Southern Health **NHS**

NHS Foundation Trust

SH CP 47

Dual Diagnosis Policy

(Substance Misuse & Mental Health Problems)

Version: 2

Summary:	This policy sets out the arrangements for working with service users who present with a dual diagnosis of mental health and substance misuse problems. It describes the service access, pathway arrangements and care responsibilities of mental health services.

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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
18.08.16	David Kingdon (lead)	V2	Throughout	Major update due to changes in services, commissioning and evidence-base including from SIRIs
9/11/17		V2	16	added web link within the references https://www.nice.org.uk/guidance/ng58

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Dual Diagnosis Policy

1. Introduction

1.1 Historically, substance misuse and mental health services have evolved and been commissioned separately and few services exist which explicitly deal with clients with both substance misuse and mental health problems. These clients have either been treated within one service alone which has meant that some aspects of their problems have not been dealt with as well as they might; or shuttled between services with a corresponding loss of continuity of care; or attempts have been made at collaborative working with varying success.

1.2 There have also been repeated changes in the commissioning and design of both mental health and substance use services which has led to confusion around access routes and interfered with collaboration. Development of new services such as those for Improving Access to Psychological Treatment (iTalk and Steps to Wellbeing) also has led to new interfaces.

1.3 The provision of care for people with a combination of mental health problems and substance misuse requires needs to be organised around the user with service commissioners and providers working together with this aim.

1.4 Substance Misuse is more common amongst adults with mental health problems than in the wider population and it is generally accepted that 30 – 40% of people with severe mental illness also have problems with substances.

1.5 Alcohol and drug misuse is common among people with mental health problems and the relationship between the two is complex. Up to 70% of people in drug services and 86% of alcohol services users experience mental health problems. Mental health problems, e.g. depression and anxiety, have been found to precede the development of substance abuse problems in most individuals.

1.6 The National Confidential Inquiry Into Suicide And Homicide By People With Mental Illness 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.

1.7 Co-existing alcohol use with mental health issues featured prominently in hospital admissions data - of mental health crisis related admissions to acute hospital via A&E in 2012/13, 20% were due to alcohol use (the second highest proportion after self-harm and undetermined injury).

1.8 A high prevalence exists among prison populations with the 2009 Bradley report recognising that co-existing alcohol and drug misuse and mental health issues are the norm rather than the exception among most offenders. Prisoners are also at increased risk of self-harm and suicide.

1.9 Data collected from trial sites commissioned by NHSE under the Liaison and Diversion Programme showed that over 55% of service users identified in with mental health needs also had problem with either substance abuse, alcohol misuse or both. Similarly, amongst those with alcohol misuse issues, over three-quarters also suffered a mental health problem. In the case of people with other substance misuse, the percentage who also demonstrated mental health needs was even higher at 79%.

1.10 Both alcohol and drug misuse and mental health problems can lead to considerable physical morbidity and premature mortality (15-20 years in people with mental health problems and 9-17 years in those with alcohol and drug misuse disorders compared to national norms

1.11 The National Service Framework (NSF) for mental health (Department of Health 1999) and the subsequent Dual Diagnosis Good Practice Policy Implementation Guide (PIG), Department of Health 2002, recommend that the people with dual diagnosis should be provided within mainstream mental health services. This is also reflected in the Hampshire Dual Diagnosis Commissioning Strategy

1.12 This policy therefore sets out how Adult Mental Health Services provide effective and responsive integrated services for individuals with a dual diagnosis of mental illness and substance misuse including arrangements for managing the risks associated with dual diagnosis in collaboration with Substance Misuse Services (which SHFT does not provide). It sets out the service access, pathway arrangements and care responsibilities for both mental health and substance misuse services.

1.13 The Dual Diagnosis forum will set the overall direction for the model of care for dual diagnosis in the Trust. It provides advice and guidance to the Divisional Quality & Strategy Board (DQSB). It is the focal point for the discussions to which partner agencies will be invited and debate about Trust-wide issues relating to dual diagnosis.

1.14 It is proposed that Local Dual Diagnosis Pathways groups are established in Southampton, SE and North & West Hampshire. Where problems and gaps exist within services for people with dual diagnosis, these will be discussed at these fora.

