource

- 2) 1 day awareness and enhanced course accredited by the University of East Anglia. Both are run regularly by DAAT and are free of charge. Also a day's awareness training in dual diagnosis and young people
- 3) DAT general workers have a 3 day mental health training course
- 4) One day multi-agency introductory training & awareness raising workshops for mental health staff including voluntary sector by community drugs teams. Some staff have attended level dual diagnosis module at Suffolk college, Ipswich
- 5) Norfolk has provided two types of dual diagnosis training; a 1 day's awareness training course and an enhanced course accredited by the University of East Anglia. Both courses are now being offered free of charge by Norfolk DAAT and run regularly each year

### South East

- 1) The University of Greenwich continues to offer a post-graduate Diploma in Dual Diagnosis. The University of Kent provides one stand alone module for Dual Diagnosis within their BSc programme and the Canterbury Christchurch University is also developing a training programme
- 2) Some core training is already taking place but there are plans to increase the number of sessions and open up the access to a wider group of potential participants. Practitioners and health promotion staff from within local services deliver this training
- 3) Dual diagnosis included in training for all staff groups in NHS provider Trust
- 4) There is a gap in training across the divide
- 5) Training is offered and provided as required. The training plan is determined by the service objectives established through the annual business planning cycle. Specific DD training provided to teams by DD Masters trained staff

### South Central

- 1) Specialist provider can offer training. Local training available in some CMHTs. Annual training plans in place within statutory provider
- 2) The Oxford Cognitive Therapy Centre (OCTC) is a specialist agency within the Trust with a brief to deliver expert training, supervision, research and clinical care in cognitive behaviour therapy (CBT) and other both within and outside the Trust. The centre also does training sessions on: training skills for trainers, trauma, and personality disorders
- 3) The DAT run annual courses on substance misuse awareness and information on service provision, the mental health trust block purchase a number of modules on dual diagnosis from Southampton university, one person per year is funded to undertake the diploma in dual diagnosis course, the DAT have recently commissioned a number of courses on dual diagnosis to facilitate implementation of the dual diagnosis strategy
- 4) Dual diagnosis included in training for all staff groups in NHS provider Trust: in-house 8 session training programme for CMHT's on DD and DANOS, seminars on dual diagnosis included in training workshops
- 5) Motivational training, dual diagnosis training (Southampton University Module)

### South West

- 1) Development of an e-learning resource and interagency training and support between mental health services and substance misuse services has been developed and carried out in some parts of the Trust
- 2) Drug Awareness Training Levels NVQ1 & NVQ2. NVQ2 in development mandatory CPA training for mental health staff
- 3) All courses are open to mental health and drugs staff, and take-up is monitored. The Trusts policy is to employ service users and carers in delivering training

- 4) There is a LIT/ countywide training programme on dual diagnosis for all statutory and non statutory workforce in MH and D&A services
- 5) In house dual diagnosis workshop, motivational interviewing and acute inpatient training programme

## London

- 1) The Pan London dual diagnosis training offers 5 day training package for both mental health and substance misuse services. This is delivered by local experts in the field and followed by practice development forums and case conferences.
- 2) Additional training programmes commissioned for mental health staff to raise awareness and improve skills of professionals working with people with dual diagnosis. Plans in place to roll out and cascade knowledge initially through community teams
- 3) Introductory 2 day courses are provided for all drugs/alcohol workers through the DAT

- 4) Two day training courses for staff across all mental health team and statutory and non-statutory providers courses are provided to leaving care teams (for young people leaving residential, foster care etc). Training is provided to in-patient staff. It is offered to substance misuse services. Additional lunchtime training is available to anyone interested. Information training is carried out through joint working with specialist dual diagnosis staff
- 5) Training is available and includes specialist courses that are available at local Universities:
  - a) 10 day dual diagnosis module is available at the Institute of Psychiatry. This attracts 30 credits at level 6.
  - b) An addictions diploma/degree is run at Kings College.

