DUAL DIAGNOSIS POLICY
JANUARY 2017

This policy supersedes all previous policies for Dual Diagnosis
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---|---
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Accountable director | Director of Nursing and Performance
Approved by (Group): | Quality Review Group 12 December 2016
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**Document history**

<table>
<thead>
<tr>
<th>Date</th>
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</thead>
<tbody>
<tr>
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Membership of the policy development/review team | Simon Peel, Dual Diagnosis lead Nurse Andy Stopher – Deputy Chief Operating Officer Peter Kane – Clinical Director Substance Misuse Harriet Wells-Martin – ICAS AOT Team Leader/Senior Alcohol Nurse

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Circulated to C&I Mental Health and Substance Misuse Commissioners.9th December 2016

**DO NOT AMEND THIS DOCUMENT**

Further copies of this document can be found on the Foundation Trust intranet.
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1. Introduction

1.1 Background


In 2011 the National Institute of Clinical Excellence (NICE) published CG 120, “Psychosis with substance misuse in over 14s: Assessment and management”. Key concepts include developing a “motivational approach” when working with people with substance misuse issues.

In 2011 NICE published CG 115, Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

In 2014 NICE published CG 178, Psychosis and schizophrenia in adults.

In November 2016 NICE published NICE guideline NG 58, Coexisting severe mental illness and substance misuse: community health and social care services.

Key ideas from the new NICE guidelines include the adapting of existing services rather than creating new ones, ensuring harm reduction techniques are applied, ensuring assessments procedures are robust for first contact services and the availability of motivational interviewing interventions.

Key standards concerning substance misuse and mental health can be found in appendix 1.

1.2. The Trust’s Position Statement

This policy describes how Camden and Islington Foundation Trust (C&I) will provide effective, responsive and integrated clinical services for individuals with dual diagnosis of mental illness and substance misuse.

It relates to service users in both inpatient and community settings.

C&I recognises that the management of dual diagnosis is everyone’s business, and that it also affects physical health, social issues, housing, family and relationships as well as increasing the risk of readmission, suicide, victimisation and violence and death.

The national policy position identifies that the primary responsibility for the treatment of individuals with mental illness and problematic substance misuse should lie with mental health services. This approach is referred at as “mainstreaming” and aims to lessen the likelihood of people being “shunted” between services or losing contact completely.

C&I has been working closely with key stakeholders including service user groups and substance misuse commissioning teams to improve services, increase the skillset of frontline staff and apply policy to practice.

In addition, a Commissioning for Quality and Innovation (CQUINs) target was negotiated early in 2016 in order to roll out a substance misuse screening tool for use on admission to psychiatric inpatient units.

Pilot programmes to bring expert substance misuse experience to frontline staff and, enhance care plans and risk assessments are embedded in several teams.

The C&I assertive outreach teams have a dedicated substance misuse consultation session monthly.
There are also several “SMART” (Self-Management and Recovery Training) groups operating on acute inpatient units at regular intervals. Due for review 2017.

Differing perspectives were sought as part of a broad consultation for this policy. Narratives from service users, mental health services and substance misuse services are included in appendix 2.

The key ideas from the consultation that informed this policy are:

- To simplify screening, referral and appeal procedures
- To centralise all referral information.
- To set up a mobile dual diagnosis case conference team.
- To promote the use of substance misuse assessment and screening tools.
- To provide a framework for training and on-going support for trust staff
- To create aspirational objectives on an annual basis.

2. Definition of Dual Diagnosis

When people have co-existing mental health and substance misuse issues they are commonly described as having a dual diagnosis. The discussion of whether the substance misuse or mental health problems is a primary or secondary diagnosis may be unhelpful and can lead to service users being declined treatment when in reality both problems are likely to need treatment in their own right.

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

- A mental disorder precipitating or leading to substance misuse.
- Substance misuse worsening or altering the course of a mental disorder.
- Substance misuse and/or withdrawal leading to a mental disorder.

Co-existing substance misuse and mental health problems may also be coincidental rather than causative. Substances in this definition include alcohol, novel psychoactive substances (NPS), and illicit drugs including stimulants (cocaine, methamphetamine), volatile substances and prescription drugs/over the counter medicines used in a potentially hazardous way.

The prevalence of substances on in-patient wards is approximately 64% (Philips, P. Johnson, S. Prevalence of substance misuse in inpatient settings 2003).

