Dual Diagnosis Policy: Protocol for the Joint Working between Mental Health Services and Drug and Alcohol Services in Cumbria

Document Summary

[To ensure that a framework is in place to enable collaborative working between substance misuse services and mental health specialists.]

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<td>ACCOUNTABLE DIRECTOR</td>
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<td>POLICY AUTHOR</td>
<td>Dual Diagnosis Working Group</td>
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Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendments.
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1 SCOPE

The Dual Diagnosis policy and care pathway sits within the Cumbria Partnership NHS Foundation Trust Care Coordination and the Local Services Operational Policies for Non Scheduled Care Service in Mental Health.

This policy applies to all mental health teams regardless of Service Users’ age, including CAMHS and OPMH within the Cumbria Partnership NHS Foundation Trust. It confirms the service access and care responsibilities of both the Mental Health and the main Drug and Alcohol Service provider in Cumbria, currently known as UNITY.

The document underpins continued partnership working to develop agreed care pathways across Substance Misuse and Mental Health Services in respect of the care and treatment protocol to Service Users.

2 INTRODUCTION

Cumbria Partnership is committed to raise awareness, challenge stigma and promote good practice by supporting Recovery centred care for people who experience mental health and substance misuse problems. Individuals with these issues deserve high quality; Service User focused and integrated care. Central to this aim is an optimistic view and effective collaboration between different Services in order to support our care pathways, minimise harm and offer the best chance of recovery to Service Users and their Carers.

In order to deliver recovery-oriented services, there is an acknowledgment that partnership with UNITY, housing, employment and family services must be firmly established and integrated into overall treatment plan. Supportive relationships with families, carers and social networks must be also promoted.

2.1 Values

Recovery is the organising principle for the delivery of our Service. We believe that the overall pattern of care, support and professional practice should be based on learning ‘what works’ from people in recovery, should be conducted by staff with appropriate attitudes and skills in ‘offering treatment and care with hope and optimism’ (National Institute for Health and Clinical Excellence 2009).

This in line with several national documents including the implementation framework (Centre for Mental Health 2012b) built on a broad coalition (Future Vision Coalition 2009), which proposed that: ‘If adopted successfully and comprehensively, the concept of recovery could transform mental health services […]. Recovery should become not only an increasingly common experience, as endorsed in the current outcomes strategy (Department of Health 2011), but also a guiding purpose that can be understood and held in common by all participants and provider.

At time of austerity Recovery may also offer an opportunity to focus on the outcomes whilst maintaining attention to the costs (Roberts 2013 and 2014).
Recovery oriented principles are also at the heart of commissioning principle and delivering of specialist Drug and Alcohol Services. Several documents have emphasized recovery oriented treatments including:

- Putting Full Recovery First a cross governmental paper was published in March 2012. The document outlines the Government’s roadmap for building a new treatment system based on recovery, guided by three overarching principles; wellbeing, citizenship and freedom from dependence.

- The national Drugs Strategy 2010 signalling a shift in emphasis from harm reduction to a focus on recovery and describing the elements of recovery as an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people.

  The Recovery Orientated Drug treatment- an interim report (NTA 2011) to provide guidance to the drug treatment services on the proper use of medications to aid recovery and on how to care for those in need of effective and evidence-based drug treatment is more fully orientated to optimise recovery”.


The National Alcohol Strategy 2012 aiming to a change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others.

The publication in 2010 by the NTA of Commissioning for Recovery, which focuses on outcome-based commissioning for the drug treatment, re-integration and recovery system in drug partnership areas for drug users. It sets out to highlight good practice in a recovery-based treatment system.

3 STATEMENT OF INTENT

The local landscape of Service provision and Commissioning for Service Users with Dual Diagnosis has led to consider the parallel model as the most suitable to work with this group of Service Users in Cumbria.

The parallel model implies the concurrent but separate treatment of both conditions. This approach can also be problematic since it may require the individual to attend different services and engage with different therapeutic structures and approaches. However, liaison across mental health and substance misuse services may make this model more viable if it enables treatment for both conditions to be delivered on one site. The successful application of this approach also brings the added benefit of imparting knowledge and skills across specialisms (Dual Diagnosis Good Practice Guide, 2002).
The parallel/liaison model is recommended by NICE and adopted elsewhere in the UK (i.e. Lancashire).

3.1 Liaison Guiding Principles

- **Dual Diagnosis is common** – increasing overlap between the two services as evidenced in literature. The message is therefore to expect substance misuse in psychiatry. Similarly, substance misuse services should be vigilant in detecting mental health related issues.

- **Don’t create a super specialism** – every worker that a Dual Diagnosis client makes contact with is a Dual Diagnosis worker.

