DUAL DIAGNOSIS POLICY
(MENTAL HEALTH AND SUBSTANCE MISUSE)

This policy is only relevant to staff who work in mental health services

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**Amendments**
New Trust Policy (previously procedures followed within the Somerset DAAT joint working protocol)

**Document objectives:** To inform and guide staff in effective working practice with service users who have a Dual Diagnosis

**Intended recipients:** All Trust Employees who work in mental health services

**Committee/Group Consulted:** Team Managers CMHTs and Inpatient Wards, Clinical Policy Review Group, Clinical Governance Group

**Monitoring arrangements and indicators:** CSCE Annual Audit

**Training/resource implications:** please refer to section 14

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**Date of issue** November 2012

**Review date** October 2015

**Contact for review**
- Consultant Clinical Psychologist – Dual Diagnosis
- Service Manager Adult Community Services (East)

**Lead Director**
Director of Mental Health and Social Care

**CONTRIBUTION LIST** Key individuals involved in developing the document

<table>
<thead>
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<tr>
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<td>Consultant Clinical Psychologist – Dual Diagnosis</td>
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<tr>
<td>Paul Milverton</td>
<td>Service Manager Adult Community Services (East)</td>
</tr>
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<td>Team Managers</td>
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<tr>
<td>Jean Glanville</td>
<td>Claims and Litigation Manager</td>
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1. **INTRODUCTION**

1.1 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.**

*Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide: Department of Health*


1.2 The Trust’s Clinical Assessment and Management of Risk of Harm to Self and Others Policy, Safeguarding Children – Child Protection Policy and Safeguarding Vulnerable Adults Policy should be read in conjunction with this policy and the procedures applied and actions taken and recorded appropriately. These and other Trust policies are accessible in the policy section of the Trust Intranet.

2. **PURPOSE AND SCOPE**

2.1 Dual Diagnosis refers to people who require treatment and/or support for co-existing severe and enduring mental disorders, personality disorders, learning disabilities or who are experiencing an acute psychiatric episode who also misuse drugs or alcohol or who have drug or alcohol dependency. **This policy is focused on people with severe mental health problems and problematic substance misuse.**

2.2 **This policy refers to any individual who requires treatment and/or support for co-existing mental health and substance misuse problems who:**

- Is aged 18 years and over.
- Is normally resident in Somerset (either permanently or temporarily).
- Is registered with a Somerset GP.
- Requires specialist mental health services provided by Somerset Partnership NHS Foundation Trust under Care Coordinator or Lead Professional arrangements.
- Requires specialist drug and alcohol services provided by Turning Point
- Requires the joint care. (Not all service users with severe and enduring mental disorders will be receiving specialist mental health services. For example some will be self-managing and others may be supported by their GP).

2.3 **Up to their 18th birthday people are seen by Specialist Substance Misuse Workers within the CAMHS teams** (contact details are included in Appendix G).

2.3.1 The work of CAMHS is guided by the following policies and joint working protocols:

- **CAMHS Operating Procedures**
• Interagency Joint Working and Transitions Protocol For Young People With Substance Misuse Problems

2.4 If a young person is felt to warrant services beyond their 18th birthday

• A Care Coordinator from the Adult Service will be identified before the young person reaches 17½ years.
• A joint care planning meeting would be held around the young person’s 17th birthday and a Care Plan put in place to manage the subsequent 12 months, including what needs to be done to identify resources that may be appropriate post 18. (It is the responsibility of team managers from CAMHS and Adult services to organise this)
• A date would be set at which it would be proposed to transfer care coordination from CAMHS to Adult Services.
• During this period of transfer, it would be expected that a young person would benefit from services provided by both CAMHS and Adult Services in order to assist the transition from one Service to another.
• It is recognised that there is a degree of flexibility around the age and developmental needs of the young person.

3. DUTIES AND RESPONSIBILITIES

3.1 Working with people with Dual Diagnosis is the responsibility of all care providers who come into contact with them. Employees of Somerset Partnership NHS Foundation Trust should be able to recognise and respond to the needs of these service users, liaise with other individuals and agencies involved with their care and promote effective joint working.

3.2 The Director of Mental Health and Social Care Services is the Executive Lead responsible for this policy covering the care of patients with Dual Diagnosis.

3.3 The Clinical and Social Care Effectiveness Group will be responsible for monitoring compliance with this policy and will provide assurance and escalate areas of concern/risk issues to the Clinical Governance Group.

3.4 Staff responsibilities are to engage service users, use a harm minimisation based approach to care, work on motivation and match interventions to the patients readiness to change.

3.5 The Somerset Partnership Care Coordinator (or Lead Professional) is responsible for:

• Ensuring there is regular contact with the service user .
• Advising other members of the care team of changes in circumstance of the service user which might require a review or change of Recovery Care Plan.
• Recording - including updating the Recovery Care Plan and risk management and relapse plans as necessary.