Known prevalence of mental health issues in substance misuse teams is 70% and 86% in alcohol services, Comorbidity of substance misuse and mental illness in community mental health and substance misuse services (Weaver et al. The British Journal of Psychiatry September, (2003) Vol.183 (4) 304-313).

This means that dual diagnosis is core business, which needs a unified approach from all services.

3. Aims and Objectives

- To provide a consistent, coherent and integrated model of service provision.
- To outline care pathways to support service users through our services.
- To provide a comprehensive range of services for the treatment and management of dual diagnosis involving the service users and their relatives and/or carers.
• To make provision for the education and training required for staff that support integrated care delivery.
• To continue to develop a culture of continuous evaluation and development including that of learning from good practice.

4. Scope
This policy applies to all staff involved in the provision of services for those with dual diagnosis of mental health problems and substance misuse, working principally in Adult Mental Health Services, Substance Misuse Services, and Mental Health Services for Older People.

5. Procedures and management

5.1 Assessments and screening

When people need help and support, the first service they access may not be the most appropriate.

For example: they may go to a substance misuse team then need mental health support or be admitted to an inpatient ward and then want help with reducing their alcohol or substance use.

Moving people from one service to other increases the chance that someone will fall out of contact with services altogether.

All people who come in to contact with C&I services should be helped to discuss their drug or alcohol use. This conversation is not simply to inform an initial assessment but is the start of an on-going dialogue.

Ensuring that all staff members have the knowledge and skills to carry out any interventions and assessments is an essential part of all NICE guidelines. This is not just about using tools but how they are used e.g. a motivational approach as described in NICE CG 120 “Psychosis with substance misuse in over 14s: Assessment and management”. More details in section on training in section 6.12.

Substance misuse teams should ensure that their assessment processes include:

- Personal history
- Mental health history
- Current mental state and thoughts of self-harm or suicide.

These can be difficult questions to ask, but should not be avoided. If a person is expressing a current wish to end their lives this should be treated as a mental health emergency.

All Mental health teams should ensure that their assessment processes include:

- Alcohol use disorder identification test (AUDIT)
- Drug use disorder identification test (DUDIT)

Both screening tools are available on the trusts electronic patents record system under “Assessments”. A brief example of both is in appendix 3.
These tools are designed to help clarify clinical pathways and to encourage discussion with service users about substance use, not to generate automatic referrals. Screening tools for withdrawal are discussed in section 6.4.

Where teams feel that they are not meeting the needs of their service users, or there has been a request for more support by a service user, a formal referral can be made. It is always important to discuss the referral with the service user.

Substance misuse teams cannot provide effective help to people who are not motivated to change their behaviour. Therefore community treatment orders or section 17 leave conditions should not be used to encourage attendance at substance misuse services.

5.2 Access to Services

C&I provide several distinct types of mental health services.

The C&I dual diagnosis lead can provide non-emergency information and guidance regarding access to services on 0203 317 7009.

<table>
<thead>
<tr>
<th>Needing help in a crisis or emergency:</th>
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<tbody>
<tr>
<td>In mental health, the term “crisis” usually suggests that someone may need urgent help to support them with mental health problems. It is important to distinguish crisis support from emergency support.</td>
</tr>
<tr>
<td><strong>If someone is already cared for by C&amp;I mental health services, they should call:</strong></td>
</tr>
<tr>
<td>020 3317 6333.</td>
</tr>
<tr>
<td><strong>If not known to mental health services the number is:</strong></td>
</tr>
<tr>
<td>020 3317 6777.</td>
</tr>
<tr>
<td>The numbers are available 24 hours a day, 7 days a week. Service users can self-refer.</td>
</tr>
<tr>
<td>In an emergency, someone's life might be in danger and you should call 999 or go to the nearest accident and emergency dept.</td>
</tr>
<tr>
<td>Mental health crisis teams help people whose mental health might be deteriorating to the level that hospital admission is being considered.</td>
</tr>
<tr>
<td>C&amp;I's Crisis Resolution and Home Treatment Teams (CRTs) are multi-disciplinary mental health teams based in the community that provide a safe and effective home-based assessment and treatment service as an alternative to in-patient care</td>
</tr>
<tr>
<td><strong>The crisis teams accept referrals by telephone only. Call 020 3317 6333.</strong></td>
</tr>
</tbody>
</table>

Suggestions of possible routes into substance misuse services available here:


First point of contact for substances in Camden is: The Margaret Centre 0203 317 6000

s cds@candi.nhs.uk
First point of contact for Alcohol in Camden is: Integrated Camden Alcohol Service (ICAS) for Alcohol 0203 227 4950 camden.referrals@cgl.org.uk

First point of contact for Islington is: IDASS 0203 317 6240 idass.referrals@nhs.net

5.3 Referrals Procedure

Every C&I team must provide a referral and appeals process to referrers on request.

