Policy:

OPS 007 Dual Diagnosis Protocol (Mental Health and Substance Misuse)

Executive or Associate Director lead	Executive Director of Operations
Policy author/ lead	Consultant – Specialist Services
Feedback on implementation to	Consultant – Specialist Services

Document type	Policy
Document status	Version 5
Date of initial draft	January 2019
Date of consultation	January 2019
Date of verification	May 2019
Date of ratification	6 June 2019
Ratified by	Executive Directors Group
Date of issue	7 June 2019
Date for review	31 October 2020

Target audience	Staff in Mental Health and Substance Misuse Services

Keywords	Dual, diagnosis, substance, misuse

Policy Version and advice on document history, availability and storage

This is version 5 of this policy. This version replaces the previous version 4 (dated October 2016).

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of previous versions should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

1. Introduction

Dual Diagnosis features prominently in the Government's Mental Health Strategy. The National Service Framework states that "the primary responsibility for the treatment of severe mental illness (including *Dual Diagnosis*) lies with Mental Health Trusts (standards 4 and 5)"

This policy has been developed with the involvement of Adult mental health and substance misuse services and describes arrangements for joint working between Mental Health, and Substance Misuse services within Sheffield Health and Social Care Trust NHS Foundation Trust (SHSCFT). In addition, this policy provides more general advice and guidance for those that have both mental health and substance misuse needs but who do not meet the particular definition described in section 3.

This policy includes a specific definition of those with significant Dual Diagnosis and describes arrangements for joint working between Mental Health and Substance Misuse services to meet the needs of this service user group.

2. Scope

This policy relates to SHSCFT staff (including seconded staff) and services. Although it refers to services within the voluntary sector it is a Trust policy and deals with the interfaces between Trust services.

This policy applies to services in both inpatient and community settings with co-existing mental health and Alcohol/Drug issues (Substance Misuse)

3. Definitions

In general terms for the purposes of this policy "Dual Diagnosis" is defined as the presence of co-existing mental health illness in conjunction with problematic alcohol/drug misuse.

This more specific definition applies to Section 6 of this policy, which sets out the particular requirements for Mental Health Services and Substance Misuse Services to work together to meet the needs of this service user group.

Dual Diagnosis refers to persons who present with co-existing mental health problems and co-morbid substance misuse,

- All mental health conditions, including common mental health conditions~~,~~ severe mental illnesses, personality disorders and learning disabilities
- Substance misuse difficulties in the moderate/severe category (see appendix G)
- The range of all psychoactive substances includes alcohol, opiates e.g. heroin; methadone; cannabis; sedative hypnotics; stimulants such as amphetamines; cocaine; khat; hallucinogens volatile substances; novel psychoactive substances; prescribed medications and over the counter medicines.
- Poly-drug misuse is not uncommon and, in a number of cases, the use of illicit substances will be multiple rather than singular.
- In the context of this document a Dual Diagnosis service user is defined as an individual with concurrent needs arising out of their mental illness(es) and their substance misuse.

4. Purpose

The purpose of this policy is to provide guidance for staff working with people who have a Dual Diagnosis (Mental Health and problematic Alcohol/Drug Misuse). The policy sets out standards for:

- Joint working
- Liaison between Mental Health and Substance Misuse Services
- Referral and Assessment.
- Setting out duties and expectations of staff in the Mental Health Services and Substance Misuse Services.

5. Duties

Identifying and providing relevant care for individuals with co-existing substance misuse and mental health conditions should be an integral part of care by **mental health staff and colleagues in substance misuse services.**

There is a **general responsibility of all services** to liaise with each other in cases of joint working and to work effectively and collaboratively in partnership to provide the best possible service to those with a Dual Diagnosis.

More specific role responsibilities are laid out in Sections 6.

6. Process

6.1 Applicability

Service users who present with mental health conditions and co-morbid substance misuse disorders as laid out in the definition in Section 3

6.2 Assessment

Assessment is complex and can take place over a period of time (2-6 sessions) before a definitive decision can be made on the nature and impact that drugs might be having upon an individual's mental health. Often it may not be possible to say that a service user has a primary diagnosis of either mental illness or a primary diagnosis of a substance misuse disorder. A major difficulty is that, in many cases, the closeness in the reported time of onset of both disorders makes it difficult to come to definitive conclusions regarding aetiology.

Information from assessment should be used to develop Collaborative care plans.

(i) Assessment by Mental Health Teams

When making an assessment of an individual's substance misuse a number of issues should be taken account of:

- Why they take substances
- Their history of substance taking
- The effects of substances (both positive and negative) on their mental health
- The results of any available urine or blood tests

Part of the assessment process is to engage the service user to monitor and evaluate their own substance use in relation to circumstances around use, mood changes, compliance with prescribed medication and mental health symptoms.

As good practice: All assessments by Mental Health Services should routinely include the consideration of substance misuse problems.