3.6 The Service Leads roles and responsibilities of the Somerset Partnership Care Coordinator and Lead Professional are described in section 15 of this document and are detailed in the Recovery Care Programme Approach Policy
3.7 There will be circumstances when a service user is admitted to a ward from the community, then the responsibility for the day-to-day Recovery Care Plan will lie jointly with the in-patient and community mental health teams.

3.8 During an inpatient stay, the named Somerset Partnership care coordinator will maintain an active interest including:

- Close liaison about reasons for admission.
- Early identification of and action on community issues that will need addressing before discharge.
- Providing input into multidisciplinary meetings.
- Attending discharge RCPA meetings.
- Ensuring seven day follow up post discharge.

3.9 For further detail please refer to the CMHT Operational Policy.

4. EXPLANATIONS OF TERMS USED

4.1 Dual Diagnosis refers to people who require treatment and/or support for co-existing severe and enduring mental disorders, personality disorders, learning disabilities or who are experiencing an acute psychiatric episode who also misuse drugs or alcohol or who have drug or alcohol dependency. This policy is focused on people with severe mental health problems and problematic substance misuse.

4.2 The definition of “substance” for the purposes of this policy will include alcohol, illicit drugs, misuse of prescribed drugs and over the counter preparations and substances such as volatile solvents and ‘legal highs’.

4.3 RiO is the electronic tool used within the Trust to record Electronic Patient Records.

4.4 All other terms used are explained throughout this document.

5. Referral

5.1 Service users, whether referred from Somerset Partnership or Turning Point, who remain in the care of Somerset Partnership will have reached the threshold criteria for Mental Health CPA such that: The coordinator will be the Care Coordinator from Somerset Partnership.

5.2 Somerset Partnership staff will refer the service user to Turning Point and record the date that this was done on the RiO substance misuse screen (Appendix D):

- Core assessments
- Mental Health
- Alcohol/Substance misuse (inc. Dual Diagnosis)

5.3 Where a service user declines referral to Turning Point this discussion should be documented within the RiO substance misuse screen (Appendix D):
6 ASSESSMENT, MANAGEMENT AND RECORDING

6.1 All service users accessing Trust mental health services should be screened for substance misuse needs, including assessment of associated risks, as part of their initial comprehensive assessment.

6.2 Information relating to substance use should be summarised and recorded within the RiO substance misuse screen (Appendix D):

- Core assessments
- Mental Health
- Alcohol/Substance misuse (inc. Dual Diagnosis)

6.3 Where the use of alcohol is reported this should be further assessed using the Alcohol Use Disorders Identification Test (‘AUDIT’ – See appendix E) to identify hazardous or harmful drinking. If physical dependence syndrome is suspected (daily dependent drinking) the Severity of Alcohol Dependence Questionnaire (SADQ – See appendix F) should be used to assess the degree of physical dependence.

6.4 Where significant substance use problems are identified the Care Coordinator should discuss with the service user referral to the specialist provider of drug and alcohol treatment services in Somerset (Turning Point). This discussion and the service user’s response should be documented within the RiO substance misuse screen (Appendix D):

- Core assessments
- Mental Health
- Alcohol/Substance misuse (inc. Dual Diagnosis)

6.5 For further information regarding the service provision and responsibilities of Turning Point see:

Somerset Joint Working Protocol For Co-existing severe, enduring mental disorders and substance misuse (dual diagnosis) (accessible on the Trust intranet.)

For the care pathway of referrals from Somerset Partnership to Turning Point see Appendix A

6.6 Substance use must be included when completing the Risk Screen and Risk Information on Rio (Appendix C).

6.6.1 Where problematic or substance use risks are identified (this may include binge episodes and/or impulsive behaviour whilst intoxicated, risk of unconsciousness or death and risks associated with the method of use (e.g. Intravenous) a specific entry is to be made on the service users Care Plan (Rio).

6.6.2 Where problematic or risk laden substance use is identified a specific entry is to be made in the Risk Information.
6.7 During ongoing contact with existing service users of the Somerset Partnership when substance use is identified the steps detailed above 5.2 and 5.3 should be followed as soon as the Care Coordinator or Lead Professional becomes aware of the substance use.

6.8 Somerset Partnership provides planned in-patient medical detoxification (assisted withdrawal from alcohol or drugs in a supportive and safe environment where there is medical supervision and 24-hour nursing support) to Turning Point. The care pathway is provided as Appendix A. For further information please refer to the:

Alcohol Detoxification Guidelines:

6.9 In instances where Somerset Partnership inpatient wards admit clients of Turning Point primarily for the treatment of mental health problems Somerset Partnership will have responsibility for managing any substitute prescribing.

7. RESPONDING TO DUAL DIAGNOSIS RELATED CRISIS SITUATIONS

7.1 In the event of a client being referred to a Crisis Team or Psychiatric Liaison in a crisis situation where the referrer indicates that the individual is or may be under the influence of drugs or alcohol, the service will see the individual to assess risk, ascertain whether a mental health assessment can take place and devise an appropriate risk management plan in accordance with the Clinical Assessment and Management of Risk of Harm to Self and Others Policy.