- **It’s good to talk** – communication and information sharing is the backbone of this model. Its importance is highlighted in the Report of the National Confidential Inquiry (Appleby, 2000).

- **Do not argue what is a primary problem** – Dual Diagnosis clients present with multiple needs. They require expert and high quality response from both services. In a significant number of cases the chronology of the disorder is not clear. This model encourages joint assessment and joint working between the two services.

- **Developing competencies** – a commitment to provide intensive and comprehensive training.

- **Collaboration not conflict** – best care for Dual Diagnosis clients can only be provided by collaboration and joint working between mental health and substance misuse services. Services provided concurrently can result in higher chances of engagement as opposed to the serial or parallel model of service delivery.

3.2 Philosophy of Service

The overall philosophy of services should enable clients to maintain a therapeutic relationship where possible with the current key worker.

*We should avoid at all costs the situation where Service Users are continually referred between services and advised to address their mental health problem or substance misuse problem before the other can be treated.* This does not support holistic care planning or whole systems intervention but rather focuses attention on and reinforces a serial model of working. The strategy is actively discouraging this as it is not conducive to facilitated through care which is a critical element of service delivery. The respective service that is treating the Service User can expect advice, support and guidance from its partner service to enable them to draw up a good quality care plan, which will meet the needs of the client. Exceptions to this would be those clients who are cared for under the Care Program Approach whereby the mental health practitioner takes the role of care coordinator.
4 DEFINITIONS

4.1 Definition of Dual Diagnosis

The Department of Health issued the following definition of dual diagnosis:

‘The term ‘dual diagnosis’ covers a broad spectrum of mental health and substance use problems that an individual may experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:
• Substance use worsening or altering the course of a psychiatric illness;
• Intoxication and/or substance dependence leading to psychological symptoms;
• Substance use and/or withdrawal leading to psychiatric symptoms or illnesses.’

The term ‘Dual Diagnosis’ covers a wide range of problems that have both mental health and substance misuse in common. Dual Diagnosis can consequently mean different things to different service providers, but it can be summarised within four principal definitions:

• A primary mental health problem that provokes the use of substances (As may be the case with someone suffering from schizophrenia who finds that heroin reduces some of his symptoms).

• Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses (emergence of depression post-detoxification – insomnia and low mood; also the emergence of a psychiatric disorder to which the individual was vulnerable pre-substance misuse).

• A psychiatric problem that is worsened by substance misuse (for example, a person with heightened anxiety of danger from others who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation).

• Substance misuse and mental health problems that do not appear to be related to one another (for example, someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug or alcohol use).

4.2 Abbreviations in this document

The acronym D&A Service and UNITY are used as synonyms for the purpose of this document.

General Hospital: GH
Single Point of Access: SPA
Multi-Disciplinary Team (MDT)
Mental Health Team (MHT)
Mental Health Service (MHS)
Crisis Resolution and Home Treatment (CRHT)
Community Mental Health Team (CMHT)
Service User (SU)
Does Not Attend (DNA)
5 DUTIES

5.1 General principles of joint working between the teams

Any Service User with Dual Diagnosis who has specialist needs arising from both mental health and substance misuse is likely to come into contact with the Services provided by Cumbria Partnership NHS Foundation Trust or UNITY. The Above Services will liaise with and involve other allied agencies as appropriate Police Probation Housing Welfare Benefits Agencies, Turning Point or Community Alcohol and Drug Advisory Service (CADAS). For young people under 18 Drug & Alcohol and Sexual Health (DASH) provides free, confidential information about drugs, alcohol and sexual health. The team works with people on a one-to-one or group basis, at times and venues that meet young people's needs. They provide support and guidance to help young people make healthier choices and manage risk taking behaviour. DASH also supports parents and Carers, and offer awareness raising groups on young people's risk taking behaviour. Young people from DASH have helped design a website to provide help and advice to young people in Cumbria about a range of issues, from body image and bullying, to divorce and dealing with feelings of anger, worry and stress. Visit Life is a Rollercoaster at www.rollercoaster.nhs.uk.

The focus of Mental Health Services is mainly on the Service Users with substance misuse and a severe and/or enduring mental illness and substance use problems (Psychosis and coexisting substance misuse (CG120 NICE). According to Payment by Results, the new contracting system for mental healthcare in the UK, Service Users with Dual Diagnosis are classified under the Care Cluster 16. According to the definition, this group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles and co-existing substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired. However, it is recognised that a number of Service Users with a diagnosis of Personality Disorder, Depression or less severe mental health difficulties have been unable to engage with UNITY or Mental Health Services. These Service Users can also fall between the remit of different services: when necessary Cumbria Partnership and UNITY will work with this group carrying out joint assessments of need with a view to engaging them in their own or other appropriate services.

