Sheffield Health and Social Care
NHS Foundation Trust

Policy:

OPS 007 Dual Diagnosis Policy (Mental Health and Substance Misuse/co-occurring mental health and alcohol/drug use conditions)

Executive Director lead	Medical Director
Policy author	Consultant – Specialist Services Interim General Manager Specialist Services
Feedback on implementation to	Consultant – Specialist Services

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Target audience	Staff in other Service Lines (for example, Acute Care, Crisis, Community, Rehab & Specialist, Primary Mental Health, Learning Disability and IAPT)

Keywords	Dual, diagnosis, substance, misuse

Policy Version and advice on document history, availability and storage

This is version 7 of this policy. This version replaces the previous version 6 (dated July 2021 2019).
This is a temporary draft following the transfer of Substance Misuse Services in August 2023 to HumanKind Charity. This draft is to ensure that the policy remains fit for purpose until a full review can be undertaken working with HumanKind as a new partner delivering substance misuse services in Sheffield under the new name LikeWise.

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

Co-morbid mental illness and substance misuse occurs frequently, with evidence suggesting that 70% of patients in UK drug treatments services, and 86% of patients in UK alcohol treatment services have a diagnosed mental illness concurrent with their substance misuse diagnosis. This population is frequently referred to as 'dual diagnosis', though other synonymous terms such as 'co-occurring mental health and alcohol/drug use conditions' are now commonplace. It is acknowledged that this population with co-occurring conditions are often excluded from services and experience worse outcomes, including completed suicide than those patients with a singular diagnosis.

Recent national-level initiatives to address this imbalance have included the publication of NICE guidelines in 2016, with the aim to improve care for this group, through the provision of co-ordinated services to address patients' wider health and social care needs, and specific guidance to secondary care services, for example through the mandating of care co-ordinators for patients in this group. Building on this, Public Health England (PHE) and NHS England produced in 2017 guidance for commissioners and providers of relevant services, with the stated aim of helping 'commissioners and service providers to work together to improve access to services which can reduce harm, improve health and enhance recovery, enabling services to respond effectively and flexibly to presenting needs and prevent exclusion'. Two core principles were identified:

1) **Everyone's job:** Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
2) **No wrong door:** Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

This policy includes a specific definition of those with significant Dual Diagnosis and describes arrangements for joint working between SHSC services and LikeWise (Sheffield Substance Misuse Service) to meet the needs of this service user group and 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.

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 other Service Lines 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 F)
- 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 common, and the use of illicit substances can be multiple rather than a single substance.
- 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/co-occurring mental health and alcohol/drug use conditions). The policy sets out standards for:

- Joint working
- Liaison between other Service Lines and Substance Misuse Services
- Referral and Assessment.
- Setting out duties and expectations of staff in SHSC

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 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 alcohol/ substance misuse disorders as laid out in the definition in Section 3

6.2 Assessment

PHE guidance states that ‘services should be built around the specific needs, and work to overcome potential issues of stigma, mistrust based on poor past experiences or other barriers preventing access’.

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. In many cases the proximity of onset of symptoms makes it difficult to come to definitive conclusions about aetiology.

Information from assessment should be used to develop Collaborative Care Plans and detailed risk assessment (DRAM) both of which should be developed in conjunction with the service user and other professionals involved in their care and treatment.

(i) Assessment by SHSC service Lines

When undertaking an assessment of an individual's substance misuse, the following factors should be taken into account:

- Why they take substances
- Their history of substance use
- Current level and frequency of use
- The effects of substances (both positive and negative) on their mental health
- The results of any available urine or blood investigations

The assessment process involves engaging the service user in evaluating and monitoring their own substance use as well as its effects on their mental wellbeing (e.g. mood changes, compliance with prescribed medication and mental health symptoms).

All assessments should routinely include the consideration of substance misuse problems.

Appendix I 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, a person reveals a substance misuse issue, an initial assessment by that team is appropriate. Further consideration can be made to contact the substance misuse service if additional input is required.

Clinicians within the Trust all work using the same EPR system and can view documentation, including risk assessment (DRAM); collaborative care plan. Other useful tools include:

- AUDIT C (via DRAM/www.alcoholscreeningsheffield.co.uk/content/alcohol-screening-tool
- Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)
- Clinical Opiate Withdrawal Scale (COWS)

Consent from the service user for referral to substance misuse services should be obtained. However, appropriate sharing of information/joint discussion around risk can take place even if the service user is unwilling to directly engage with other professionals.

6.2.1 Referral

(i) Referral by SHSC to LikeWise

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

The basic information required for any referral to LikeWise should include:
- Name/DOB/telephone number/address
- Substance being used

6.2.2 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.
  Home safety including fire risk.
- 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.