The reason for referral should be laid out in simple terms and must include the consent for the service user. This means that the service user should know where they are being referred to and why.

Ideally information or leaflets about services should be supplied.

The result of the referral should be supplied to the service user as well as the referring team.

In the case where a referral is not agreed, the reason for refusal should be laid out in the plainest terms, avoiding jargon.

All referrals between SMS and MH services must be logged by the dual diagnosis lead.

The C&I dual diagnosis lead can also provide non-emergency information and guidance regarding access to services and pathways on 0203 317 7009

5.4 Dual Diagnosis Case Conference

In order to discuss particularly complex treatment plans it may be helpful for the dual diagnosis lead to facilitate a case conference.

This may be helpful if a treatment pathway isn’t clear or if a person is in the process of moving to another service.

Attendance should be multidisciplinary, consisting of staff from each service, and the trust dual diagnosis lead. Attendance of expert advisers, from either substance misuse and or mental health teams can be arranged by the dual diagnosis lead.

Advice and action plans from the meeting will be formalised by inserting minutes into service user notes.

5.5 Risk and Safety

A 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 symptoms.

Special attention should be given in regard to users of substances where abrupt withdrawal can cause serious harm or even a fatality.

This might be at the point a person in admitted to an in-patient environment.

There are three high-risk substances where abrupt withdrawal can cause a serious health risk.
**Alcohol:**

Where abrupt alcohol withdrawal is a concern, all staff need to be aware of the possibility of a convulsion, delirium tremens and Wernicke’s Encephalopathy (due to thiamine deficiency).

The Severity of Alcohol Dependency Questionnaire (SADQ) should be used as soon as possible, then if applicable The Clinical Institute Alcohol Withdrawal Assessment (CIWA-AR) is helpful measure the severity of alcohol withdrawal symptoms. See appendix 4.

Trust guidelines on alcohol withdrawal can be found here:


The use of Thiamine (Pabrinex) is recommended for people at high risk of developing thiamine deficiency whether detoxing from alcohol or not.

More information regarding Pabrinex can be found in the trust “Pabrinex prescribing protocol” July 2015 available on the intranet.


**Benzodiazepines:**

Where a person comes into treatment where abrupt benzodiazepine withdrawal is a concern. All staff need to be aware of the possibility of a high level of distress with the risk of withdrawal fits and delirium.

More information about this can be found in the trust “Anxiety disorder prescribing guidelines 2016” available via the trust intranet.

**Opiates and Opioids:**

Withdrawal from opiates is very uncomfortable and painful but not usually life-strengthening with symptoms such as sweating, tremor, muscle cramps, diarrhoea and retching. Of more concern is the loss of tolerance that follows opiate withdrawal which puts the service user at significantly increased risk of opiate overdose should they relapse. Service users should be given advice that if they have a period without using opiates/opioids, their tolerance could be greatly lowered. This may be the case if they have been detoxified from opiates, such as may happen in prison or a substance misuse rehabilitation unit. This may lead to an opiate overdose if the service user relapses when released/discharged. Opiate overdose can be fatal.

Summary and guidelines for detoxification from opiates can be found in on the trust intranet under “Pharmacy – Substance Misuse”


In the event of an overdose, Naloxone is highly effective. It acts as an antidote for opioids and opiates and its use is potentially life-saving. Please note the effects usually wear off within 4 minutes which requires further doses.
More Information about the use of Naloxone can be found in the trust “Guidelines for the use of Naloxone Injection – February 2016” available on the intranet.


Please note Naloxone training is now required training for staff in clinical areas.

5.6 Specialist Further Assessment

Once initial assessment and screening has taken place, a more comprehensive assessment may be necessary. This can be carried out over a longer period of time, by the team with primary responsibility.