## Question 19b Has an assessment been made of training needs?

### Results

AREA	YES%	NO%	Under Development /Review	Unanswered
North East Yorkshire and Humber	60% (9)	27%	0	13%
North West	55% (11)	10%	15%	20%
North East	60% (6)	0	0	40%
East Midlands	67% (4)	0	33%	0
West Midlands	29% (4)	7%	21%	43%
East of England	20% (2)	10%	0	70%
South Central	50% (5)	10%	0	40%
South East	40% (2)	0	0	60%
South West	14% (2)	36%	7%	43%
London	70% (19)	3%	15%	12%

National Data	YES%	NO%	Under Development /Review	Unanswered
	49%	11%	10%	30%

## Question 19c Are training needs monitored for the future?

### Results

AREA	YES%	NO%	Under Development /Review	Unanswered
North East Yorkshire and Humber	74% (11)	13%	13%	0
North West	62% (12)	6%	24%	8%
North East	90% (9)	0	10%	0
East Midlands	33% (2)	0	67%	0
West Midlands	36% (5)	0	28%	36%
East of England	30% (3)	10%	20%	40%
South Central	40% (4)	0	10%	50%
South East	20% (1)	20%	40%	20%
South West	43% (6)	7%	29%	21%
London	77% (21)	4%	4%	15%

National Data	YES%	NO%	Under Development /Review	Unanswered
	57%	5%	20%	18%

### Commentary

There is a pressing need for the mental health and substance misuse workforce to have appropriate training in dual diagnosis. The All Party Parliamentary Drugs Misuse Group report (2000) recommended: 'better training in substance misuse and dual diagnosis for doctors, nurses, social workers, probation officers and voluntary sector personnel, would assist in the early recognition of the condition and better accessibility to appropriate treatment provision'.

There are a variety of options regarding training modules for dual diagnosis across the country. Some areas have developed a systematic approach based on a planned strategy to dual diagnosis education and training, involving all key local partners.

There is significant regional variation in the monitoring of future training needs.

**Question 20 Does a training strategy exist to equip staff with the capabilities required to deliver care and treatment to people with dual diagnosis?**

As training is a key factor for the workforce, and an integral part of service provision, a training strategy should form part of the local Dual Diagnosis Strategy. The issue of training has been consistently highlighted within key documents such as The NSF – Five Years On, Avoidable Deaths, CN MHO nursing review and the DDGPG.

In 2006 the CSIP National Dual Diagnosis Programme commissioned and developed, in partnership with the Centre for Clinical and Academic Workforce Innovation (CCAWI), a capabilities framework for dual diagnosis training (Hughes, 2006). This document sets out a clear framework linking capabilities with levels of training in a way that can be used across the mental health and substance misuse workforce. [visit.lincoln.ac.uk/C6/C12/CCAWI/default.aspx](http://visit.lincoln.ac.uk/C6/C12/CCAWI/default.aspx)

**Results**

AREA	YES%	NO%	Under development
North East Yorkshire and Humber	40% (6)	60%	0
North West	50% (10)	35%	15%
North East	30% (3)	50%	20%
East Midlands	50% (3)	17%	33%
West Midlands	14% (2)	36%	50%
East of England	30% (3)	30%	40%
South Central	70% (7)	30%	0
South East	0	80%	20%
South West	28% (4)	22%	50%
London	67% (18)	7%	26%

National Data	YES%	NO%	Under development
	43%	31%	26%

## Structured Capability Questions

### Question 21a What specific skills/capabilities have been acquired within generic or specialist mental health services e.g. crisis teams etc. for dealing with dual diagnosis patients?

The following points were commonly cited throughout many of the returns to this question.

- the PAN-London 5 day training
- drugs awareness
- risk assessment
- motivational assessment (basic motivational interviewing)
- screening
- medication management
- specialist practitioners within teams: “We have two specialist dual diagnosis workers embedded

within the CMHTs assertive outreach team. There are also identified dual diagnosis link workers within mental health services who are being trained appropriately. The knowledge and skills framework is used to evidence-base these skills”.

