

**DUAL DIAGNOSIS POLICY:
Coexisting severe mental illness and substance misuse:
Community health and social care services**

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DOCUMENT CONTROL

Reference	Version	Status	Author
HB/Dec17	2	Final	Consultant Clinical Psychologist – Dual Diagnosis Lead
<p>Amendments</p> <p>To inform and guide staff in effective working practice with service users who have a Dual Diagnosis (comorbid serious mental illness and substance misuse).</p> <p>Ensure Trust policy is consistent with current NICE clinical guidance NG58 (<i>Coexisting severe mental illness and substance misuse: community health and social care services</i> (November 2016)).</p> <p>Significant changes:</p> <ul style="list-style-type: none"> • Applies to services users aged 14 and over (previous policy applied to over 18 years) • Increased emphasis for Mental health taking lead in assessment, risk management and care planning • Increased emphasis on multi-agency working and joint integrated treatment approaches • Increased emphasis on involving families, carers and significant others • Includes section on People with Multiple Complex Needs and requirement for proactive approach in working with individuals who may not quite meet the threshold for acceptance into a number of services (following the MEAM approach) • Contains appendices to guide assessment and management of dual diagnosis patients • Contains flow charts for decision making for: <ul style="list-style-type: none"> ○ assessment of intoxicated individuals ○ referral for Psychological Therapy 			
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CONTRIBUTION LIST Key individuals involved in developing the document

Contributor – Designation or Group
Consultant Clinical Psychologist – Dual Diagnosis Lead
Alcohol and Substance Use Best Practice Group
Clinical Policy Review Group

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1. INTRODUCTION

- 1.1 Adults and young people with coexisting severe mental illness and substance misuse have some of the worst health, wellbeing and social outcomes (Relationship between dual diagnosis: substance misuse and dealing with mental health issues Social Care Institute for Excellence, 2009).
- 1.2 Alcohol and drug misuse is common among people with mental health problems. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) found that suicides among patients with a history of alcohol or drug misuse (or both) accounted for 54% of the total sample, an average of 671 deaths per year. Other evidence shows that alcohol use disorder is an important predictor of suicide/premature death.
- 1.3 The Department of Health's Refocusing the Care Programme Approach identifies people with coexisting severe mental illness and substance misuse as one of the groups in need of an enhanced Care Programme Approach. That is because they are not being identified consistently and services are sometimes failing to provide the support they need. The policy highlights the need for a whole systems approach to their care, involving a range of services and organisations working together.

2. PURPOSE AND RATIONALE

- 2.1 NICE Guideline 58 *Coexisting severe mental illness and substance misuse: community health and social care services* (November 2016) underpins this policy. The policy covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse (Dual Diagnosis).
- 2.2 A new national drug (and alcohol dependence) strategy was published in December 2010 (HMG, 2010), and a mental health strategy a few months later (HMG, 2011). Both strategies acknowledge the association between mental health problems and drug and alcohol problems. Successful outcomes for both problems need early intervention and effective joint working between drug and alcohol treatment and mental health services in integrated, recovery-oriented local systems.
- 2.3 This procedural document applies to all staff (including Temporary, Locum, Bank and Agency staff) working in Adult and Child Mental Health Services within Somerset Partnership NHS Trust.
- 2.4 Dual Diagnosis in this policy refers to people over 14 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.

- 2.5 This policy refers to any individual who requires treatment and/or support for co-existing severe mental health and substance misuse problems who:
- Is aged 14 years and over.
 - Is normally resident in Somerset (either permanently or temporarily).
 - Is registered with a Somerset GP.
 - Requires health care services (including urgent care and liaison services) provided by Somerset Partnership NHS Foundation.
 - 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 the Somerset Drug and Alcohol Service (SDAS)
 - 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).

3. POLICY STATEMENT

- 3.1 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, 2002*).
- 3.2 *A client will not be declined an assessment or excluded from services based upon the perceived cause of their problems being drug or alcohol induced (NICE Guideline 58, 2016). Assessment may be declined and rescheduled where an individual presents as currently under the influence of substances – in such instances relevant risk assessment and management procedures should be initiated.*

4. DEFINITIONS

- 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 **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 Novel Psychoactive Substances (NPS) formerly known as 'legal highs'.

- 4.3 **Care Programme Approach (CPA):** the national framework for effective mental health care with its principles of assessment, care plan, care coordination and review.
- 4.4 **CPA Review (or Care Plan Review):** the periodic evaluation and review of a patient's care and treatment by all those involved (including the patient, family/carers, other agencies) to ensure that needs are being met in the best interests of the patient.
- 4.5 **Electronic Patient Record (EPR):** a computerised system to record demographic details, episodes of care and all clinical notes in a structured, systematic way
- 4.6 **Relapse** is a recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both.
- 4.7 **Somerset Drug and Alcohol Service (SDAS)** is the local specialist provider of drug and alcohol services.
- 4.8 **Specialist services** refers to secondary care mental health services and dual diagnosis services.
- 4.9 **Substance misuse** refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage. This may include low levels of substance use that would not usually be considered harmful or problematic, but may have a significant effect on the mental health of people with a mental illness such as psychosis.

5. DUTIES AND RESPONSIBILITIES

- 5.1 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.
- 5.2 The **Director of Mental Health Services** is the Executive Lead responsible for this policy covering the care of patients with Dual Diagnosis.
- 5.3 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**.
- 5.4 **Staff responsibilities are to:**
 - 5.4.1 Ensure that mental health services take the lead for assessment and care planning

- 5.4.2 Engage service users; use a harm minimisation based approach to care, work on motivation and match interventions to the patients' readiness to change.
- 5.4.3 Identify and provide support to people with coexisting severe mental illness and substance misuse.
- 5.4.4 Offer interventions that aim to improve engagement with all services, support prevention or delay of onset of drug misuse, harm reduction, change behaviour and prevent relapse.
- 5.4.5 Aim to meet their immediate needs, wherever they present. This includes:
- looking out for multiple needs (including physical health problems, homelessness or unstable housing)
 - remembering they may find it difficult to access services because they face stigma.
- 5.4.6 Be aware that the person may have a range of chronic physical health conditions including:
- cardiovascular, respiratory, hepatic or related complications
 - communicable diseases
 - cancer
 - oral health problems
 - diabetes.
- 5.4.7 Be aware that people's unmet needs may lead them to commence drug misuse, or can continue drug misuse in occasional users, and have a relapse or may affect their physical health. This could include: social isolation, homelessness, poor or lack of stable housing, or problems obtaining benefits.
- 5.4.8 Provide direct help, or get help from other services, for any urgent physical health, social care, housing or other needs.
- 5.4.9 Ensure the safeguarding needs of all people with coexisting severe mental illness and substance misuse, and their carers and wider family, are met.
- 5.4.10 The responsibilities of the Somerset Partnership Care Coordinator and Lead Professional are detailed in the Integrated Care Planning Approach Policy
- 5.4.11 The Trust "Clinical Assessment and Management of Risk of Harm to Self and Others Policy", "Safeguarding & Protection of Children Policy" and "Safeguarding Adults at Risk Policy" should be read in conjunction with this policy and the procedures applied and actions taken recorded appropriately