Based on the DOH good practice guide 2002, the specialist assessment should include:

- Mental health treatment history
- Consideration of the relationship between substance misuse and mental health problems
- Recovery supports such as: family, friends, partners, carers, community support, housing status, benefits stability, education, employment, voluntary work, peer group support (MIND, Narcotics Anonymous, and Alcoholics Anonymous), hobbies, interests, ambitions.
- Assessment of knowledge of harm minimisation in relation to substance misuse.
- Determination of individual's expectation of treatment and their degree of motivation for change.
- The need for pharmacotherapy for substance misuse.
- Service user's capacity to make decisions concerning treatment options
- Additional areas that should be covered in a subsequent care plan could include:
  - Family and personal relationships
  - Sport and Recreation
  - Sexual health
  - Diet
  - Employment
  - Personal Care
  - Smoking

5.7 Care Programme Approach (C.P.A)

The C&I CPA policy describes the approach used in secondary mental health to assess, plan, co-ordinate and review the range of treatment, care and support needs for people in contact with secondary mental health services that have complex characteristics.

Substance misuse services cannot hold care coordination responsibilities, so service users who are placed on CPA should also be under the care of one of the trust mental health teams.

The following characteristics have been identified as a guide for deciding who should be eligible for CPA (DH, 2008).
- Severe mental disorder (including personality disorder) with high degree of clinical complexity. The high degree of clinical complexity relates to need regarding mental illness and/or behaviour.
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drug misuse.

Some service users who are in contact with substance misuse services will meet this threshold for CPA and will require input from mental health services.

5.8 Care Planning

In 2015, staff from C&I substance misuse services and assertive outreach teams (AOT) developed a brief assessment / harm minimisation tool based on NICE guidance for substance misuse, which has been in use by the Assertive Outreach Team (AOT) for over a year.

This is a required tool for assessing risk and designing care plans. This can be found in Appendix 5. For a digital version, or advice on its use please contact the trust dual diagnosis lead nurse on 0203 317 7099/ simon.peel@candi.nhs.uk or Dr Dominic O’Ryan 0203 317 6016/Dominic.ORyan@candi.nhs.uk (clinical psychologist).

This care plan must be available to in-patient staff if a service user is admitted to ensure continuity of treatment.

5.9 Involvement of Families and Carers in Service Users’ Care

Staff should ask families and carers to discuss concerns regarding, the impact of drug and alcohol use or misuse on themselves and other family members, including children. Areas or concern for children could include:

- Parents involved in crime or antisocial behaviour
- Children not attending school regularly
- The need to buy drugs taking precedence over the needs of the child
- Exposure of children to drugs or paraphernalia
- Exposure of children to other drugs users or dealers entering the family home
- Emotional neglect
- Adults out of work or at risk of financial exclusion
- Young people at risk of being jobless
- Children who need help (At risk of sexual exploitation or on child protection register.
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

Camden and Islington Social Services can offer help as well as financial support through their Stronger Families (Islington) and Resilient Families (Camden) programmes. Guidelines around eligibility criteria for each scheme are available online here:

Islington Stronger Families:


Camden Resilient Families:

Staff should offer family members and carers an assessment of their personal, social and mental health needs.

**Where the needs of families and carers of people who misuse drugs have been identified, staff should:**
- Offer guided self-help, typically consisting of a single session with the provision of written material.

Provide information about, and facilitate contact with, support groups, such as self-help groups specifically focused on addressing families and carers' needs.

**Where the families of people who misuse drugs have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, staff should consider offering individual family meetings. These should:**
- Provide information and education about drug misuse.
- Help to identify sources of stress related to drug misuse.
- Explore and promote effective coping behaviours. A referral to a clinical psychologist will be essential for this. (N.B. This is from NICE Psychological Interventions Guidelines (CG178).

### 5.10 Partnership Working.

**Some excellent examples of partnership working already exist in the trust such as:**
- Consultation services to mental health teams - providing advice and information; promoting integrated recovery care planning that addresses both substance misuse and mental health needs; and facilitating engagement with specialist services.
- Co-facilitation and supervision of “SMART” recovery groups on trust in-patient units.
- Training workshops and shorts courses facilitated by substance misuse staff by for several of the trusts specialist services.
- Addiction psychiatry consultation sessions to in-patient units.

**Other ways that mental health and substance misuse teams could work closer are:**
- Substance misuse team input to the integrated practice unit for service users with long-term mental health conditions.
- Additional mental health consultation sessions for the substance misuse teams.
- Dual diagnosis case conference advisory group to review care pathways and options for people. This can be accessed for people who do not meet CPA criteria but receive services via substance misuse services.
- One off information sessions for wards to give updates on new substances or trends in substance misuse.

