## Policy: D2

### Dual Diagnosis

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<th>Version:</th>
<th>D2/04</th>
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<td>Trust Management Team</td>
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<td>Date ratified:</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; January 2013</td>
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<td>Title of Author:</td>
<td>Dual Diagnosis Lead</td>
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<td>Title of responsible Director</td>
<td>Medical Director</td>
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<td>Clinical Effectiveness &amp; Compliance</td>
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<td>Target audience:</td>
<td>All staff Trust wide</td>
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<td>NHSLA relevant?</td>
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<td>B Can be disclosed to patients and the public</td>
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### EIA / Sustainability

Not required

### Implementation Plan

G:\Trust Policies and Procedures\TMT\Dec

### Monitoring Plan

### Other Related Procedure or Documents:

### Equality & Diversity statement

The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all policies will be required to undergo an Equality Impact Assessment and will
**Sustainable Development Statement**

The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.
## D2 – Dual Diagnosis

### Version Control Sheet

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Title of Author</th>
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<tr>
<td>D2/01</td>
<td>December 2008</td>
<td>Associate Director Integrated Risk Reduction</td>
<td>Local Consultation</td>
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<td>Minor amendments made to para: 5.4, re-issued 12.09.13</td>
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1. INTRODUCTION
1.1 The Department of Health’s Dual Diagnosis Good Practice Policy Implementation Guide (PIG) 2002 highlighted that substance misuse is usual rather than exceptional amongst people with severe mental health problems and that the needs of people with a dual diagnosis of mental health and substance misuse should be provided for within mainstream mental health services.

1.2 Substance misuse amongst individuals with mental illness has been associated with significantly poorer outcomes including:
- Worsening mental health
- Increased incidents of suicide
- Increased rates of violence
- Increased rates of homicide
- Increased use of in-patient services
- Poor medication adherence
- Homelessness
- Increased risk of HIV, Hepatitis infection
- Poor social outcomes including impact on carers and family
- Contact with the criminal justice system.


1.3 The Trust endeavours to ensure service users with a dual diagnosis of mental illness and drug and alcohol use receive age-appropriate mental healthcare from mainstream services in line with NICE Guidelines CG120 ‘Psychosis with Co-existing substance misuse’ and the WLMHT ‘A Dual Diagnosis Strategy for Adults’ (March 2009).

1.4 The Trust mental health services will take responsibility for care co-ordination for service users with a dual diagnosis and ensure that their substance misuse needs are met. This does not mean a reduction in the role of drug and alcohol services who will continue to treat the majority of people with complex drug and alcohol problems and advise on substance misuse issues.

1.5 This policy will consider the definition of dual diagnosis and provide clarity of responsibility and service models in the Trust as well as providing guidelines for the delivery of effective care for those service users with a dual diagnosis.

2. **SCOPE**

2.1 This policy applies to all service users with mental health problems and substance misuse.
2.2 The policy applies to all staff involved in the provision of services for those with dual diagnosis of mental health problems and substance misuse in all services provided by the Trust.

3. DEFINITIONS

3.1 The term dual diagnosis refers to a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between the two is complex. Possible mechanisms include:

- A primary psychiatric illness precipitating or leading to substance misuse.
- Substance misuse worsening or altering the course of a psychiatric illness.
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illness.

3.2 (Department of Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide 2002; Avoidable Deaths: 5 year report of the national confidential enquiry into suicide and homicide by people with mental illness. 2006)

4. DUTIES

4.1 Chief Executive

The Chief executive has ultimate responsibility for the implementation and monitoring of this policy and other national guidance to ensure safe and effective clinical care within the Trust. This responsibility may be delegated to an appropriate colleague.

4.2 Accountable Director

The Medical Director is the accountable director who is responsible for the development of relevant policies and to ensure they comply with NHSLA standards and criteria where applicable. They are also responsible for Trust wide implementation and compliance with the policy.

b. CSU Responsibilities

Ensure all Service Users are screened for substance and alcohol misuse. Facilitate service users and carer’s access to health promotion, advice and group-work, as per local arrangement, information brochures and availability.