2. Scope

2.1 This policy applies to service users in both inpatient and community settings with comorbid mental health and substance misuse problems.

2.2 This policy applies to service users in both inpatient and community settings with comorbid mental health and substance misuse problems

2.3 The policy applies to all Trust clinical and managerial staff involved in the provision of services for those with comorbid mental health and substance misuse problems.

3. Definitions

3.1 Substance use or misuse for the purposes of this policy includes alcohol, illicit drugs, including volatile agents (e.g. solvents) and prescription drugs used in a non-beneficial or potentially hazardous way.

3.2 The term 'dual diagnosis' or 'co-morbidity' covers a broad spectrum of mental health conditions and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:-
- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of psychiatric illness
- Intoxication and/or substance dependence leading to psychiatric symptoms or illness

3.3 Substance use does not inevitably lead to deterioration in mental health problems and may be used to cope with anxiety, hallucinations and sedation from medication with mixed effects. Assessment of individual responses, both positive and negative, is necessary for effective engagement and management.

3.4 Problematic substance misuse is defined as that which would warrant the person being referred to the drug and alcohol service in the absence of a mental illness. However the presence of mental illness may lead to problems developing at a lower level of intake of substances and a lower severity of mental illness lead to greater problems with use of substances.

3.5 'Personality disorders' especially borderline and antisocial frequently provide a further degree of complexity. Where these have developed from complex trauma, psychological intervention can be successful but practitioners may need to work with substance misuse services to enable individuals to access it.

4. Duties / Responsibilities

4.1 **Trust Board and Nominated Director** are responsible for ensuring that policies are in place and that an audit program exists to monitor compliance with aforementioned policies.

4.2 **Divisional Director of Operations, Clinical Director, Lead Nurse** are responsible for
   - ensuring that this policy is being followed through the receiving and monitoring of audit reports and the creation of action plans to address any identified problems.
   - translating and supporting areas to transpose this into real changes and better working at local levels
   - achieving the vision that each team (CMHT/AMHT) would develop a local joint working procedure with their local substance misuse team so that together they agree how they will work based on the wider policy and direction from the Trust and their CCG.

4.3 **Area Managers, Clinical Service Directors and Acute Care and Community Team Managers** are responsible for:-
   - The implementation of the policy within their areas of responsibility
   - Being the next point of escalation in cases where there are differences of opinion at Team Manager level
   - Ensuring all relevant staff access the agreed training plan
   - Establishing and supporting Local Dual Diagnosis Pathway meetings to meet at regular intervals, e.g. quarterly, to improve working relationships and inviting membership from CCG, SHFT, Substance use service providers, Housing, Voluntary sector, Service users.
   - Appointment of Dual Diagnosis 'champions' in each CMHT, AMHT and Acute unit.
   - Review of SIRIs of patients with DD in contact with SHFT services that have died from drug overdose with substance misuse specialists.

4.4 **Ward Managers / Community Team Leaders** are responsible for:-
   - Ensure staff undertake full assessment of both mental health and substance use needs, including risk assessments, to identify co-morbidity
   - When substance misuse problems are identified from clinical assessment &/or Health of the Nation Outcome Scales (HoNOS) Scale 3 that AUDIT or DUDIT are completed

- Ensuring that staff provide care to service users identified as having a dual diagnosis and that staff refer to substance misuse services as appropriate depending on the need of the service user.
- Ensuring that staff access the agreed training
- The appropriate allocation of cases of service users with dual diagnosis to staff
- Ensuring staff have access to clinical supervision
- Receive and process referrals to mental health according to the integrated pathway
- Ensure that staff work collaboratively with substance misuse services. Joint working may not be necessary in every case, particularly in cases where staff have the necessary skills to work with service users with co-existing mental health and substance misuse needs. However in more complex cases where the service user is open to both services, joint working should occur.