Appendix K provides workers with a list of useful questions to ask at assessment to assist in identifying the:
- Extent of the individual's substance misuse;
- Possible impact on their health and social wellbeing;

If, following assessment or during treatment with the mental health team, a person reveals a substance misuse issue, consideration should made to contact the substance misuse service and request a joint assessment.

As clinicians within the Trust all work using the Trust 'Insight' system, workers can view all documentation, including risk assessment (DRAM); collaborative care plan.

Consent from the service user for referral should be obtained. However, appropriate sharing of information/joint discussion and dialogue and involvement in planning care can take place even if the service user is unwilling to directly engage with other professionals.

(ii) Assessment by Specialist Substance Misuse Service (SMS)

Drug and Alcohol Assessments within Substance Misuse services should routinely include an assessment of the person's mental health.

If, following assessment or during treatment with the SMS, a person appears to meet the local definition as in 6.1: The substance misuse worker should contact the mental health worker and request a joint assessment

The majority of patients with mild to moderate mental illness can be managed in conjunction with the GP. In instances where this is not possible, discuss their presentation with a duty clinician in SPA (Single Point of Access) to request a joint assessment. (
As clinicians all work to the Trust 'Insight' system, workers can view all documentation, including risk assessment and the collaborative care plan.

The consent from the service user for referral should be obtained. However, joint discussion and dialogue and involvement in planning care can take place even if the service user is unwilling to directly engage.

6.2.2 Referral

(i) Referral by Mental Health Team to Substance Misuse Service

A referral should ideally include the following:
- Presenting problem, including details of mental health needs
- Alcohol/substance(s) of use
- Whatever is known about amounts and frequency

- Impact on health and social functioning
- Current use: results of investigations around substance use
- Specific risks and details of priority/urgency & reasons for urgency
- Motivation/readiness to change or acknowledge the problem
- Diagnosis
- current care plan/management arrangements

(ii) Role of Alcohol Triage

Alcohol Workers with basic awareness of mental illness offer triage utilising audit tools, brief advice around levels of alcohol consumption and brief interventions aimed at facilitating reduction in alcohol consumption audit score (0-18). Alcohol workers are unable to make a diagnosis or offer treatment interventions. The Alcohol service accepts self-referrals, which can be made via telephone, email or in person.

The nursing team offer comprehensive assessments, individualised packages of care including: preparation and engagement of complex service users; detoxification; relapse prevention; recovery orientated interventions specific to alcohol use.

6.2.3 Risk Assessment

Risks should be assessed and documented using the DRAM
Risk assessment processes are integral to assessment and care planning. **The risk assessment and risk management plan will be completed with joint consultation between staff from all the services involved**.. In all cases, the following should also be considered:

- Current drug use and quantities;
- Social circumstances;
- History of sharing injecting equipment (using other people's equipment, passing on equipment to others);
- History of sexual risk behaviours;
- Dependants under the age of 18 years (names and date of birth as a minimum data set) and any other caring responsibilities;
- Safeguarding (Adult/Children) including domestic violence and human trafficking;
- Poly substance use (including co-morbid use of alcohol and drugs)
- Co-morbid medical conditions, including those which may be associated with substance misuse e.g. Hepatitis (B, C, alcoholic); cirrhosis and other liver damage/disease; deep vein thrombosis (DVT); and pulmonary embolism (PE); endocarditis; lung disease.
- Storage of medicines
- Forensic history, in particular past history of violent and/or exploitative crime, including domestic abuse and human trafficking.

6.2.4 Roles of Staff

The primary expectation is that the mental health worker and SMS worker will work collaboratively to meet the needs of the individual.

Communication with the service user must take into account their ability to take in, understand and weigh up information, in order to make and communicate informed decisions. Assessment and documentation regarding mental capacity (decision and time specific) is advised. Information should be available in language which avoids the use of medical jargon and in a variety of appropriate forms. Individuals engaged in services are entitled to:

- Full information on their diagnosis and the assessment of their health and social needs;
- Be fully involved in their care plan, together with a relative, carer or friend as appropriate;
- Full information on the services available in the community relevant to their care
- Be given appropriate information on how to contact services in an emergency;
- Have access to the Trust's complaints procedure and be informed that any complaint is investigated and a full explanation given.

Where CPA applies the mental health worker involved will assume the role of Care Co-ordinator and take the lead in setting up CPA reviews for service users with Dual Diagnosis.

The SMS worker will take the lead in referring/linking the service user to:

- Substance misuse focused treatment interventions;
- Recovery groups;
- Counselling and residential rehabilitation for their substance misuse needs if required.

6.2.5 Collaborative Care Plan

- All individuals who meet the local definition of Dual Diagnosis (6.1) must have a written collaborative care plan, shared with the patient (unless assessed risks deem sharing of information to be harmful to the service user and/or puts others at potential risk). This should reflect individual needs that take into account the cultural and ethnic background, age, gender, sexuality and parental status and any other caring responsibilities (e.g. for elderly and/or unwell relatives) of the service user.
- Care plans should include specific interventions that address the different aspects of the individual's presentation.
-

Both services will endeavour to engage the service user into fully shared care and management. Joint working may include:

- Joint home visits;
- Joint appointments at substance misuse or mental health bases
- A key-worker attending CPA reviews, team meetings, ward round, section 117 meetings etc.