- DANOS competencies
- specialist detoxification skills
- assessments
- family involvement
- relapse prevention
- care planning

The following table illustrates the prevalence of answers indicating what skills/ capabilities have been acquired. It should be noted that the majority of submitted responses listed that ‘training was in place’, but did not identify the nature of the said training.

Motivational interviewing skills	Acquired through joint working between services/ access to specialist workers/ training	Harm reduction/ risk assessment
23%	49%	11%
30	65	14

### Question 21b Do assertive outreach teams have evidence-based skills/capabilities for working with dual diagnosis?

One of the key recommendations from the NSF – Five Years On is the important role Assertive Outreach teams have working with dual diagnosis. In particular the need for Assertive Outreach teams to have workers with specialist training, knowledge and skills to engage and work with individuals who have mental health and substance misuse difficulties.

*“Training meets DANOS competencies through learning objectives and outcomes. Training is embedded and staff competencies in dual diagnosis are included within staff supervision and staff learning and development”*

#### Hertfordshire

The following points were commonly cited throughout many of the returns to this question:

- Assertive outreach sited as expected to deliver to dual diagnosis client groups
- some teams claiming to meet DANOS competencies
- to be addressed
- training strategy under development
- attitudes mentioned (values and attitudes exercises/work on attitudes and specific relapse prevention interventions), and
- integrated working.

#### Commentary

The nature of Assertive Outreach and Early Intervention team caseloads means that a significant proportion of clients will be experiencing issues with severe mental health problems and substance misuse. The Mental Health Policy Implementation Guide (DH 2001) recognised that AO teams would be working with people with multiple, complex needs such as dual diagnosis of substance misuse and serious mental illness.

#### **Question 21c Do psychiatric in-patient services have evidence-based skills/capabilities for working with dual diagnosis?**

Research suggests that between 22 and 44% of adult psychiatric inpatients also have problematic drug or alcohol use, up to half being drug dependent<sup>5</sup>. Urban patient populations have higher prevalence figures than those in rural services. In high secure hospitals, between 60 and 80% of patients have a history of substance

use prior to admission<sup>6</sup>. It has been suggested that fewer than 20% of psychiatric inpatients receive treatment for their substance use.

Due to the nature of this question and the free text answers that were supplied we have taken the approach of looking at a snapshot from three of the areas. Namely, the North West (as one of the larger contributors), the South East and the West Midlands. These are outlined below:

#### The North West

- yes, liaison worker in this team
- no, but training is planned
- while no specific dual diagnosis training is provided to staff of in-patient services, there is a shared access agreement to training provided by the substance misuse service, and in-patient staff attend this training regularly. The KSF is used to evidence-base the skills attained
- as in other parts of the Partnership Trust, staff in the inpatient service have developed skills and capabilities with working with dual diagnosis clients through either previous experiences working within these services or by undertaking Trust training programmes in this area
- there are some skills within in-patient services. Following the recent agreement of the dual diagnosis care pathway a review of skills and competencies is to follow
- within the adult and older peoples inpatient unit have identified lead nurses with specific skills in dual diagnosis. Teams are also supported by a member of staff on the low secure ward who has obtained a Masters in Drug and Alcohol and is using his skills to support staff in other areas
- yes, lead by nurse consultant
- they adhere to the inpatient substance misuse policy. The rolling dual diagnosis programme emphasises recruitment of inpatient and has been relatively successful. Inconsistencies exist and require constant attention to address, and
- there is some cross fertilisation of skills through a specialised Dual Diagnosis worker based in substance misuse services. Collaboration with

CMHTs in the management of dual diagnosis and support in case work has resulted in some enhanced capability in generic mental health teams. Accredited training focuses on the domains of:

- Recognition
- Assessment
- Motivational interviewing
- Psychological interventions.