4.5 **Mental Health Practitioner or Inpatient Staff** are responsible for:-
- Making a full assessment of mental health problems and substance use
- Completing HoNOS at initial assessment and discharge, and subsequent defined periods (e.g. annually) including the substance use scale (3). If it is suspected that substances are being misused, complete AUDIT and/or DUDIT scales.
- Providing care to service users identified as having a dual diagnosis and act as their Care Co-ordinator or primary Nurse
- Acting as a resource for Substance Misuse staff on mental health issues when required
- Working in partnership with Substance Misuse team members when appropriate

5.   Main policy content:

Guidance for delivery of care

5.1 Secondary treatment services should work collaboratively and co-operate to meet the needs of people with dual diagnosis through existing mental health and drug and alcohol services. Any interventions designed to meet these needs should be reflected in individualised care plans that are jointly developed with service users, their families or carers and any care agencies.

5.2 This policy acknowledges that there are differences in clinical recording systems. However, services need to ensure that they communicate effectively so that the differences do not create a barrier to communication.

5.3 An initial assessment of mental health and substance misuse needs should be completed, and individuals should be supported to access other services as appropriate. The following principles should inform service delivery and development of working protocols between providers in mental health and substance misuse services:

Principle 1 – Providers in alcohol and drug, mental health and other services should have an open door policy for individuals with co-existing alcohol and drug misuse and mental health issues, and should make every contact count.

What this means:

5.4 Service users can access screening, advice and comprehensive assessment which address alcohol and drug and mental health issues, and other presenting needs in both alcohol and drug and mental health services. All local services need to be ready to respond to the needs of individuals with co-existing substance misuse and mental

health issues, not just the presenting issue. Use of diagnoses as exclusion criteria compounds issues of stigma and this is likely to result in unmet need and increased risk of harm. Services should work to identify risks and mitigations to support engagement of all presenting individuals (including intoxicated individuals). Additionally, every opportunity should be taken to reduce health harms and early death among individuals with these co-existing issues by offering advice and support to:

- stop smoking
- eat healthily
- maintain a healthy weight
- drink alcohol within the recommended daily limits
- undertake the recommended amount of physical activity

5.5 Components of the Assessment Process

A comprehensive assessment should include initially dealing with urgent and complex presenting need together with the following elements:
- Comprehensive risk assessment
- Identification of response to any emergency or acute problem
- Assessment of patterns of substance misuse and the degree of dependency and withdrawal problems
- Assessment of physical, social and mental health problems
- Assessment of current and recent pharmaceutical intervention e.g. substitute prescribing
- Consideration of the relationship between substance misuse and mental health problems
- Assessment of carer involvement and need
- Safeguarding issues (Adults and Children)
- Working towards abstinence and a reduction of harm in relation to substance misuse
- Assessment of treatment history, particularly any involvement with specialist mental health services
- Determination of individuals' expectation of treatment and their degree of motivation for change
- The need for pharmacotherapy for substance misuse or mental health issues
- Stability of accommodation
- Employment status/daytime activity

5.6 Risk assessment

The risk assessment process should explore the presence of different risk factors across a range of indicators and cover the dual issues of mental health and drug alcohol use.

Factors associated with the increased likelihood of particular risks include:-
- Poor compliance with medication regimes
- Increased rates of inpatient admissions
- Homelessness
- Social exclusion
- Offending behaviour
- HIV or other BBV or physical health concerns
- Disengagement from services
- Suicidal ideation and actions

5.7 Crisis response:

People presenting in crisis frequently have dual diagnosis and management can present complex problems. Presentations can be to the Emergency Department, Police, Ambulance or Acute and Community Mental Health Teams and Substance misuse services. Safety issues often arise in terms of risk to self or others especially when the individual is intoxicated.

Management of the acute situation will focus on reducing agitation and risk to self or others. Assessment of mental state, including under the Mental Health Act, may be attempted but may have to await reduction in the intoxication. During this period, safety of the individual and others will be the priority. Assessment can then commence and appropriate actions taken which may include referral to substance misuse or mental health services.

Prevention of further such presentations should then be undertaken through prompt re-assessment and offering appropriate services. Work on motivation to access services should be considered as it may be possible between periods of substance misuse.

Early intervention should be facilitated by contact with relevant services through referral or duty worker/manager systems including early intervention for psychosis services.

Frequent attenders at ED or presenting to emergency services should be considered by area High Intensity User Groups including mental health and substance misuse lead practitioners.