This list is not exhaustive and should be reviewed yearly by the trust dual diagnosis lead nurse and discussed at operational level in order to ensure resources and staff are available.

### 5.11 Legal Considerations

The use of alcohol or non-prescribed drugs on any mental health services premises is unacceptable and illegal under the Misuse of Drugs Act 1971.

Novel psychoactive substances (NPS), previously known as “legal highs”, remain banned from trust sites and are now covered under the Psychoactive Substances Act 2015. Alcohol and the smoking of tobacco are also prohibited on trust sites.
Under the Act, it is also an offence for a person concerned with the management of the premises to permit preparation and use of illicit substances. This places responsibility on trust staff to take action if an offence is being committed.

A letter stating the trust's position on illegal substances is given to service users on admission. It is important to be very clear on this as alcohol and substances can be seized, confiscated and disposed of under this policy.

All incidents should be recorded in the person's care notes and Datix as soon as possible. Categorising these incidents under “Substance Misuse” will ensure the trust local security management specialist (LSMS) is made aware.

**What to do if you find banned substances on a Trust Site.**

Any alcohol found on the premises should be disposed of unless the service user objects. In which case it should be confiscated, labelled and kept secure for them until their discharge from the premises. Staff should ensure an explanation for action taken is documented on care notes.

Any suspected illicit substance found on trust premises must be bagged and labelled and ideally placed in a controlled drug cupboard. This must be witnessed by another member of staff and documented in the service user's notes and controlled drugs book. They should not be returned to the service user.

If empty alcohol containers or drug packaging and paraphernalia are found on trust ground they should be removed and safely disposed of for the protection of the public.

**All environments should have access to armoured gloves for handling sharps if IV equipment is found.**

If staff are working alone - or do not have access to a controlled drug cupboard they should log the incident with the police by ringing 101 and inform their line manager during office hours and on-call manager out of hours.

The service user’s primary nurse/key worker and consultant psychiatrist should be involved or notified of this at the earliest opportunity.

Where substance misuse is suspected, but a service user is reluctant to discuss their use, a team may feel drug screening will be the only therapeutic option. In this case the team should bear in mind that many substances are undetectable after 72 hours (apart from cannabis which can be found up to 28 days later).

Service users in in-patient settings may be searched for substances under the trust search policy.

The trust service managers in discussion with care teams may consider banning or discharging a service user or visitor under its duty of care towards other service users and staff.

The metropolitan police will be kept informed and regularly updated about substance misuse incidents on trust sites. Senior trust staff, including the dual diagnosis lead and local security management specialist will meet with representatives from the London Ambulance Service and MET police quarterly to discuss incidents and patterns.

In addition there are regular police surgeries at both HMHC and The Huntley Centre for staff to discuss issues with.
Action will always be taken in response to any suspicion or knowledge of possession of illicit substances.

However the trust recognises that a substantial number of its service users regularly use substances and that bringing charges in every case may not be appropriate.

Services users involved in dealing substances and incidents involving violent behaviour and substances will always be directly reported to the police.

Further advice and information can be sought from via the site coordinator, local security manager and/or lead dual diagnosis lead.

5.12 Safeguarding

Feedback from various service user groups suggested that they may feel reluctant to disclose details about their substance misuse due to fears that their children may be removed by social services, or that they will be charged by the police.

The trust has a duty to ensure vulnerable people are offered protection and support if an issue is highlighted.

It is important to ensure that if a service user is under assessment whether in a substance misuse or mental health setting he/she understands that the information they give could be interpreted under the C&I safeguarding policy.

All staff members should explain that the safeguarding policy is intended to be supportive, and should ensure the wellbeing of individuals.

5.13 Training

Staff working in mental health teams should have the knowledge and skills to:

- Assess drug and alcohol use using the AUDIT and DUDIT in Appendix 3.
- Understand intoxication and withdrawal.
- Know the difference between occasional and dependent use.
- Have an understanding of the most commonly known substances used by services users and be able to speak non-judgementally to service users.
- Assess levels of confidence and importance in changing substance misuse behaviour.

Staff working in substance misuse teams should have the knowledge and skills to:

- Understand common mental health problems.
- Describe symptoms of mental illness
- Have an opinion about the relationship between substance misuse and mental illness.