5.2 Role of Mental Health Team

All teams will support the liaison model with UNITY. Resource and capacity issues will need to be determined by each service.

All Mental Health Teams will be responsible for developing and maintaining an interface between mental health and UNITY. It would be expected that the Trust Dual Diagnosis working group facilitate this role across the Trust with the following aims:
To create, maintain and foster effective communication and working relationships between Services.

- To contribute to the initiation and implementation of change and improvement to service and care delivery.
- To actively engage in and foster multi-disciplinary/multi agency co-operation and collaboration in respect of Service User care and service development.
- To contribute to the formulation and review of care pathways, policies and protocols.
- To facilitate plan and contribute towards the teaching and training of staff.

5.3 Medical Director

The Medical Director has board level responsibility for the implementation of national policies as well as the implementation of the dual diagnosis policy. The Medical Director will ensure that the Clinical Governance Committee and the Trust Board receive assurance that policy requirements are implemented.

5.4 Chief Executive

Ultimate responsibility for the implementation of this policy and other national guidance lies with the Chief Executive but is devolved to the Medical Director.

5.5 Cumbria Dual Diagnosis Network

In line with DOH recommendations a steering group is established in the development of the current Dual Diagnosis policy.

The aims of the group are to:

1. Consider strategic issues relating to Dual Diagnosis;
2. Discuss any issue that may arise between the Service Providers;
3. Deliver effective services within tight financial constraints;
4. Develop and implement protocols;
5. Develop plans for delivering Dual Diagnosis services over the long term;
6. Consider models of good practice and how to apply them locally;
7. Be informed by Government guidance on Dual Diagnosis;
8. Commission and oversee research and evaluation projects;
9. Liaise with commissioners;
10. Discuss difficult cases and learn lessons from particular cases that didn’t have a favourable outcome.

6 RESPONSIBILITIES, ELIGIBILITY CRITERIA AND CARE PATHWAYS

6.1 Responsibilities

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It is the responsibility of all clinicians in Mental Health Teams to ensure that:

1. All Service Users are asked about Alcohol and Substance misuse during the assessment process;
2. This policy will be amended or integrated according to any change of the Non Scheduled Service provision that will occur in the near future.
3. The Drug and Alcohol history should be taken into account in the development of care plan;
4. Including evidence of the process of joint working with UNITY.

It is the responsibility of every member of clinical staff in substance misuse services to ensure that mental health needs are taken into account in the development of care plans.

In line with national guidance, UNITY staff members cannot take on CPA Care Coordinator responsibilities. This is for the following reasons:

- Community substance misuse teams use the Models of Care approach to delivering care and treatment, and the accompanying single assessment documentation developed specifically for substance misuse care, rather than the Care Co-ordination (CPA/Care Management) mental health care documentation.

They (and their Managers) cannot take clinical legal responsibility for care which is the responsibility of another team.

Mental Health Care Co-ordination Care Plan documentation allows more holistic and integrated mental health care interventions than the Models of Care Single Assessment documentation. The latter is not required to include complex care and contingency /crisis planning and risk management, but is tailored to substance misuse needs and services rather than mental health care. Care Co-ordination therefore takes precedence over Models of Care Single Assessment when both services are required.

### 6.2 Mental Health Services Care Coordination eligibility criteria (for Substance Misuse)

In keeping with national guidance, any dually diagnosed Service User with care needs for specialist mental health services will receive that care and treatment within the Mental Health Care Co-ordination framework. This means that the Mental Health Care Coordinator must retain responsibility for the care of any Service User to whom the “Dual Diagnosis” label applies.

The main focus of Mental Health Services will be on Service Users with severe mental disorder, including psychosis, personality disorder or less severe mental health difficulties with concomitant use of drugs that present particular challenges to mainstream mental health services.

These challenges include:

- Low motivation to engage in attempts at therapy
• At high risk of severe self-harm or suicide as assessed under CPA
• Recurrent readmissions to hospital
• Anti-social and chaotic behaviours – criminal and forensic activity
• Adverse impact of substance misuse on psychiatric symptoms

The eligibility criteria for specialist Mental Health Services assessment are as described in the Cumbria CMHT and Non Scheduled Care Service in Mental Health Operational Policies: This criterion is based on an ageless service and therefore applies to any person that requires an assessment by a Specialist Mental Health practitioner.

Levels of urgency:

**Crisis** - Serious risk to self or others; imminent marked deterioration in mental state.

**High** - Risk to self or others; disturbance greatly affects normal functioning; CPA or Sec 117; severe or enduring mental illness or acute phase of illness.