How to know if this principle is translating to delivery:

5.8 **Service users:**
- are never turned away from services based on levels of alcohol and drug use or degree of mental ill health, and are supported to access the care they need in the service(s) most appropriate to their needs
- have their alcohol and drug needs recognised, prioritised and responded to by mental health practitioners, and their mental health needs recognised, prioritised and responded to by alcohol and drug practitioners
- regardless of their entry point to the care pathway, report that the care they receive is timely, compassionate and responsive to their needs
- are encouraged and supported to make healthier choices to achieve positive long-term behaviour change

5.9 **Clinicians and frontline staff:**
- Use effective screening, assessment, and (where appropriate) diagnosis information to inform development of comprehensive care planning, never to exclude people from services
- ensure where people are assessed as having co-existing issues that the provider addresses both initially and refers on when needed, rather than only addressing one area of need
- Work flexibly across organisational boundaries to enable service users to access the care that they need for alcohol, drug and mental health issues.

5.10 **Service managers:**
- Agree jointly owned care pathways and protocols for delivery of care to individuals across the full spectrum of alcohol and drug misuse, and mental health need
- Ensure that staff are supported to develop the competencies they need to respond effectively to individuals with co-existing alcohol, drug and mental health issues.

- Foster a service culture where clinicians and frontline staff can respond flexibly and offer care that is timely, compassionate and responsive to the needs of the individual

Principle 2 - Providers of substance misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing substance misuse and mental health issues

What this means:

5.11 The assessment and treatment of people who need care for co-existing alcohol and drug misuse and mental health issues are the responsibility of both mental health and alcohol & drug services, and all partners need to work together effectively across and outside organisational boundaries to meet their needs.

5.12 Mental health and alcohol and drug services should work together in line with relevant NICE and other national guidance, to deliver evidenced based interventions as part of jointly agreed care pathways. These should be jointly planned, designed to minimise any gaps in provision and opportunities for disengagement and relapse. Services should also work in partnership with other services as necessary, particularly housing, employment and criminal justice services. If services are unable to engage certain individuals this should be seen as a system failure not a client failure. The partnership should work with the individual and services involved to establish better or more appropriate ways of engaging these individuals.

5.13 Individuals with co-existing alcohol, drug and mental health issues are often at significant risk of suicide and self-harm, particularly during periods of intoxication or untreated withdrawal. Services (particularly crisis care services) need to be able to respond appropriately and safely to mental health needs such as suicide risk which arise during periods of intoxication where the individual is not dependent on alcohol or drugs.

5.14 Services also need to be able to respond effectively to individuals who present a risk to others e.g. violent/sex offenders or MAPPA clients who may not engage well with treatment services, but may present in crisis. This is likely to require short-term safety measures with provision of longer-term support with mental health and/or substance use issues.

5.15 Treatment Pathway (see Appendix 3)

Following identification of Dual Diagnosis or Co-morbidity, AMH will allocate a Care Co-ordinator or lead professional who will develop a care plan. The allocated Care Co-ordinator maintains lead responsibility for the care and is responsible for arranging a joint assessment with Substance Misuse Services when appropriate. A joint assessment with Substance Misuse is when the care needs identified may be best met by a joint intervention and joint care planning from both Mental Health and Substance Misuse Services.

Depending on service user's needs, it may not be necessary to refer to a substance Misuse co-worker, however, it is the responsibly of the care co-ordinator to ensure that the service user's substance misuse needs are assessed and met and mental health may not have all the resources required to meet the substance misuse needs. In addition, the service user may not consent to a referral to Substance Misuse Services. In such circumstances, it is the care co-ordinators responsibility to assess the risks and plan the management of these risks in relation to the Substance Misuse needs.

Pharmacological treatments, e.g. naltrexone, methadone and acamprosate, will usually be prescribed through substance misuse services but Shared Care Guidelines (SH CP 73) exist to enable their use by other doctors with support.

AMH and Substance Misuse will proceed with the treatment intervention, monitor progress against the Care Plan objectives which will be reviewed regularly.

Throughout the Pathway the care co-ordinator is responsible for leading co-ordination and communication to all other involved agencies.