It is essential that service users are provided with details of arrangements, contact details and any relevant information regarding their future treatment and care.

Where appropriate, carers should be involved in the care planning process. Assessments must be offered to those carers who meet the eligibility criteria under the Care Act 2014

6.2.6 Care Plan Review

A Care Plan should be reviewed and evaluated at regular intervals or at the request of a member of the care team, the service user or their carer. The date of the next review is set and recorded at each review meeting.

6.2.7 Presentation in crisis

Emergency Mental Health Services should offer appropriate interventions and support for individuals with Dual Diagnosis that present in crisis. As part of advance crisis planning, it is essential that service users are provided with contact details for appropriate emergency service provision.

6.2.8 In-Patient Admissions

When a person with Dual Diagnosis is admitted to inpatient services the ward based staff should ensure that the mental health worker and substance misuse team is informed of the admission.
There should be good liaison between the inpatient ward team, the mental health team and substance misuse service in line with the Admission and Discharge pathway. Wherever appropriate the service user should be encouraged and supported to maintain their involvement with the Substance Misuse Service.

Both the mental health team and the Substance Misuse Service should be involved in the discharge planning / CPA meeting. The ward team should ensure that the mental health team and Substance Misuse service are informed of discharge or any significant periods of leave.

<u>Referrals from Inpatient Services to Substance Misuse</u>
Referral and access systems need to be flexible, transparent and inclusive. Services need to support individuals and carers to find their way through the process. Where inpatient services identify a current service user who requires referral under this protocol, the referral should be co-ordinated with the Care Co-ordinator. This should not prevent acute inpatient staff seeking advice from the Substance Misuse Service where there are urgent concerns and timely discussion is encouraged and welcomed.

The ward assessment should include difficulties relating to substance misuse. Where the ward team identifies that the person meets the locally agreed definition of Dual Diagnosis then they should consider a referral to the Substance Misuse service. **Dependent on the patient's risk assessment and needs, an assessment by the substance misuse team can take place either at the Fitzwilliam Centre or on the inpatient ward.**

Ward staff should give patients relevant information on non-statutory substance misuse services (Appendix J).

Instances may arise where the ward team may utilise the SHSCFT policy for Managing Substance Misuse and Harmful Substances on Inpatient wards.

6.2.9 Early Intervention Service

The Early Intervention Service (EIS) provides care to people aged 16 – 65 who are experiencing a first episode of psychotic illness. A major principle of the EIS is to provide treatment early in the illness to prevent the development of further deficits or further deterioration in functioning. This means that diagnostic uncertainty or a suspicion of psychotic symptoms is acceptable as a basis for referring a service user from SMS to EIS. A prompt sheet included in Appendix L may assist in making a referral. Discussions with a team member prior to referral are welcomed.

In common with other Dual Diagnosis service users, EIS service users often present with a complex interplay of psychotic symptoms and substance use. Cannabis is commonly used by EIS service users however; the pattern of substance use in these service users is often not established and may vary rapidly.

Alongside cannabis, other substances used such as cocaine, novel psychoactive substances and amphetamine have the potential to exacerbate or trigger psychotic symptoms in vulnerable service users and timely intervention to address this is required.

Where a service user's substance use appears to be problematic in terms of their psychotic symptoms, the EIS should offer a range of basic interventions such as advice, education and referral contact with the non-opiate service at Sidney Street.

The Corner is the appropriate agency to refer to for service users aged under 19 years. If service users do not respond to this, referral to and discussion with the SMS should be considered early, again with an emphasis on preventing further deterioration in the service user's functioning. See section 6.2.2 Referral for making referrals to the SMS.

6.2.10 Care Management

Dual Diagnosis service users may at times need to access services (e.g. residential care, home care etc) that are purchased via the Neighbourhood and Community Care services Care Management budgets.

It would usually be expected that mental health staff would undertake the assessment and application for care purchased services related to mental health, and that such applications would be forwarded to the Care Management Panel for Adult Mental Health.

Similarly, Substance Misuse Services would be expected to undertake assessment and application for residential packages for Substance Misuse treatment and these would be forwarded to the Care Management Panel for Substance Misuse.

However, on occasions joint funding of placements and packages of care is possible and in cases where one service considers that joint funding is appropriate, application to both panels should take place. In these circumstances, a joint assessment may be necessary.

The respective reviewing officers for each service should be informed as early as possible that joint funding is being considered. The above applies to working age adults: for those over this age, then older adult care management arrangements will be required.

6.2.11 Discharge

When a service user is identified as meeting the locally agreed definition of dual diagnosis (see 6.1) and where the involvement of a service or services is no longer necessary, Mental Health or Substance Misuse Services should not discharge without discussion.