Ensure carers of those with a dual diagnosis have access to a carers’ assessment. This will be evidenced by agreed indicators recorded within the patient record.

c. Managers
Managers are responsible for ensuring policies are communicated to their teams / staff. They are responsible for ensuring staff attend relevant training and adhere to the policy detail. They are also responsible for ensuring policies applicable to their services are implemented.

d. **Policy Author**

Policy Author is responsible for the development or review of a policy as well as ensuring the implementation and monitoring is communicated effectively throughout the Trust via CSU / Directorate leads and that monitoring arrangements are robust.

e. **Local Policy Leads**

Local policy leads are responsible for ensuring policies are communicated and implemented within their CSU / Directorate as well as co-ordinating and systematically filing monitoring reports. Areas of poor performance should be raised at the CSU / Directorate SMT meetings.

f. **Clinicians and Health Professionals**

Clinicians and health professionals providing mental health care for clients with Dual Diagnosis should have a working knowledge of relevant policies and have training in dual diagnosis care. They should be aware that the style of intervention required should be non-confrontational, empathetic and respectful of the Service Users’ experiences of substance misuse.

Clinicians and health professionals should work with voluntary and statutory organisations in the community to liaise in regard to dual diagnosis issues.

g. **All Staff**

All staff should be aware that, for those who use the services provided by the Trust, dual diagnosis is a critical issue for many.

All staff providing services and care for people should be aware that the style of intervention should be non-confrontational, empathetic and respectful of the Service Users’ experiences of substance misuse.

**5. IDENTIFYING SERVICE USERS WHO HAVE A DUAL DIAGNOSIS**

5.1 All service users who are in receipt of care and treatment from the Trust are subject to a full and ongoing assessment of their needs.

5.2 In relation to Dual Diagnosis the DH (2002) Good Practice Guidelines identify the following assessment components:

5.3 Detection and screening

Substance and alcohol misuse should be considered in all assessments undertaken by mental health services. Current and past substance misuse should be asked about. Staff in mental health settings should
routinely ask service users about recent and illicit drug use. Detection and screening can be conducted through self-report methods, laboratory tests, from collateral data sources, clinical interview / assessment and/or by screening tools eg AUDIT, Bromley, CAGE.

5.4 Risk assessment

The risk assessment should explore the possible association between substance misuse and increased risk of aggressive or anti-social behaviour and offending behaviour as well as impact on mental health symptomology. The severity of substance misuse, including the combination of substances used, is related to the risk of overdose and/or suicide and should be clearly documented. An appropriate risk management plan should be put in place (C27 - Clinical Risk Policy).

5.4.1 NOTE: Special attention should be given in regard opiate users whose tolerance pre admission could be greatly lowered post admission. It is very important that a discussion is held with these service users in regard the risk of overdose and that this discussion is documented.

5.5 Specialist Assessment

All individuals with a dual diagnosis will receive a comprehensive mental health assessment, covering both health and social care needs. For some service users this will be the combined result of separate assessments carried out by different agencies. This assessment builds on the initial assessment and will include strengths based Assessment is a continuous process: formal assessments will be kept under review, added to and amended as necessary and reviewed in the period leading up to any review meeting.

5.5.1 The assessment should comprise of the following:

- Identification and response to any emergency or acute problem
- Assessment of patterns of substance misuse and degree of dependence/withdrawal problems
- Assessment of physical, social and mental health problems
- Consideration of the relationship between substance misuse and mental health problems
- Consideration of any likely interaction between medication and other substances
- Assessment of carer involvement and need
- Assessment of knowledge of harm minimisation in relation to substance misuse
- Assessment of treatment history
- Determination of individual’s expectation of treatment and their degree of motivation for change
- The need for pharmacotherapy for substance misuse
- Notification to the National Drug Treatment Monitoring System

5.5.2 The assessment should be clearly documented and where the patient electronic record is in use the core assessment fields:

- ‘Substance & Alcohol Use’
• Problematic Substance & Alcohol use’ should be completed. Where dual diagnosis needs are identified a care plan to address these needs should be put in place (C2 - Care Programme Approach Policy).