5.16   Treatment Approaches

The Dual Diagnosis Good Practice Guide highlights the following stages of treatment to be included in any service model for this group:

- Engagement – this should be non-confrontational, empathic and respectful of the client's subjective experience of substance misuse. It may also have to focus on meeting a client's immediate practical need rather than focusing on the cessation of substance misuse.
- Motivation for change – the purpose is to strengthen a person's motivation and commitment to change whilst avoiding confrontation and resistance. Techniques include detailing objective assessment of the current situation, pros and cons of continual use, barriers to change etc.
- Active treatment – it needs to be acknowledged that it may take some time before the person is ready to engage in active treatment interventions for their substance misuse, it may be more appropriate to focus on harm reduction.
- Relapse prevention – given the chronic relapsing nature of substance misuse it is important that interventions focus on identifying high-risk situations and rehearsing coping strategies. As people may be in different stages in relation to their mental health and substance misuse, it is important that interventions are flexible and that the workforce is skilled in working in this way.

How to know if this principle is translating to delivery:

5.17   **Clinicians and front line staff:**
- know where to escalate issues with local pathways – including whistleblowing/making use of local safeguarding procedures if the system is failing to provide an adequate response to vulnerable people
- Use assessment information to develop comprehensive care plans rather than to exclude people from service
- Are competent, adequately trained and supervised to recognize and respond to presenting alcohol, drug and mental health need
- are able to work persistently and flexibly across organizational boundaries to ensure the full range of service user needs are met
- Always work within the limits of their competence and know when to involve other agencies
- Have participated in the development of/ have a clear understanding of locally agreed pathways and are able to support individuals to navigate these
- Are competent to respond to individuals presenting in mental health crisis and/or in states of intoxication, including assessing risk and involving other agencies as appropriate

5.18 **Service Managers:**
- Have agreed a continuous care pathway with alcohol and drug, mental health and other providers, with appropriate links to other supporting services (e.g. primary care, homelessness)
- Have agreed assessment protocols to ensure mental health needs and substance misuse issues can be identified, and information shared with other professionals as necessary
- have established supervision structures for staff around treating this patient group.
- work constructively and flexibly across organizational boundaries, and negotiate solutions to issues which arise without adversely affecting continuity of care
- understand and make use of local quality governance structures, including safeguarding and SUI reporting
- are able to escalate issues with the agreed care pathway to local commissioners as appropriate
- have established recording systems so that the coordination and communication of care planning between substance misuse and mental health is consistent and well-articulated.
- have established agency level structures which support service user involvement, and regularly involve service users in service design activity as well as decisions about their care

5.19 **Service users:**
- know where to escalate issues if they are not happy with the offer of care they have received.
- are consulted and involved in decisions about their care, including involvement of other agencies
- are involved the design of services and care pathways by service providers and commissioners

Principle 3 – People can and do recover from alcohol and drug misuse and mental ill health

What this means:

5.20 The concept of recovery features prominently in both alcohol and drug misuse and mental health service sectors. While there is no single definition of recovery in either sector, there are some elements which are very relevant to both:

5.21 **The recovery process:**
- provides a holistic view of mental illness and alcohol and drug misuse that focuses on the person, and their strengths or 'recovery capital' not just their symptoms
- believes that recovery from mental illness and alcohol and drug misuse is possible
- is a journey rather than a destination
- does not necessarily mean getting back to where you were before
- happens in 'fits and starts' and, like life, has many ups and downs
- calls for optimism and commitment from all concerned
- is profoundly influenced by people's expectations and attitudes
- requires a well organised system of support from family, friends or professionals

What this means:

5.22 Above all, it is vital that people working with individuals with co-existing alcohol and drug misuse with mental health issues demonstrate a genuine belief in the possibility

of recovery, defined by the patient, for all service users, and that all interaction and engagement with service users is undertaken in a spirit of optimism and commitment to supporting the individual to achieve this. In practical terms, services should adopt a 'whole person' approach, supporting individual service users to enjoy the rights and responsibilities of active participation in their community. This may involve ensuring that their housing needs, education, training and employment needs are understood and met; it may require family or parenting support. Local mutual aid organisations and recovery communities can often play a key role in supporting the recovery journey of an individual.