**Medium** - Low risk to safety but daily function considerably affected; stabilization phase of acute illness; CPA.

**Low** - Capable of daily functioning; bereavement, relationship difficulties, reactions to life stresses or physical illness, Primary Care Service User.

It would be expected for UNITY to be involved in the care and treatment of Service Users identified as ‘low’ without input from mental health services. By definition, a complex Dual Diagnosis case that would indicate the need for formal joint working under CPA arrangements would be those Service Users identified as ‘crisis’, ‘high’ and medium in the latter especially if there is a risk of further deterioration or if there is risk to dependants.

### 6.3 Eligibility criteria for UNITY involvement (for Service User with mental health needs)

The eligibility criteria for UNITY assessments are: anyone who is seen to have, or believes themselves to have a substance misuse problem, either drug or alcohol and who wish to address their substance misuse over the age of 18.

**Severe:**
- Physically dependent with risk of complex withdrawal symptoms if supply of drug interrupted
- High risk pattern of use and/or consequences on health, overdose, legal or child care risks
- Requires planned Inpatient Detox and possibly Specialist Rehab care
- Risk of physical social or mental harm

**Moderate:**
- Problematic use of substance(s); borderline/intermittent physical or psychological dependence
- Risk of physical social or mental harm
- Requires specialist assessment and possibly specialist intervention (Specialist Community Service or possibly Inpatient Detox)
Mild:
• Occasional, non-dependent use of substance(s)
• Low risk pattern of use or consequences
• Unlikely to require specialist services (possibly Service User in Primary Care or Community Service).

Mental Health Services will be expected to be involved in the care and treatment of Service Users identified as ‘mild’ without input from substance misuse services. This will be considered to be part of the work undertaken by Primary care services. However, it may be appropriate for liaison arrangements to be in place as and when the need for more formal joint working arises. By definition, Service Users classified as moderate to severe would require formally joint care; their care will be coordinated by MH Services under CPA arrangements.

6.4 Care Pathways

The care pathways provide a general framework for the access to Mental Health and Unity Services. They will need to be followed to make sure that Service Users are cared for without any gap through their journey with different services of different Trusts.

It is acknowledged that there is still work to do especially in regards of communication between the Trust and UNITY; specifically this is due to the IT systems of the two Organizations not able to communicate allowing electronic sharing of Service Users files. It is also important to take into account that the new Non Scheduled care Policy is also being re-written. Hence this policy will be amended or integrated accordingly if significant changes will need to be made.

6.4.1 Standard Referrals from Mental Health Services to UNITY (Appendix 1)

1. UNITY will accept all referral from Mental Health Services according to Eligibility Criteria.
2. The referral will be assessed within 5 working days.
3. Where a referral by Mental Health Services to UNITY is considered minimum data for referral will be the most recent assessment, including an updated risk assessment, and current care plan.
4. In selected difficult situations (eligibility criteria in the spectrum of Severe – Crisis/High) Mental Health Teams will liaise with UNITY to arrange a joint timely assessment whenever possible.
5. UNITY feedback on the outcome of the first or follow up assessment in a timely manner according to the flowchart in Appendix 1.

6.4.2 Standard Referrals from UNITY to Mental Health Services (APPENDIX 2)

1. The most appropriate Mental Health Team will accept referrals via the Single Point of Access (SPA) according to Eligibility criteria.
2. The referral will be assessed depending on the level of need and urgency.
3. Where a referral from UNITY is considered minimum data for referral will be the most recent risk assessment, and current medication. All the available information should be communicated via telephone to the Single Point of
Access when referring the patient.
4. The Mental Health Team will signpost all assessed referrals to Non Scheduled Care (CRHT, Liaison), CMHT, First Step or CAMHS if under 18 years of age or elsewhere appropriate.
5. If there is no evidence of mental health needs but only of a drug or alcohol problem (Eligibility Criteria: Mild), the Service User will be transferred back to UNITY.
6. UNITY will communicate if involvement is no longer required by their Service following a referral.
7. Mental Health Teams will feedback on the outcome of the assessment in a timely manner.
8. There might be a case were the Service User is already known to both Unity and the Mental Health Service: in this particular case these Services will liaise directly for any assessment and joint working.

6.4.3 Community or General District Hospital Management of Medical or Psychiatric Emergency of a Service User with both D &A and Mental Health needs (APPENDIX 3 & 4)

Mental Health staff and/or UNITY workers are more likely to face the following scenarios: Service Users who require immediate attention in the Community due to a medical or psychiatric emergency (see also APPENDIX 3); Service Users who require attention in A&E or Medical Wards of the General Hospital (see also APPENDIX 4).