8. RESPONDING TO INCIDENTS RELATING TO DUAL DIAGNOSIS

8.1 In the event of an incident arising relating to a service user with dual diagnosis needs, the mental health needs of the service user and associated risk to self and others are priority. The service user will not be discharged or excluded from premises unless a formal review of care and risk assessment has taken place and it is agreed that this course of action is appropriate in meeting the service user’s needs. All incidents should be recording using the Trust DATIX web-based Untoward Events Reporting form (accessible on the home page of the Trust intranet).

8.2 Circumstances may arise where staff believe there is a high risk of potential harm to others. In this case the Police and/or Social Services (regarding children at risk) should be contacted immediately instead of following the care pathway.

Prevention and Management Of Violence And Aggression (PMVA) Policy
Safeguarding Children – Child Protection Policy
Safeguarding Vulnerable Adults Policy and Process
‘Management of Substance Use on Trust Premises’ and Department of Health Guidance
9. **LIAISON WITH TURNING POINT**

9.1 Where the service user gives consent (see Consent and Capacity to Consent to Treatment Policy), Somerset Partnership staff should refer the service user to Turning Point or arrange a joint meeting wherever substance use is considered to be causing harm to the individual or others.

9.2 Guidance on joint working with Turning Point is provided by the Somerset Joint Working Protocol for Co-existing severe, enduring mental disorders and substance misuse (dual diagnosis) accessible on the Trust Intranet.

9.3 The key tasks of the care coordinator, within Somerset Partnership, in respect of joint working arrangements are to:

- Ascertain the service user’s willingness to share information and meet with Turning Point. Service user consent is required to make a referral to, or hold a joint meeting with, Turning Point.
- Make initial contact with Turning Point. (See contacts Appendix G).
- Ensure the date, time, venue and all other relevant information pertaining to the substance misuse assessment to be carried out by Turning Point is clarified, communicated and agreed with the service user and recorded in the RiO (electronic Patient Record).
- Ensure that all relevant assessment information (including AUDIT (Appendix E) and SADQ (Appendix F) where completed) is provided to Turning Point with the referral so as to avoid unnecessary duplication of the assessment process.
- Clarify who the care coordinator is within Turning Point.
- Ensure that all contacts made with the Partnership by Turning Point workers are recorded in RiO (the electronic Patient Record).
- Convene the multi-agency assessment, review or other meetings as required.
- Ensure a copy of the substance misuse assessment made by Turning Point (or a summary of key issues from this) are received and recorded onto RiO.
- Ensure a copy of the substance misuse aspects of the care plan are considered in terms of their alignment with the mental health care plan.
- Ensure there is no unnecessary overlap or duplication in the provision of the different elements of the joint care plan.
- Ensure the Turning Point Care Coordinator receives a copy of the Joint Care Plan and relevant assessments of risk – this should occur at the point of referral to Turning Point and when any changes are made to the care plan.
- Communicate with the Turning Point Care Coordinator to ensure that a regular update is received on the service users’ progress with the substance misuse elements of care plan.
- Communicate with the Turning Point Care Coordinator on an appropriate basis about all issues relevant to the service user’s engagement with either service.
- Mental health aspects of joint assessment, joint care planning and joint care plan reviews are led and conducted by staff from Somerset Partnership.
When Somerset Partnership in-patient wards admit clients of Turning Point for treatment of their mental health symptoms the in-patient care team have responsibility for:

- Informing Turning Point when the client has been admitted.
- Where a client is receiving substitute prescribing from Turning Point the in-patient team must liaise with the client and Turning Point and establish the dispensing chemist.
- It is the duty of the in-patient care team to inform the dispensing chemist and the GP of admission and discharge (or where a client becomes AWOL) whether planned or unplanned. *This is to ensure community prescriptions are suspended during inpatient treatment episodes.*
- Informing Turning Point of the planned discharge date and liaising with them regarding pharmacological treatment, to ensure smooth transitions for the client.
- Wherever possible Somerset Partnership will give Turning Point 5 days notice of discharge of dual diagnosis clients to enable Turning Point to arrange for community prescribing and dispensing to recommence.
- Informing Turning Point when a client has become AWOL or self-discharged.
- Informing the GP when a client has become AWOL or self-discharged.
- When a client is receiving substitute prescribing inform Turning Point and the GP of the date, time and dose of last administration on the ward.

9.4.1 *Allocation of a Care Coordinator*

When a service user is admitted to an inpatient ward without an allocated Somerset Partnership care coordinator, one must be appointed within 7 days of the CMHT being informed that the patient is on the ward. The Ward Manager may be recorded as the Care Coordinator or as an interim measure, this may be a member of the Home Treatment and Crisis Resolution Team if the length of admission is less than 7 days.