5.23 **Service users:**
- Have an agreed recovery plan which includes an assessment of strengths and recovery supports
- Report that staff convey a spirit of hope and belief that they can make positive change, and also that staff offer a range of support to enable them to make this change.

5.24 **Clinicians and frontline staff:**
- Approach every contact with people with co-existing alcohol, drug and mental health issues in a spirit of hope and belief in the possibility of positive change.
- Ensure that screening and assessment protocols focus on strengths and recovery capital as well as presenting issues and challenges
- Assertively promote alcohol and drug recovery and community engagement, in all forms (12 Step, SMART, peer support workers, service user and mutual aid groups, family and carer groups), across all alcohol, drug and mental health services for those with co-existing issues.

5.25 **Service managers:**

- foster a culture which promotes hope, commitment and belief in recovery
- ensure that access to mutual aid, recovery communities and recovery support feature prominently in the agreed care pathway
- support effective engagement with carers and family members in support of the individual's recovery

Special Consideration Groups

5.26 Certain groups of individuals are emphasised in the Dual Diagnosis Good Practice Guide as requiring special attention and practitioners working in these areas were interviewed to identify local themes.

5.27 Young People

Substance Misuse is identified as a major contributory factor in the development of mental health problems in the young. Early onset of substance misuse is linked with higher rates of major depressive disorders and it is estimated that a third of young people committing suicide are intoxicated with alcohol at the time of death (Dual Diagnosis Good Practice Guide).

Currently, there are separate Substance Misuse Services commissioned for under 18s in Hampshire.

5.28 Homeless People

Studies have highlighted high levels of concurrent substance misuse and mental health problems amongst the homeless and rough sleepers. Homelessness almost

trebles a young person's chance of developing a mental health problem (Dual Diagnosis Good Practice Guide 2002). Collaborative working with the Homeless Healthcare Team in Southampton can lead to benefits for this group.

5.29 People from Ethnic Minorities

Severe mental illness and substance misuse present difficulties across cultures and ethnic groups. Ethnicity is associated with poor access to services generally and, with different meanings and values attributed to drugs and alcohol, need to be understood. Service provision must therefore be congruent with and sensitive to the needs of each ethnic group.

5.30 **Safeguarding Vulnerable Children and Adults**

The Children Act sets out the responsibilities of local authorities and other services for protecting children and promoting their welfare. The key principle of the Act is that the well-being of the child is paramount. The Act places a duty on agencies engaging with people who misuse substances who have dependent children and on mental health services to assess the needs of children, their health and well-being as they may be at risk. The Act states that parents should normally be responsible for their children. This implies that health and social care agencies should not separate the child from the parents unless it is clearly in the interests of the child to do so.

Within the risk assessment full account should be taken of the particular challenges posed by parents with dual diagnosis problems, and the need for supervision, staff training, assessment, care management, and inter- agency liaison.

Where there are safeguarding concerns for the service user, the Mental Health Service will remain the lead agency for the safeguarding process.

The Adults Safeguarding policy is available on the below link:-
http://www3.hants.gov.uk/proc-2810.pdf

5.31 **Information Sharing and Communication between Services**

The principle of confidentiality should not be used to prevent the sharing of information where risk to the client or others including dependant children, has been   identified. The client and where appropriate the carers should be informed of   information shared.

A record of all risk assessments, care plans, meetings needs treatments relating to the service user's mental health problems and substance misuse must be kept in the service user's notes. The policy acknowledges that there are challenges with recording electronic record keeping because staff from the different mental health and substance misuse services do not have access to each other's systems. However, joint working and information sharing and communication is important so staff must liaise with each other to ensure records are kept up-to-date.

It is vitally important that joint working and good communications between all involved should be maintained throughout to effectively address the needs of clients. This should be ensured by the CPA process/Models of Care system and include the client and carers. Robust record keeping will be required.

Care co-ordinators and local workers will be expected to attend meetings/reviews and present reports when required together with the general sharing of plans, problems

and changing needs, e.g. Attendance at safeguarding reviews and anything outside their usual remit, plus clinical review meetings.

