Birmingham and Solihull Mental Health NHS Foundation Trust

DUAL DIAGNOSIS

Coexisting Severe Mental Illness and Substance Misuse

Policy number and category	**C 35**	**Clinical**
Version number and date	**3**	**March 2024**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**July 2024**	
Next anticipated review	**July 2027**	
Executive director	**Executive Medical Director**	
Policy lead	**Head of Service, ICCR, BSMHFT - Solihull CYP/EI, Homeless/Addiction**	
Policy author *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- To promote the implementation of an integrated treatment approach to dual diagnosis across BSMHFT.
- Ensure that there is a clear model of collaborative working between services working with dual diagnosis across BSMHFT.
- Ensure that there is a process of tiered, targeted training delivered to clinicians who work with dual diagnosis across all trust services.

Provide a support and supervision process for staff across the trust to enable them to work confidently and effectively with dual diagnosis.

Policy requirement (see Section 2)

- When providing care to service users identified with dual diagnosis all clinicians should ensure:
  - That a comprehensive assessment of dual diagnosis is undertaken to identify service user need and appropriate care pathways.
  - Clear joint working arrangements between services are in place, to ensure that service users can access appropriate services.
  - The use of detailed guidance and referral pathways included within this policy.
- The trust will provide a process of tiered, targeted training to clinicians who work with dual diagnosis across all trust services. COMPASS will support the trust in the evaluation of this training.
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Training will focus on need within clinical areas to maximise the development of staff skill relevant to their clinical areas. All relevant clinical staff will be supported by their managers and within their teams to work confidently and effectively to support the needs of service users with

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1 Introduction:

All Trust Policies are written to demonstrate the incorporation of the Trust values of Compassion, Inclusiveness and Commitment.

1.1. **Rationale** (why):

BSMHFT provides a range of mental health services to a diverse population of 1.2 million people. The 2003 Co-morbidity of Substance Misuse and Mental Illness Collaborative study (COSMIC), identified that 44% of mental health service users either reported drug use or were assessed to have used alcohol or hazardous or harmful levels in the past year; and the NICE Clinical Guideline 120 'Psychosis with coexisting substance misuse - assessment and management in adults and young people' (2011) advises that 'Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population.'

In addition to high prevalence within mental health services dual diagnosis is known to be associated with poorer outcomes for service users, as is highlighted by, the Mental Health Policy Implementation Guide - Dual Diagnosis Good Practice Guide (2002). More recently the importance of meeting the needs of people with a dual diagnosis has been recognised in the mental health outcomes strategy 'No health without mental health' (2011) which highlights that 'Dual diagnosis (coexisting mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need.' Public Health England published **'Better care for people with co-occurring mental health and alcohol/drug use conditions PHE guidance 2016'**.

This policy sets out a process for ensuring service users with dual diagnosis have access to effective services that respond to their complex needs, and to ensure that BSMHFT supports recommendations in **NICE Guidance Coexisting severe mental illness and substance misuse quality standard [QS188] Published: 20 August 2019**.

This includes having a process that identifies that the needs of service users with a dual diagnosis are being met and that there are internal and external joint working arrangements in place.

1.2. **Scope** (when, where and who):

This policy covers all service users who present with severe mental illness (SMI) and problematic drug/alcohol use. The policy covers all trust services to ensure accessible and integrated services to meet the needs of service users with dual diagnosis. The policy also covers clinical staff in terms of identifying roles and responsibilities and a training process to enhance staff confidence and skills to work with dual diagnosis effectively, including safeguarding. Consideration should be given by all clinicians to adopt a think family approach and make every contact count due to the high number of Domestic Homicide Reviews (DHR) and Patient Safety Incident Investigations (PSII's). Safeguarding Adult Reviews (SAR) indicate that there is often a

combination of Domestic Violence, Substance misuse and Mental ill Health (Trio of Vulnerabilities). All of which are significant risk factors relating to the abuse and neglect of children who are living with or having contact with parents or carers who have a dual diagnosis, within this cohort of Service users.

1.3. Principles (beliefs):

Research indicates that it has been difficult for service users to access appropriate care for their complex needs. Although most policies and guidance refer to dual diagnosis it is vital from BSMHFT's perspective that our focus is on the needs and strengths of individuals and the impact that their mental health and substance use has on quality of life and daily functioning. An agreed trust dual diagnosis policy is therefore required to ensure that the needs of people with dual diagnosis can be addressed by all trust services and not seen as either an addictions service issue or mental health service issue alone.

The trust positively supports individuals with learning disabilities and neuro diverse presentations e.g. Autism and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately to support this.

2: The policy

When providing care to service users identified with dual diagnosis the trust will endeavour to ensure that service users receive support that;

- provides a comprehensive assessment of dual diagnosis to identify service user need and appropriate care pathways, including where appropriate the use of validated measures,
- promotes work with service users to enhance recovery and promotes co production and experts by experience engagement.
- promotes clear joint working arrangements with effective multi-agency communication to increase access for service users to a range of trust services.
- supports comprehensive assessment of risk and the development of an appropriate risk management plan,
- Promotes Think Family Approach. Ensuring service users are considered within the context of their family and relationships, and their role as parents or care givers, and takes account of the needs of children and adults with care and support needs. This approach supports early identification and offer of support and considers any safeguarding concerns. **(Safeguarding connect Page)**
- encourages assessment for carers of people with dual diagnosis, and
- provides a process of tiered, targeted training to clinicians who work with dual diagnosis across all trust services.
- uses guidance and referral pathways included within this policy, this includes local services such as Change Grow Live (CGL) AA, NA.

Training will focus on need within clinical areas to maximise the development of staff skill relevant to their clinical areas. Three levels of training have been identified within this policy two levels of which will be implemented and evaluated by the COMPASS Programme.

All relevant clinical staff will be supported by their managers and within their teams to work confidently and effectively to support the needs of service users with dual diagnosis. This also includes clinical staff working in Substance Misuse Services (Recovery Near You and Solihull

Integrated Addiction services) who will be offered mirrored training with a focus upon mental health awareness.

3: The procedure

- When working with service users with a dual diagnosis trust services will work to an integrated approach aiming to work with mental health and drug/alcohol issues concurrently.
- Service users should have issues related to drugs and alcohol included in mental health assessments.
- When drug/alcohol use is identified as part of assessment this should be clearly recorded within service user care plan, risk assessment and relapse prevention plan (ICR documentation). On clinical notes system – RIO and Illy.
- 'A person must be assumed to have capacity unless it is established that he lacks capacity' (Capacity Act, 2005). Where concerns around a patient's capacity to make a specific decision regarding Dual Diagnosis treatment concerned in this policy and associated appendix, the 'principles' of the Capacity Act 2005 are to be enacted, with details of assessment (if undertaken) and outcome recorded on clinical notes.

Once staff have dual diagnosis training trust staff should be able to provide a range of interventions to address dual diagnosis with supervision from the COMPASS Programme.