6.4.3.1. Emergency in the Community (APPENDIX 3)

When a Service User is seen in the Community in a state such that it requires immediate medical or psychiatric attention the staff involved will need to appraise the situation and make a decision as follows:

1. if the Service User is physically unwell and physical health is at risk (i.e. confused, delirious, shaky, unconscious, unsteady gait,) call 999 for an ambulance;
2. if the Service User is at high risk of violence to others (i.e. violent, aggressive and threatening) call Police or inform Police if Service User poses a risk to staff and doesn’t want to leave or has already left the premises;
3. if the Service User is at high risk of self-harm or requires immediate psychiatric care and attention (i.e. suicidal, depressed, agitated) call 999 for ambulance and advice the Crisis Resolution and Home Treatment/Liaison Team as soon as possible (ASAP) if patient is agreeing to further assessment by Mental Health Services;
4. if the Service User is at high risk of self-harm or requires immediate psychiatric care and attention (i.e. suicidal, depressed, agitated) but they are not agreeing to further assessment by Mental Health Services inform the Police if Service User has left premises; if the Service User hasn’t left the premises try to use all possible means to persuade them to be assessed including the use of the Mental Health Act;
5. if the Service User is moderately intoxicated and not at immediate risk of self-harm requiring psychiatric care and is agreeing to further assessment by Mental Health Services make a standard referral to the relevant Mental Health Team (APPENDIX 2) who will assess according to level of urgency in a suitable and
safe environment (i.e. patient’s home, primary care Unity premises, CMHT or elsewhere deemed appropriate);
6. In principle a Service User at immediate risk of self-harm shouldn't be left alone unless otherwise decided by referrer (i.e. a family member has agreed to stay with the patient).

6.4.3.2. Emergency in A&E and Medical Wards (APPENDIX 4)

6.4.3.2.1. Alcohol

1. When a Service User is seen in A&E or admitted to the general hospital the Liaison Nurse will contact Unity ASAP after a Service User is promptly assessed;
2. Unity will ensure that their Recovery Worker contacts the Service User ASAP to achieve engagement in recovery before discharge;
3. The Psychiatric Liaison Team and Unity will support the medical team on the general hospital ward advising that detox is made in line with NICE guidance. For instance, liaison workers should be talking to District General Hospital (DGH) staff about detox regimes as soon as the need is identified. Training should be provided to DGH and A&E staff by Mental Health Services and Unity;
4. Service Users should not be discharged: unless declared medically fit by DGH doctors; before the detox is completed; unless otherwise agreed with Unity or the Psychiatric Liaison Team;
5. The Liaison Nurse will maintain a signposting role re mental health/Dual Diagnosis Service Users for all Service Users referred in A&E or seen on the wards.
6. CRHT: All Service Users who are in hospital or A&E because they are intoxicated or for detox purposes with ongoing mental health needs will be assessed when judged to be medically fit by DGH doctors by the CRHT/Liaison prior to hospital Admission for consideration of alternative intensive support options (i.e. home treatment);
7. Service Users admitted to acute psychiatric inpatient care in crisis, who subsequently turn out to have substance misuse problems and are not currently under UNITY care, will be referred as soon as possible by the named nurse, with Service User consent, to UNITY; Community detox is generally offered as a first option by UNITY, when possible; if this is not appropriate 2 dedicated beds in the Kentmere ward (Kendal) are allocated for planned alcohol detox.

6.4.3.2.2. Drugs

Most detoxes from OST will take place in the community. Complex cases are referred to the Chapman Barker Unit in Prestwich, as are those with Dual Diagnosis and complex needs.

6.5 Inpatients

* When Service Users with substance misuse problems who are currently
under UNITY care are admitted in mental health crisis UNITY should be notified as soon as possible, i.e. the same day (or the next working day if out of office hours).

- **Inpatient staff should identify the relevant UNITY worker and MH Care Coordinator early in the admission process i.e. the same day (or the next working day if out of office hours) in order to invite them to planned MDT reviews and ensure a seamless and coordinated approach to care via inpatient services.**

- Service Users admitted to acute psychiatric inpatient care in crisis, who subsequently turn out to have substance misuse problems and are not currently under UNITY care, **must be referred as soon as possible by the named nurse, if the Service User is in agreement to be assessed by UNITY.**

It is important that inpatient services maximize their connections to community services and supports and vice versa. Therefore a joint assessment between community and inpatient teams improves accuracy and comprehensiveness. The care coordinator, the UNITY worker, the inpatient care team and others should be involved in the Service User’s care during their inpatient stay and reassess their care needs jointly.