## The South East

- not specifically, however guidance (quick guide to addiction, mental health and dual diagnosis) is now in place as well as access to specific training in 2007/08
- this is limited. This is a sector of the service where the prevalence of drug and alcohol issues is high, but the practice skills around SMS need to be developed. Role legitimacy and values are important elements of this that need specific work. There is always difficulty securing training time
- this remains part of staff training programme
- no, some staff have skills but lack training, and
- the senior nurse practitioner within the crisis resolution home treatment team/ acute services provides specialist expertise/ training/ capabilities in dual diagnosis. All staff have access to basic level skills & capabilities training.

## West Midlands

- some staff on the inpatient units have had training in assessment, engagement and running groups. This area will be developed further as part of the city wide training strategy
- training for in-patient staff has been provided and continues to be available for all staff. The inpatient wards are supported by a specialist dual diagnosis nurse
- training is available & utilised by inpatient staff and the dual diagnosis team are regularly available to support staff on the wards providing

informal guidance & training through feedback & joint assessments. For all the above staff groups individual training needs are also addressed in annual PDP's & KSK outlines with supported development as required

- inpatient services are knowledgeable about detoxification and have developed skills through direct practice. However, further skills in dealing with complexity of dual diagnosis needs presenting – e.g. social care elements – would be helpful
- a few in patient staff have been trained however the dual diagnosis nurse is now regularly offering sessions in the in patient area which should increase awareness and recognition of the issue, and
- inpatient staff do not generally have specific expertise in this are, however, their skills in general psychiatry are transferable.

## Commentary

Recent guidance (DH 2006) covers the assessment and clinical management of patients with mental illness being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs. It also covers organisational and management issues to help mental health services manage these patients effectively, as well as issues in assessment, care and treatment, discharge and follow up.

Further experiences can be found within the 'Acute Care Collaborative' document available from: [www.londondevelopmentcentre.org/silo/files/458.pdf](http://www.londondevelopmentcentre.org/silo/files/458.pdf)

"The acute care collaborative, established by the London Development Centre in partnership with the King's Fund and London's mental health inpatient provider trusts, ran from September 2004 to December 2005. The collaborative was set up in response to a range of concerns about acute inpatient services, and aimed to improve responses to substance use and safety by working with inpatient teams to support and encourage small, but effective, changes in local services".

# Appendix 2: Discussion points arising from themed review on Dual Diagnosis

## DH autumn assessment process

The main recommendation from LITs has been that this year's system should allow the end user to save partial returns to their data. This will be included when re-developing the online presence.

The proposed website will be made available to staff early November in order to allow the users a greater length of time to familiarise themselves with the online site, its functionality and the appropriate guidance.

Future dual diagnosis data collation could gather evidence that agreed definitions have led to shared commissioning.

## Strategic development

Defining the 'dual diagnosis' population and sub-groups are an essential pre-requisite to local strategy and care pathway development.

The issue of Dual Diagnosis provision can be included in Local Area Agreements and Service Level Agreements.

## Public health and primary care

Physical health issues associated with substance use should be incorporated into initiatives being developed to address the physical health care of people with Severe Mental Illness (e.g. blood borne viruses, alcohol related health problems).

The Quality Outcome Framework can be a lever to ensure that physical health checks explicitly address alcohol and drug related issues.

Engagement with the Regional Public Health agenda and Regional Government Offices can develop links between a number of policy drivers and health and wellbeing outcomes for populations.

## Vulnerable groups

For people who do not fulfil the criteria to access secondary care, there are opportunities to develop services in primary care and within the third sector community settings.

The needs of people with mild to moderate mental health problems and substance misuse problems will need careful attention through evidence based approaches; there are people who find it difficult to engage with substance misuse services or mental health provision, who have significant alcohol and/or drug problems and pose a risk to themselves or others as a consequence of their co-morbidity.

Assertive outreach frameworks, developing cooperative joint protocols, sharing risk information and management strategies are helpful methods of engaging with people who are less likely to present to services.

Further attention/research is required to populations within rural settings, homeless populations, people within the criminal justice system, Black and Minority Ethnic groups, pregnant women who misuse substances, children and adolescents, and older populations, to clarify and address specific needs.