5.5.3 The service user should also be allocated to a needs-based cluster.

6. IDENTIFYING THE APPROPRIATE LEAD SERVICE

6.1 Once a client is identified as having a dual diagnosis the Minkoff’s quadrant model should be used to identify which service area should treat a particular client group (DOH 2002).

Figure 1: Minkoff Model 2002.

![Minkoff Model 2002](image)

<table>
<thead>
<tr>
<th>Quadrant A</th>
<th>Quadrant B</th>
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<tr>
<td>e.g. a dependent drinker who experiences increasing anxiety</td>
<td>e.g. an individual with schizophrenia who abuses cannabis on a daily basis to compensate for social isolation</td>
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<tr>
<td><strong>Severity of mental illness</strong></td>
<td><strong>Severity of problematic substance misuse</strong></td>
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<tr>
<td>Low</td>
<td>High</td>
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<tr>
<td>e.g. a recreational user of ‘dance drugs’ who has begun to struggle with low mood after weekend use</td>
<td>e.g. an individual with bipolar disorder whose occasional binge drinking and experimental misuse of other substances destabilises their mental health</td>
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6.2 In WLMHT this translates into the following service provision:

- **Quadrant A (high substance misuse and low mental illness): Will be treated by Drug and Alcohol Services.** This will be in accordance with National Training Agency Models of Care case management framework. These will be clients with primary substance misuse disorder with secondary low level mental illness e.g. a dependent drinker who experiences symptoms of anxiety or depression, a dependent opiate user or regular stimulant user with symptoms of anxiety. This care will primarily be provided by SMS partner agencies.

- **Quadrant B (high mental illness and high substance misuse): Will be jointly treated by Local or Forensic MHS and Drug and Alcohol Services.** This will be in accordance with an enhanced CPA case management framework. Case management responsibility for individuals with severe and enduring mental illness will remain the responsibility of the Mental Health Service. These clients will have
severe and enduring mental illness and high levels of substance misuse or dependence e.g. an individual with schizophrenia who has alcohol dependence. These clients will remain the responsibility of Mental health services in consultation / collaboration with Substance Misuse Services.

- **Quadrant C (low mental illness and low substance misuse): Will be treated in the primary care setting.** These clients will be individuals who have low-level mental health and low-level substance use. This will include a recreational misuser of ecstasy who struggles with low mood after using the drug or a non-dependent drinker who feels they are not coping well with anxiety.

- **Quadrant D (high mental illness and low substance misuse): Will be treated by Local or Forensic MHS and as required Drug and Alcohol Services.** This will be in accordance with an enhanced CPA case management framework. Case management responsibility for individuals with severe and enduring mental illness will remain the responsibility of Mental Health Services.

- Clinicians from both services should refer to the Minkoff model in order to establish the functioning of an individual client to ensure care is provided by the appropriate agency(ies). It is accepted that clients are often on a 'pathway', whereas some movement is both expected and anticipated between Quadrants. (e.g between Quadrants B & D.) Communication channels therefore need to remain open for discussion / update.

6.3 In accordance with the DOH guidelines it is the responsibility of Mental Health Services to take the lead for the care and treatment of all Service Users in quadrant B and D with an identified dual diagnosis. Within this framework Mental Health Services, will have responsibility to:

- Ensure all Service Users are screened for substance and alcohol misuse, either by clinical interview / assessment and/or by screening tools eg AUDIT, Bromley, CAGE – must be recorded on RIO.

- Following referral, liaise with SMS partner agencies and establish the need for joint assessments and/ or follow up assessments and interventions.

- Ensure primary and secondary diagnostic codes are confirmed and recorded onto applicable systems. This is reported by the information team and monitored by the CSU SMT’s.

- Clustering; HoNOS scores must be recorded for all patients where appropriate. Where applicable patients should also be clustered in relation to PbR. Care cluster 16; is the designated care cluster for Dual diagnosis clients, but this may deviate dependant on diagnosis and situation.