6. ASSESSMENT, MANAGEMENT AND RECORDING

- 6.1 Secondary care mental health services must ensure they:

- Do not exclude people with severe mental illness because of their substance misuse.
- Adopt a person-centred approach to reduce stigma and address any inequity to access to services people may face (see NICE's guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings and service user experience in adult mental health for the principles of using a person-centred approach).
- Undertake a comprehensive assessment of the person's mental health and substance misuse needs (see also NICE's guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings – the section 'recognition of psychosis with coexisting substance misuse' and the recommendations on assessment in 'secondary care mental health services'). Also assess vulnerability to drug misuse (NG64)

6.2 **Substance Use Assessment**

All service users accessing Trust health services should be routinely asked questions about their substance use needs as a minimum standard at their first contact with the treating service, also with a view to identifying those vulnerable to drug misuse as per NG 64. This should include assessment of any associated risks and be reviewed throughout the treatment episode in accordance with the Clinical Assessment and Management of Risk of Harm to Self and Others Policy and ICPA Policy.

6.3 Guidance notes for assessment of substance use and risk assessment and management in relation to substance use are attached as appendix A.

6.4 During ongoing contact with existing clients of the Somerset Partnership when substance use is identified the steps detailed above should be followed as soon as the practitioner becomes aware of the substance use.

7. **INTERVENTION AND TREATMENT PLANNING**

7.1 **On acceptance to secondary care mental health services** provide a care coordinator working in mental health services in the community to:

- act as a contact for the person
- identify and contact their family or carers
- help develop a care plan with the person (in line with the Care Programme Approach) and coordinate it
- Support the service user to sustain change and prevent relapse and promote recovery.

7.2 The care coordinator adopts a collaborative approach with other organisations (involving shared responsibilities and regular communication) when developing or reviewing the person's care plan. This includes substance misuse services, peer support and mutual aid groups, primary and

secondary care health, social care, local authorities and organisations such as housing and employment services.

7.3 Consider approaches to keep people involved in their care plan. Ensure agencies and staff communicate with each other so the person is not automatically discharged from the care plan because they missed an appointment. All practitioners involved in the person's care should discuss a non-attendance.

7.4 **The Somerset Partnership care coordinator (or Lead Professional) responsibilities are fully detailed in Appendix E.**

7.5 **Involving people with coexisting severe mental illness and substance misuse in care planning**

Involve the person (and their family or carers if the person wants them involved) in developing and reviewing the care plan (as needed) to ensure it is tailored to meet their needs. This includes offering the person information about the services available so they can decide which ones would best meet their jointly identified needs and goals. Also involve practitioners as appropriate from:

- adult or child and adolescent mental health teams and substance misuse services
- other health and social care disciplines such as medicine, pharmacy, nursing, social work, occupational therapy and housing, peer support/mutual aid groups.

7.5.1 Ensure the care plan:

- Is based on a discussion with the person about how their abilities (such as the extent to which they can take part in the activities of daily living) can help them to engage with services and recover.
- Takes into account the person's past experiences (such as their coping strategies to deal with crises).
- Lists how the person will be supported to meet their identified needs and goals. This includes listing any carers they have identified to help them, and the type of support the carer can provide. (Also see 'ensure interventions meet individual needs' in NICE's guideline on behaviour change: individual approaches).
- Takes into account the concerns of the person's family or carers.
- Recognises and, if possible, reconciles any goals the person may have decided for themselves if they differ from those identified by their service provider.
- Is optimistic about the prospects of recovery.
- Is reviewed at every contact.

7.5.2 Share a copy of the care plan with the person's family or carers (if the person agrees). In line with local information sharing agreements, share copies with other services as needed.

7.6 Involving families and significant others in care planning

The Trust Strategy for Families and Carers states that we should have a “social network perspective”. This would include gathering information from families/ carers about risk. Insights and information from families & carers can be particularly valuable for the assessment and management of risk. The Trust **requires** involvement of families/carers in risk assessment and management. All registered staff need to document the process they used to arrive at exceptions.

7.6.1 Ensure carers (including young carers) who are providing support are aware they are entitled to, and are offered, an assessment of their own needs. If the carer wishes, make a referral to the Carers Assessment Team or the local authority for a carer's assessment (in line with the Care Act 2014). When undertaking an assessment, consider:

- carers have needs in their own right
- the effect that caring has on their mental health
- carers may be unaware of, or excluded from, any plans or decisions being taken by the person
- any assumptions the person with coexisting severe mental illness and substance misuse has made about the support and check that they agree the level of support their carer will provide.

7.6.2 Based on the carer's assessment:

- Advise the carer that they may be entitled to their own support. For example, using a personal budget to buy care or to have a break from their caring responsibilities.
- Give information and advice on how to access services in the community, for example respite or recreational activities or other support to improve their wellbeing.

7.7 Review

7.7.1 Hold multi-agency and multidisciplinary case review meetings annually, as set out in the Care Programme Approach or more frequently, based on the person's circumstances. Use this to check the person's physical health needs (including any adverse effects from medications), social care, housing or other support needs. Involve practitioners from a range of disciplines, including:

- secondary care mental health
- substance misuse
- primary care
- emergency care (if applicable)
- voluntary sector
- housing
- adult and young people's social care.

7.7.2 Ensure the care plan is updated and shared in response to changing needs or circumstances.

7.8 Discharge or transition

7.8.1 Before discharging the person from their care plan or before they move between services, settings or agencies (for example, from inpatient care to the community, or from child and adolescent mental health services to adult mental health services) ensure:

- All practitioners who have been, or who will be, involved are invited to the multiagency and multidisciplinary meetings and the discharge or transfer meeting.
- There is support to meet the person's housing needs.
- The discharge plan includes strategies for ongoing safety or risk management and details of how they can get back in contact with services.
- There are crisis and contingency plans in place if the person's mental or physical health deteriorates (including for risk of suicide or unintentional overdose).
- Providers share information on how to manage challenging or risky situations (see also NICE's guideline on violence and aggression: short-term management in mental health, health and community settings).

7.8.2 Reassess the person's needs to ensure there is continuity of care when they are at a transition point in their life. Particular groups who may need additional support include:

- young people who move from child and adolescent mental health services to adult health or social care services.
- looked after children
- people who move from adult to older adult mental health or social care services.