## Training, capabilities and education

Given the high prevalence of psychiatric diagnosis in people accessing Substance Misuse services and a large proportion of 'drug/ alcohol' workers without formal professional qualifications, services need to ensure that training/ learning opportunities are in place to equip staff to work with people with Mental Health problems.

The DANOS and dual diagnosis capability framework provide the key areas for workforce education and development.

## Secondary care

The NTA recommends referral to specialist substance misuse services for people with dependent alcohol problems, but given the high prevalence of people being admitted to acute psychiatric inpatient facilities who are also dependent drinkers, staff in inpatient services need to be skilled in the assessment and management of alcohol (and other substances). Medics need to be able to prescribe appropriate pharmacological interventions for this client group, in line with guidance.

Given the high prevalence of substance use by young people, all staff in Early Intervention services should be trained to level 2 of the dual diagnosis capability framework. All other community teams will need to consider the level of capability they have around dual diagnosis.

The NHS litigation authority is piloting risk management standards in a number of mental health trusts in England, due to report in 2008. The draft standards include a requirement that organisations have approved documentation which describes the process for managing risks associated with the management of service users who present with dual diagnoses of mental health problems and substance misuse

As a minimum the approved documentation must include a description of the:

- duties
- arrangements for addressing the needs of this client group
- details of joint working arrangements with other departments and agencies
- process to be followed where a difference of opinion between professionals is apparent
- organisations expectations in relation to staff training as identified in the training needs analysis, and
- process for monitoring the effectiveness of all of the above.

NHSLA pilot risk management standards for mental health and learning disability trusts May 2007.  
[www.nhsla.com/RiskManagement/CnstStandards/](http://www.nhsla.com/RiskManagement/CnstStandards/)

## Commissioning

Commissioners of Early Intervention (EI) services and young people's Substance Misuse services should work in partnership to ensure that the needs of young people with co-morbidity are being adequately addressed.

All EI services should have access to expertise for the provision of consultation/supervision of dual diagnosis cases.

Acute inpatient services should have robust protocols in line with NIHCE guidance for assisted withdrawal/detoxification.

Crisis Resolution/Home Treatment Teams may be well-placed to carry out community alcohol detoxifications. Providers are encouraged to work in partnership with DD/SM services to develop appropriate protocols/services, through joint commissioning.

It may be prudent that any further Dual Diagnosis Data collation includes evidence that such agreed definitions have resulted in shared commissioning.

## Training

Training related to dual diagnosis can be mapped against the dual diagnosis capability framework.

Practice development and supervision opportunities should be made available for everyone undertaking training to level 2 of the capability framework and above.

## Leadership

Each mental health trust should identify someone at board level who has responsibility for dual diagnosis.

Each mental health trust should identify a lead clinician for dual diagnosis.

*“Providing appropriate, person-centred, holistic services for people with mental health and substance misuse, and their relatives and carers is everyone’s business.”*

**Scarborough**

# Appendix 3: Original Questions (In full)

## Question

### Strategic Planning

- Question 1** Is there a local definition of Dual Diagnosis, which clarifies the treatment population for services?  
What is the definition? Is it in place or being implemented?
- 
- Question 2** Is any local definition agreed between agencies and DAT/MH commissioners?
- 
- Question 3** Is there an agreed local strategy and which key stakeholders has this been agreed with?
- 
- Question 4** What indicators are used to see if DD interventions and service provision are well integrated across LIT and the Drug and Alcohol Action Teams to meet patient's needs as per the 'Dual Diagnosis good practice guidance 2002'?
- 
- Question 5** And if not well integrated, what measures are being taken to integrate DD into the mainstream MH services, (including Primary Care MH services and GPs) to deliver effective patient assessment and care for people who require both MH and substance use interventions?
- 
- Question 6** To what extent are the physical health problems like HIV, CHD or diabetes etc associated with substance use addressed within local MH service provisions?
- 
- Question 7** What service provision are there for less severe MH problems i.e. individuals accessing community DAT with moderate MH needs?