- Dual Diagnosis service users (identified via diagnostic codes) are subject to CPA (as per Dept of Health recommendations) Quadrant B (high mental illness and high substance misuse) are always subject to CPA.
Others are considered for CPA, unless two Senior clinicians, one of whom will be a Consultant Psychiatrist consider this is unnecessary on clinical grounds. When individuals are not supported within CPA the reasons should be clearly documented within the clinical record. (C2 CPA policy)

7. ADDRESSING THE NEEDS OF DUAL DIAGNOSIS SERVICE USERS

7.1 Evidence stresses that it is important that staff are realistic and have a longitudinal view of treatment. ‘Mainstreaming’ in Dual Diagnosis refers to the policy of clients being provided treatment interventions by mental health staff who have received relevant training. Treatment should be staged according to the Service User readiness to change and to engage with services. There are seven main evidence based treatment interventions for substance misuse:

- **Engagement**: the development and maintenance of a therapeutic relationship between the worker and the Service User. The strength of the relationship will depend on the value the Service User attributes to the service. The style of intervention should be non-confrontational, empathetic and respectful of the Service Users’ experiences of substance misuse.

- **Motivation**: motivational interviewing techniques have been found to be effective and should be used when attempting to motivate a Service User to commit to change without becoming confrontational. A variety of techniques can be used i.e. education about the drug of choice and the problems that can be associated with its use, presentation of objective assessment data e.g. liver function tests, a balance list from the Service User of the positives and negatives of use, exploration of barriers to the attainment of future goals, reframing problems or previous events and emphasising the influence of substance misuse. The approach must always remain non-confrontational and empathetic. Active listening and reflection should be used to remind the Service User of those aspects of their behaviour, which are problematic due to their substance misuse. Audit of the above is undertaken quarterly by the dual diagnosis service to gauge service delivery. Care plan ‘interventions’ (RIO) are monitored to ensure that this policy is being utilised by staff.

- **Harm reduction**: whilst the Service User is in the pre-contemplation and contemplation stages of change, harm reduction techniques may be employed to reduce the damage to the client whilst they continue to misuse substances. The Service User should be encouraged to take responsibility for their substance misuse and encouraged to stabilise and attempt to further reduce the intake of substances i.e. consume lower strength alcohol, inject using safer techniques.

- **Active treatment**: it may take months or even years for a Service User to be engaged enough to receive active treatment for their substance misuse. Treatment goals must be realistic and the goal of abstinence may not be one the Service User wishes to agree to for some time (if at all) Staff need to retain a supportive and patient attitude.
8. INTERNAL JOINT WORKING ARRANGEMENTS

The Drug and Alcohol Support Service [DASS] provides a service to all male and female adult patients in Specialist Forensic Services who have, or have had, difficulties related to their use of drugs or alcohol.

8.1 DASS aims to promote a supportive and non-judgemental attitude to patients who use substances whilst promoting a philosophy of harm reduction within an overall approach of supporting abstinence when this is achievable. Patients’ substance-related needs are integrated into the care planning process so that these needs can be met within a holistic framework. DASS also aim to increase staff’s knowledge and confidence in relation to substance misuse and to develop a shared, professional and evidence-based approach among everyone working with patients who use substances.

9. EXTERNAL JOINT WORKING ARRANGEMENTS

9.1 Some dual diagnosis clients with significant substance misuse will require joint working. Workers from Mental Health Services and SMS partner agencies will strive to engage the client in treatment. Joint working will include sharing of information;

9.2 Copies of all care plans / risk plans, to be shared between agencies. This is arranged via interagency communication. The processing of this information is covered under Condition 8 of Schedule 3 of the Data Protection Act 1998 (Conditions relevant for purposes of the first principle: processing of sensitive personal data)
9.3 **Condition 8 states:**

(1) *The processing is necessary for medical purposes and is undertaken by:*

(a) *a health professional, or*

(b) *a person, who in the circumstances, owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.*

(2) *In this paragraph "medical purposes" includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services.*

10. **PROCEDURE TO BE FOLLOWED WHERE THERE IS A DIFFERENCE OF OPINION BETWEEN PROFESSIONALS**

10.1 The care co-ordinator and the drug and alcohol service clinician shall in the first instance manage differences of opinion through open discussion in multi-disciplinary forums such as professionals meetings. If a satisfactory conclusion is not reached, the Mental Health Service Dual Diagnosis Clinical Lead, DD Lead, and SMS partner agencies Team Manager will call a multi-disciplinary meeting to agree a way forward. If this, in turn, is ineffective the matter should be referred to the Medical Director or Director of Nursing.