6.2.3 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 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 takes into account individual needs. Individuals engaged in services are entitled to:
- Be fully involved in their collaborative care plan, together with a relative, carer or friend as appropriate.
- Information on their diagnosis and the assessment of their health and social needs.
- 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.

6.2.4 Collaborative Care Plan

- All individuals 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 and in accordance with Models of Care

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 SHSC bases
- A keyworker attending care plan 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

6.2.5 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.

6.2.6 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.

PHE guidance recommends that:

There should be a 24/7 response to people experiencing mental health and alcohol and drug use crisis, including intoxicated individuals, with episodes of intoxication being managed safely, and an agreed plan to help people access ongoing care and manage future crisis episodes.

Episodes of intoxication are safely managed; people can be at risk of harm to self and/or others when experiencing a mental health crisis and the risks are heightened if they are intoxicated. Services need to ensure that they are equipped to respond. This means having staff able to identify the signs of intoxication and responding appropriately to the associated risks, not being able to maintain one's own safety, physical risks (toxicity, overdose) and

disinhibition (possibly enhancing feelings of distress or anger). Once the crisis has been managed and urgent mental and physical health needs have been met it is important to use the opportunity to engage the person in subsequent treatment.

6.2.7 In-Patient Admissions

When a person with Dual Diagnosis is admitted to inpatient services the ward-based staff should ensure they seek consent to inform their worker and substance misuse team of the admission.
There should be good liaison between the inpatient ward team, other Service Lines 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.

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

Referrals from Inpatient Services to Substance Misuse
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 key worker. 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 Portland House or on the inpatient ward.**

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

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

6.2.8 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 staff within Service Lines 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 follow the substance misuse process for sign off.

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 officer/lead 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.

6.2.9 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, SHSC Service Lines or Substance Misuse Services should not discharge without discussion. See Appendix N.

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

6.2.10 Non – Engagement

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

6.2.11 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, key workers, consultant psychiatrists and representatives from other services as appropriate should hold a care-planning meeting. If this does not resolve any issues, this can be escalated to the appropriate senior manager.

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 SHSC services 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 do not meet these thresholds good practice should include the guidance set out below.

The following paragraphs set out standards for advice, referral, assessment, information sharing and liaison between SHSC and Substance Misuse services. 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. SHSC 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 SHSC and Substance Misuse services can be discussed first 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 and with consent assessments can be conducted jointly to avoid duplication and ensure the workers have the same information. If it is not possible, feedback to the referrer should always take place afterwards and the assessments should be accessible on the EPR.

  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 SHSC 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.

- Ongoing 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 an SHSC Service Line Appendix K contains further guidance on this and advice is available from the substance misuse service.

- 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 appendix H

7. Dissemination, storage, and archiving (Control)

The issue of this policy will be communicated to all staff via the SHSC Communications email. 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 but training will be evaluated once a new policy has been developed.

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 Network (to be re-established with SHSC and LikeWise)
Details of internal and external joint working arrangements	Collaborative working: Yearly audit (both other Service Lines and substance misuse services) to identify jointly worked Dual Diagnosis service users have received parallel provision as intended Development of joint care and referral pathways	Consultation by Dual diagnosis working group	Quarterly	Dual diagnosis working group Other Service Lines and substance misuse service leads	Dual diagnosis working group Other Service Lines and substance misuse service leads	Dual diagnosis working group

	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 other Service Lines 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 31 March 2024.

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	Director of Corporate	Within 5 working days of issue	

the Communication Digest immediately following publication.	Governance		
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	
Group of relevant stakeholders to be convened to carry out thorough policy review	Consultant – Specialist Services	From June 2024 – Policy review	

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
- Suicide Prevention Strategy 2023

12. Contact details

Title	***Name***	***Phone***	***Email***
Consultant – Specialist Services	Ruta Rele	0114 3050540	Ruta.rele@shsc.nhs.uk
Medical Director	Helen Crimlisk	0114 3050719	Helen.crimlisk@shsc.nhs.uk
Head of Nursing, Acute and Community	Chris Wood	0114 3050788	Chris.wood@shsc.nhs.uk
Clinical Director, Acute and Community	Jonathan Mitchell	0114 3050720	Jonathan.mitchell@shsc.nhs.uk

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

'Coexisting severe mental illness and substance misuse: community health and social care services', NICE guideline [NG58] 2016

'Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers', Public Health England 2017

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.
4	Review / ratification / issue	November 2016	Ratification, finalisation and issue
5	Review / ratification / issue	2019	Revised and approved
6	Minor revisions/extended	2021	Policy extended
7	Reviewed / approved / issued	May 2024	Amendments made following contractual move of substance misuse services from SHSC to Humankind.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
4	Nov 2016	Nov 2016 via Communications Digest	
6	July 2021	July 2021 - Connect	
7	TBC	TBC	