7.9 Inpatient Admissions

There will be circumstances when a service user is admitted to a unit from the community, then the responsibility for the day-to-day Care Plan will lie jointly with the in-patient and community mental health teams.

7.9.1 **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 CPA meetings.
- Ensuring seven day follow up post discharge.

7.9.2 When a service user is admitted to an inpatient unit without an allocated Somerset Partnership care coordinator, one must be appointed within 72 hours of the CMHT being informed that the patient is on the ward. The Ward Manager may be recorded as the Care Coordinator as an interim measure.

- 7.10 Somerset Partnership may admit patients for treatment of their mental health conditions and during this provide medical detox for alcohol dependency (assisted withdrawal from alcohol in a supportive and safe environment where there is medical supervision and 24-hour nursing support)

Alcohol Detoxification Guidelines:

http://intranet.sompar.nhs.uk/services/specialist_services/pharmacy_meds_mgmt_service/drug_and_therapeutics_group/alcohol_misuse_guidance.aspx

- 7.11 Somerset Partnership inpatient units admit clients of SDAS for treatment of their mental health symptoms and during this time will have responsibility for managing any substitute prescribing.

- 7.12 **The in-patient care team responsibilities for liaison in relation SDAS patients are detailed in Appendix F**

8. RESPONDING TO DUAL DIAGNOSIS RELATED CRISIS SITUATIONS

- 8.1 In the event of a client being referred to a Crisis Resolution Home Treatment Team (CRHTT) or Psychiatric Liaison Team (PLT) 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 Trust Policies regarding risk management.

- 8.2 **The process of decision making and ensuring patient and public safety is guided by the flow chart attached as appendix G**

- 8.3 The Trust “Clinical Assessment and Management of Risk of Harm to Self and Others Policy”, “Safeguarding & Protection of Children Policy” and “Safeguarding Adults at Risk Policy” should be read in conjunction with this policy and the procedures applied and actions taken recorded appropriately

9. RESPONDING TO INCIDENTS RELATING TO DUAL DIAGNOSIS

- 9.1 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).

- 9.2 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

Clinical Assessment and Management of Risk of Harm to Self and Others Policy

Safeguarding & Protection of Children Policy

Safeguarding Adults at Risk Policy

Substance Use Management on Trust Premises Policy

10 LIAISON WITH SOMERSET DRUG AND ALCOHOL SERVICE (SDAS)

- 10.1 Where the service user gives consent, Somerset Partnership staff should refer the service user to SDAS or arrange a joint meeting wherever substance use is considered to be causing harm to the individual or others.

See Appendix H for SDAS referral criteria

For the care pathway of referrals from Somerset Partnership to SDAS see Appendix I

- 10.2 Wherever possible, a single care plan should be drawn up which includes both the mental health and substance misuse aspects. In the main this will be facilitated by a joint care planning meeting at which both sets of staff, the service user and relevant others are invited. The service user's agreement to this should be ascertained in advance.
- 10.3 Guidance on joint working with SDAS is provided by the **Somerset Joint Working Protocol For Co-existing severe, enduring mental disorders and substance misuse (dual diagnosis)**
- 10.4 **The key tasks of the care coordinator, within Somerset Partnership, in respect of joint working arrangements are detailed in Appendix J.**

11 DISAGREEMENT ABOUT URGENT ACTION BETWEEN SOMERSET PARTNERSHIP AND SDAS

- 11.1 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. An assessment a Dual Diagnosis lead 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.

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

12 REFERRAL FOR PSYCHOLOGICAL THERAPIES

- 12.1 The psychological therapies service offers a range of specialist therapeutic interventions to people being treated within secondary mental health care teams and the Somerset Partnership Talking Therapies Service (SPTT) offers psychological therapies to people with common mental health problems in primary care.
- 12.2 Substance misusing clients with mental health problems should have access to NICE-recommended psychological interventions, including CBT for depression and anxiety and there is no evidence that substance misuse per se makes the usual psychological therapies ineffective (NICE, 2007).
- 12.3 **Considerations regarding suitability for psychological therapies for dual diagnosis clients are guided by the document attached as appendix K.**
- 12.4 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.
- 12.5 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.

13 SERVICE USERS WITH MULTIPLE COMPLEX NEEDS

- 13.1 **People facing multiple needs and exclusions are in every community in Britain.**
- 13.2 They experience several problems at the same time, including (but not restricted to) mental ill health, homelessness, drug and alcohol misuse, offending, domestic violence, social displacement (including refugees), learning difficulties and family breakdown. They may have one main need complicated by others, or a combination of lower level issues which together are a cause for concern. They live in poverty and experience stigma and discrimination.
- 13.3 People with multiple complex needs often have ineffective contact with services because most public services are designed to deal with one problem at a time and to support people with single, severe conditions. As a result, professionals often see people with multiple needs (some of which may fall below service thresholds) as 'hard to reach' or 'not my problem', no one takes overall responsibility.

- 13.4 This policy recognises the need for local organisations to work together to improve services for people with multiple and complex needs. In line with the Making Every Adult Matter (MEAM) approach workers of both organisations are required to make effort to deliver flexible and more joined-up services that prioritise individuals' recovery and rehabilitation. To do this, workers will proactively support the service user in accessing the full range of support services required by that person.
- 13.5 People can and do recover from alcohol and drug misuse and mental ill health- the principle of recovery features predominantly in both sectors. While no common definition is in place there are common themes and services should adopt optimism and commitment to supporting the whole person.
- 13.6 Recovery approach:
- Provide a whole person holistic approach to mental illness and drug misuse
 - Focus on the person's strengths or 'recovery capital'
 - Believe recovery is possible
 - The process is a journey with ups and downs rather than a destination
 - Optimism and commitment
 - Requires social network of support from family, friends, peers and professionals.

14 SERVICE USER CONSENT TO SHARE INFORMATION

- 14.1 The application of this policy requires that personal and confidential information about service users is exchanged between Somerset Partnership NHS Foundation Trust and SDAS.
- 14.2 Staff are expected to follow the organisational policy in terms of establishing service user's consent to share information.

Information Governance Policy

- 14.3 **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 SDAS 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 SDAS 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
- This discussion should be documented within the RiO substance misuse screen:

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

15 INFORMAL SHARING OF INFORMATION

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

16 BREACHING CONFIDENTIALITY

16.1 Staff of the Somerset Partnership 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 societal interest or protect themselves and/or others from harm.
- Through an order of the court.

16.2 These are detailed in the organisational policy: **Confidentiality and Data Protection Policy**

16.3 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).