9.5 *The psychological therapies service offers a range of specialist therapeutic interventions to people being treated within secondary mental health care teams.*

- Where the primary focus needs to be on treating substance misuse problems, or where addiction or substance misuse appears to be the primary presenting problem, psychological therapies are rarely indicated and are unlikely to be offered.
- Where there is clinical uncertainty or disagreement around this, a fuller assessment for readiness for psychological therapy can be arranged by the Psychological Therapies Service, so that decisions can be made on an individual and personalised basis.

10 *DISAGREEMENT ABOUT URGENT ACTION BETWEEN SOMERSET PARTNERSHIP AND TURNING POINT*

10.1 Wherever possible the staff from both organisations are expected to come to an agreement about the most appropriate course of action based on the service users needs and best interests. However if agreement cannot be reached by staff, the case should be referred to the next tier of management
who are expected to discuss this again and reach an agreed position. A second assessment by the Dual Diagnosis lead psychiatrist may be required in some more complex cases but not at the expense of providing appropriate treatment and care in the interim. Commissioners may be consulted only at Director level in to find a resolution in cases that are particularly vexed or have unmet needs.

10.2 A record of all discussions and decisions made should be clearly recorded within Rio progress notes.

11. SERVICE USER CONSENT TO SHARE INFORMATION

11.1 The application of this policy requires that personal and confidential information about service users is exchanged between Somerset Partnership NHS Foundation Trust and Turning Point.

11.2 Staff are expected to follow the organisational policy in terms of establishing service user’s consent to share information in line with the Consent and Capacity to Consent to Treatment Policy and the Information Governance Policy.

11.3 Where substance misuse is identified during an assessment by Somerset Partnership staff they should:

- Gain the service user’s consent to share information
- Make contact with the relevant member of staff at Turning Point and discuss the key aspects of the service user’s situation, presenting risks behaviours and relevant personal issues
- Use the agreed information exchange options to send Turning Point the following information, where required:
  - Demographics
  - Summary of assessment
  - Summary of risk assessment with alerts
  - Summary of substance use issues identified to date
  - Copy of care plan

11.4 Somerset Partnership staff will use the Turning Point Dual Diagnosis referral forms accessible in RIO.

11.5 Where a service user declines referral to Turning Point this discussion should be documented within the RiO substance misuse screen (Appendix D):

Core assessments
Mental Health
Alcohol/Substance misuse (inc. Dual Diagnosis)

12. INFORMAL SHARING OF INFORMATION

12.1 This policy recognises that in some circumstances staff will need to share information anonymously without making a formal referral to gain advice on a particular situation. Staff should feel empowered to do this as their clinical judgement dictates. Where informal discussions are had an entry should be made in RiO summarising the contact and any advice or guidance provided.
13. BREACHING CONFIDENTIALITY

13.1 Staff of both the Somerset Partnership and Turning Point are expected to disclose information without seeking the service user’s consent in certain circumstances. These include exceptional circumstances where:

- There is justification that overruling the right of an individual to confidentiality will serve a broader public interest or protect themselves and/or others from harm.
- Through an order of the court.

13.2 Further detail is described within the Confidentiality Policy.

13.3 Where a decision is made to breach confidentiality the rationale for the decision and any supporting documentation should be clearly recorded in Rio (the electronic patient record).

14. SHARING INFORMATION SECURELY

14.1 After consent has been established confidential information should be exchanged using:

- Secure e-mail
- Phone.
- Fax for anonymised information only.

14.2 Somerset Partnership staff will use Rio to access these forms:

- A Turning Point Dual diagnosis referral form.
- A Dual diagnosis monitoring form.

15 ROLE OF SERVICE LEADS

15.1 The Somerset Partnership employs two specialist leads for Dual Diagnosis:

- A lead Consultant Psychiatrist for Dual Diagnosis
- A lead Consultant Clinical Psychologist for Dual Diagnosis
  (Contact details are provided in Appendix E)

15.2 Referrals to Service Leads

- In the first instance contact should be made with the appropriate Consultant Psychiatrist directly. The following information should be supplied:
  - The completed Substance Misuse screen (appendix D)
  - AUDIT and SADQ where the service user presents with problematic alcohol use (Appendices E and F).
  - Details of the client’s current care plan and involvement with Turning Point (or refusal of this) should be up to date.
15.2.1 Both Service Leads are available for advice and guidance on clinical cases that do not require formal referral, please make direct contact with the relevant lead in the first instance.

16. TRAINING REQUIREMENTS

16.1 The Trust will work towards all staff being appropriately trained in line with the organisation’s Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

16.2 Somerset Partnership NHS Foundation Trust make education and training opportunities available for their staff based on staff appraisal and identification of training needs.

16.3 As described within the Learning Development and Mandatory Training Policy all training attendees will be required to sign the attendance register and the training facilitator will forward to the Learning and Development Team to register on ESR (the Electronic Staff Record).

17. EQUALITY IMPACT ASSESSMENT

‘All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry’

18. MONITORING COMPLIANCE AND EFFECTIVENESS

18.1 An annual audit will be conducted to ensure that the joint working protocol is followed in practice. The audit will be led by the Dual Diagnosis lead for Somerset Partnership in collaboration with members of the Joint Working Protocol Group.