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	**No**		
DISABILITY	**No**		
GENDER REASSIGNMENT	**No**		
PREGNANCY AND MATERNITY	**No**		
RACE	**No**		
RELIGION OR BELIEF	**No**		
SEX	**No**		
SEXUAL ORIENTATION	**No**		

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**

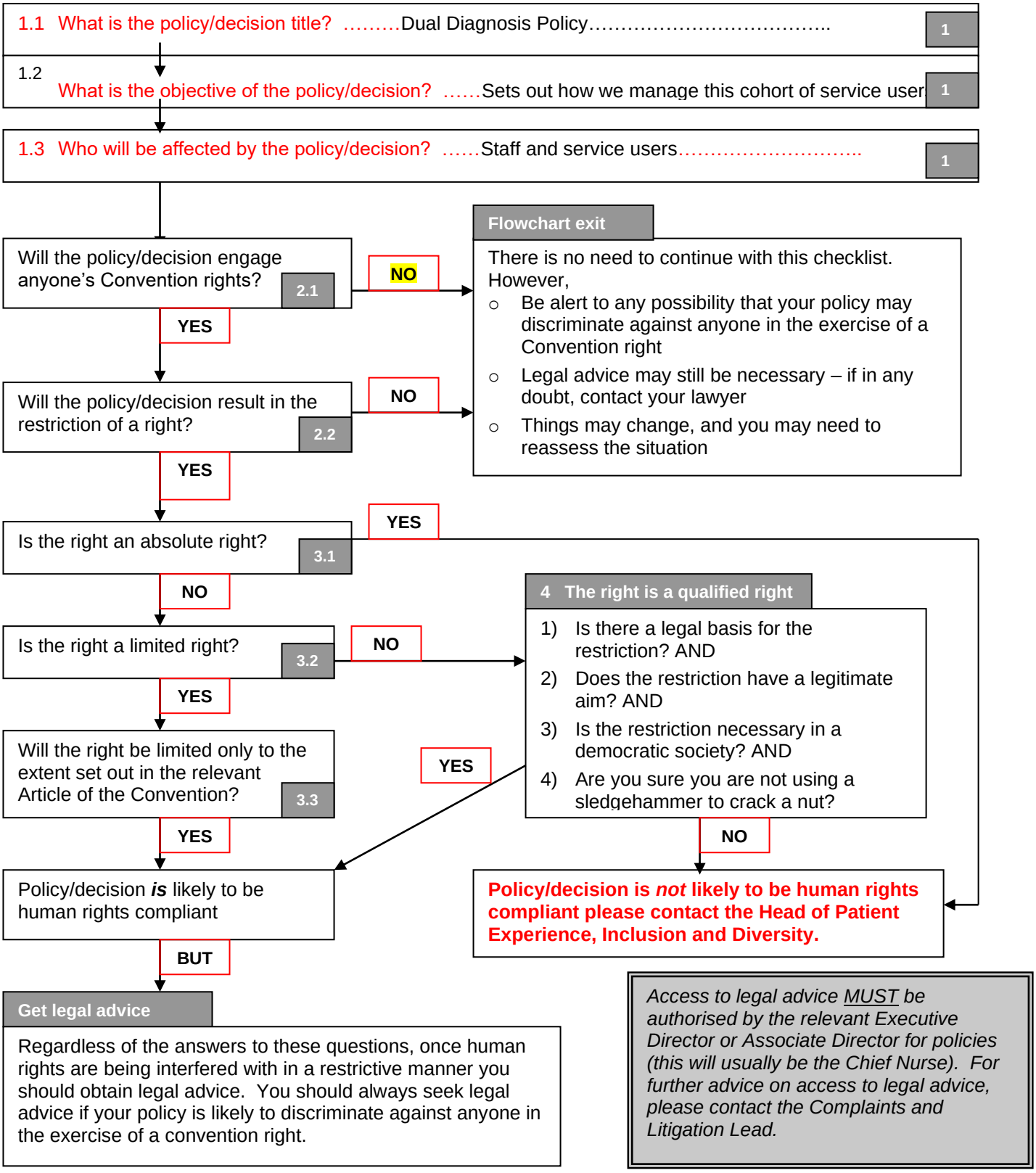
3. Complete the table below to provide details of the actions required

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 –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 F - 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/or 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**
- **Likely to need psycho-education/brief interventions and/or PSI**

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 assessment alongside brief interventions/PSI/ specialist intervention**

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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 comprehensive assessment with a view to prescribing intervention

Appendix G - Descriptions of treatment in substance misuse, based on the National Treatment Agency Models of Care for the Treatment of Adult Drug and Alcohol Misusers (Update 2006)