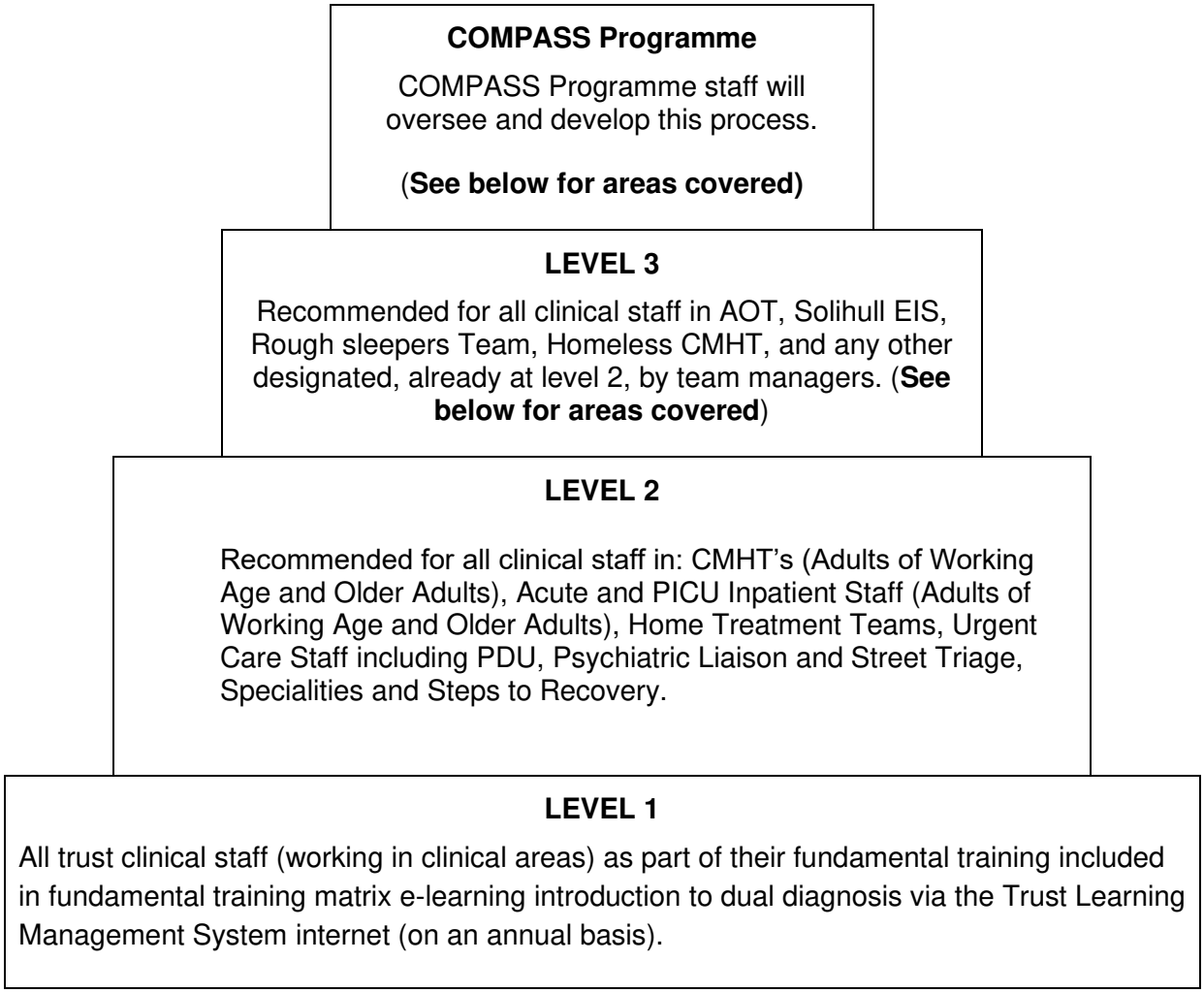
For consultation and advice regarding dual diagnosis, the COMPASS Programme should be contacted to discuss individual patients via their local COMPASS clinician using the COMPASS email address: BSMHFT.COMPASS@NHS.NET

TRAINING

It is recommended that BSMHFT ensure that the trust has a workforce that are trained and supported to provide integrated shared treatment across services. Staff utilisation of training will help to ensure that they are maintaining clear responsibilities and can ensure access and a smooth care pathway through services for service users with a dual diagnosis and severe mental illness. This will enable more effective management of the risks and complex needs of service users with a dual diagnosis.

The COMPASS programme has developed training packages and aligned these to the Dual Diagnosis Capabilities Framework (Hughes 2006). The Dual Diagnosis Capabilities Framework (Hughes 2006) identifies three levels of competence for staff working with service users with a dual diagnosis. This document is highlighted in the Dual Diagnosis Themed Review and recommended as a model to enhance staff competencies. Please refer to diagram 1, Tiered Training Structure for Dual Diagnosis

Diagram 1, Tiered Training Structure for Dual Diagnosis



Level One Fundamental Training

Level one training will address fundamental training requirements of the trust based on trust training analysis and will focus on all clinical staff working in clinical areas. Clinical staff working in other/corporate areas will have the need for further dual diagnosis training assessed on an individual basis through the ADR process. This training will provide staff with an awareness of dual diagnosis and the impact on service users. Information will also be provided to staff to enhance their knowledge of care pathways and services that service users can be referred to, in order to enhance the delivery of comprehensive care packages. Staff who receive level two training will need to have first completed the level one training.

Level one training is delivered via the Trust E-Learning platform and will be completed on an annual basis.

Nursing students on placement will receive face to face training from COMPASS clinicians that fit with the appropriate University syllabus.

Areas covered on level one includes:

- Drug and alcohol awareness.
- Impact of substance misuse on mental health, i.e., daily functioning.
- Harm reduction techniques.
- Reasons for Substance misuse.
- Assessment.
- Cycle of change.

Level Two Training

Level two training is suitable for all clinical staff working in CMHT's (Adults of Working Age and Older Adults), Acute and PICU Inpatient Staff (Adults of Working Age and Older Adults), Home Treatment Teams, Urgent Care Staff including PDU, Psychiatric Liaison and Street Triage, Specialities and Steps to Recovery to enhance assessment and intervention skills across services. In some services it may only be necessary to train identified staff that can act as a lead within their teams and have support through the COMPASS Programme. Training will equip staff with dual diagnosis competencies as outlined in the Dual Diagnosis Capabilities Framework (2006, see appendix). Level two training is available to all clinical staff including inpatient staff wishing to augment their skills. The primary aim of this training is to ensure that service users have access to assessments, motivational interventions, signposting to appropriate services and enhanced joint working between mental health and addiction services. Training will include the following areas:

- drug and alcohol awareness,
- screening and assessment,
- harm reduction.
- developing a formulation,
- treatment planning,
- interventions to enhance engagement and motivation,
- interventions focused on Negotiating Behaviour change,
- service users care pathways.

Level Three training (6 x half day Cognitive Behavioural Integrated Treatment (C-BIT) training programme).

Level three training is suitable for all clinical staff working in Assertive Outreach Teams, Solihull Early Intervention Service, Rough Sleepers Team and Homeless CMHT. These staff will have competencies to provide a range of interventions to service users from assessment to relapse prevention for mental health and substance use. There will be an expectation that staff who attend this training will commit to engaging with ongoing supervision in practice from the COMPASS Programme clinicians to ensure they are able to continuously develop their clinical skills in practice.

Areas covered in this training will include:

- developing an understanding of the principles of integrated treatment for mental health and substance use and develop an awareness of national guidance.
- developing an awareness of dual diagnosis and the impact on individuals:
- developing knowledge of drugs and alcohol including impact on mental health and daily functioning.
- ability to carry out a detailed assessment of substance use and mental health.