Planning for discharge, via the CPA review process and support after inpatient care should commence in the initial care plan and consideration needs to be given to appropriate involvement of the Crisis Intervention / Home Treatment Team in the care planning process. Therefore prior to discharge a Care Coordination review would take place, involving the Service User, and relevant people (including Carers) involved in the person’s care and treatment, and the agreed care plan to meet the needs of the person in the community will be agreed and a copy provided to the Service User prior to discharge.

The outcome on discharge from mental health inpatient care is generally best if shared care is available throughout the inpatient admission and appropriate care available on leave from the ward and promptly on discharge.

Everyone who is already involved with the Service User should be involved and their role recorded in the care plan prior to leave and on discharge. A clear discharge care plan as outlined in the Integrated Discharge Policy (001/033) needs to be in place that ensures a 48 hour follow up and seeks to meet their ongoing needs.

### 6.6 Severity Tools

Severity tools used in the decisional tree for Alcohol detox will follow the NICE recommendations as detailed in the Trust Guideline for Inpatient Alcohol Detoxification (http://cptportal.cumbria.nhs.uk/SiteDirectory/MedicinesManagement/Alcohol%20Detoxification%20Guidelines%20documents/CPART%20Guideline%20for%20inpatient%20Alcohol%20Detoxification%20Final%20V1%20June%202013.pdf).

### 6.7 Rehabilitation

Access to residential (substance misuse) rehabilitation follows a comprehensive joint assessment between mental health, D&A services and social workers employed by the Council who are co-located in Unity premises. This includes a Dual Diagnosis Policy
comprehensive substance misuse assessment (which is required to access community care funding for substance misuse).

6.8 Prescribing

Opiate substitute prescribing: For any Dual Diagnosis Service User there will be a Mental Health Services Care Co-ordinator and care is shared between the MH Services and the D&A Service.

The responsibility for any opiate substituted prescribing should be clearly agreed between the relevant professionals from the two services, based on an assessment by D&A services with reference to the multi-disciplinary teams, as appropriate. Details of who is taking responsibility for prescribing and monitoring the opiate substitute should be incorporated into the Service User’s written Care Co-ordination Care Plan, and implemented according to the Department of Health clinical guidelines and contracts of the D&A Service. Any doctor prescribing in this context for the Service User must see them regularly; the frequency should be defined in the care coordination care plan. How to manage non-compliance and disengagement with care and treatment should be recorded in the care plan.

Other Prescribing: The roles and responsibilities for all other prescribing should be clearly identified in the care plan. Advice and guidelines on prescribing for Service Users with substance misuse problems, e.g. on home alcohol detoxification programs, are available from D&A Service medical staff.

6.9 Ending shared Care

Achievement of goals: The agreement of the ending of any service involvement in the Service Users because the agreed goals have been reached, should be achieved via the CPA review process with an amended care plan reflecting the end of involvement. The care coordination process will continue if specialist mental health services remain involved. When specialist mental health services are no longer required and D&A services remain involved, the models of care process will be adopted.

Service Users discharged due to non-contact or withdrawal of consent: If high-risk Service Users under shared care between CMHTs and the D&A Service fail to maintain contact with one service, but remain in touch with the other, it is essential that any decision to end the involvement of one of those services is arrived at by means of a Care Co-ordination (MH) Review and based on an up to date risk assessment. There must be a commitment to support the partner team that remains in touch; this would include prioritized prompt reassessment should the Service User consent to this.

6.10 Service Users in Prison

The same principles apply to prisoners with a Dual Diagnosis to those who are inpatients. The care coordinator will remain in contact with the Service User throughout their custodial sentence and coordinate the CPA process. This will include ongoing and regular review. The review process should result in a care plan
which includes the clarification of the roles and responsibilities of everyone concerned, including the involvement of D&A services, and the next review date. A care plan to meet the needs of the Service User in the community should be in place prior to the person’s release.

6.11 Arbitration

In circumstances where there is some disagreement regarding whether a service will become involved in the assessment and / or care and treatment of a Service User, line management support and negotiation will be required with the potential to review the needs of the Service User and allocate the resources most appropriate to meet the needs of the Service User. The service which the Service User was initially referred to will remain involved until the disagreement has been resolved and where there is mutual agreement between the services. If the line managers are unable to resolve the difference of opinion then the Executive Director of Operations will be asked to intervene.

Should the difference of opinion arise between the Trust and non-Trust providers and the situation is not resolved through the line management structure, commissioners of the non-Trust provider will be involved.

7 TRAINING

7.1 Mandatory Training

Training will overall increase the capacity of acute staff to manage Service Users with co-morbid physical and mental health problems. It will improve the acute staffs’ ability to identify mental health issues and improve the quality of care for Service Users.