Clear information should be given as to how the individual is able to re-access services in the future.

6.2.12 Non – Engagement

It is recognised that service users with a dual diagnosis may have problems with engagement, where this is the case, services should communicate with each other and agree a plan for the service user.

There is a commitment by SMS to prioritise reassessment should the person agree to this.

6.2.13 Dealing with Disagreements

From time to time, a situation could arise where there is a disagreement regarding continued involvement or input from a service. In all such cases, the team managers, care co-ordinators, consultant psychiatrists and representatives from other services as appropriate should hold a care-planning meeting.

The Trust's Resolving Differences of Opinion between Practitioners Policy should be adhered to.

6.3 Good practice in working with service users who have Dual Diagnosis but do not meet the locally agreed definition laid out in section 3 above

Section 6.2 dealt specifically with arrangements for joint working between Mental Health and Substance Misuse services for those service users that meet the specific definition of Dual Diagnosis outlined in section 3. However, there are also many other service users that have mental health difficulties and difficulties relating to substance misuse and whom will need Mental Health and/or Substance Misuse services either contemporaneously or at different times.

The following paragraphs set out standards for advice, referral, assessment, information sharing and liaison between Mental Health and Substance Misuse services within SHSC. The overriding principles of MDT working with good communication and liaison between all teams is essential.

- <u>Advice</u>
  In some situations a worker from one service may be seeking advice regarding a service user and their needs. Mental health and Substance Misuse do have systems in place to respond to these requests via duty workers or senior practitioners/team managers.

- <u>Referrals</u>

Referrals between Mental Health services and Substance Misuse services within SHSCFT can be discussed first, face to face, or by telephone to check that this is an appropriate way forward. This discussion can take place with the worker on duty, the senior practitioner or the team manager. Written referrals between these services need to be clear about what service is being asked for.

- Assessments
  Where possible assessments should be conducted jointly to avoid duplication and ensure the workers have the same information and make use of the insight system. If it is not possible, feedback to the referrer should always take place afterwards and the assessments should be accessible on Insight.

  Within Adult Mental Health services the standard for feedback to referrers is the same day for urgent referrals and within two weeks for routine referrals. When a member of staff from Mental Health or Substance Misuse makes a routine referral to the other service that requires earlier feedback then the referral should make this clear.

- Care Plan
  The Trust preferred document for care planning is the "Collaborative Care Plan", and ensures that care is shared and coordinated across services.
- On-going treatment/support
  Regular contact between workers is important to keep each other up to date with the service user's progress. It is essential that mental health workers are informed if the service user fails to keep appointments with their substance misuse worker and vice versa.

- Discharge
  Service users should not be discharged from a case load without prior discussion with the other service. A discharge summary should always be provided.

- Urine Testing
  There may be some circumstances in which it is appropriate for urine testing to be undertaken within Mental Health services Appendix M contains further guidance on this and advice is available from Substance Misuse services

- Other services available
  It is important to recognise that many Mental Health services and Substance Misuse services are provided outside of SHSC and either in the statutory or voluntary sector. This Protocol recommends prior discussion of referrals in order to allow for sign posting to more appropriate services.

- Mental Health Services within the Voluntary Sector
  There is a large range of voluntary sector Mental Health services. The Mental Health Guide provides a lot of information around these services. In addition, contacting the local mental health service for signposting advice maybe appropriate.

- Voluntary Sector Substance Misuse Services
  Please see appendices 3 and 4.

7. Dissemination, storage and archiving (Control)

The issue of this policy will be communicated to all staff via the Communications Digest. Local managers are responsible for implementing this policy within their own teams.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version should be destroyed and if a hard copy is required, it should be replaced with this version.

8. Training and other resource implications

This is not a new process. There is no plan for any additional training.

9. Audit, monitoring and review

NHSLA Risk Management Standards - Monitoring Compliance Template

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Duties	Appraisal/ Supervision	Line managers	Annual	Line managers	Line managers/ appraisee	Line managers
How the organisation addresses the needs of this group of patients	Develop a Dual Diagnosis specific audit checklist tool. Consultation on this Finalise tool Then pilot small sample in mental health and substance misuse services	Policy writers Identified mental health leads Lead commissioner for Dual diagnosis Dual Diagnosis working group	Quarterly	Audit department in SHSC Dual diagnosis working group	Dual Diagnosis working group Policy writers	Dual diagnosis working group
Details of internal and external joint working arrangements	Collaborative working: Yearly audit (both mental health and substance misuse services) to	Consultation by Dual diagnosis working group	Quarterly	Dual diagnosis working group Mental health and substance misuse service leads	Dual diagnosis working group Mental health and substance misuse service leads	Dual diagnosis working group