- formulating assessment and identifying key areas that maintain service users in a problematic cycle of substance use.
- using a formulation to guide treatment planning and interventions that are most likely to engage service users based on individual need.
- providing participants with knowledge of a range of evidence-based interventions that can be incorporated within clinical practice to enhance services for service users based on stage of change/engagement.
- To adopt a trauma informed approach throughout clinical practice
- introduction of the concept of lapses and relapses in substance use and to use interventions to minimise this.
- developing comprehensive relapse prevention plans for mental health and substance use and to develop relapse signatures for mental health and substance use.
- working with service user strengths and utilise interventions focused on skills building and mood management.
- working with social networks and including family and carers.
- Increasing awareness of the latest emerging substance use trends and their effects.

Level 3 refresher training will be offered for those staff who feel this is required.

Specialist bespoke training will be offered as need is identified utilising face to face and e-learning.

LOCAL WORKING ARRANGEMENTS/CARE PATHWAYS

The COMPASS Programme supports clinicians in the Trust to provide dual diagnosis integrated service provision. The COMPASS Programme is part of the Integrated Community Care and Recovery (ICCR), Recovery Programme, within, BSMHFT. As dual diagnosis is a service issue for all trust services the work of the COMPASS Programme is conducted across all trust structures. The service works to a philosophy of shared care and integrated treatment as outlined in the Dual Diagnosis Good Practice Guide. A manualised treatment model for working with dual diagnosis Cognitive Behavioural Integrated Treatment (C-BIT) has been developed and researched by the COMPASS Programme within local assertive outreach services (Graham et al 2004, check Graham et al 2006) and the Brief integrated motivational intervention for inpatients (BIMI) (graham et al 2016)

A Birmingham Dual Diagnosis Protocol has been developed (Appendix 8). The protocol clarifies responsibilities and arrangements between mental health services and the current substance misuse service in Birmingham (CGL) and in Solihull (SIAS). This gives details of the specialist treatment pathways for Trust service users. The protocol is currently under review and is near completion – estimated Summer 2024. Once available, this will be added to the Dual Diagnosis Policy as an addendum.

Care Pathways

Assertive Outreach, Early Intervention, Homeless Services

These teams are supported to implement skills learnt during level 3 dual diagnosis training within clinical practice through clinicians based within teams from the COMPASS Programme. There are a variety of ways in which the above teams can utilise the support of the COMPASS clinician as detailed in the Dual Diagnosis Referral/Treatment Pathway Guidance (Appendix 8) Service users can therefore be seen directly within these teams to address both their mental health and substance use concurrently. Service users can and should be referred to local drug

and alcohol services after an assessment of need. Work with service users within these teams is carried out on an outreach basis to enhance engagement and motivation to address mental health and substance use.

Inpatient wards

The COMPASS Programme provides a consultation, supervision, and a brief motivational enhancement intervention service to Inpatient wards. The brief intervention is based on direct work with patients (where consent is in place from the patient), alongside inpatient staff members. The rationale for joint working is to enhance an integrated treatment approach and develop inpatient staff members' clinical skills in this area. At the end of this intervention a plan will be agreed with individual service users and MDT's to enhance motivation to address drug/alcohol misuse on an on-going basis. This may include engagement with a statutory/non statutory drug/alcohol service or engagement in occupational activities which may minimise drug/alcohol use and promote alternative coping strategies based on service user identified goals.

Referrals will be screened by the COMPASS Programme and individualised needs will be assessed on a case-by-case basis. COMPASS will liaise with MDT with recommendations, which may include:

- Referral to Wellbeing Practitioner, Recovery Practitioner or Senior Practitioner for brief intervention
- Senior Practitioner offer of 1:1 or team supervision
- Signposting to existing interventions available, such as Assistant Psychology group programme, OT group programme, Ward Resource folder
- Signposting or referral to CGL/SIAS/Mutual Aid.

Secure Care Services

Training is provided by FIRST to Secure Care staff. COMPASS do not offer support to secure care services.

Differences of Opinion

There may be times when due to the complex presentation of service users with dual diagnosis differences of opinion may arise both within and between teams. Where this arises the needs of individual service users are paramount. Service users can be referred to the COMPASS Programme who will support services to reach agreement and to advocate for service users to ensure that they have access to services that are best placed to meet their needs.

Within C-BIT trained teams COMPASS Programme clinicians will facilitate individual/team supervision to address difficulties and promote a resolution in the interest of service users.

For all other teams, COMPASS Programme Clinicians will offer Consultation Slots which teams will be able to book into via CONNECT to access consultation on complex cases.

Difficulties may arise when service users present in crisis, for example present with psychotic symptoms but it is unclear if their presentation is drug induced or a mental health crisis. In these cases, service users will require access to services and treatment. A prolonged period

of assessment may be required; however initial presentation will need to be addressed regardless of underlying cause.

During partnership working and in the event of a clinical difference of opinion, escalation and dispute resolution processes are outlined in the Dual Diagnosis Protocol (appendix 8)

Diversity and Dual Diagnosis

People from ethnic minorities– though definitive studies on the influence of culture and ethnicity upon individuals with a dual diagnosis have yet to be conducted, it is known that severe mental illness and substance misuse present differently across cultures and ethnic groups. For example, ethnicity is associated with poor access to services and with different meanings and values attributed to drugs and alcohol. "Service provision must therefore be congruent with and sensitive to the needs of each ethnic group" (DOH, 2002). In addition, provision should consider the needs of individuals background and religious or spiritual beliefs.

The Health Advisory Service (2001) recommends that attention is given to special populations in relation to co-morbidity.

Mental health services for older people should explicitly tackle the misuse of alcohol and tranquillisers. This issue is also highlighted in the Dual Diagnosis Themed Review, and by 'Our Invisible Addicts' (2018), the second edition of the Older People's Substance Misuse Working Group of the Royal College of Psychiatry. The report identifies the risk of non-detection of alcohol and drug use within the older person's population, and highlights the need for improved detection, particularly of excessive alcohol consumption, acknowledgement of the requirements of an ageing population, and the need to offer appropriate treatments.

The needs of young people with dual diagnosis should be addressed by child-centred services. Particular consideration should be given to the effects upon prognosis and treatment outcomes of children and young people with psychosis and dual diagnosis.

Mental health professionals should consider post-traumatic stress among clients with dual diagnosis and among refugees and asylum seekers in particular.

The assessment and care of service users should take into account gender-specific issues.

The care of parents with dual diagnosis needs to focus on the needs of their children, assessing the need for support and interventions to prevent harm, Using the "Think Family Approach" including where required involvement from the trust safeguarding team, other professionals involved and Childrens Social Care.

The Equality Act (2010) '…provides a legal framework to protect the rights of individuals and advance equality of opportunity for all', and thereby directs how services and those delivering interventions impacted through this policy are to take in to account those services users who are identified with protected personal characteristics.

INTERNAL STAKEHOLDERS

Involvement of Service Users and Carers

There are key areas to consider ensuring the active inclusion of service users and their carers through service user evaluation and feedback.

Personality Disorder

The enhanced personality disorder pathway works across trust services. As there is high prevalence of problematic substance use amongst people with personality disorder it will be important to develop collaboration between the COMPASS Programme and the personality disorder pathway, particularly in relation to the provision of joint training in working with personality disorder and problematic substance use.

Interface between Mental Health and Addictions Services

National guidance on dual diagnosis recommends that there should be enhanced joint working between mental health and addictions services. This includes clear protocols between services in terms of referral, communication, joint reviews/CPA reviews and clearly identified care pathways. The opportunity of partnership system working, which may include joint training across services, will enhance this process and enhance a consistent approach for service users.