11. **MANAGEMENT OF DUAL DIAGNOSIS IN LOCAL SERVICES**

11.1 Local Services operates the ‘parallel’ model in the management of dual diagnosis. (Treatment is delivered by substance misuse teams and mental health teams concurrently.)

11.2 The use of a the ‘parallel’ model to provide services to dual diagnosis clients allows the knowledge and expertise in both mental health and substance misuse services to be used to provide a high level of care to this client group without isolating them from mainstream services. We aim to ‘mainstream’ (mental health services take the lead in caring for persons with severe and enduring mental illness and concomitant substance misuse / dependence) clients, working collaboratively with providers and ensuring we subscribe to a recovery model which champions social inclusion and client strengths.

11.3 Philosophy

11.3.1 The NICE guidelines for Dual Diagnosis (March 2011) NICE clinical guideline 120 – Psychosis with coexisting substance misuse ‘capture’ this concept when they prescribe (P7) “*When working with people with suspected psychosis and substance misuse, take time to engage the person, build a respectful, trusting, non-judgemental relationship, in an atmosphere of hope and optimism*. This
approach then describes our goal and our philosophy and is the basis for our interventions and actions

11.3.2 Our philosophy is to ensure that local services provide the most effective practice which is streamlined across organisational boundaries. The aspiration is to enhance the service user and carers experience within local services. The involvement of client, families and carer is central to the care planning process. This includes:

- Engagement
- Comprehensive assessment
- A non-confrontational, empathic and committed approach.
- Access to relevant services
- Responsive and flexible approaches,
- A longitudinal perspective
- Adequately trained staff
- The retention of therapeutic optimism.
- Harm reduction techniques
- Relapse prevention

11.3.4 This involvement includes:

- Involving clients in their treatment, in the planning, delivery and development of existing services, and in the planning and commissioning of future services.
- Our aim is to include service user & carer involvement in all aspects of planning of care and services.

11.3.5 Managing Acute Presentations

Experience of SUI reviews within the trust has found that problems have arisen when individuals have been referred for urgent assessment, presenting with psychotic symptoms and a history of drug use. Disagreements over whether mental health or substance misuse teams should initially assess has caused delay in initiating assessment and appropriate treatment, resulting in serious, and in some cases, tragic consequences. The guiding principles in cases such as these are as follows:

11.3.6 An acute presentation of a patient in a psychotic state requires timely and assertive treatment. In such cases organising joint assessments between MHS’ s and SMS’s will result in an unreasonable time delay.

11.3.7 Whether an individual’s psychotic symptoms are perceived to be caused by substance use, organic causes or due to an emerging or relapsing mental illness, mental health teams are the most appropriate service to lead on the assessment, diagnosis and acute treatment.

11.3.8 For service users with complex needs, a care coordinator will be allocated and formal CPA process will be initiated. It is essential that the care co-ordinator assumes the role of commissioner of care for the service user. The care co–ordinator is responsible for the effective planning and facilitation of the CPA meeting on behalf of the service user and the wider care team.
11.3.9 The care co–ordinator role for community staff and the primary nurse role for inpatient staff are interchangeably used to refer to as ‘care co–ordinator’ throughout this document.

11.3.10 Each service user will be supported in formulating a comprehensive plan of care and crisis contingency plan. The purpose of these care plans are to identify those issues that may impinge on the clients pathway to recovery. They will also clearly contain the following information;

- The names, roles and responsibilities of the care team and their contact details (including outside agencies involved)
- Who the person has trust in and will be most responsive to
- How to make contact with that person
- Previous coping strategies that the person has found to be helpful and supportive in similar situations.
- The emergency out of hour’s telephone number to ring should an emergency or crises arise.