A higher level or regular contact should be established and maintained with a clear emphasis that any change in circumstances be shared on a need to know basis.

5.32 The process to follow where there is a difference of opinion

Services and agencies should work together to overcome misunderstandings and/or agency differences in order to protect the best interests and promote the best possible range of care for dual diagnosis clients. Conflicts over appropriate care pathway and services must be escalated to the locality manager for resolution and documented in the service user's clinical records.

5.33 Discharge and disengagement from services

Referral should be made to the relevant policy (SH CP 97). Decisions should be made with the referrer and with other involved agencies.

There will nevertheless be circumstances in which substance misuse services reach the conclusion that they have offered available evidence-based treatments and the individual has not been able to utilise them either through inefficacy of the intervention or inability of the person to engage with the requirements of the intervention. There will similarly be occasions where mental health services reach the same conclusion.

Where one service remains involved, the support and ability to consult the other should remain available. Where both decide that discharge is appropriate, it is especially important that within the bounds of confidentiality restraints, other involved agencies including the GP are aware of the reasons for this and the circumstances in which re-referral may be considered (as in SH CP 97).

6   Training Requirements

Training will be available to all staff in both Adult Mental Health and Substance Misuse Services, who routinely come into contact with people with dual diagnosis and will seek to involve reciprocal training from partner agencies.

6.1   Training needs around complexity of care planning and risk management are met within current risk management and CPA training.

6.2   Level 1 Dual Diagnosis training addresses skills, attitudes and knowledge to screen, detect and be aware of the needs of service users with dual diagnosis (LEaD interactive training package)

6.3   Level 2 dual diagnosis training addresses skills and competencies to deliver effective care in relation to comprehensive assessment engagement and treatment approaches.

6.4   Level 3 Training for dual diagnosis 'Champions' – individually assessed and may include secondment opportunities to substance misuse services.

6.5   All staff who are required to complete Dual Diagnosis level 1 training are identified on the Training Needs Analysis (appendix 1). Other staff may be identified to complete the training however this will not be considered mandatory.

7   Monitoring Compliance

Sources of data for monitoring include Public Health England 'Fingertips' site, NHS Digital (formerly HSCIC), National Drug Agency Data and local data sources (baseline date to be attached).

The Trust monitors its compliance with the Dual Diagnosis Policy through the following processes:

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Implementation of the policy including adherence to the service access and pathway arrangements		Audit	Annual	Integrated Governance
Level 1 training		Training Records	Annual	Performance Group

8   Policy Review

This policy will be reviewed and monitored by the AMH Dual Diagnosis Forum.

9   Associated Documents

- Dual Diagnosis Good Practice Guide, Department of Health (2002)
- National Treatment Agency (2002) Models of Care
- Department of Health (2008) Refocusing the Care Programme Approach policy and Positive Practice Guidance
- National Institute for Mental Health in England (NIMHE) (2003) Preventing Suicide – a Toolkit for Mental Health Services
- Department of Health Care Services Improvement Partnership (CSIP) (2006) Closing the Gap – A Capability Framework for Dual Diagnosis
- Hampshire County Council Dual Diagnosis Commissioning Strategy (2009)

10   Supporting References

- The Dual Diagnosis Good Practice Guide (DOH) (2002)
- Relevant NICE pathways and guidelines (https://www.nice.org.uk/guidance/cg120/ifp/chapter/psychosis-and-drug-andor-alcohol-use?print=true; https://www.nice.org.uk/guidance/health-protection/drug-misuse https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/alcohol) https://www.nice.org.uk/guidance/ng58

APPENDIX 1

LEAD (Leadership, Education & Development) Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEAD department (Deputy Head of LEAD or LEAD Strategic Education Lead) before the policy goes through Policy Board.