A Birmingham Dual Diagnosis Protocol has been developed (Appendix 8). The protocol clarifies responsibilities and arrangements between mental health services and the current substance misuse service in Birmingham (CGL) and in Solihull (SIAS). This gives details of the specialist treatment pathways for Trust service users. The protocol is currently under review and is near completion – estimated Summer 2024. Once available, this will be added to the Dual Diagnosis Policy as an addendum.

EXTERNAL STAKEHOLDERS

The trust works with a wide range of external service providers and organisations i.e. other mental health services, Primary Care Networks, addictions services, social services, day-care, housing, and GPs in primary care. The COMPASS Programme may provide training to all or any of these services upon their request and subject to agreed costs and capacity.

4: Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities

All Staff	• Ensure that care plans appropriately identify dual diagnosis and how these needs are being addressed through regular audit and supervision. • Ensure adherence to the policy within clinical practice. • Ensure that staff receive training in dual diagnosis in accordance with this policy. • Consideration should be given to safeguarding, throughout care planning. • Enhance care pathways between services for service users with a dual diagnosis. • Ensure that ICR documentation and assessments are inclusive of issues related to drug/alcohol use. Develop processes within services to ensure that dual diagnosis is seen as part of service core business.
Service, Clinical and Corporate Directors	• Ensure the policy is implemented in their Directorates. • Bring the policy to the attention of all clinical staff. Ensure that all staff receive training which has been identified and is required to implement the policy. This will be monitored through the trust's Fundamental Training Policy.
Policy Lead	• Ensure that there is compliance with the policy through clinical audit. • Ensure that training is delivered as outlined in the policy. • Ensure that training is evaluated to demonstrate impact on clinical practice. • Raise any issues relevant to the implementation of the policy through management and clinical governance structures. Ensure that the policy is updated as agreed.

5: Development and Consultation process consisting of:

- An outline of who has been involved in developing the policy and procedure including Trust forums and service user and carer groups.

Consultation summary	
Date policy issued for consultation	March 2024
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**

PDMG – Policy Development Management Group	June 2024
Staff consultation	March 2024

Where received	Summary of feedback	Actions / Response

6: Reference documents:

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The Equalities Act. (2011)

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Hughes. L. (2006). *Closing the Gap: A capability framework for working effectively with People with combined mental health and substance use problems (Dual Diagnosis).* CSIP.

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Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers

7: Bibliography:

Graham H.L. & Baker, A. (2016). Innovations in Cognitive Behaviour Therapy for the Treatment of Co-existing Mental Health & Substance Misuse. In R.Menzies, M. Kyrios & Kazantzis (Eds.). Innovations and future Directions in Behavioural and Cognitive Therapies. Australian Academic Press.

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8: Glossary:

None

9: Audit and assurance:

As outlined throughout this document the implementation of comprehensive dual diagnosis services and training across the trust is a complex challenge. It is therefore essential that that service developments and training are audited to monitor impact for service users, trust services and staff confidence and skills. Audits will be completed jointly by the COMPASS programme research assistant and the trust R&I service and audit department on an annual basis.

Audits will also be carried out on The COMPASS Programme brief intervention, Service user feedback and an audit to evaluate C-BIT in Assertive Outreach, Early Intervention and the Homeless CMHT. Outcomes achieved in the C-BIT trial (Graham et al 2006) will be used to set standards. Audits will be registered and supported by the trust clinical governance department.

This will be an on-going process and The COMPASS Programme will continue to be involved in research in relation to dual diagnosis as carried out by BSMHFT

In addition:

- it is proposed that this policy be monitored by the trust dual diagnosis lead, as it will require on-going development and be seen as a living document as detailed below:

Element to be monitored	Lead	Tool	Freq	Reporting Committee

Dual diagnosis level 1 training: team and individual team members' compliance with fundamental training.	Service, Clinical, Operational and Corporate Directors	Training 'Traffic Lights'	As per Fundamental Training Policy	Shows in date compliance for all fundamental training for a team of staff. Red – out of date Amber – training booked. Green – in date and compliant
Ensure that level 2 and level 3 dual diagnosis training is delivered as outlined in the policy.	COMPASS Team Manager	Audit and Inter-rater observation of training delivery	Annual	COMPASS Team/ Recovery Clinical Governance Committee
Raise any issues relevant to the implementation of the policy through management and clinical governance structures.	DD policy lead	Audit	As and when required	Through Recovery/Trust Clinical Governance Committees
Ensure that the policy is updated as agreed.	DD policy lead	Review	Every three years	Addictions/Trust Clinical Governance Committees

10. Appendices:

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Policy	**Dual Diagnosis Policy**		
Person Completing this policy	Steve Scrimshaw	**Role or title**	**Head of Service, ICCR, BSMHFT - Solihull CYP/EI, Homeless/Addiction**
Division	ICCR	**Service Area**	Addictions
Date Started	21/03/24	**Date completed**	22/03/24
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
Dual Diagnosis Policy updated to promote more effective management of the Dual Diagnosis needs of BSMHT patients.			
Who will benefit from the policy?			
All service users of the Trust with a Dual Diagnosis All clinical staff working with patients with a Dual Diagnosis			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
Application of the policy will promote: - Improved service for patients with Dual Diagnosis need. - Improved confidence and skills of employees which may reduce stress or working with this client group. Wider community will benefit as families and friends of patients will be reassured that their loved ones are having their needs met			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
Application of the policy will lead to an improvement in service delivery and result in reduction of unmet needs for Dual Diagnosis Client Group			
Does it involve a significant commitment of resources?			

How will these reduce inequality?				
No.				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
Yes. Research indicates that it has been difficult for service users to access appropriate care for their complex needs. This policy aims to reduce these equalities and ensure that the needs of people with dual diagnosis can be addressed by all trust services and not seen as either an addictions service issue or mental health service issue alone.				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	Improved care and care pathway for dual diagnosis service users
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	Improved care and care pathway for dual diagnosis service users
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			X	Improved care and care pathway for dual diagnosis service users
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				

Marriage or Civil Partnerships			X	Improved care and care pathway for dual diagnosis service users
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			X	Improved care and care pathway for dual diagnosis service users
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			X	Improved care and care pathway for dual diagnosis service users
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			X	Improved care and care pathway for dual diagnosis service users
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			X	Improved care and care pathway for dual diagnosis service users
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			X	Improved care and care pathway for dual diagnosis service users
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights			X	Improved care and care pathway for dual diagnosis service users

Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
No negative impact due to improved policy and treatment pathway and protocol				
How will any impact or planned actions be monitored and reviewed?				
Though clinical governance reporting				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				
Through review of the updated policy at clinical governance meetings				
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis				

Appendix 2

Referral/Care Pathway Guidance when working with service users who present with dual diagnosis.

(Mental health and problematic drug/alcohol use)

Service users who present with dual diagnosis can pose a challenge to mental health and addiction services due to their often-complex needs. There can be a lack of clarity as to which service should be involved or where service users should be referred, to gain access to services that are best placed to meet their needs. These issues are further complicated as service users may have various presentations which cover the broad spectrum of dual diagnosis, i.e.

- a primary mental health problem with problematic alcohol or drug use.
- alcohol or drug use affecting the course of mental ill health.
- intoxication leading to psychological problems.
- Alcohol or drug use and/or withdrawal leading to mental health symptoms and syndromes.