### Service Delivery

- Question 8** What are the criteria for accessing MH services and substance use services?
- 
- Question 9** Is there a system in place to measure how many used the services in the past six months?  
Has there been any local needs assessment? Is this information available?
- 
- Question 10** Are there any age restrictions on DD services?
- 
- Question 11** Are there any specialist DD provisions for Older People with Mental Health, including provisions for alcohol-related cognitive impairment?
- 
- Question 12** What financial impact on Mental Health Services are people with DD having? (scale from 1 to 4 with 1 = Very severe; 2 = Quite severe; 3 = Some impact; 4 = Little impact)

- Question 13** What resources are available for assisted withdrawal/detoxification within mental health services?
- 
- Question 14** Is evidence being collated to show that DD users are satisfied with service provision?
- 
- Question 15** Does risk assessment tools in the care plan pick up the additional risks of substance misuse? Are appropriate steps to address the risks in this context?

## Health Promotion

- Question 16** Locally, how is information on the impact of drug and alcohol use for those with mental health problems promoted?
- What types of outlets are used to disseminate information on DD?
- What types of information are provided?
- 
- Question 17** How do MH services make sure that staff ask questions on substance use that are consistent with 'good practice guidance' as set out in the 'MH Policy Implementation Guide, Dual Diagnosis Good Practice Guide'?
- 
- Question 18** How do practitioners know about the availability of services for people with DD? Do they know about the carers support groups/forums for this client group?

## Training and Practice Development

- Question 19** What training is in place and what is the nature of that training? Are training needs monitored for the future?
- 
- Question 20** Who in the organisation is responsible for DD? Has an assessment been made of training needs?
- 
- Question 21** Does a Training Strategy exist which seeks to equip staff with the capabilities required to deliver care and treatment to people with DD?
- 
- Question 22** Structured capability questions:
- a) What specific skills/capabilities have been acquired within generic or specialist MH services e.g. crisis teams etc. for dealing with DD patients?
  - b) Do AO teams have evidence-based skills/capabilities for working with DD?
  - c) Do psychiatric in-patient services have evidence-based skills/capabilities for working with DD?

# Appendix 4: Models of care for treatment of adult drug misusers

Models of care for treatment of adult drug misusers sets out national frameworks for the commissioning of adult substance misuse treatment in England. Originally published in 2002, models of care outlined a four-tiered model for service delivery, with increasing levels of intervention.

This guidance was updated in 2006 and Models of Care: Update 2006 builds upon, clarifies and refines the four-tier model of service provision outlined in the original 2002 framework, providing national guidance on commissioning and provision of treatment.

The guidance places a greater focus on harm reduction, with interventions integrated into all tiers of drug treatment. Particular emphasis is placed on minimising the spread of blood-borne viruses, reducing the risks of overdose and minimising the harm to local communities, and users' partners and families:

- Models of Care: Update 2006 replaces Models of Care: Part 1 (NTA, 2002) , and
- Models of Care: Part 2 Full Reference Report (NTA, 2002) summarises much of the evidence base and is still relevant as a valuable reference source.

# Appendix 5: Returning organisation's listing

## East Midlands

Lincolnshire  
Derbyshire  
Leicester City, Leicestershire  
and Rutland  
North Nottinghamshire  
Northamptonshire  
Nottingham South

---

## East of England

Bedfordshire  
Cambridgeshire  
Gt. Yarmouth  
Waveney  
Hertfordshire  
Luton  
Norfolk  
North Essex  
Peterborough  
Suffolk

## London

Barnet  
Barking and Dagenham  
Bexley  
Brent  
Bromley  
Camden  
City and Hackney  
Croydon  
Ealing  
Enfield  
Greenwich  
Hammersmith and Fulham  
Haringey  
Harrow  
Hounslow  
Islington  
Kensington and Chelsea  
Kingston Upon Thames  
Lambeth  
Lewisham  
Newham  
Redbridge  
Richmond and Twickenham  
Southwark  
Waltham Forest  
Wandsworth  
Westminster