	identify jointly worked Dual Diagnosis service users have received parallel provision as intended Development of joint care and referral pathways Implementation of care programme approach Formal information sharing protocol across statutory and non-statutory agencies and criminal justice systems					
Procedure to be followed where there is a difference of opinion between professionals	Record the number of unresolved disputes by MDTM escalated to senior manager Number of unresolved disputes referred to Assistant Clinical Directors and or medical directors	Dual diagnosis working group to agree processes that record and identify cases Publicise process to all directorates Establish collection/collation systems within teams	Quarterly	Assistant Clinical Directors Medical Directors	Assistant Clinical Directors/medical Directors and Dual Diagnosis leads	Dual diagnosis training group Dual Diagnosis working group
How the organisation trains staff in line with the training needs analysis	Development of a joint training plan with criminal justices, substance misuse and mental health services Implement agreed training plan for all staff	Dual diagnosis training group Set E-learning and	Quarterly	Dual diagnosis training group	Dual diagnosis training group Policy writers	Dual diagnosis training group Audit department

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is 30 April 2017.

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11. Links to other policies, standards and legislation (associated documents)

- Department of Health Dual Diagnosis Guide, 2002
- Safeguarding Adults Policy
- Safeguarding Children Policy
- CPA policies and procedures
- Operational policies of relevant teams and services in SHSCFT
- Managing substance misuse and harmful substances on in patient wards
- Drug Misuse and Dependence, UK Guidelines on Clinical Management (The Orange book), Department of health, 2007
- Models of Care for the Treatment of Adult Drug and Alcohol Misusers 2006

12. Contact details

Title	***Name***	***Phone***	***Email***
Consultant – Specialist Services	Dr Olawale Lagundoye	50539	Olawale.Lagundoye@shsc.nhs.uk
Deputy Chief Nurse			

13. References

Department of Health Dual Diagnosis Guide, 2002

Drug Misuse and Dependence, UK Guidelines on Clinical Management (The Orange book), Department of health, 2007

Models of Care for the Treatment of Adult Drug and Alcohol Misusers 2006

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
V2 D0.1	Initial draft	October 2016	
V2 D0.2	Review	October 2016	Consultation / review. See Appendix E.
3.0	Review / ratification / issue	November 2016	Ratification, finalisation and issue

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
4.0	Nov 2016	Nov 2016 via Communications Digest	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE			
DISABILITY			
GENDER REASSIGNMENT			
PREGNANCY AND MATERNITY			
RACE			
RELIGION OR BELIEF			
SEX			
SEXUAL ORIENTATION			

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date)

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

☐ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

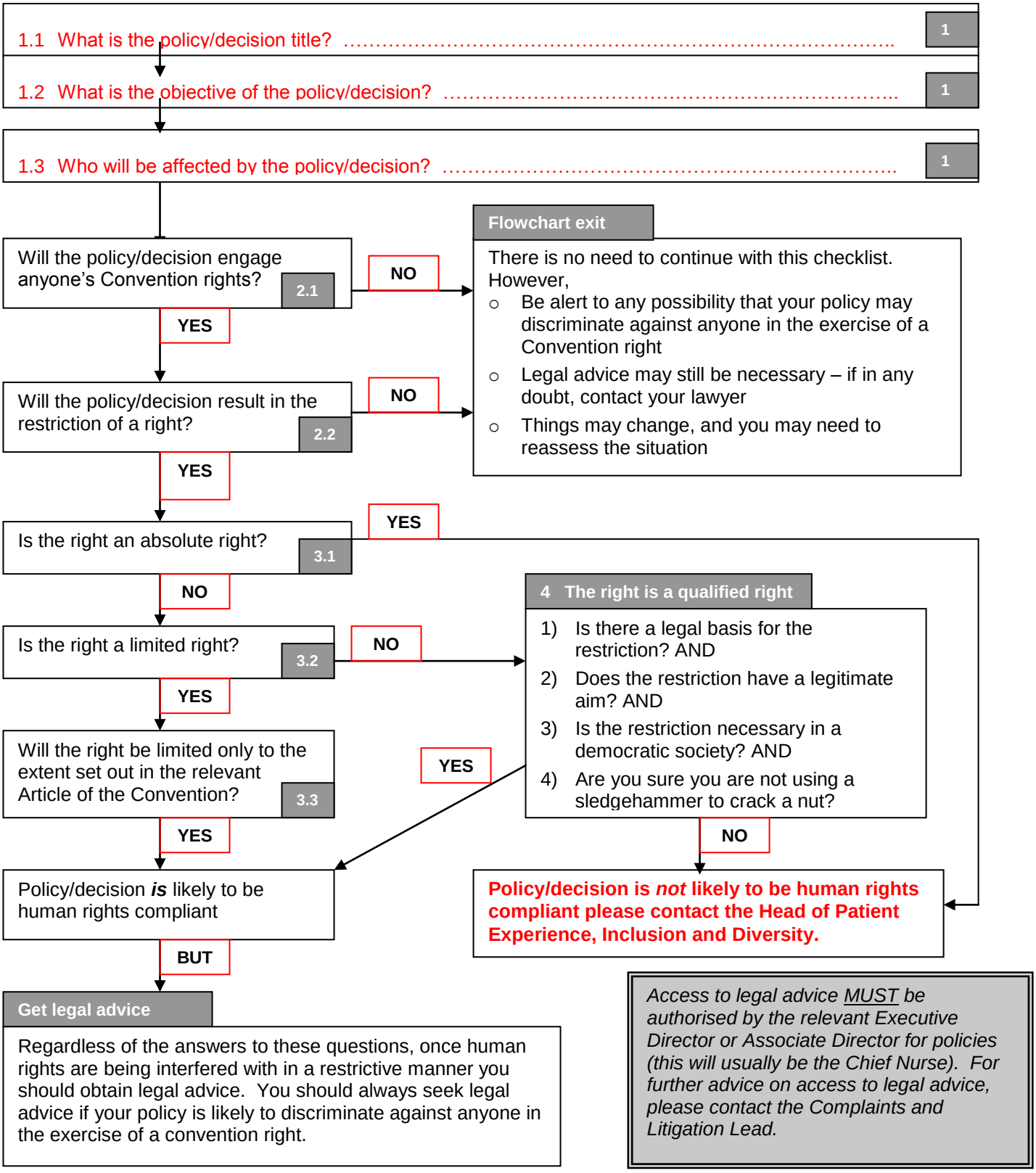
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