An online E-learning package has also been developed as part of a two-year CQUIN target aimed at providing expert information to frontline teams.

In addition, all substance misuse staff will be given training in brief mental health assessment and how to access mental health services.

The Middlesex University include a two-day motivational interviewing (MI) course as part of their training programme, which can be accessed via the training dept.

Substance misuse services also offer an MI short course on request.
The C&I recovery college offers a half-day MI course for all trust staff and service users.

Proposed model for the support and training of C&I staff:

Specialist Consultation and Supervision
Available in groups, monthly

Level 3
Three-day workshop, available twice yearly
Motivational Interviewing and Brief Interventions
for Substance Misuse

Level 2
One-day workshop, available quarterly
Holding conversations for substance misuse assessments and care planning
Understanding referral pathways and partnerships

Level 1
E – Learning Package, 2 hours, available on demand
Substance knowledge (including opiates, stimulants, new psychoactive and alcohol)
includes routes of administration and basic harm reduction

6. Duties and Responsibilities

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.

Director of Nursing
The director of nursing is the director who is responsible for the development of relevant policies and to ensure they comply with NHS Litigation Authority (NHSLA) standards and criteria where applicable. They are also responsible for trust wide implementation and compliance with the policy.

Managers
Managers are responsible for ensuring policies are communicated to their teams. 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.

Dual Diagnosis Lead Nurse
The C&I dual diagnosis lead is responsible for the development and review of the dual diagnosis policy as well as ensuring that it is implemented effectively.

They should also ensure that monitoring arrangements around incidents and Datix are in place.

The dual diagnosis lead is available for advice and support as well as facilitating dual diagnosis case conferences on request.

Clinicians and Health Professionals
Clinicians from both mental health and substance misuse teams providing care and treatment 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 and mental health problems and always in line with trust values.

Clinicians should liaise with voluntary and statutory organisations in the community to concerning dual diagnosis issues.

All staff should ensure all service users are offered screening and support for substance misuse issues. They should facilitate service users and carer’s access to health promotion, advice and group-work, as per local arrangements, information brochures and availability.
## 8. Appendices

### Appendix 1  KEY STANDARDS

<table>
<thead>
<tr>
<th>Adult Mental Health</th>
<th>Alcohol</th>
<th>Drugs</th>
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<tr>
<td>• Psychosis and schizophrenia in adults: treatment and management (CG178) February 2014</td>
<td></td>
<td>• Methadone and buprenorphine for the management of opioid dependence (TA 114) January 2007</td>
</tr>
<tr>
<td>• Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185) Sept 2014</td>
<td></td>
<td>• Naltrexone for the management of opioid dependence (TA115) January 2007</td>
</tr>
<tr>
<td>• Coexisting severe mental illness and substance misuse: community health and social care services (NG 58) NOV 2016</td>
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Appendix 2  SERVICE USER INPUT and MH SERVICES PERSPECTIVES

Camden Borough User Group consulted on the 16th August 2016.

Questions raised highlighted issues around people with mental health problems feeling vulnerable in substance misuse settings and preferring to receive substance misuse advice and treatment without needing referral out.

Frustrations around having multiple assessments

Issues around people who may have just started using substances who may feel they do not identify with any particular group.

Questions around alcohol usage and getting clear advice from professionals

People who are still using substances or alcohol being refused access to services.

Frontline Substance Misuse Group consulted on the 1st September.

Themes raised included issues around substance misuse staff needing more knowledge of mental health issues and pathways.

Also concerns about consent and how sensitive information is dealt with. Especially where service users have children

Also issues arose around EPR and how information is stored.

Representatives from Voiceability (Alex Boyt and Daniel Slee) consulted in early July 2016.

Both expressed a desire to see referral processes and assessment procedures streamlined

A Dual Diagnosis peer research report article published via Voiceability in 2014 found that:

Substance use services seem better able to support people with a dual diagnosis than mental health services do.

People are reluctant to disclose their mental health experience or substance use to professionals, for fear of consequences for the treatment and support they receive.

If people used different services, the communication between those services was
generally poor.

And recommended that:

Frontline staff (including GPs, mental health professionals, and substance use staff) are supported (and trained to) communicate in a way which ensures more service users feel they can be honest about their experiences.

Make greater efforts to engage people at different stages of their recovery; excluding those who smell of alcohol from services should be reviewed and relaxed where possible.