17 SHARING INFORMATION SECURELY

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

- Secure e-mail (encrypt).
- Phone.
- Fax for anonymised information only.

18 ROLE OF SERVICE LEADS

18.1 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 L)

- 18.2 The service leads support the working practices outlined within this document and provide advice and second opinions where needed. They provide input with patients care co-ordinated by Somerset Partnership where advice on management of drug and alcohol use is required. These can either be inpatients or those receiving community intervention and will include those whose drug and alcohol difficulties who do not meet referral criteria for SDAS.
- 18.3 The lead Consultant Psychiatrist provides oversight to inpatient detoxifications undertaken by Somerset Partnership, these including planned alcohol detoxification for SDAS patients and detoxification undertaken on emergency admission. The Consultant Psychiatrist also provides guidance to Somerset Partnership concerning detoxification from illicit drugs (either emergency admissions taken onto an inpatient unit for treatment of their mental health difficulties who require concurrent detoxification and also management of any drug detoxifications purchased by SDAS for their clients).
- 18.4 The lead Consultant Clinical Psychologist provides supervision, consultation and training on the identification and management of people with Dual Diagnosis to Somerset Partnership staff. The Trust will provide training, development and support opportunities for clinical staff in mainstream mental health services to enable them to develop dual diagnosis capabilities in order to respond effectively to service users needs.
- 18.5 **Requests to Service Leads**
- In the first instance contact should be made with the appropriate consultant directly. The following information should be supplied:
 - Completed 30 day profile (for all substance use), AUDIT and SADQ (where the client presents with problematic alcohol use). Details of the client's current care plan and involvement with SDAS (or refusal of this) should be up to date.
 - The Dual Diagnosis screen has been completed in the EPR
- 18.5.1 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.

19 MONITORING COMPLIANCE AND EFFECTIVENESS

- 19.1 Somerset Partnership NHS Foundation Trust has in place audit processes around clinical practice and effectiveness.
- 19.2 Audit will be conducted to ensure that Dual Diagnosis policy is followed in practice. This audit will be led by the Alcohol and Substance Use Best Practice Group
- 19.3 Audit Reports will be discussed at the Alcohol and Substance Use Best Practice Group which will agree and monitor action plans and will provide

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assurance and escalate areas of concern/risk issues to the Clinical Governance Group.

- 19.4 Reporting and review of incidents relating to Dual Diagnosis through the Datix system and the Trust Clinical Governance systems
- 19.5 Monitoring staff development of clinical staff in relation to Dual Diagnosis through the Trust appraisal system

20 TRAINING AND COMPETENCY REQUIREMENTS

- 20.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff 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.
- 20.2 Somerset Partnership NHS Foundation Trust make education and training opportunities available for their staff based on staff appraisal and identification of training needs.
- 20.3 Different attitudes towards, or knowledge of, mental health and drug- or alcohol-related problems may exist between agencies and that this may present a barrier to delivering services. To overcome this we will educate staff to:
 - challenge negative attitudes or preconceptions about working with people with coexisting severe mental illness and substance misuse
 - develop leadership skills so staff can challenge attitudes and preconceptions
- 20.4 Specialist Dual Diagnosis training is accessible through the Learning and Development Team. This training seeks to ensure practitioners have the resilience and tolerance to help people with coexisting severe mental illness and substance misuse through a relapse or crisis, so they are not discharged before they are fully equipped to cope or excluded from services.

21 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

21.1 References

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<http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/>

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NICE *Drug misuse in over 16s: opioid detoxification*, Clinical guideline [CG52] Published date: July 2007

NICE *Drug misuse in over 16s: psychosocial interventions* Clinical guideline [CG51] Published date: July 2007

NICE guideline [NG58] Published: 30 November 2016, *Coexisting severe mental illness and substance misuse: community health and social care services*, November 2016

NICE Clinical guideline [CG120] Published date: March 2011 *coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings*. March 2011

NICE guideline [NG64] *Drug misuse prevention: targeted interventions* February 2017

21.2 Cross reference to other procedural documents

CLINICAL ASSESSMENT AND MANAGEMENT OF RISK OF HARM TO SELF AND OTHERS POLICY (2015)

<http://www.sompar.nhs.uk/media/2267/clinical-assess-and-management-of-risk-policy-v5aug-2015.pdf>

CONFIDENTIALITY AND DATA PROTECTION POLICY (2015)

<http://www.sompar.nhs.uk/media/4528/confidentiality-and-data-protection-policy-v4aug-2015-ext-sep-17.pdf>

INTEGRATED CARE PLANNING APPROACH POLICY (2016)

<http://www.sompar.nhs.uk/media/3148/icpa-policy-v1may-2016.pdf>

INFORMATION GOVERNANCE POLICY (2015)

<http://www.sompar.nhs.uk/media/4529/information-governance-policy-v4aug-2015-ext-sep-2017.pdf>

**PREVENTION AND MANAGEMENT OF VIOLENCE AND
AGGRESSION POLICY (2012)**

<http://www.sompar.nhs.uk/media/1550/pmva-policy-v4nov-2012.pdf>

SAFEGUARDING ADULTS AT RISK POLICY (2015)

<http://www.sompar.nhs.uk/media/2258/safeguarding-adults-at-risk-policy-2015-v5aug-2015.pdf>

**SAFEGUARDING AND PROTECTION OF CHILDREN POLICY AND
PROCEDURE (2015)**

<http://www.sompar.nhs.uk/media/2161/safeguarding-and-protection-of-children-policy-v6aug-2015.pdf>

**SUBSTANCE USE MANAGEMENT ON TRUST PREMISES POLICY
(PATIENTS AND VISITORS) (2015)**

<http://www.sompar.nhs.uk/media/1408/substance-use-management-on-trust-premises-policy-patients-and-visitors-v2apr-15.pdf>

22 APPENDICES

- 22.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Please note the complete list of appendices on the Contents page.

Guidance notes for assessment of substance use, risk assessment and management

1. Information relating to substance use should be recorded within the RiO substance misuse screen:

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

2. Where the use of alcohol is reported this should be further assessed using the Alcohol Use Disorders Identification Test (AUDIT) [Appendix B] (linked from Dual Diagnosis Screen) and Severity of Alcohol Dependence Questionnaire (SADQ) [Appendix C] (specialist assessments menu) where AUDIT identifies hazardous or harmful drinking.
3. Where **any** current substance use is identified the 30 day substance use profile should be completed [Appendix D] (linked from Dual Diagnosis screen).
4. Where significant substance use problems are identified the assessing practitioner should discuss with the service user referral to the specialist provider of drug and alcohol treatment services in Somerset (SDAS). This discussion and the service user's response should be documented within the Dual Diagnosis screen.