This policy has been reviewed and updated as part of the on-going policy development and revision process.

Consultation:

Dr Olawale Lagundoye
Vyvyan Hopkinson
Dr Yash Thakur
Dr Catherine Hardy

Extract from minutes dated 31.10.2016:

1. We reviewed the definitions of the Dual Diagnosis and acknowledged that individuals with mild to moderate mental illness would usually be managed in Primary Care. For this reason the Trust definition for Dual Diagnosis would refer to individuals with moderate to severe mental illness.

2. We discussed referral management across the different tiers of the service and highlighted that the referral management process are different between CMHTs.

3. We identified that a critical aspect of the pathway relates to Access.

4. **CPA:** We discussed practical difficulties in relation to specific caseloads but this point would be best discussed with a much wider audience.

5. **Recovery College:** We discussed proposals for a Drug Awareness course as part of the prospectus for Recovery College and agreed the next steps to developing the content for this course in conjunction with a service user representative. (This would be part of a resource that service users, carers and staff can access to learn about mental illness).

Verification:

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ☐
- Date of issue ☐
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart N/A

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Require-ment	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. **Implementation plan** ✓
14. **Links to other policies (associated documents)** ✓
15. **Contact details** ✓
16. **References** ✓
17. **Version control and amendment log (Appendix A)** ✓
18. **Dissemination Record (Appendix B)** ✓
19. **Equality Impact Assessment Form (Appendix C)** ☐
20. **Human Rights Act Assessment Checklist (Appendix D)** ☐
21. **Policy development and consultation process (Appendix E)** ✓
22. **Policy Checklist (Appendix F)** ✓

Appendix G - Substance Misuse Categories of Severity

Alcohol, substance use or substance misuse can be further sub-classified as abuse, harmful use or dependence.

This protocol is concerned with the provision of services for those individuals with a dual diagnosis who require Mental Health Services and Tier 3 and/or Tier 4 Substance Misuse Services (page 11).

It must not be forgotten that services other than these also play a significant and valuable role in the support of people with dual diagnosis.

Patterns of drug/alcohol misuse:

Mild: low risk non complex cases
Occasional *use:* ***People who have not used in the last month, but have used drugs in the last year***

- **Non-dependent use of substance(s)**
- **Low risk pattern of use or consequences relating to substance use**
- **Unlikely to require Specialist Services; (*Substance Misuse Tier 1 or possibly Tier 2 Services see page 11).***

Moderate: non-dependant substance misuse
Regular use: ***equated with use of alcohol or substances in the last month***

- **Problematic use of substance(s); borderline/intermittent physical or psychological dependence**
- **Suspicion of risk of physical, social or mental harm relating to substance misuse**
- **Requires specialist assessment and possibly specialist intervention *(Substance Misuse Tier 2 or possibly 3 Services see page 11)***

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Severe: high risk/complex cases
Dependence: ***daily use including psychological and physical symptoms of dependence associated with the particular substance***

- **Physically dependent with risk of complex withdrawal symptoms if supply of drug interrupted**
- **High-risk pattern of use and/or consequences e.g. social, health, overdose, legal or child care risks**
- **Persistent use despite clear evidence of harmful effects**
- **Polydrug use**
- **Intravenous drug use**
- **Pregnancy**
- **Difficulties in controlling substance taking behaviour**
- **Requires Tier 3 and Tier 4 substance misuse care, *see page 11***

Appendix H - Descriptions of treatment in substance misuse, based on the National Treatment Agency Models of Care for the Treatment of Adult Drug and Alcohol Misusers