It is therefore important that all trust services are clear on referral care pathways to ensure accessible and inclusive services for those service users who present with mental health and problematic alcohol/drug use and to ensure that service users are not denied services on the basis of either of these.

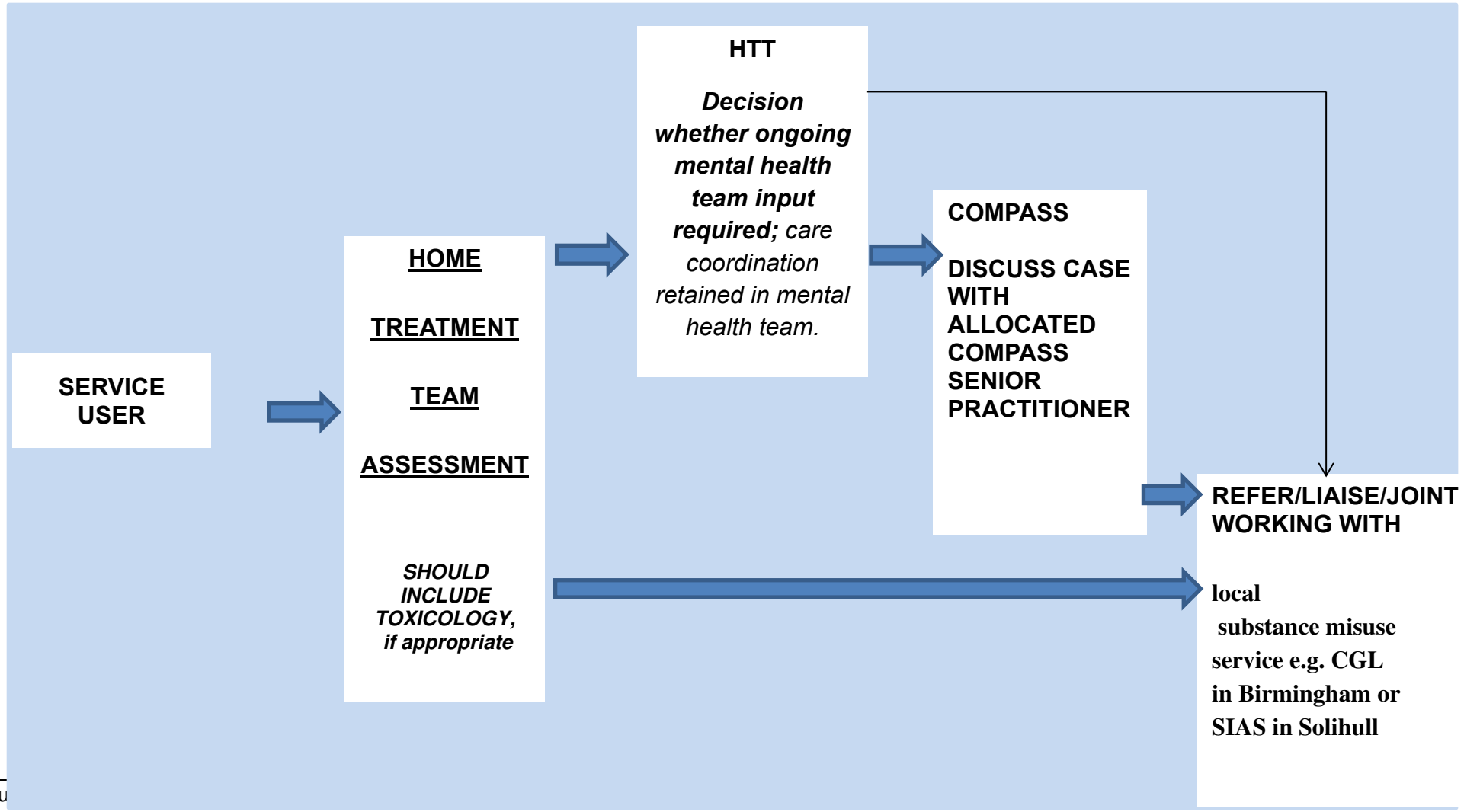
Who should take responsibility for service users with dual diagnosis?

National Guidance on dual diagnosis suggests that service users who present with severe and enduring mental health problems and use alcohol/drugs problematically should be care co-ordinated within mainstream mental health services and remain subject to CPA.

Service users who present with a primary alcohol/drug problem and minor mental health problems (anxiety, depression) should, in most cases, be possible to manage and care co-ordinate in the alcohol/drug services. Some depressive and anxiety problems that are either severe and/or enduring may require the provision of more intensive psychological interventions that may only be available within the mainstream mental health services.

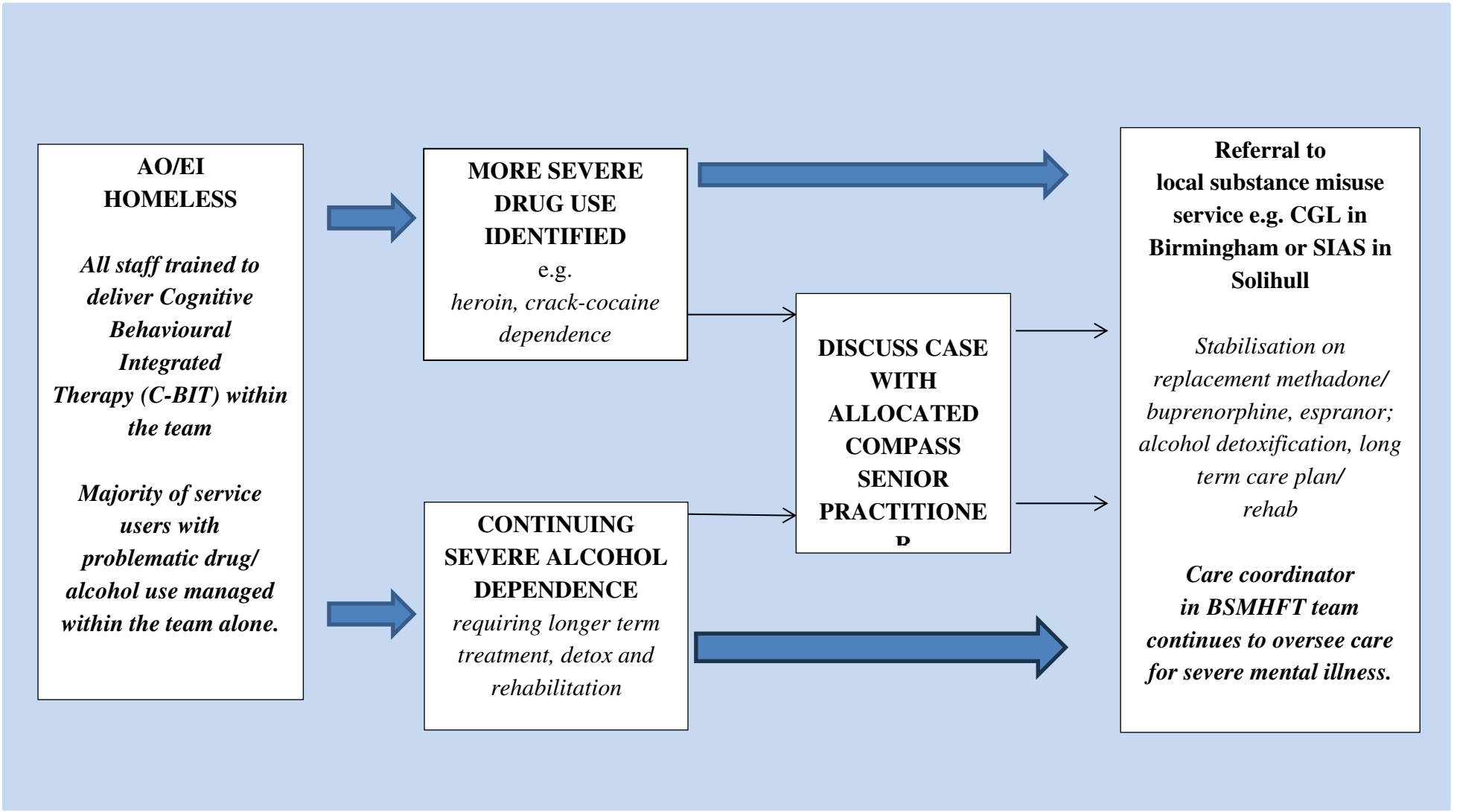
Thus for a lot of service users there will be a need for mental health and addiction services both internal and external to the trust to be involved and to work jointly. Where this is the case services should ensure that there is good communication, sharing of information and joint reviews.