Training Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
Dual Diagnosis Level 1	Once	April – March each year Face to face 2 hours e-learning- 1 hour	face to face, e-learning	LEaD	LEaD	Mark Morgan Divisional Manager

Directorate	Division	Target Audience
MH/LD	Adult Mental Health	Sisters/charge nurses and ward managers working in acute in patient settings. Band 7 team leaders in community teams.
	Learning Disabilities	Not applicable
	Older Persons Mental Health	Not applicable
	Specialised Services	Not applicable
	TQtwentyone	Not applicable
ICS	Adults	Not applicable
	Childrens & Wellbeing	Not applicable
	Dental	Not applicable
Corporate Services	All (HR, Finance, Governance, Estates etc.)	Not applicable

APPENDIX 2

Southern Health NHS Foundation Trust
Equality Impact Assessment / Equality Analysis Screening Tool

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on different groups within the community

For guidance and support in completing this form please contact a member of the Equality and Diversity team on 01256 376358

Name of policy/service/project/plan:	Dual Diagnosis
Policy Number:	
Department:	Adult Mental Health
Lead officer for assessment:	Debra Moore Deputy Director of Nursing & Quality MH & LD
Date Assessment Carried Out:	29.05.12

1. Identify the aims of the policy and how it is implemented.	
Key questions	**Answers / Notes**
Briefly describe purpose of the policy including • How the policy is delivered and by whom • Intended outcomes	Aim of policy is to set out the arrangements for managing the risks associated with the management of service users with dual diagnosis and confirm service access, care responsibilities and pathway arrangements. This is a review policy written for Southern Health NHS Foundation Trust and replaces Hampshire Partnership NHS Trust Dual Diagnosis Strategy (2002).
Provide brief details of the scope of the policy being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?	Review of existing Dual Diagnosis Strategy

APPENDIX 2

2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **SIRIs**, **external inspections** or audit reports

	Key questions	Data, research and information that you can refer to
2.1	What is the equalities profile of the team delivering the service/policy?	N/A
2.2	What equalities training have staff received?	Trust mandatory training
2.3	What is the equalities profile of service users?	National research evidence practice guidance highlights service users with a dual diagnosis can fall between services
2.4	What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?	National PHE data
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	AMH Dual Diagnosis Forum.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	EIA will be reviewed with policy at next review date.

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this.

	Positive impact (including examples of what the policy/service has done to promote equality)	Negative Impact	Action Plan to address negative impact			
			Actions to overcome problem/barrier	Resources required	Responsibility	1.15 Target date
Age	This policy highlights the needs of young people and the specific risks that may occur to young people who are using substances.					
Disability	The Trust will ensure that all its facilities and estates are accessible and safe through disability access audits and design of service areas.					
Gender Reassignment						
Marriage and Civil Partnership						
Pregnancy and Maternity						

	Positive impact (including examples of what the policy/service has done to promote equality)	Negative Impact	Action Plan to address negative impact			
Race	This policy highlights that substance misuse can present problems across all cultures and ethnic groups.	Ethnicity may be associated with poor access to services generally and with different measures and values attributed to drugs and alcohol.	Service provision will be congruent with and sensitive to the needs of people from different ethnic groups.		Service Managers	EIA will be reviewed with policy.
Religion or Belief						
Sex						
Sexual Orientation						

Dual Diagnosis and Co-Morbidity Treatment Care Pathway (example from Southampton)

Best Practice in Dual Diagnosis
Who is Responsible for Co-ordinating Care?

Client assessed in mental health, drugs or alcohol services

Standardized measures completed to supplement clinical assessment

Concerns re alcohol – use AUDIT

Concerns re drug use – use DUDIT

Concerns re mental health problems – less severe – use PHQ-9 & GAD-7
– more severe – use CORE-OM

HIGH mental health need HIGH substance misuse need	HIGH mental health need LOW substance misuse need	LOW mental health need HIGH substance misuse need	LOW mental health need LOW substance misuse need
Lead: AMH Joint working with: Assessment, Review & Monitoring Service (ARMS) (25yrs+) No Limits / DASH (11-24yrs)	Lead: AMH Support from: Assessment, Review & Monitoring Service (ARMS) (25yrs+) No Limits / DASH (11-24yrs)	Lead: Assessment, Review & Monitoring Service (ARMS) (25yrs+) No Limits / DASH (11-24yrs) Support from: Steps to Wellbeing	Joint Working: Assessment, Review & Monitoring Service (ARMS) (25yrs+) No Limits / DASH (11-24yrs) & Steps to Wellbeing

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