The SDAS referral forms can be accessed via the following link:

<http://www.somersetdap.org.uk/page/sdas-news/78/>

5. Where a service user declines referral to SDAS this discussion should be documented within the RiO substance misuse screen:

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

6. For further information regarding the service provision and responsibilities of SDAS see the Somerset Joint Working Protocol For Co-existing severe, enduring mental disorders and substance misuse (dual diagnosis).

7. Risk assessment

- Identify hazardous or harmful drug or alcohol use on the Risk Screen (yes/no tick box) - **this should be complete for all service users.**
- Where hazardous or harmful drug or alcohol use is identified on the Risk Screen ensure that there is a corresponding entry on the Risk Information
- Ensure the severity of substance misuse, including the combination of substances used, is related to the risk of overdose and/or suicide.
- Explore the possible association between substance misuse and increased risk of aggressive or anti-social behaviour; this forms an

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integral part of the risk assessment and should be explicitly documented if present

8. Where substance use is identified as problematic or hazardous or harmful in the *acute* risk screen there should be:

A corresponding entry in the risk information, detailing the specifics (what, when, where, how constitutes risk and to whom – with informed clinical judgement about the likelihood of the event occurring)

A corresponding entry in the care plan (in accordance with the ICPA policy)
Appropriate specialist service and community support contacts for substance use specifically detailed in the crisis plan.

Documented discussion about referral to specialist services, this discussion should be documented in the relevant box on the Dual Diagnosis screen – these discussions should be revisited during treatment using a motivational approach.

9. Where substance use is identified as problematic or hazardous or harmful in the *long term* risk screen there should be:

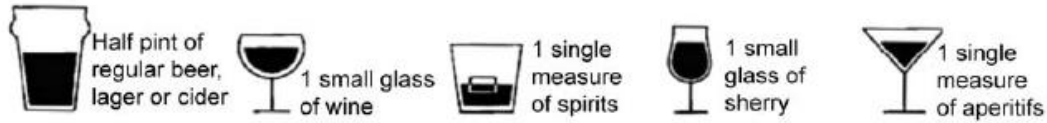
- corresponding entries in the risk information.
- Substance specific care plan entries should be tailored to the individuals current stage of change and need
- There are 3 specialist Care Plan Libraries for 1) Dual Diagnosis, 2) Alcohol and 3) Substance use are available within RiO. These have been designed to guide staff through the treatment approaches most appropriate to the patient's current presentation.
- Interventions offered and brief advice given should be clearly documented in the EPR.

10. The risk screens and risk information sections of the EPR should be updated in accordance with practice standards and ICPA policy.

11. Risk Management

- Crisis plan information should detail the local SDAS office contact information for all service users who have substance use problems (regardless of their level of motivation to engage with the service at the time).
- Crisis plans and risk management plans should clearly identify the individuals High Risk Situations for substance use and detail specific strategies to manage them that are tailored to the individual (including distraction techniques, self-help organisations and online resources, community support and specialist services).
- Ensure these are updated to reflect changing circumstances.

This is one unit of alcohol...



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



AUDIT - PC

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

A total of 5+ indicates increasing or higher risk drinking.
 An overall total score of 5 or above is AUDIT-PC positive.



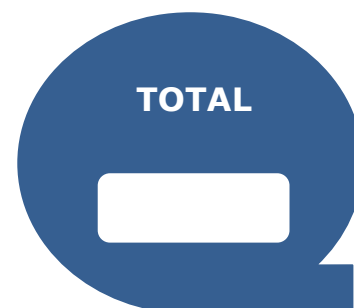
Score from AUDIT- PC (other side)



Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

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



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.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

2. The day after drinking alcohol, my hands shook first thing in the morning.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

5. The day after drinking alcohol, I dread waking up in the morning.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

8. The day after drinking alcohol, I felt very frightened when I awoke.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.

<i>ALMOST NEVER</i>	<i>SOMETIMES</i>	<i>OFTEN</i>	<i>NEARLY ALWAYS</i>
---------------------	------------------	--------------	----------------------

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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:

Almost never	0
Sometimes	1
Often	2
Nearly always	3

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.

30 DAY PROFILE OF SUBSTANCE USE

1. Select number of days used in past 30 days. Select 0 for no use.
2. Enter amount used on a typical day in the past 30 days (in weight or money)
3. Select main route of administration.

DRUG	DAYS USED	AMOUNT	MAIN ROUTE
Alcohol			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Heroin			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Illicit Methadone			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Illicit Benzodiazepine			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Cocaine powder			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Crack Cocaine			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Amphetamine			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Cannabis			Oral Sniff/snort Smoke/chase Intravenous Intramuscular

DRUG	DAYS USED	AMOUNT	MAIN ROUTE
Name of any other problem substance			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Name of any other problem substance			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Name of any other problem substance			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Name of any other problem substance			Oral Sniff/snort Smoke/chase Intravenous Intramuscular
Name of any other problem substance			Oral Sniff/snort Smoke/chase Intravenous Intramuscular