## North East Yorkshire and Humber

Bolton  
Calderdale  
Craven  
Doncaster  
East Yorkshire  
Hambleton and Richmondshire  
Harrogate  
Leeds  
North East Lincolnshire  
North Lincolnshire  
Rotherham  
Scarborough  
Sheffield  
Wakefield  
York

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## North East

County Durham  
Darlington  
Gateshead  
Hartlepool  
Middlesbrough  
Newcastle  
North Tyneside  
South Tyneside  
Sunderland  
Redcar and Cleveland

## **North West**

Blackburn with Darwen  
Blackpool  
Bury  
Central Cheshire  
Cumbria  
East Cheshire  
East Lancashire  
Fylde and Wyre  
Knowsley  
Manchester  
Oldham  
Rochdale  
Salford  
Sefton  
St. Helens  
Stockport  
Tameside and Glossop  
Western Cheshire  
Wigan  
Wirral

## **South Central**

Berkshire West  
Buckinghamshire  
East Berkshire  
East Hampshire  
Eastleigh, Test Valley, New Forest  
Hampshire  
Milton Keynes  
Oxfordshire  
Portsmouth  
Southampton

---

## **South East**

East Kent  
East Sussex  
North East Hants and Surrey heath  
West Kent and Medway  
West Sussex

## **South West**

Avon and Wiltshire  
Bournemouth  
Bristol  
Cornwall and the Isles of Scilly  
Devon and Torbay  
Dorset  
Gloucestershire  
North Somerset  
Plymouth  
Poole  
Somerset  
South Gloucestershire  
Swindon  
Wiltshire

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## **West Midlands**

Birmingham East and North  
Coventry  
Dudley  
Heart of Birmingham  
Sandwell  
Shropshire  
Solihull  
South Birmingham  
Staffordshire  
Telford and Wrekin  
Walsall  
Warwickshire  
Wolverhampton  
Worcestershire

# Glossary

<b>AO</b>	Assertive outreach teams, which target adults, aged 18 to 65 years with severe and enduring mental health problems and additional complex needs such as homelessness, self-harm or neglect, or high levels of disability.	<b>NSF</b>	National Service Frameworks (NSF's) establish a set of minimum national standards for clinical quality and access to services for the major care and disease groups. Their aim is to improve performance and reduce local variations in care standards. Each NSF is developed with the assistance of an expert reference group, which brings together health professionals, service users, and carers, health service managers, partner agencies and others.
<b>CDAT</b>	Community Drug and Alcohol Team	<b>NTA</b>	National Treatment Agency
<b>CMHT</b>	Community Mental Health Team	<b>PIG</b>	Policy Implementation Guide
<b>CPN</b>	A nurse trained to work with people living in the community who experience mental health problems.	<b>QOF</b>	Quality Outcomes Framework
<b>DD</b>	Dual Diagnosis	<b>SHA</b>	In 2002 England's 95 health authorities were replaced by 28 larger health authorities, each covering an average population of 1.5 million. Many of their former responsibilities were passed on to primary care trusts and they now have a more strategic function. Strategic health authorities manage the NHS locally and are a key link between the Department of Health and the NHS. They also ensure that national priorities are integrated into plans for the local health service. They are responsible for: developing strategies; ensuring high-quality performance; and, building capacity in the local health service.
<b>DAT</b>	Drug action teams are multi-agency partnerships bringing together senior representatives from all of the local agencies involved in anti-drugs activity in an area, including the NHS, local authority, police, probation, social services, education and youth services and the voluntary sector. They are responsible for the delivery of the National Drug Strategy at local level.	<b>SMI</b>	Severe Mental Illness.
<b>DAAT</b>	Drug and Alcohol Action Team		
<b>DANOS</b>	Drugs and Alcohol National Occupational Standards		
<b>LIT</b>	Local Implementation Team		
<b>NDTMS</b>	National Drug Treatment Monitoring System		

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