11.3.11 Contingency plans are directed at helping an individual stay in control of their decision making to keep themselves well and to help prevent a crisis. They must include instructions that are based on the persons own identified needs and unique early warning signs of becoming unwell. This may include what to do in the event of choosing to stop medication or other treatment regimes, including no longer attending scheduled appointments. The plan should ideally be seen as a dynamic agreement between the person and their care team and must be updated as indicated by the changing personal circumstances affecting the individual’s wellbeing.

12. SPECIFIC INTERVENTIONS FOR CLIENTS WITH DUAL DIAGNOSES IN LOCAL SERVICES.

12.1 **Dual Diagnosis Review Group (Pilot)**

- This group is comprised of representatives from MHS and SMS. The function of this group is to meet on a two weekly basis (or more often in ‘urgent’ situations) to review the care of clients with a substance misuse condition who are either;
  a) Presenting with complex and challenging issues in regard to dual diagnosis. AND:
     Not prepared to accept assistance or recommendation in regard to their substance misuse. AND / OR
  b) Having an extended stay (generally over 40 days) in hospital due to dual diagnosis issues.

Method;

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1 For patients detained under the Mental Health Act (1983) choice and involvement in decision making remain important factors but so too is the safety of the patient and those around them making the option to opt out of some treatment choices a dynamic risk focused dialogue between the person and their care team.
This consultation is ‘electronic’ in the sense that all that is required is the relevant name and RIO number, with relevant RIO sections current and updated.
This group will suggest and reinforce treatment options and advise on possible strategies / adjuncts in therapy.
(**scheduled to start Feb 2013)

12.2 Dual Diagnosis (DD) ‘Champions’.

- The ‘DD Champion’ within each team is expected to be the first point of contact for members of their own team to approach for advice, support and signposting if they are working with a Client with a dual diagnosis, or have concerns that a Client may have an undiagnosed / unrecognised dual diagnosis.

- The DD Champion is expected to improve the treatment and care of Dual Diagnosis Clients within West London Mental Health Services through the formulation and application of best practice procedures in line with the Department of Health’s Mainstreaming Model.

- The DD Champion is expected to facilitate, improve and maintain the interaction and joint working between Mental Health Services and Substance Misuse Services.

- A Staff member would be considered a named ‘DD Champion’ after they have completed a minimum of 1 years specialised training in dual diagnosis. ‘Champions’ are those staff who have been nominated to improve practice.

- A DD champion job description is available in the supporting documentation.

12.3 SMS’s can provide coordinated shared care to address any substance misuse issues in a timely manner.

13. MANAGEMENT OF DUAL DIAGNOSIS IN SPECIALIST FORENSIC SERVICES

13.1 All new admissions to the forensic in-patient unit receive a substance use screening assessment within one week of admission, using a modified version of the Bromley Screening Tool adapted for mental health services.

13.2 For those service users with a positive result, or who have a significant history of substance use associated with their mental health problems.
and forensic history, a comprehensive substance use assessment is offered by DASS.

13.3 The patient care pathway has three main stages:

- **Engagement & assessment**: Focusing on assertively engaging service users with the team through in-reach onto clinical areas, establishing rapport and conducting a comprehensive substance use needs assessment.

- **Psycho-educational and motivational enhancement work**: Focusing on increasing a service user’s understanding of the relationship between their substance use, mental health problems and offending, aiming to increase levels of concern and willingness to engage in treatment.

- **Relapse prevention/management work**: Focusing on skills training around identifying triggers for cravings and appropriate coping strategies, managing high-risk situations for substance use, managing difficult emotions and recognising and modifying patterns of thinking that maintain substance use behaviour. This stage also contains a significant amount of skills training, focusing on lifestyle balance factors, anxiety management, social networks and assertiveness.

13.4 The latter two stages are offered as either individual or group interventions. Service users complete the programme with an individual substance use recovery plan that links substance use relapse prevention with individual early warning signs work.