A model of Care provides a conceptual framework to aid rational and evidence based commissioning of drug treatment in England. It is applied to both drug and alcohol.
This enables those not working in the substance misuse field to understand arrangements of pathways into treatment for this service user group

Tier 1: non- substance misuse specific services requiring interface with drug and alcohol treatment

The tier 1 service work with a wide range of service users including drug and alcohol misusers, but their sole purpose is not drug or alcohol treatment. They should as a minimum provide screening and referral to local drug and alcohol treatment service in tier 2 and 3. Tier 1 consists of services offered by a wide range of professionals (e.g. primary care, teachers, and probation officers, housing officers)

Tier 2: open access drug and alcohol treatment services

Tier 2 services provide accessible drug and alcohol specialist services for a wide range of drug and alcohol misusers referred from a variety of sources including self referral. This tier is defined by having a low threshold to access services and time limited requirements on drug and alcohol misusers to receive services. They will provide advice and information, services to reduce risk caused by injecting, services to minimise the spread of blood borne viruses, services that reduce overdose, out reach and screening and assessment.

In Sheffield examples of Tier 2 services are Open access to the Alcohol Service and Addaction.

Tier 3: Structured community based drug treatment services.

Tier 3 services are provided solely for drug and alcohol misusers in structured programmes of care. Included are: psychotherapeutic interventions (CBT, motivational interviewing, structured counselling, methadone maintenance programmes, community detoxification)

In Sheffield service users requiring tier 3 assessment are referred to SPAR (Single Point for Assessment and Referral c/o Fitzwilliam Centre). Following referral service users will receive a comprehensive assessment of their needs and if required onward referral will be organised

Tier 4: Residential services for drug and alcohol misusers

Tier 4 services are aimed at individuals with a high level of presenting need. Services in this tier include: inpatient drug and alcohol detoxification or stabilising services, drug and alcohol residential rehabilitation units and residential drug crisis intervention centres. Referral is usually via tiers 2 or 3 or community care assessments.

Appendix I - Sheffield Alcohol and Non-Opiate Treatment Services information

Sheffiled Treatment and Recovery Team (START) operates open access across the service for service users who are experiencing substance misuse difficulties.

The alcohol/drug workers main role is to facilitate care packages using a triage assessment process, provide Brief or extended Brief Interventions and where indicated stepping up to formal Psychosocial Interventions (PSI)

Appendix J – START Opiate Service information

Sheffield also operates a Single Point for Assessment and Referral (SPAR) for service users who need a comprehensive assessment for prescribed drug treatment. Following assessment by a Clinical Nurse Specialist/Social Worker, service users who are appropriate for prescribed treatment will be placed into the appropriate treatment pathway based complexity e.g. criminal justice involvement, mental health, child protection, poly drug use etc)

For more advice or information or to discuss a potential referral to drug or alcohol services Tel: The Fitzwilliam Centre on 3050500

There are also other services in Sheffield that will provide a variety of interventions for drug users including:

Substance Misuse Referrals
http://www.alcoholscreeningsheffield.co.uk/content/substance-referral

Appendix K - Useful questions at assessment for mental health staff

The following points highlight some of the questions or issues to discuss with your service user:

- What drug do they take? **Do they know what they are taking and its effects**
- When do they take it and how much?
- How do they take it? **Injecting holds different risks and is more intoxicating than smoking**
- What do the drugs do for them? **Do they help reduce anxiety related to mental health problems or help reduce the incidence and severity of the symptoms of their mental health problems**
- What are the positive and negative sides to their problem? **Do they perceive any negatives that might give an indication of their motivation to change? What positive effects make them take the drug?**
- Have they ever stopped taking drugs of their own accord? **This gives an indication of their own levels of control and other things that have worked in the past to help them stop taking substances, that may be valuable in their future attempts at controlling intake**
- What do they know/understand about the substances and their effects**? Many service users are unaware of the effects that they may experience as a result of substance taking. Graham (1999) talks about the fact that service users with psychiatric problems tend to focus on the positives of drug taking and have little or no awareness of the negatives. Giving your service user information is often the best way to change, or help them examine, their attitude towards substance misuse**
- What effects do they get from their psychiatric medication**? This may give an indication of whether they are self medicating, over medicated or give an idea of patterns of substance misuse in relation to their prescribed drugs which may be significant in moving the individual forward**
- What are their social circumstances**? Is there a family history of similar problems or are they being bullied into taking a substance that they might otherwise not? It is always worth bearing in mind that service users may be being abused by others around them.**
- What are the effects on others, e.g. family & friends? **Are they responsible for children or vulnerable others? How does their substance misuse affect their abilities to carry out this role?**
- What have they done in the past that has been successful in helping them control or abstain from their drug of choice**? Gives an indication of things that may be helpful to pursue in future and also gives an indication of whether they have any control over their substance taking**

There are many more important questions to ask when assessing these problems but the above questions are ones that may often be omitted but are essential to ask if you are going to establish the nature and complexity of your service user's problems. Very often you may not need to conduct an in depth assessment. It may be more appropriate to make a brief assessment with a view to clarifying the service user's problem and a referral onto a specialist agency