Explore the provision of a ‘no wrong door’ service that can support people with a dual diagnosis, instead of people having to primarily identify with either mental health or substance use.

Further research the prevalence and experiences of those with a dual diagnosis in Camden; this snapshot study can be used as learning for this.

Islington Borough User Group (IBUG) Consulted on the 27th September.

Points around having multiple assessments expressed.

Points made about having greater involvement in policy development.

Discussion around safeguarding and use of personal information. The was a request for more information about how care notes (EPR) holds information.

**Mental Health Services Perspective**

Acute services have a particular interest in ensuring service users with substance misuse issues are appropriately screened and issues identified at an early stage.

As well as the ability to use standard screening tools, staff require the skills to engage service users in non-judgemental conversation about their drug and alcohol use in order to understand the interplay between substance misuse and mental health.

This is critical to reducing re-admissions where substance misuse is a factor in precipitating relapse and crisis. Substance misuse also contributes to longer lengths of stay. The impact of dual diagnosis on suicidality and our services role in reducing the number of suicides is also key.

Enhancing motivation for change and encouraging use of specialist SMS services will be supported by training and understanding of referral pathways.

Our staff need to be aware of the particular risks posed by use of drugs and
alcohol and risk management strategies that can assist service users in minimising harm to themselves or others when they are crisis and at their most vulnerable.

Our inpatient settings need to be skilled in managing detoxification from alcohol, GHB and opiates, as well as maintaining prescribing of opiate substitutes. Our Crisis Houses need to be clear about their limitations in regard to managing controlled drugs and the lack of adequate medical support to manage any detoxification regime.
## Appendix 3 AUDIT TOOLS

### Alcohol Use Screening (AUDIT)

<table>
<thead>
<tr>
<th>Question</th>
<th>Circle One</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - How often do you have a drink containing alcohol?</td>
<td>Never, Monthly or less, 2 - 4 times per month, 2 - 3 times per week, 4+ times per week</td>
</tr>
<tr>
<td>What alcoholic drinks do you most often use? e.g. spirits, wine, strong lager, normal-strength lager, ale, cider</td>
<td></td>
</tr>
<tr>
<td>2 - How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1 - 2, 3 - 4, 5 - 6, 7 - 9, 10+</td>
</tr>
<tr>
<td>This is one unit of alcohol…</td>
<td></td>
</tr>
<tr>
<td>...and each of these is more than one unit</td>
<td></td>
</tr>
<tr>
<td>3 - How often have you had 6 or more units on a single occasion in the last year?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>Total Score: If equal to or greater than 4, please complete full AUDIT and substance misuse assessment. Consider referral to or consultation with SMS.</td>
<td></td>
</tr>
</tbody>
</table>

### Drug Use Screening (DUDIT)

<table>
<thead>
<tr>
<th>Question</th>
<th>Circle One</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - How often do you use drugs other than alcohol?</td>
<td>Never, Monthly or less, 2 - 4 times per month, 2 - 3 times per week, 4+ times per week</td>
</tr>
<tr>
<td>What drugs other than alcohol do you most often use? This might include heroin, codeine, cocaine, crack, speed/amphetamine, mephadrone, cannabis, spice, benzos (valium, diazepam), GHB/GBL, ketamine, MDMA etc.</td>
<td></td>
</tr>
<tr>
<td>2 - Do you use more than one type of drug on the same occasion?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>3 - How many times do you take drugs on a typical day when you use drugs?</td>
<td>0</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td><strong>Total Score:</strong></td>
<td></td>
</tr>
<tr>
<td>If equal to or greater than 4, please complete full DUDIT and substance misuse assessment. Consider referral to or consultation with SMS.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ-C)

NAME____________________________________AGE____________No._______

DATE:_____________

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

When was this? Month:________________________ Year:________________________

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

During that period of heavy drinking

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

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

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

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

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

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

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

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

10. The day after drinking alcohol, I always gULPED my first few alcoholic drinks down as quickly as possible.

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

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

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

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

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

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

Imagine the following situation:
1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily for two days**
How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.
   - **NOT AT ALL**
   - SLIGHTLY
   - MODERATELY
   - QUITE A

18. My hands would shake.
   - **NOT AT ALL**
   - SLIGHTLY
   - MODERATELY
   - QUITE A

19. My body would shake.
   - **NOT AT ALL**
   - SLIGHTLY
   - MODERATELY
   - QUITE A

20. I would be craving for a drink.
   - **NOT AT ALL**
   - SLIGHTLY
   - MODERATELY
   - QUITE A

**SCORE**

CHECKED BY:

ALCOHOL DETOX PRESCRIBED: YES/NO
Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: ____________________ Date: __________________ Time: __________________ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: __________________ Blood pressure: __________

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too
bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation.