18.2 The Annual Audit Report will be discussed at the Clinical and Social Care Effectiveness Group (at the next due quarter meeting). The CSCE Group will agree and monitor action plans and will provide assurance and escalate areas of concern/risk issues to the Clinical Governance Group using the Governance Group reporting template.

18.3 Reporting and review of incidents relating to Dual Diagnosis through the Datix system and the Trust Clinical Governance systems

18.4 Lesson learning will be forwarded to the Clinical Effectiveness team to hyperlink into Somerset Partnership Improving Clinical Effectiveness (SPICE) distributed monthly to all employees.

18.5 Monitoring staff development of clinical staff in relation to Dual Diagnosis through the Trust appraisal system
19. **COUNTER FRAUD**

The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

20. **RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS**

The standards and outcomes which inform this procedural document are as follows:

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<td>19 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the MHA 1983</td>
</tr>
<tr>
<td></td>
<td>20 Notification of other incidents</td>
</tr>
<tr>
<td></td>
<td>21 Records</td>
</tr>
<tr>
<td>Suitability of management</td>
<td>23 Requirement where the service provider is a body other than a partnership</td>
</tr>
<tr>
<td></td>
<td>28 Notifications – notice of changes</td>
</tr>
</tbody>
</table>

**Relevant National Requirements**

Dual Diagnosis In patient Guidance: Dual Diagnosis in Mental Health inpatient and day hospital settings. Guidance on the assessment and management of patients in inpatient and day hospital settings who have mental ill-health and substance use problems. (2006) Department of Health

Mental Health Policy Implementation Guide; Dual Diagnosis Good Practice Guide. Department of Health [www.dh.gov.uk](http://www.dh.gov.uk)

NHSLA Risk Management Standards 2012-2013 for NHS Trusts providing Acute, Community, or Mental Health and Learning Disability Services and Non-NHS Providers of NHS Care
21 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

21.1 References

Assessment and Management of Risk of Harm in Clients with Dual Diagnosis. Alcohol Concern and Drugscope

Refocusing the Care Programme Approach. (2008) Department of Health

Closing the Gap; A capability framework for working effectively with people with combined mental health and substance use problems. Care Services Improvement Partnership.


21.2 Cross reference to other procedural documents

Clinical Assessment and Management of Risk of Harm to Self and Others Policy
CMHT Operational Policy
Consent and Capacity to Consent to Treatment Policy
Confidentiality Policy
Information Governance Policy
Management of Substance of Misuse on Trust Premises
Prevention and Management of Violence and Aggression (PMVA) Policy
Recovery Care Programme Approach (RCPA) Policy
Safeguarding Children – Child Protection Policy
Safeguarding Vulnerable Adults Policy and Process
Search of Patient, Persons or Property Policy
Substance Misuse Within Inpatient Settings Policy
Untoward Events Reporting Policy and Guidance
Serious Incidents Requiring Investigation (SIRI) Policy

All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet (on the home page, click on information, then local Guidance).

22 APPENDICES

Appendix A Identification Of Substance Misuse By Somerset Partnership And Care Pathway To Turning Point
Appendix B Planned And Spot Purchased Inpatient Drug And Alcohol Detoxification
Appendix C Completed Risk Information
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Substance Misuse Screen</td>
</tr>
<tr>
<td>E</td>
<td>Alcohol Use Disorders Identification Test (AUDIT)</td>
</tr>
<tr>
<td>F</td>
<td>Severity of Alcohol Dependence Questionnaire (SADQ)</td>
</tr>
<tr>
<td>G</td>
<td>Contacts</td>
</tr>
</tbody>
</table>
Identification of substance misuse by Somerset Partnership and care pathway to Turning Point

**Somerset Partnership NHS Foundation Trust**

- Identifies service user as having co-morbid drug and or alcohol problems
- Ascertains willing of service user to have initial meeting with Turning Point
- Ascertains service user’s agreement to share information

**Service user willing to meet TP and for staff to share information**

- **Y**
  - Staff consider options for first meeting in terms risk of non-attendance and other factors and discuss options with service user
  - Staff contact Turning Point to briefly discuss: service user’s overall situation, preferred location for meeting, risk issues, joint approach, time and date of meeting

- **N**
  - Approach issue again as appropriate

**Separate or joint meeting with Turning Point**

- Service user encouraged to self refer to Turning Point
- Appointment made for service user to see Turning Point staff
- Sompar and Turning Point staff meet service user together at either: Sompar site, Turning Point site, home visit or another location (agreed by all parties)
Planned and Spot Purchased Inpatient Drug and Alcohol Detoxification

Care Pathway

Terms of reference – Community Substance misuse services in Somerset are provided by Turning Point. This paper describes the care pathway between Turning Point the local NHS inpatient detoxification service. This pathway does not apply to unplanned detoxification activity where the primary reason for admission is a mental health problem and the referral source is not Turning Point.