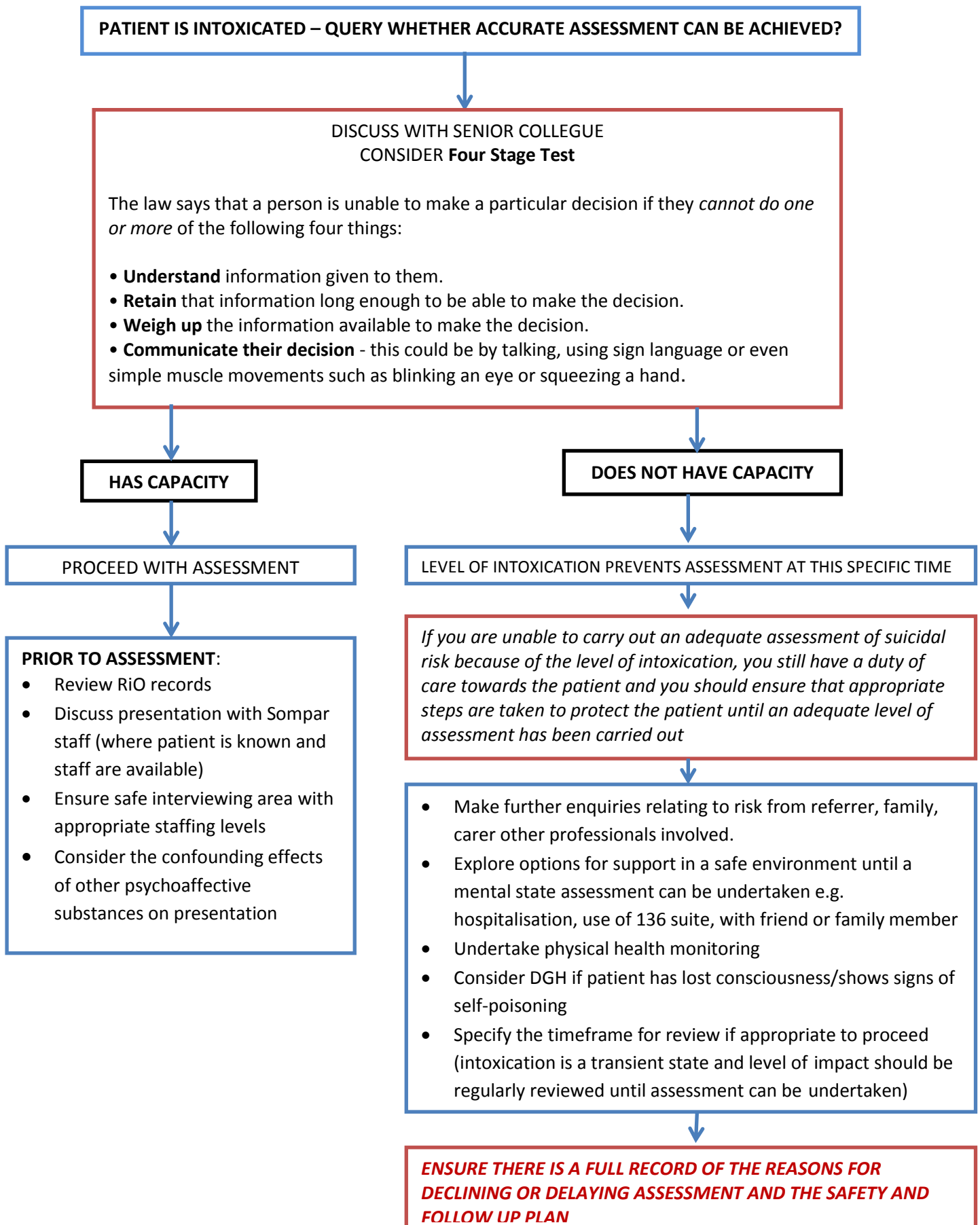
Responsibilities of the Somerset Partnership care coordinator (or Lead Professional) to Dual Diagnosis Service Users

1. Ensuring there is regular contact with the service user.
2. Advising other members of the care team of changes in circumstance of the service user which might require a review or change of the Care Plan.
3. Recording - including updating the Care Plan and risk management and relapse plans as necessary.
4. Ensuring the care plan includes an assessment of the person's physical health, social care and other support needs, and make provision to meet those needs.
5. Consider covering behaviours in the care plan that may affect the person's physical or mental health, in addition to their substance misuse (see NICE's pathways on drug misuse and alcohol-use disorders).
6. Exploring any barriers to self-care to help the person look after their own physical health. Address these barriers in the care plan.
7. Consider incorporating activities in the care plan that can help to improve wellbeing and create a sense of belonging or purpose.
8. Consider approaches to keep people involved in their care plan. Ensure agencies and staff communicate with each other so the person is not automatically discharged from the care plan because they missed an appointment. All practitioners involved in the person's care should discuss a non-attendance.
9. Recognise that even though building a relationship with the person and seeing even small improvements may take a long time, it is worth persevering.
10. Help those who may find it difficult to engage with services to get into and stay connected with services. Start and maintain contact using proactive, flexible approaches
11. Recognise that people with coexisting severe mental illness and substance misuse are at higher risk of not using, or losing contact with, services. There are specific populations who are more at risk. These include men, young people, older people and women who are pregnant or have recently given birth. It also includes:
 - people who are homeless
 - people who have experienced or witnessed abuse or violence
 - people with language difficulties
 - people who are parents or carers who may fear the consequences of contact with statutory services.

- 12.** Explore with the person why they may stop using services that can help them. Ensure any loss of contact or non-attendance at any appointment or activity is viewed by all practitioners involved in the person's care as a matter of concern. Follow-up actions could include:
- contacting the person to rearrange an appointment
 - visiting the person at home
 - contacting any other practitioners involved in their care, or family or carers identified in the person's care plan

The in-patient care team responsibilities for liaison in relation to SDAS patients

1. Informing SDAS when the client has been admitted.
2. Where a client is receiving substitute prescribing from SDAS the in-patient team must liaise with the client and SDAS and establish the dispensing chemist.
3. 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.*
4. Informing SDAS of the planned discharge date and liaising with them regarding pharmacological treatment, to ensure smooth transitions for the client.
5. Wherever possible Somerset Partnership will give SDAS 5 days' notice of discharge of dual diagnosis clients to enable SDAS to arrange for community prescribing and dispensing to recommence.
6. Informing SDAS when a client has become AWOL or self-discharged.
7. Informing the GP when a client has become AWOL or self-discharged.
8. When a client is receiving substitute prescribing inform SDAS and the GP of the date, time and dose of last administration on the ward.