Better knowledge of mental health conditions can reduce stigma.

Mandatory training associated with Dual Diagnosis should be identified by the Trust’s relevant bodies including the Learning Network and provided in accordance with the Trust’s training needs analysis. Attendance and non-attendance at the training sessions will be managed in accordance with the Trust’s Learning and Development Policy.

7.2 Additional Training Resources

NICE on line training is available to all practitioners in both MH and Unity Teams http://www.dualdiagnosis.co.uk/National_e-learningHub.ink.

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trusts’ monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.
<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitorin g method</th>
<th>Individual responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group committee which will receive the findings/monitoring report</th>
<th>Group committee / individual responsible for ensuring that the actions are completed</th>
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<tbody>
<tr>
<td>Adult Mental Health staff will have a broad understanding of drug and alcohol issues.</td>
<td>Audit of a random sample of cases.</td>
<td>Clinical Lead, Drug and Alcohol Recovery Service</td>
<td>Annual</td>
<td>Clinical Effectiveness and Audit Committee</td>
<td>Drug and Alcohol Governance Committee</td>
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<td>Drug and Alcohol staff will have a broad understanding of mental illness</td>
<td>Audit of a random sample of cases.</td>
<td>Clinical Lead, Drug and Alcohol</td>
<td>Annual</td>
<td>Clinical Effectiveness and Audit Committee</td>
<td>Drug and Alcohol Governance Committee</td>
</tr>
<tr>
<td>Compliance with the protocol will be monitored, including:</td>
<td>Audit on a random sample of case notes</td>
<td>Recovery Service Clinical Lead, Drug and Alcohol Recovery Service</td>
<td>Annual</td>
<td>Clinical Effectiveness and Audit Committee</td>
<td>Drug and Alcohol Governance Committee</td>
</tr>
<tr>
<td>• Appropriate initial risk assessment s completed</td>
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<tr>
<td>• Appropriate, current risk assessment</td>
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<tr>
<td>• Appropriate care plans</td>
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<tr>
<td>• Appropriate delivery of interventions (including joint working)</td>
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<tr>
<td>• Appropriate amendment s to care</td>
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<tr>
<td>• Process for arbitration</td>
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<tr>
<td>Training will be delivered in accordance with the TNA</td>
<td>Training will be monitored in accordance with the Trust’s Learning and Development Policy.</td>
<td></td>
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</tr>
</tbody>
</table>

9 REFERENCES/ BIBLIOGRAPHY


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http://publications.nice.org.uk/psychosis-with-coexisting-substance-misuse-cg120
10 RELATED TRUST POLICY/PROCEDURES

POL/001/001 – Care Co-Ordination policy

POL/001/034 – The management of service users with a Dual Diagnosis of Mental Health and Learning Disability

POL/001/033 – Integrated Discharge Policy

Guidelines for Inpatient detoxification:

Staffs are also expected to work according to any Cumbria Partnership NHS Foundation Trust Information Sharing protocols.
APPENDIX 1: Standard referral. All Mental Health Services, including inpatient (MHS) to UNITY

1. Mental Health Services identify Service User with MH and substance misuse problems
2. Psychological and Risk assessment completed including Drug and Alcohol history.
3. Consider referral to UNITY for triage assessment: pt. responsibility stays with MH Service
4. Does the service user consent to referral to UNITY?
   - No: Ongoing input from MH Service
   - Yes: Option of MHS of obtaining general advice from UNITY.
5. Is substance misuse problematic?
   - Yes: Refer to UNITY for assessment that will take place within 5 working days. Specialist MH Services retain care coordinator role.
   - No: Unity will communicate one of the following outcomes;
     - SU DNAs appointment with UNITY
     - Not suitable for UNITY
     - SU engaged with UNITY
APPENDIX 2: Standard Referral. From UNITY to any Mental Health Service (MHS) via SPA for patients with current or ongoing mental health needs and substance/alcohol misuse.

UNITY identifies Service User (SU) with mental health problems

UNITY will refer to SPA sharing all available information to SPA and most recent risk assessment/current medication

MHT accept referral and assess need: jointly if possible especially in complex cases

ROUTINE REFERRAL
Where: to be agreed by MHT and SU
When: within 15 days

URGENT (CRHT or CMHT)
Where: To be agreed between Liaison and SU
When: within 24/72 hr

EMERGENCY (CRHT)
Where: Suitable and safe community location
When: within 4 hours (see Appendix 5)

ACUTE LIAISON in DGH
Where: A/E Medical Wards
When: within 2 hours (see Appendix 4)

Agreement with UNITY re ongoing care plan

Is UNITY input still required?