Appendix L – EIS Checklist for referrals

- **Use this checklist during consultation** ⇦

CHECKLIST FOR PSYCHOSIS	SCORING	SUGGESTED QUESTIONS
Score 1 point each		
Spending more time alone Arguing with friends and family The family is concerned Excess use of alcohol Use of street drugs (including cannabis)	_____ _____ _____ _____ _____	❖ Do you feel you have turned into a loner or have become less talkative? ❖ Do you prefer to spend time alone? Have you started to with draw from your group of friends? ❖ Have you stopped doing things with others? ❖ Has anyone said they've been worried about you? ❖ Are you unusually irritable or angry or do you find yourself more involved in arguments with relatives and friends? ❖ Have you been drinking heavily recently? ❖ Have you used any drugs recently? If so, could you give details of what type of drug and when you last used the drug?
Score 2 points each		
Sleeping difficulties Poor appetite Depressive mood Poor concentration Restlessness Tension or nervousness Less pleasure from things	_____ _____ _____ _____ _____ _____	❖ How have you been sleeping recently? ❖ How have you been eating? ❖ Have you felt less like eating than usual? How long for? ❖ Have you been feeling low? ❖ Have you been feeling anxious or panicky? How long for? ❖ Does it happen that different thoughts are getting mixed up in your mind; do you find it difficult to structure your thoughts? ❖ Do you feel nervous, restless or tense? ❖ Do you feel jumpy, edgy or do others think that you appear this way and have remarked on it?
Score 3 points each		
Feeling people are watching you* Feeling or hearing things that others cannot*	_____ _____	❖ Do you have the impression people are watching you or trying to take advantage of you? ❖ At any time could you see, hear, smell or taste things that others could not? Did you sometimes hear noises or voices while on your own?
Score 5 points each		
Ideas of reference* Odd beliefs* Odd manner of thinking or speech Inappropriate affect Odd behaviour or appearance First degree family history of psychosis plus increased stress or deterioration in functioning* **TOTAL**	 _____ _____ _____ _____ _____	❖ Do you ever feel that events or other people's actions have a special for you? ❖ Do you have the feeling others laugh or talk about you? Or do you receive messages? (ideas of reference) ❖ Do you believe anything that other people have found unusual or strange? (odd beliefs) ❖ At any time, did you ever experience that people or things in your environment appeared to be changed? ❖ Has anyone commented to you recently that you have said unusual or confusing things? ❖ Has anyone in your family ever had a mental illness?

20 points or more consider referral for assessment. If any items* are scored consider referral even if score is less than 20

With acknowledgements to: Salford EIS Service; South Worcestershire EIP Service; IRIS and Leeds Aspire

Appendix M - Guidelines for urine drug toxicology screens

Rationale:

- To establish whether the patient has taken any illicit substances prior to admission where a patient admitted may be known or suspected of using substances.
- To monitor and establish a pattern of use which may be significant to the patients mental health progress on the ward.
- To enable service users who have a drug dependence pattern to be able to refer for assessment for drug treatment interventions.

Taking a urine sample:

1. Ask the service user for their consent for a sample explaining the rational.

2. Wherever possible and appropriate observe the patient when providing sample.

3. Approximate 20mls of urine is required for testing. Use clear Universal specimen container.

Testing the sample:

The urine sample may be tested using an instant testing kit. There are single test kits and multi test kits. Be clear about what you are testing for. These tests will confirm whether the patient has used a substance (for example a positive or negative result to an opiate test) for confirmation of what opiate has been taken and a break down of how recently it has been taken the sample will need to be sent to the labs. Again be clear about why you would send a sample to the labs.

Sending a sample to the labs:

1. Ensure medical staff complete medical request form for toxicology screen. Ensure that the form and bottle are clearly labelled with all service user details.

2. Details of patient medication needs to be included to help the laboratory interpret the results and perform confirmatory test indicated

3. Send specimen to clinical chemistry on G Floor. Consider whether the sample needs to be identified as a 'high risk' sample in accordance with ward policy
4.

Advice can be sought from the Substance Misuse Service at the Fitzwilliam Centre on tel 3050500

Continued overleaf:

Drug Detection Periods

A rough guide to how long different drugs can be detected in urine after use at dose levels typically taken by drug misusers

Amphetamine 2 – 4 days

Ecstasy 1 – 2 days Detected in routine drug screen through Confirmation of initial test requires one additional working day

Heroin 2 – 4 days

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Diazepam 1 – 2 days (longer after IV use) Detected in routine Drug screen

Cocaine 12hrs – 3 days Detected in routine Drug screen

Cannabis

Casual Use 2 – 7 days

Heavy Use Up to 30 days Detected in routine drug screen

Alcohol 12hrs – 24hrs Detected in routine Drug screen

Methadone 2-11 days approx Detected in routine Drug screen.

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Buprenorphine 2 – 3 days LSD