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: Drug/Alcohol Interventions and generic services

Tier 1 consist of a range of drug/alcohol interventions that can be provided by generic providers depending on their competence and partnership arrangements with specialist substance misuse services. 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, probation officers, housing officers, Social Care)

Tier 2: Open access drug and alcohol treatment services

Tier 2 services include:

- Interventions to engage people into drug/alcohol treatment
- Interventions to support people prior to structured treatment
- Interventions to help retain people in the treatment system
- A range of harm reduction interventions
- Interventions to support people who may not want or need intensive structured treatment at that point in their lives

  These interventions can include health interventions to meet service users immediate health needs and a range of brief interventions targeted at engaging clients in treatment.

Tier 3: Structured treatment services.

Tier 3 interventions are provided in the context of a comprehensive assessment, care planning, keyworking and substitute prescribing interventions Also included are: psychotherapeutic interventions (CBT, motivational interviewing, structured counselling, methadone maintenance programmes, community detoxification)

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 H – LikeWise Sheffield

We provide information, advice and support so people can make better choices around alcohol and drugs. We work with people to be safer through a range of dedicated, professional support.

We support people to make better choices around alcohol and drugs and reduce risk-taking behaviour through dedicated prevention, intervention, and support.

We also support people to achieve and sustain recovery from problematic alcohol and drug use through a range of treatments. We offer a range of support and advice to people no matter the disadvantages they are experiencing.

LikeWise can be contacted for further information, advice or referral on:

Telephone 0114 3087000
Email - info@likewisesheffield.org.uk
Online - Likewise – Get help (likewisesheffield.org.uk)

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

Project 6 - 0114 258 7553:

Kickback Recovery - contact Mick on 07468457383 or via www.facebook.com/KickBackRecovery/

Supporting recovering alcoholics/addicts & their families. Recovery groups, workshops mentoring, outdoor activities, public speaking. Raising awareness in schools & colleges. Sign-posting, connecting people to services, mutual aid groups & rehabs.

Now offering brief assessments between 12 and 2 every Thursday - a 20-minute chat and introduction to recovery and associated services on offer in the city. Followed by the in-person peer-support group meeting allowing people new to recovery to get a taste of what is on offer.

De Hood - Contact Leroy by ringing 07753 720 454 or emailing Leroy@dehood.org
Gym space that runs recovery meetings via Zoom and when possible face-to-face, also organises recovery walks and fitness classes.

Cocaine Anonymous - contact Jonathan Cooper on 07711036803
Offering recovery meetings for people with issues related to cocaine use

Alcoholics Anonymous - 0114 270 1984 (South Yorkshire and North East Derbyshire Intergroup) -
0800 917 7650 (National Helpline) - http://www.alcoholics-anonymous.org.uk/ - help@aamail.org

SURE Recovery App - via App Store / Google Play - further info at **https://s.coop/surerecoveryapp**

SURE Recovery for people who are using alcohol or other drugs, in recovery, or thinking about recovery

The app is free to use and has been designed to help people track their own recovery journeys and achieve their personal goals. The app has been developed with people at different stages of recovery and is based on their ideas and feedback, resulting in six key features:

1**. Recovery Tracker 2. Sleep Tracker 3. Diary 4. Artwork 5. Naloxone 6. Reading**

Drugs Meter - https://www.drugsmeter.com/ **-** comparison of drug use & get unbiased, anonymous feedback

Safer use limits - http://saferuselimits.com/ - guidelines for safer drug use (only for Cannabis currently)

Drinks Meter - https://www.drinksmeter.com/ **-** compare alcohol intake & get unbiased, anonymous feedback.

Down Your Drink - https://www.downyourdrink.org.uk/ - support to help people drink more safely

One You - Drink Less - https://www.nhs.uk/oneyou/for-your-body/drink-less/ - offers reduction advice

SMART Recovery Online Meetings - https://smartrecovery.org.uk/online-meetings

SMART Recovery Online Forum - https://www.smartrecovery.org/community/join/

E-AA – Online Forum about AA - https://www.e-aa.org/forum/

Naked Mind - https://www.thisnakedmindcommunity.com/ & facebook.com/groups/TNMgroup/

Recovery.org Forums - https://www.recovery.org/forums/

Reddit Stop Drinking Forum - https://www.reddit.com/r/stopdrinking/

In the Rooms: A Global Recovery Community - https://www.intherooms.com/

Club Soda - https://www.joinclubsoda.com/

Hello Sunday Morning - https://www.hellosundaymorning.org/

Result For Addiction - https://www.result4addiction.net/

Appendix I - 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 J – 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 K - 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.

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	
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.
Buprenorphine	2 – 3 days	LSD