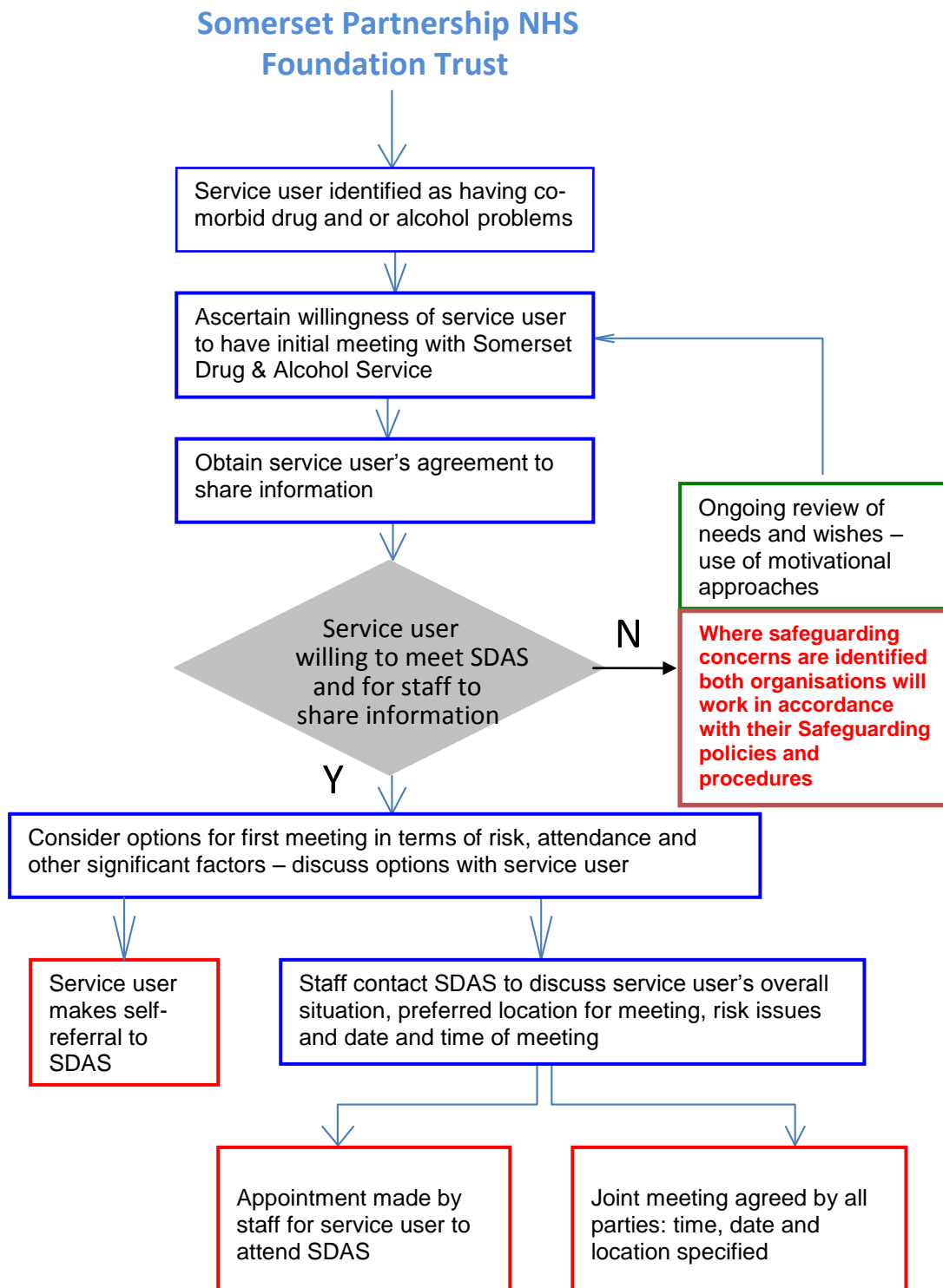
Criteria for accessing SDAS

People who exhibit the following in relation to their drug or alcohol use:

1. Harm or potential harm in relation to:
 - Use of a range of substances including alcohol, heroin, amphetamine, cannabis, cocaine and Novel Psychoactive Substances
 - Injecting (including neck and groin injecting)
 - Sharing of injecting equipment
 - Pregnancy
 - Dependent, hazardous or harmful drinking
 - Preoccupation with substance use at the expense of social functioning, physical health, legal status or caring responsibilities.
 - Vulnerability to harm from others including physical and sexual abuse
 - Risk of harm to others in their care including children or vulnerable adults

2. Other needs often associated with substance misuse:
 - Chaotic, disorganised and unstructured lifestyles
 - Unstable or inadequate living arrangements, including homelessness
 - Poor general health including poor dental hygiene
 - Unknown hepatitis B and C status
 - Physical health problems associated with substance use
 - Psychological problems and emotional needs
 - Poor or deteriorating personal relationships
 - A range of other unresolved personal issues, including debt and housing

Identification of substance misuse by Somerset Partnership and care pathway to Somerset Drug & Alcohol Service



The SDAS referral form is available at:
<http://www.somersetdap.org.uk/page/sdas-news/78/>

It is also attached as appendix 1 of this protocol.

The key tasks of the Somerset Partnership Care Coordinator or Lead Professional in respect of joint working arrangements with SDAS:

1. Ascertain the service user's willingness to share information and meet with SDAS. Service user consent is required to make a referral to, or hold a joint meeting with, SDAS.
2. Make initial contact with SDAS.
3. Ensure the date, time, venue and all other relevant information pertaining to the substance misuse assessment to be carried out by SDAS is clarified, communicated and agreed with the service user and recorded in the EPR.
4. Ensure that all relevant assessment information (including AUDIT and 30 day substance use profile) is provided to SDAS with the referral so as to avoid unnecessary duplication of the assessment process.
5. Clarify who the named worker is within SDAS.
6. Ensure that all contacts made with the Partnership by SDAS workers are recorded in the EPR.
7. Convene the multi-agency assessment, review or other meetings as required
8. Ensure a copy of the substance misuse assessment made by SDAS (or a summary of key issues from this) are received and recorded onto RIO
9. 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
10. Ensure there is no unnecessary overlap or duplication in the provision of the different elements of the joint care plan
11. Ensure the SDAS worker receives a copy of the Joint Care Plan and relevant assessments of risk – this should occur at the point of referral to SDAS and when any changes are made to the care plan.
12. Communicate with the SDAS worker to ensure that a regular update is received on the service users' progress with the substance misuse elements of care plan
13. Communicate with the SDAS worker on an appropriate basis about all issues relevant to the service user's engagement with either service
14. Mental health aspects of joint assessment, joint care planning and joint care plan reviews are led and conducted by staff from Somerset Partnership.

Considerations regarding suitability for psychological therapies for dual diagnosis clients

Somerset Partnership Psychological Therapies services (Somerset Partnership Talking Therapies Service (SPTT) in primary care and the Adult Psychology and Psychological Therapies service in secondary care) and Somerset Drug and Alcohol Service (SDAS) are committed to working jointly and inclusively with those who have drink or drug problems.

We recognise that successful outcomes for both problems need early intervention and effective joint working between drug and alcohol treatment and mental health services in integrated, recovery-oriented local systems.

The SPTT responds to people with common mental health problems. The Adult Psychology and Psychological Therapies service responds to people with severe and enduring mental health problems in secondary mental health care services.

Information-sharing and communication between Psychological Therapies (primary and secondary care) and SDAS follow the principles and procedures outlined in the Somerset Partnership and SDAS Joint Working Protocol.

This appendix outlines criteria for deciding whether people with different kinds of drug and alcohol use are suitable for Psychological Therapy services and summarises how services can work together more closely to improve outcomes for clients.

SPTT services do not provide complex interventions to treat substance use problems but drug and alcohol use are not be an automatic exclusion criterion for accessing psychological therapy. A prerequisite for SPTT involvement is that the client has a depression or anxiety disorder that falls within IAPT's usual criteria.

Psychological Therapists work with substance using clients is guided by the **IAPT positive practice guide for working with people who use drugs and alcohol (January 2012)**

- We recognise most drug and alcohol users do not need specialist or clinical interventions to change their substance use behaviour and, of those that do, many will respond to brief interventions delivered in primary care.
- Only a small proportion of drug and alcohol users will require specialist treatment services and, in some circumstances, referral to drug and alcohol services will be appropriate.
- Routine assessment of current use of drugs and alcohol is undertaken for all Psychological Therapy clients.