Definition – Assisted withdrawal from alcohol or drugs in a supportive and safe environment where there is medical supervision and 24-hour nursing support.

Aims and Objectives –
- To assist the service user to achieve physical withdrawal from the substance upon which they are physically dependent.

Service Content -
- Medical Assessment
- Psychiatric Assessment
- Medical Management of withdrawal
- 24 hour nursing care
- Commencement of disulfiram, naltrexone or acamprosate as appropriate if planned.

Eligibility Criteria –
- Service users who have an established physical dependence syndrome
- Services users who have a post detoxification care planned strategy determined by Turning Point to prevent relapse and progress with other life issues.

Exclusion criteria or contraindications –
- Service users whose personal goals are not concordant with achieving and maintaining a drug/alcohol free state
- Service users without a post detoxification care plan package addressing relapse prevention and life progression needs.
- Caution in pregnancy – especially second trimester for opiate withdrawal.
- Presence of any neuropsychiatric signs suggestive of Wernicke’s syndrome/ Korsakoff’s Syndrome

Referral route –
- Turning Point, having undertaken a comprehensive assessment of the service users needs and identified the need for an inpatient detoxification will make a written referral to the inpatient ward manager, copy to Sue Smith, Name Patient Manager, Somerset Partnership NHS and Social Care Trust HQ.
Procedural algorithm –
Red = Turning Point Responsibility
Blue = Somerset Partnership Responsibility

Turning Point Area Office Team Leader identifies need and makes written referral to Inpatient Ward Manager

Turning Point arranges client visit to the ward for tour and signing of treatment contract

Ward Manager puts service users on list for planned admission within 6 weeks and liaises with named Turning Point worker

Admission:
- Medical Examination
- Prescribed detoxification Regimen
- Inpatient care plan

Service User successfully detoxified:
- Pre Discharge Psychiatric Assessment
- Discharge

Turning Point provides follow up within 48 hours and resumes care coordination using written post discharge care plan

Referral information approved by Turning Point Medical staff includes:
- Turning Point ‘Comprehensive Assessment’
- AUDIT/SADQ
- Risk Assessment
- Medical Information including LFT blood assay results
- Written post discharge Care Plan
  (Copy to Named Patient Manager, Somerset Partnership HQ)

Somerset Partnership Detoxification Guidelines

Premature discharge:
- Service User choice
- Breech of contract
  - Fax Turning Point Area Office Team Leader same day

Inpatient ward to inform GP and Named Drugs worker within 1 hour
## Risk Information

**Client:** CAT, Tom - 1001067  
**Date/time:** 20 November 2012 16:07

1. **What are the key historic risks/concerns (if any)?** Review the client record, including historical Risk Incidents which can be accessed via the hyperlink below.

**Risk Incidents (view history or add incident):**

- **Summarise static historical risk factors that are unlikely to change over time such as previous suicide attempts and early life experiences (potential risks).**

Tom is prone to consider self harm when he is physically dependent on alcohol as is currently the case, his mood improves when he is able to abstain from alcohol. Tom is also more likely to use intravenous amphetamines when he is intoxicated on alcohol; he made a serious suicide attempt by stepping in front of a lorry in December 2011 and at that time he was under the influence of both alcohol and amphetamines.

- **Forensic history:**

List relevant arrests and convictions both past and pending, including index offence, with dates.

- Tom was convicted of stealing alcohol from a supermarket in June 2012 and served a Community Service Order.

2. **What risks/concerns are there?** Consider each concern and comment on likelihood, how soon expected and how severe the outcome if it does occur. Ensure that this reflects the information recorded in Risk Screening.

**Nature of current risks or concerns:**

1. Risk of self harm/suicidal behaviour increased by current alcohol dependence and subsequent use of intravenous amphetamines
2. Risk of accidental death from acute intoxication
3. Risks of harm associated with intravenous drug use

**What triggers the risk?** Consider acute risk factors or triggers such as alcohol, drugs, relationship difficulties, life events, mood etc. Factors currently exasperating risk:

- Daily drinking of alcohol increases risks - Tom is more at risk of feeling hopeless when he is an established pattern of alcohol dependence. Risks are increased further when he lapses into intravenous amphetamine use. Long periods of unstructured time alone are also known to increase his risks.

### Add
Risk Information

What mitigates the risk? Consider the protective factors such as relationships, occupation, appointments with CMHT etc. Factors currently protecting or alleviating against risk:

Tom's mental state improves if he can maintain abstinence from alcohol. During periods of employment Tom is more likely to be optimistic for his future and engage in supportive peer groups which have really helped reduce his risks in the past.

What are the views of others? Consider and include, where appropriate, the knowledge and experience of the client and family/carers when assessing risk and protective factors and include this information in the appropriate sections above. If there is additional information from the client and/or family/carers that you have not incorporated, please include it below.

Client/carers assessment of risk where it differs from your assessment.