13.5 Further bespoke interventions are also available, including easy pace and refresher work and more specialised interventions such as cue exposure.

13.6 DASS will follow service users through the discharge process, aiming to provide support to community providers and high support hostels. Onward referral to SMS partner agencies is also conducted on an as needed basis. DASS also offers support to the community forensic mental health teams in the service’s catchment area.

13.7 DASS offers consultation liaison to both in-patient and community forensic teams and also maintains a network of link practitioners across the in-patient forensic service.

14. **MANAGEMENT OF DUAL DIAGNOSIS IN HIGH SECURE SERVICES**

14.1 Broadmoor Hospital screens all admissions for substance misuse history and associations with mental health and offending behaviour.

14.2 According to patient need, psychoeducational input, individualised substance misuse assessments and access to the hospital's substance misuse group work programme are available as required.

14.3 Service provisions for substance misuse are a regularly reviewed part of the hospital’s therapeutic provisions. The service is informed and
developed in response to patient feedback, the published literature, and internal audits and research.

14.4

15. WORKING WITH AND SUPPORTING FAMILIES, CARERS AND SIGNIFICANT OTHERS

15.1 Encourage families, carers or significant others* to be involved in the treatment of adults and young people with mental illness and coexisting substance misuse to help support treatment and care and promote recovery.

15.2 When families, carers or significant others live or are in close contact with the person with mental illness and coexisting substance misuse, offer family intervention as recommended in ‘Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care’ (NICE clinical guideline 82).

15.3 When families, carers or significant others are involved in supporting the person with mental illness and coexisting substance misuse, discuss with them any concerns about the impact of these conditions on them and on other family members.

15.4 Offer families, carers or significant others a carer’s assessment of their caring, physical, social, and mental health needs. Where needs are identified, develop a care plan for the family member or carer.

15.5 Offer written and verbal information to families, carers or significant others appropriate to their level of understanding about the nature and treatment of psychosis and substance misuse, including how they can help to support the person. Written information should be available in the appropriate language or, for those who cannot use written text, in an accessible format (audio or video).

15.6 Offer information to families, carers or significant others about local family or carer support groups and voluntary organisations, including those for psychosis and for substance misuse, and help families, carers or significant others to access these.

15.7 Negotiate confidentiality and sharing of information between the person with mental illness and coexisting substance misuse and their family, carer or a significant other

15.8 Ensure the needs of young carers or dependent adults of the person with mental illness and coexisting substance misuse are assessed. Initiate safeguarding procedures where appropriate

(*Significant other’ refers not just to a partner but also to friends and any person the service user considers to be important to them)

16. TRAINING

16.1 Due to the level of dual diagnosis in our services, all clinicians working within the field of mental health will receive basic training in substance
misuse and dual diagnosis. All staff also receive Dual Diagnosis specific information during induction.

16.2 Training is based on the recommendations in the following documents;

- Dual Diagnosis in mental health inpatient and day hospital settings’ (DOH 30.10.06)
- ‘Mental Health Policy Implementation Guide’ Dual Diagnosis Good Practice Guide’ (DOH 15.04.02)
- ‘NICE Guideline 120; Psychosis with Co-existing Substance Misuse’ March 2011.

16.3 Training should incorporate Service users / carer’s and SMS staff. The aim is to update best practice, identify and resolve barriers to best practice and audit to establish change and improvement in practice.

16.4 An electronic training package is also available in the Trust E-learning site.

16.5 WLMHT also offers selected staff, University level training on substance misuse and Dual Diagnosis. These staff are supported during their training by experienced Dual Diagnosis practitioners and form the basis of a ‘Champions Network’ of specialist workers.

16.6 Training on Dual Diagnosis will be delivered in line with the training matrix as outlined in the mandatory training policy.

16.7 Compliance with training will be monitored in regular management supervision. M12 Mandatory Training Policy will be followed for staff who persistently fail to attend training.

17. MONITORING

17.1 The monitoring if the Dual Diagnosis policy (D2) will be monitored by the Trusts Clinical Effectiveness and Compliance Group.