HOME TREATMENT TEAM ACCESS TO DRUG/ALCOHOL PATHWAYS



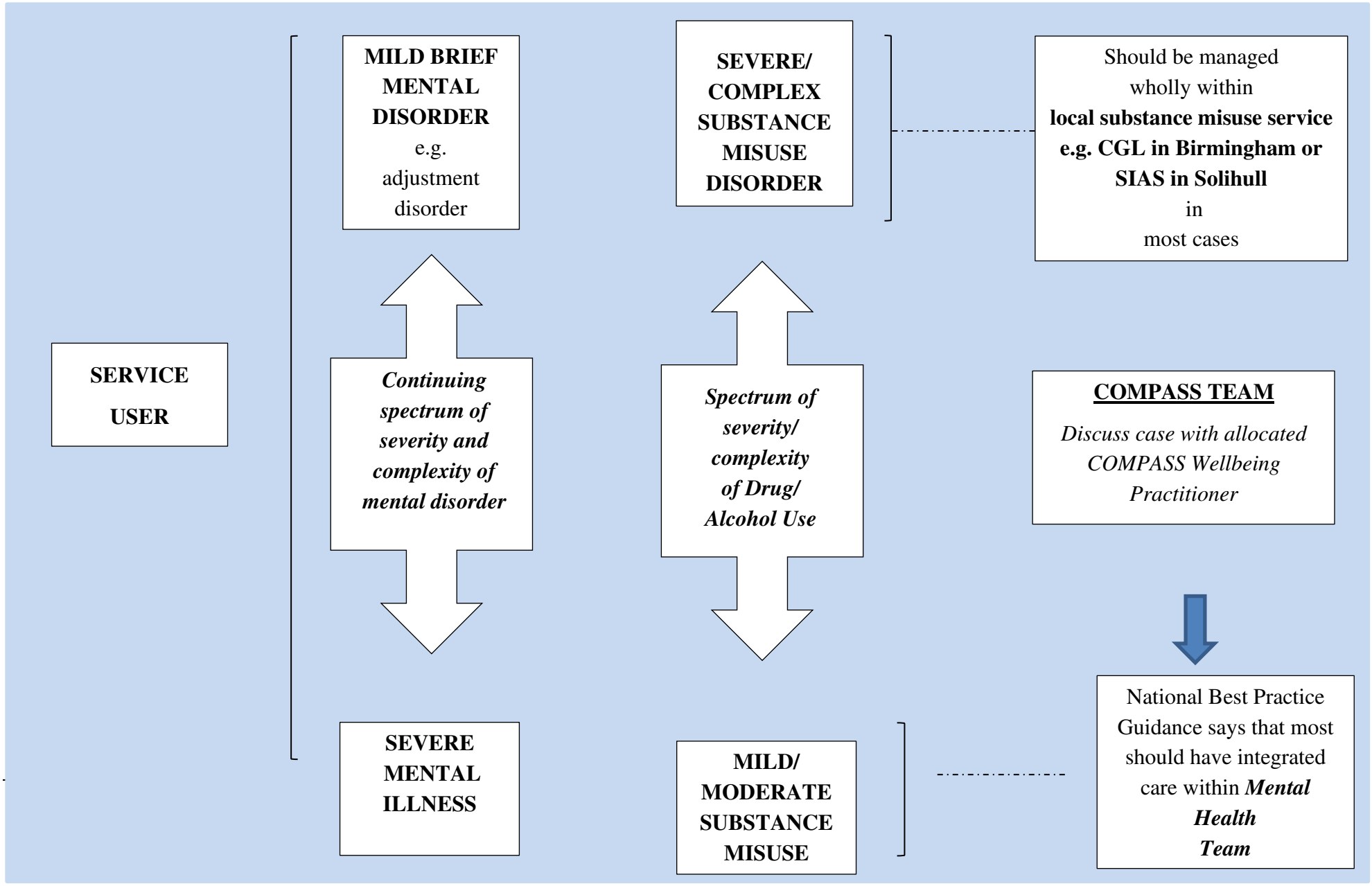
Appendix 4

ASSERTIVE OUTREACH/EARLY INTERVENTION/ HOMELESS SERVICES ACCESS TO DRUG/ALCOHOL PATHWAYS

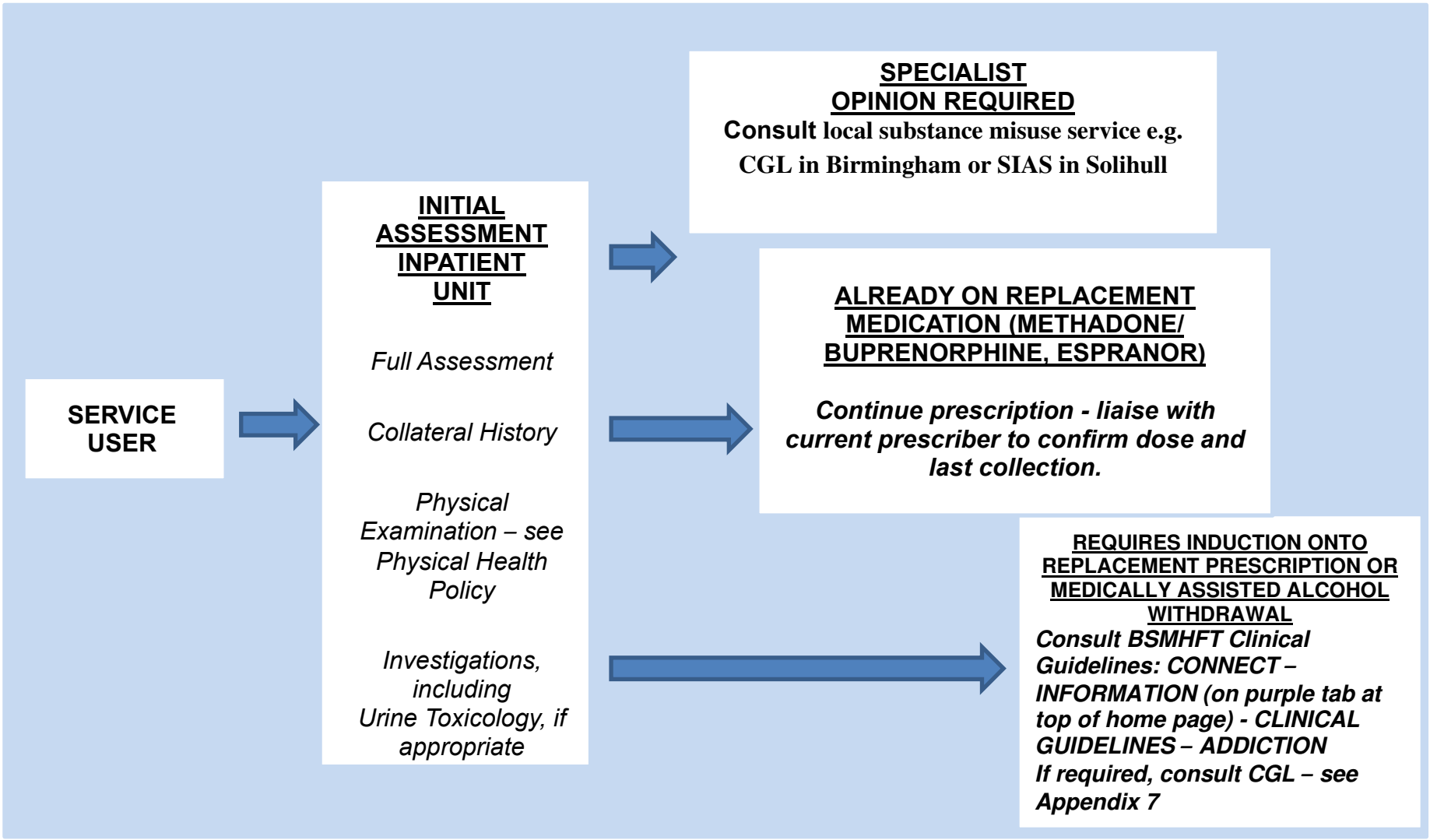


Appendix 5

CMHT ACCESS TO DRUG/ALCOHOL PATHWAYS

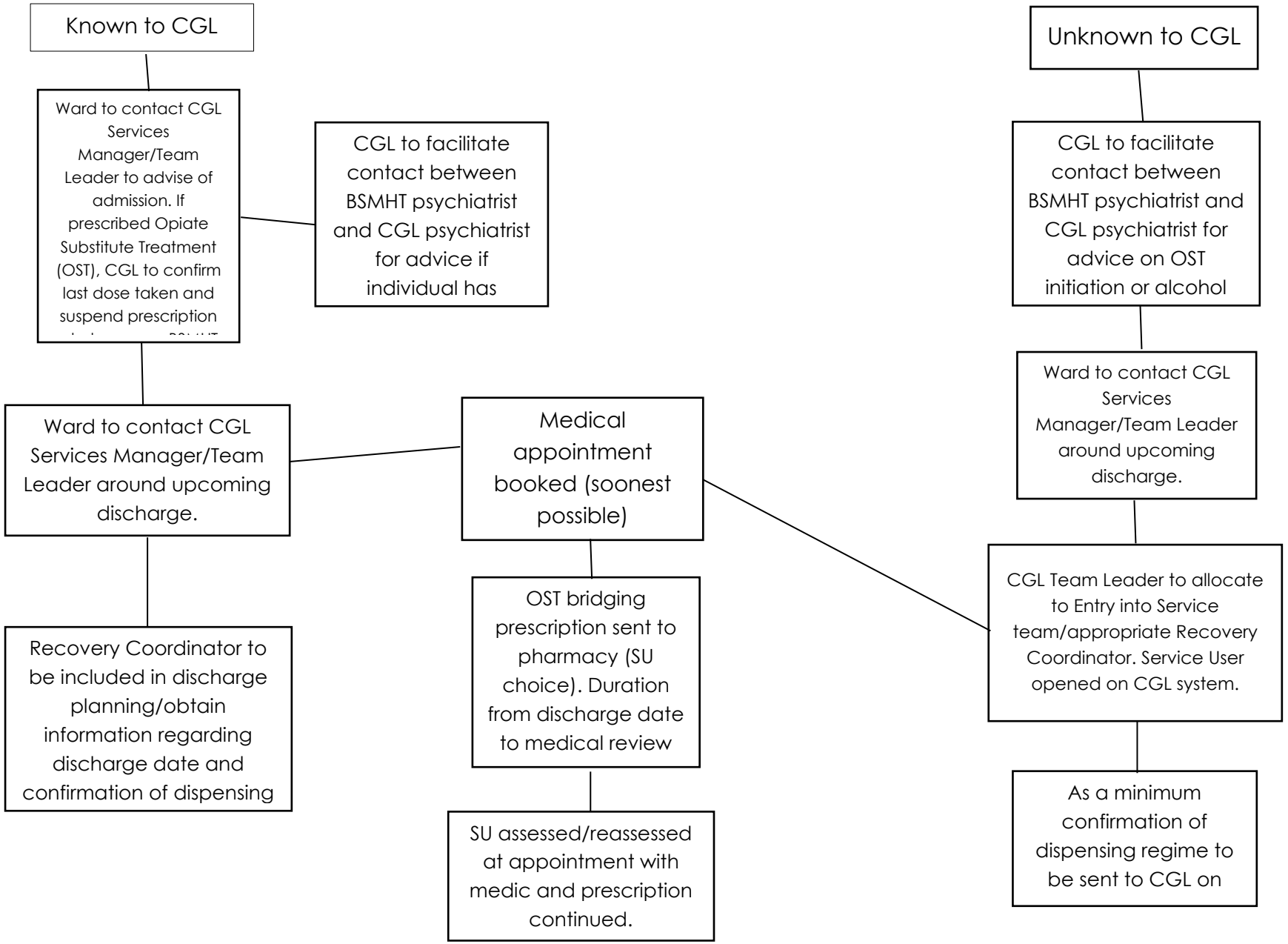


MENTAL HEALTH INPATIENT SERVICES ACCESS TO DRUG/ALCOHOL PATHWAYS



Treatment Continuation from Mental Health Inpatient Unit

Appendix 7



Appendix 8

PLEASE NOTE: THIS BELOW PROTOCOL WILL BE REPLACED. A REVIEWED AND UPDATED DUAL DIAGNOSIS PROTOCOL IS CURRENTLY IN PROCESS TOWARDS RATIFICATION. ONCE RATIFIED, THS WILL BE ADDED TO REPLACE THE BELOW, AS ADDENDUM TO DUAL DIAGNOSIS POLICY. PLEASE NOTE THE REFERENCE TO AND THE APPENDIX A-C BELOW, WILL BE REPLACED.

BIRMINGHAM AND SOLIHULL NHS FOUNDATION TRUST

Dual Diagnosis Referral/Treatment Pathway Guidance

Definitions:

Dual Diagnosis: An individual who presents with co-existing mental health (and/or personality disorders) and substance misuse problems (drugs and/or alcohol). Including personality disorder (Cluster 8), thereby avoiding 'exclusion by diagnosis.'

Problematic use of substances refers to a person experiencing social, psychological, physical, or legal problems as a result including misuse of prescribed medication or over the counter preparations.

The purpose of the Dual Diagnosis Pathway guidance and treatment pathway is to enhance service provision for the service user group, by providing a needs-led process that incorporates closer and 'joined-up' working between Mental Health Services (Community and In-patient), Substance Misuse Services and Primary Care Services.

Services should be provided based upon need, not diagnosis.