- Where a client of a Psychological Therapist is identified as having a substance use problem that requires specialist drug and alcohol service involvement referral will be made (or self-referral supported) in accordance with the processes and procedures outlined in the Joint Working Protocol.

In these circumstances the Psychological Therapist should:

- Record information about historical and current substance use
- Ascertain the service user's willingness for Somerset Drug & Alcohol Service to be involved
- Gain the service user's consent to share information
- Contact Somerset Drug & Alcohol Service
- Consider practical issues (for example the use of public transport, childcare)
- Consider emotional support issues and encourage the service user to involve or invite family members, carers or advocates.
- Send a copy of the assessment to SDAS using one of the agreed methods.
- Ensure a copy of the actions is input onto IAPTUS or RiO

Following the assessment, the Somerset Drug & Alcohol Service staff member should:

- Discuss with the Psychological Therapist the key issues arising and a proposed care plan relating to substance misuse and related problems.
- Send a copy of the substance misuse assessment to the Psychological Therapist using one of the agreed methods.

Following this the Psychological Therapist should:

- Ensure a copy of the substance misuse assessment is input onto IAPTUS or RiO

- In such cases, standard keyworking in the addictions service would continue to work on these issues until some stability is achieved.
- In line with good practice in care planning it would be helpful to specify a timeframe for reassessment in the Psychological therapy service post detoxification or when stabilisation has been achieved. This may inform a part of an agreed aftercare and recovery support plan.
- Joint case-discussion forums, supervision groups and openness to mutual consultation with addiction services are an essential component of effective

joint working. Workers can both refer cases to the monthly Dual Diagnosis supervision and Consultation group facilitated by Dr Helen Bellfield.

Psychological Therapy is considered suitable if:

1. The client is able to attend sessions and has motivation to limit their drug or alcohol use. This is demonstrated by control of their drug or alcohol use (including the ability to attend sessions without being intoxicated and to remain free of intoxicants for a period of 2 or more hours post session – this is required so as to be intellectually and emotionally available) and / or when it is limited to clearly circumscribed contexts.

Some examples include:

- A weekend user of ecstasy who finds social situations anxiety provoking.
- A client who is afraid of heights and manages flying by taking diazepam and alcohol.
- Uses the minimum amount required to manage anxiety/depression or other problems, typically in relatively small quantities spread throughout the day to maximise the beneficial effects on anxiety/mood, or
- Uses the minimum amount to prevent withdrawal symptoms, or only used rarely for positive mood enhancement (fun, euphoria, high, buzz), or only used rarely to numb or suppress thoughts, feelings or memories

2. The client is stable, i.e. using medication as prescribed and not using additional non-prescribed medication or illicit drugs. This would include clients on opioid substitution programmes (usually methadone or buprenorphine). No one will be excluded from Psychological Therapy services because they are being prescribed substitute medication.

Examples of clients suitable for Psychological Therapy and stable on, or reducing, their prescribed medication would include:

- A client experiencing low mood, taking methadone but not using heroin or drinking alcohol on top of their prescription.
- A client with panic disorder reducing their prescribed benzodiazepine use.

3. The client has a history of drug or alcohol use but is now abstinent.

For example:

- A client with social anxiety who has recently successfully completed a community alcohol detoxification.

Psychological Therapy would not initially be suitable if:

1. The client is dependent on illicit drugs or alcohol and not in contact with a treatment service.

Examples include:

- A client reporting panic attacks and drinking alcohol every morning to stop the shakes.
- A client regularly bingeing on crack cocaine and becoming very depressed in the recovery phase between these binges

2. The client is in treatment with a drug or alcohol treatment service but unable to make changes in their substance use as a consequence of mental health issues.

Examples include:

- A client continuing to use heroin in addition to their methadone because their low mood is perceived to be intolerable.
- A daily smoker of cannabis whose smoking has become a coping strategy for all daily life events

3. Frequent drug &/or alcohol used primarily for pleasure or numbing/suppression

Examples include:

- Uses the maximum amount required to give positive mood enhancement (fun, euphoria, high, buzz), typically using large quantities all at once during the day in order to maximise the positive effects on mood, often at the same time as other sedative medications), or
- Frequent use of drugs &/or alcohol to numb or suppress thoughts, feelings or memories

4. High level or uncontrolled non-prescribed drug and alcohol use

Drugs &/or alcohol use drugs, which is uncontrolled, varying from day to day, often involving a combination of drugs, and involves risk taking e.g. risk of overdose

APPENDIX L

Somerset Partnership Dual Diagnosis Leads

Lead Consultant Psychiatrist for Dual Diagnosis for Somerset Partnership	Dr Nick Airey, Consultant Psychiatrist	Somerset Partnership NHS Foundation Trust Broadway Health Park Barclay Street Bridgwater TA6 5YA Tel: 01278 454130
Lead Consultant Clinical Psychologist for Dual Diagnosis for Somerset Partnership	Dr Helen Bellfield, Consultant Clinical Psychologist	Somerset Partnership NHS Foundation Trust Broadway Health Park Barclay Street Bridgwater TA6 5YA Tel: 01278 454130

SDAS Hub Office Contact Details

Somerset Drug & Alcohol Service Team	Referrals, advice, information, interagency liaison
Mendip	Arch House 12 Palmer Street Frome Tel: 01373 475560
Somerset Coast	Bridge House 30 Taunton Rd Bridgwater TA6 3LS Tel. 01278 456561
Taunton Dean	Unity House 10, Cannon Street Taunton TA1 1SN Tel. 01823 328460
South Somerset	Maltravers House Petters Way Yeovil BA20 1SH Tel. 01935 383360

Assessing vulnerability to substance misuse.

Staff have a responsibility to identify people at risk of using drugs and then to deliver targeted harm prevention activities.

At Risk Groups:

- people who have mental health problems
- people who are being sexually exploited or sexually assaulted
- people involved in commercial sex work
- people who are lesbian, gay, bisexual or transgender
- people not in employment, education or training (including children and young people who are excluded from school or who truant regularly)
- children and young people whose carers or families use drugs
- children and young people who are looked after or care leavers
- children and young people who are in contact with young offender teams but not in secure environments (prisons and young offender institutions)
- people who are considered homeless
- people who attend nightclubs and festivals
- people who are known to use drugs occasionally or recreationally.
- Also consider people accessing gym with regards to potential to use image/performance enhancing drugs

Offer information and advice both verbally and in writing. Provide advice in a non-judgemental way and tailor it to the person's preferences, needs and level of understanding about their health.

Consider providing information on

- Drugs and their effects (NHS choices)
- Local services and where to find further information or support
- On-line self-assessment and feedback to help people assess their own drug use