0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.

0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.

0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total CIWA-Ar Score ______
Rater's Initials ______

Maximum Possible Score 67

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.
Appendix 5

Suggested template for substance use assessment, risk assessment and care plan

This template meets the requirements and prompts from the trust CQUIN, NICE guideline CG120 and Carenotes

<table>
<thead>
<tr>
<th>Core Assessment - Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current substance use - substance, quantity, frequency, route, funding, duration of current pattern</td>
</tr>
<tr>
<td>Previous substances, routes and patterns of use</td>
</tr>
<tr>
<td>Periods of abstinence</td>
</tr>
<tr>
<td>Triggers for use or relapse</td>
</tr>
<tr>
<td>Substance-related beliefs</td>
</tr>
<tr>
<td>Previous treatment</td>
</tr>
<tr>
<td>Engagement and motivation</td>
</tr>
<tr>
<td>Goals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assessment - Substance Misuse Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current or potential health harms</td>
</tr>
<tr>
<td>e.g. overdose (particularly for opiate users after periods of abstinence), injecting complications, sharing drug paraphernalia, blood borne viruses, liver damage</td>
</tr>
<tr>
<td>Current or potential psychosocial harms</td>
</tr>
<tr>
<td>e.g. mental health, cognitive impairment, social &amp; family network, education, training &amp; employment (ETE), sex working, crime, assault</td>
</tr>
<tr>
<td>Any risks associated with acute withdrawal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Plan – Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe what you are doing and offering; comment on the client’s level of buy-in.</td>
</tr>
<tr>
<td>It should include elements of:</td>
</tr>
<tr>
<td>Motivational interventions - to cultivate change talk and soften sustain talk</td>
</tr>
<tr>
<td>Harm reduction - including substitute prescribing and advice on safer injecting</td>
</tr>
<tr>
<td>Relapse prevention - especially for previous opiate users</td>
</tr>
<tr>
<td>Liaison with substance misuse services - for advice, joint care planning, training and supervision</td>
</tr>
</tbody>
</table>
### Appendix 6 - GLOSSARY OF TERMS / ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIFT</td>
<td>Camden &amp; Islington Foundation Trust</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>EPR</td>
<td>Electronic Patients Record</td>
</tr>
<tr>
<td>DD</td>
<td>Dual Diagnosis</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>SU</td>
<td>Service User</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
</tr>
<tr>
<td>SMS</td>
<td>Substance Misuse Service</td>
</tr>
<tr>
<td>HONOS</td>
<td>Health of the Nation Outcome Scales</td>
</tr>
<tr>
<td>PBR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PIG</td>
<td>Policy Implementation Guide</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>SMT</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td>SUI</td>
<td>Serious Untoward Incident</td>
</tr>
<tr>
<td>NHSLA</td>
<td>National Health Service Litigation Authority</td>
</tr>
<tr>
<td>UDS</td>
<td>Urine Drug Screen</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
</tbody>
</table>
## Appendix 7 Audit and Monitoring arrangements

<table>
<thead>
<tr>
<th>Elements to be monitored</th>
<th>Lead</th>
<th>Method for monitoring compliance</th>
<th>Frequency</th>
<th>Reporting arrangements (Which committee or group will monitor compliance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisional Aspirational targets by Divisions</td>
<td>Dual Diagnosis Lead Nurse (DDLN)</td>
<td>Review of Divisional Plans (5)</td>
<td>Annually</td>
<td>Quality Review Group (QRG)</td>
</tr>
<tr>
<td>Training</td>
<td>DDLN / L&amp;D</td>
<td>L&amp;D Register/ESR</td>
<td>6 monthly</td>
<td>QRG</td>
</tr>
<tr>
<td>Incidents</td>
<td>DDLN</td>
<td>Datix review</td>
<td>6 monthly</td>
<td>QRG</td>
</tr>
</tbody>
</table>
| Standards on Nice Guidelines | DDLN | Audit | 1. CG 120 Baseline Audit in February 2017  
2. Annually | QRG |