17.2 The Clinical Effectiveness and Compliance committee will report Dual Diagnosis Outcomes to the Trust Board.

17.3 Compliance with the Dual Diagnosis policy (D2) will be monitored through a number of methods including audit as outlined in the monitoring template.

17.4 Where poor compliance is highlighted the lead for that service will be required to develop an action plan to address these areas which will need to be reported through local clinical governance structures.

18. REFERENCES (EXTERNAL DOCUMENTS)

This policy should be read in conjunction with the following:
NICE clinical guideline 120 – Psychosis with coexisting substance misuse (2011)

Dual Diagnosis Good practice Guide (Department of health)

Dual diagnosis in mental health inpatient and day hospital settings
(Department of Health 2006)
www.dh.gov.uk/en/Publicationsandstatistics/.../DH_062649

19. GLOSSARY OF TERMS / ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CSU</td>
<td>Clinical Service Units</td>
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<tr>
<td>DASS</td>
<td>Drug Alcohol Support Service</td>
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<tr>
<td>DD</td>
<td>Dual Diagnosis</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scales -</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
</tr>
<tr>
<td>NHSLA</td>
<td>National Health Service Litigation Authority</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>Pbr</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PIG</td>
<td>Policy Implementation Guide</td>
</tr>
<tr>
<td>SMS</td>
<td>Substance Misuse Service</td>
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<tr>
<td>SMT</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td>SUI</td>
<td>Serious Untoward Incident</td>
</tr>
<tr>
<td>WLMHT</td>
<td>West London Mental Health Trust</td>
</tr>
</tbody>
</table>

20. SUPPORTING DOCUMENTS (TRUST DOCUMENTS)

WLMHT Dual Diagnosis strategy.pdf
Dual diagnosis Champions job description.pdf
## Minimum Requirement to be Monitored

<table>
<thead>
<tr>
<th>WHO (which staff / team / dept)</th>
<th>WHERE DESCRIBED IN POLICY</th>
<th>HOW MONITORED (Audit / process / report / scorecard) - list details</th>
<th>HOW MANY RECORDS (No of records / % records)</th>
<th>FREQUENCY (monthly / quarterly / annual)</th>
<th>REVIEW GROUP (which meeting / committee)</th>
<th>OUTCOME OF REVIEW / ACTION TAKEN (Action plan / escalate to higher meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line Managers</td>
<td>Section 4</td>
<td>1:1 supervision</td>
<td>Monthly</td>
<td>6.6a) Duties</td>
<td>Via Audit six monthly</td>
<td>Up to a maximum of five per service (at random).</td>
</tr>
<tr>
<td>All services.</td>
<td>Section 5</td>
<td>Via Audit six monthly</td>
<td>Six monthly</td>
<td>6.6b) How the organisation addresses the needs of this groups of patients</td>
<td>Via Audit six monthly</td>
<td>Up to a maximum of five per service (at random).</td>
</tr>
<tr>
<td>All services.</td>
<td>Section 5</td>
<td>Via Audit six monthly</td>
<td>Six monthly</td>
<td>6.6c) Details of internal and external joint working arrangements</td>
<td>Via Audit six monthly</td>
<td>Up to a maximum of five per service (at random).</td>
</tr>
<tr>
<td>MHS and SMS.</td>
<td>Section 10</td>
<td>Report written.</td>
<td>As and when</td>
<td>6.6d) Procedure to be followed where there is a difference of opinion between professionals</td>
<td>Report written.</td>
<td>As and when</td>
</tr>
<tr>
<td>HR L&amp;D</td>
<td>Section 16 M12 Mandatory Training</td>
<td>Scorecard</td>
<td>All</td>
<td>6.6e) How the organisation trains staff in line with the training needs analysis</td>
<td>Scorecard</td>
<td>All</td>
</tr>
<tr>
<td>clinical effectiveness and compliance meeting</td>
<td>Appendix 1</td>
<td>Reports</td>
<td>As above</td>
<td>6.6f) How the organisation monitors compliance with all of the above</td>
<td>Reports</td>
<td>As above</td>
</tr>
</tbody>
</table>