Tom's mother is of the view that there are certain 'friends' Tom has which are a bad influence on him and that he is less likely to mix with them when he has a job. When he is with these friends he is more likely to drink and use drugs as they encourage him to join in their activities.

Actions to be taken

- No further action
- Address in Recovery Care Plan
- Care Plan
- Record an Alert
- Alerts
Summary of Key Actions to Manage Risk
Summary of actions. Include discussions with other agencies/staff about managing risk.

Level 1 Care Coordination (Somerset Partnership)
Care plan to joint work with Turning Point with view to helping Tom through a period of alcohol detoxification. Care plan to address risk of self harm in the interim. Management of depression to be reviewed when alcohol free. Promote attendance to alcohol abstinent peer group for support and encouragement. Employment support once stabilised.

List of information sources accessed in completing Risk Profile

| Client | ✓ |
| Carer/Relative | ✓ |
| Trust client record | ✓ |
| Case notes from other area | |
| Social Services (non MH teams) | |
| GP | ✓ |
| Police/Criminal report | |
| Forensic report | |

Updated by: Paul Milverton
APPENDIX D

Alcohol/Substance Misuse (inc. Dual Diagnosis)

Client: CAT, Tom - 1001067
Date/Time: 20 November 2012 14:28

Past and present use of non-prescribed drugs, units of alcohol, triggers for use, associated behaviour.
Give details on substance (including type), frequency (e.g. how many times a week), quantity and method used.

Currently drinks daily, some days cider and some days strong lager (8% abv) - Tom's account suggests he drinks between 70 to 100 units per week. Tends to have his first drink on waking (between 8am and 10am) in order to relieve tremors and feelings of hopelessness. Over the past month he has injected amphetamines intravenously twice. Tom says he has not used any other illicit drugs over the past month. SAPQ and AUDIT forms completed and scanned into RiO notes (Other Assessment Reports).

Dual Diagnosis

Where dual diagnosis is suspected, use this section to record details.

Is there problematic alcohol use? Yes
If there is illicit drug use, please select the substance. Cannabis
Is the client also receiving a service from Turning Point? Yes
Enter the date a referral was made to Turning Point. 1 November 2012

Where a referral to Turning Point has been refused or is inappropriate, please state the reason.

Tom is willing to receive help from Turning Point and has an appointment to attend tomorrow.

Click here to view the Dual Diagnosis policy on the Intranet.

Updated by: Kirk Russell
Updated on: 20 November 2012 16:09
**APPENDIX E**

### This is one unit of alcohol...

...and each of these is more than one unit

![Units of Alcohol](image)

### AUDIT - PC

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring System</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>Never</td>
<td>Monthly or less</td>
</tr>
<tr>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
</tr>
<tr>
<td>How often during the last year have you failed to do what was normally expected from you because of your drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
</tr>
</tbody>
</table>

**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-PC positive.
Score from AUDIT- PC (other side)

Remaining AUDIT questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</td>
<td>Never</td>
<td>Less than monthly</td>
</tr>
<tr>
<td>How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never</td>
<td>Less than monthly</td>
</tr>
<tr>
<td>How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
</tr>
<tr>
<td>How often during the last year have you been unable to remember what happened the night before because you had been drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
</tr>
</tbody>
</table>

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence
APPENDIX F

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ-C)\(^1\)

NAME____________________________________AGE____________No._______

DATE: _____________

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month:……………………………… Year:…………………………

Please answer all the following questions about your drinking by circling your most appropriate response.

**During that period of heavy drinking**

1. The day after drinking alcohol, I woke up feeling sweaty.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.
   - ALMOST NEVER          SOMETIMES          OFTEN                NEARLY ALWAYS
10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 8 units of beers).

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

14. I drank more than half a bottle of spirits per day (OR 1.5 bottles of wine OR 15 units of beer).

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

15. I drank more than one bottle of spirits per day (OR 3 bottles of wine OR 30 units of beer).

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

16. I drank more than two bottles of spirits per day (OR 6 bottles of wine OR 60 units of beer)

ALMOST NEVER   SOMETIMES   OFTEN   NEARLY ALWAYS

Imagine the following situation:
1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily** for two days

How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.

NOT AT ALL   SLIGHTLY   MODERATELY   QUITE A LOT

18. My hands would shake.

NOT AT ALL   SLIGHTLY   MODERATELY   QUITE A LOT

19. My body would shake.

NOT AT ALL   SLIGHTLY   MODERATELY   QUITE A LOT

20. I would be craving for a drink.

NOT AT ALL   SLIGHTLY   MODERATELY   QUITE A LOT

SCORE   __________

CHECKED BY:

ALCOHOL DETOX PRESCRIBED: YES/NO
NOTES ON THE USE OF THE SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. It is a measure of the severity of dependence. The AUDIT questionnaire, by contrast, is used to assess whether or not there is a problem with dependence.

The SADQ questions cover the following aspects of dependency syndrome:

- physical withdrawal symptoms
- affective withdrawal symptoms
- relief drinking
- frequency of alcohol consumption
- speed of onset of withdrawal symptoms.