Yes

UNITY to arrange follow up within 5 working days

No

UNITY to inform MH Service and advise on different agencies or options

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APPENDIX 3: Community management of Medical or Psychiatric emergency including Intoxicated State

Assess immediate presentation and risk

Medical or Psychiatric Emergency including intoxicated state

Life threatening physical illness (i.e. acutely confused, unsteady gait, fitting, shaky, unconscious).

High risk (to self or others psychiatric emergency?)

No immediate risk but ongoing mental health needs

Refer to MH Service via SPA (follow standard referral Appendix 2)

Dial 999 for ambulance

consenting to be assessed for further care

No

Call and inform police if high risk to others (immediately) or self (if not engaging and left premises)

Yes

Yes

Send to A&E and refer to Mental Health Service
APPENDIX 4: Alcohol or Drugs Emergency Referrals Individual presents at A&E or Admitted on Medical Ward

Service User (SU) presents in A&E or is admitted on a Medical Ward

- 
  
- Patient assessed and admitted
  
  - Liaison team notified
    
    - Liaison team to advice Acute Trust on Detox best practice; inform/refer to Unity
      
      - SU has Mental Health needs
        
        - No
          
          - Liaison Team to inform Unity of outcomes for standard referral to UNITY; follow standard procedure (Appendix 1)
        
        - Yes
          
          - Yes
            
            - Immediate Assessment by Liaison team
              
              - No
                
                - SU referred to UNITY
                  
                  - UNITY contact SU to offer planned detox
                
                - Yes
                  
                  - Admit to Psychiatric Ward or Home Treatment or Signpost to CMHT or First Step if medically if UNITY notified if SU known. SU referred to UNITY if consenting

- Is there a medical emergency related to Drugs or Alcohol misuse?
  
  - No
    
    - Is the SU identified as suffering from a mental disorder?
      
      - No
        
        - SU referred to UNITY
          
          - UNITY contact SU to offer planned detox
        
        - Yes
          
          - Immediate Assessment by Liaison team
            
            - Admit to Psychiatric Ward or Home Treatment or Signpost to CMHT or First Step if medically if

- Yes
  
  - Liaison team notified
    
    - Liaison team to advice Acute Trust on Detox best practice; inform/refer to Unity
      
      - SU has Mental Health needs
        
        - No
          
          - Liaison Team to inform Unity of outcomes for standard referral to UNITY; follow standard procedure (Appendix 1)
        
        - Yes
          
          - Yes
            
            - Immediate Assessment by Liaison team
              
              - No
                
                - SU referred to UNITY
                  
                  - UNITY contact SU to offer planned detox
                
                - Yes
                  
                  - Admit to Psychiatric Ward or Home Treatment or Signpost to CMHT or First Step if medically if UNITY notified if SU known. SU referred to UNITY if consenting

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APPENDIX 5 –USEFUL NUMBERS

DRUG AND ALCOHOL SERVICES

South Cumbria

UNITY
92-96 Dukes Street
Barrow
LA14 1RD
Tel: 01229 615651

Unity Kendal
39 Strickland Gate
Whitehorse Yard
Kendal
LA9 4LT
Tel: 01539 742780
West Cumbria
UNITY
21b Lowther Street,
Whitehaven,
CA28 7JG
Tel: 01946 590024

Unity Workington
Finkle Street 6
Workington
CA14 2AY
Tel: 01900 873791

North Cumbria
UNITY
113-117 Botchergate,
Carlisle,
CA1 3RR,
Tel 01228 882299

Unity Penrith
2nd Floor
Clint Mill
Cornmarket
Penrith
CA11 7HW
Tel: 01768 861280

MENTAL HEALTH SERVICES

South Cumbria
WORKING HOURS

Community Mental Health Teams

Adult Services
South Lakes: Garburn House CMHT Telephone: 01539 715064
Barrow: Duddon House CMHT Telephone: 01229 407777

Out of Hours

Crisis Resolution/Home Treatment Service
**West Cumbria**

**Adult Services**

- Copeland CMHT  
  Tel: 01946 853350
- Allerdale CMHT  
  Tel: 01900 705262
- Assertive Outreach Team  
  Tel: 01900 870584

**Out of Hours**

- **Crisis Resolution/Home Treatment Service**  
  Tel: 01946 66647

**North Cumbria**

- CMHT, Portland House  
  Tel: 01228 603850
- Eden CMHT  
  Tel: 0176824 5351
- Wigton CMHT  
  Tel: 01228 602099

**Out of Hours**

- **Crisis Resolution/Home Treatment Service**  
  Tel: 01228 602453

DASH  
  tel. 01228 603890
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