Scoring

Answers to each question are rated on a four-point scale:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost never</td>
<td>0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1</td>
</tr>
<tr>
<td>Often</td>
<td>2</td>
</tr>
<tr>
<td>Nearly always</td>
<td>3</td>
</tr>
</tbody>
</table>

A score of 31 or higher indicates "severe alcohol dependence".
A score of 16 -30 indicates "moderate dependence"
A score of below 16 usually indicates only a mild physical dependency.
A chlordiazepoxide detoxification regime is usually indicated for someone who scores 16 or over.

It is essential to take account of the amount of alcohol that the patient reports drinking prior to admission as well as the result of the SADQ.

There is no correlation between the SADQ and such parameters as the MCV or GGT.
### Main contacts for Somerset Partnership

<table>
<thead>
<tr>
<th>Position</th>
<th>Contact Person</th>
<th>Address</th>
<th>Tel/Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Consultant Psychiatrist for Dual Diagnosis</td>
<td>Dr Nick Airey, Consultant Psychiatrist</td>
<td>Somerset Partnership NHS Foundation Trust</td>
<td>01278 720220</td>
</tr>
<tr>
<td>for Somerset Partnership</td>
<td></td>
<td>Glanville House</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Church Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bridgwater TA6 5AT</td>
<td></td>
</tr>
<tr>
<td>Lead Consultant Clinical Psychologist for Dual</td>
<td>Dr Helen Bellfield, Consultant Clinical</td>
<td>Somerset Partnership NHS Foundation Trust</td>
<td>01278 454130</td>
</tr>
<tr>
<td>Diagnosis for Somerset Partnership</td>
<td>Psychologist</td>
<td>Broadway Health Park</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barclay Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bridgwater TA6 5YA</td>
<td></td>
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</tbody>
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### CAMHS

<table>
<thead>
<tr>
<th>Position</th>
<th>Contact Person</th>
<th>Address</th>
<th>Tel/Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE MANAGER</td>
<td>Alison Chisholm</td>
<td>Foundation House, Wellsprings Road, Taunton</td>
<td>01823 368368</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TA2 7PQ</td>
<td>Fax: 01823 368552</td>
</tr>
<tr>
<td>SPECIALIST CAMHS COMMUNITY TEAM – SOUTH SOMERSET</td>
<td></td>
<td>Balidon Centre, Summerlands, Preston Road,</td>
<td>01935 384140</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yeovil BA20 2BX</td>
<td>Fax: 01935 411723</td>
</tr>
<tr>
<td>SPECIALIST CAMHS COMMUNITY TEAM – MENDIP</td>
<td></td>
<td>The Priory Hospital, Priory Health Park,</td>
<td>01749 836561</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glastonbury Road, Wells, Somerset BA5 1TL</td>
<td>Fax: 01749 836563</td>
</tr>
<tr>
<td>SPECIALIST CAMHS COMMUNITY TEAM – WEST</td>
<td></td>
<td>Foundation House, Wellsprings Road, Taunton</td>
<td>01823 368368</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TA2 7PQ</td>
<td>Fax: 01823 368552</td>
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</table>
# Main contacts for Turning Point

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical lead for Turning Point</td>
<td>Dr Gordon Morse</td>
<td>Maltravers House</td>
<td>01935 383360</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Petters Way</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yeovil BA20 1SH</td>
<td></td>
</tr>
<tr>
<td>Service Manager</td>
<td>Galena Thackaberry</td>
<td>Bridge House</td>
<td>01278 456 561</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 Taunton Rd</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bridgwater</td>
<td></td>
</tr>
<tr>
<td>Lead for Dual Diagnosis for Turning Point</td>
<td>Dr Jan Hernen</td>
<td>Bridge House</td>
<td>01278 456 561</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 Taunton Rd</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bridgwater</td>
<td></td>
</tr>
</tbody>
</table>

## Turning Point Area Offices

<table>
<thead>
<tr>
<th>Area</th>
<th>Offices</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mendip</td>
<td>Beckynton Place</td>
<td>Priory Park</td>
<td>01749 836000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glastonbury Road</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wells BA5 1SX</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Turning Point Team</td>
<td>Referrals, advice, information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>interagency liaison</td>
<td></td>
</tr>
<tr>
<td>Somerset Coast</td>
<td>Bridge House</td>
<td>30 Taunton Rd</td>
<td>01278 456 561</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bridgwater</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tel:</td>
<td></td>
</tr>
<tr>
<td>Taunton Dean</td>
<td>Unity House</td>
<td>10, Cannon Street</td>
<td>01823 328460</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taunton TA1 1SN</td>
<td></td>
</tr>
<tr>
<td>South Somerset</td>
<td>Turning Point</td>
<td>Maltravers House</td>
<td>01935 383360</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Petters Way</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yeovil BA20 1SH</td>
<td></td>
</tr>
</tbody>
</table>