Introduction

This will result in the identification of appropriate treatment providers and support services required to treat and support the service user, recognising that substance misuse is usual rather than exception amongst people with severe mental health problems and the relationship between the two is complex. (DOH, 2002). In addition, there should be a recognition that those with substance misuse problems are likely to have some level of mental health problems (particularly anxiety and depression). Patients should not be 'shunted' between different services or providers as increases the risk people of dropping out of care completely.

Success of the pathway is dependent upon all partners agreeing, signing up to and working within the pathway.

In addition to high prevalence within mental health services dual diagnosis is known to be associated with poorer outcomes for service users, as is highlighted by, the Mental Health

Policy Implementation Guide - Dual Diagnosis Good Practice Guide (2002). More recently the importance of meeting the needs of people with a dual diagnosis has been recognised in the mental health outcomes strategy 'No health without mental health' (2011) which highlights that 'Dual diagnosis (co-existing mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need.'

BSMHFT mental health services and CGL (Change Grow Live) drug and alcohol services should work to a philosophy of shared care and integrated treatment as outlined in the dual diagnosis good practice guide.

There may be times when due to the complex presentation of service users with dual diagnosis differences of opinion arise. In such situations, the needs of individual service users are paramount.

Difficulties may arise when service users present in crisis, for example, those who present with psychotic symptoms, but it is unclear if their presentation is drug induced or a mental health crisis. In these cases, service users will require access to services and treatment. Initial presentation will need to be addressed regardless of underlying cause. Where differences of opinion arise between BSMHFT and CGL, it is the responsibility of all of us to ensure that service users have access to services that are best placed to meet their needs**.** If it is not possible to resolve the issue quickly, the matter should be escalated, if necessary, both within BSMHFT and CGL. Both organisations are expected to provide support in reaching a resolution in the interests of individual service users.

Mental health and problematic/dependent drug/alcohol use

Service users who present with dual diagnosis can pose a challenge to mental health and addiction services due to their often-complex needs. There can be a lack of clarity as to which service should be involved or where service users should be referred, to gain access to services that are best placed to meet their needs. These issues are further complicated as service users may have various presentations which cover the broad spectrum of dual diagnosis, i.e.

- A primary mental health problem with problematic alcohol or drug use
- Alcohol or drug use affecting the course of mental ill health.
- Intoxication leading to psychological problems.
- Alcohol or drug use and/or withdrawal leading to mental health symptoms and syndromes.

It is therefore important that all services are clear on referral care pathways to ensure accessible and inclusive services for those service users who present with mental health and problematic alcohol/drug use and to ensure that service users are not denied services based on either of these.

Who should take responsibility for service users with dual diagnosis?

- National guidance on dual diagnosis recommends that there should be enhanced joint working between mental health and addictions services. This includes clear protocols between services in terms of referral, communication, joint reviews and clearly identified care pathways.

- Service users who present with a primary alcohol/drug problem and minor mental health problems (Low Level anxiety, depression) should, in most cases, be possible to manage and care co-ordinate in the alcohol/drug services. This should include service users who are accessing psychological treatments through Birmingham Healthy Minds for their minor mental health problems (see Appendix 4).

- National Guidance also suggests that service users who present with severe and enduring mental health problems and use alcohol/drugs problematically should be care co-ordinated within mainstream mental health services and remain subject to CPA.

- Some depressive and anxiety problems that are either severe and/or enduring may require the provision of more intensive psychological interventions that may only be available within the mainstream mental health services. In this type of case, it is sensible to share care.

Pathway Procedure and Thresholds

The Needs Framework and Assessment Framework **(Appendix 1 and 2)** is designed as a basic model upon which to deliver services for the dually diagnosed and can be used as a guide in relation to your decision-making processes. High and moderate level needs may require a referral along the pathway.

In addition, identifying the appropriate mental health cluster the service user falls under will support workers decision making. BSMHFT Mental Health Services delivers a stepped model of care i.e. stepping the level of a service users care up or down in response to a service user's presenting need. This is defined by the Care Cluster allocated to a client and the part of the service they are under.

Referrals should be initially processed by the Service to whom these were originally sent, whether this is a team within BSMHFT or CGL.

Where it is identified there is a need for involvement from either substance misuse or mental health services (this can be identified at the initial referral or subsequently, after assessment processes or service delivery) they will initiate a referral as described in the dual diagnosis pathway.

Following the assessment process, a decision will be made as to where the service user's needs are to be best met.

Referral Process (from external referrers)

Referral to BSMHFT and CGL should be made through their respective SPOA contact numbers.

Co-ordination & Communication

It is expected that a "lead practitioner" will be responsible for a service user during a referral along the dual diagnosis pathway, during their treatment journey to ensure that service users receive continuity of care.

The Lead practitioner role is used to encompass both the (addiction) 'key worker' and (mental health) 'care–coordinator' role and represents the staff member who is responsible for:

- Co-ordinating pre-assessment, assessment and post-assessment activity.
- Retaining or then transferring lead practitioner role to the appropriate team or,
- Where pathway entry is inappropriate, progressing the seamless transfer of the case to the relevant agency external to the system.
- CPA responsibility in relation to secondary mental health services

Joined up treatment and support should be provided to the service user group, based upon the shared working of cases between BSMHFT and CGL (with Primary Care Services, as appropriate); which should enhance communication and coordination.

Principles

- **To support this process, CGL, will coordinate and treat, from an addiction's perspective, all complex, higher risk, multiple needs individuals**

- **BSMHFT for (both community teams and where appropriate in-patient ward) will coordinate and treat individuals, based upon complexity of their mental health need.**

- **Where there is uncertainty about the suitability of a referral under the dual diagnosis pathway, and a referral has been refused, but this is not accepted by the referring agency, or a dual diagnosis referral proves contentious.**

    - **Workers should in the first instance discuss the case with a senior clinician within their own service. In the Case of BSMHFT COMPASS should contacted for advice.**

    - **Thereafter workers can contact the staff identified in Appendix 5 to discuss the referral further, either for advice or with a view to reaching agreement about a referral.**

Referral details should be communicated to the Client's GP

Joint Working

When it is identified that the referral fits the pathway criteria and where joint working has been identified and agreed between BSMHFT and CGL as a requirement; then an assessment should be undertaken jointly by a staff member from both substance misuse and mental health services.

The lead practitioner role will include the development, monitoring, and review of a care plan, including communication with and coordination of all the agencies involved for that service user's treatment/support, i.e. both within the pathway framework and with external agencies e.g. those from the criminal justice system, social services and primary care.

The care plan must include all the relevant partner agencies, clearly identify the lead agency/practitioner and must involve the input of the service user in both creating and reviewing this document.

This lead practitioner role will continue by that staff member until the service user is passed to another lead practitioner within the system (this should minimise the potential negative impact on service user engagement and retention from repeated changes in keyworker/care co-ordinator) or they exit the system and pass into the care of an external agency.

In exceptional circumstances where it is not possible to undertake a joint assessment within a reasonable period, the agency that received the referral will undertake the assessment and the lead practitioner from that agency will then liaise with the partner agency to progress their assessment also.

Information sharing

As part of this process, the service user as well as their referrer (and GP, where the GP is not the referrer) must be kept updated in relation to the status of the referral and of subsequent decisions made at all stages.

Exit

The service user may successfully complete and then exit either or both the BSMHFT and CGL. This may then result in neither service being required to treat the service user or it may result in just one of the services continuing to treat the service user (e.g. resolution of a psychotic episode but continuation of a substance misuse problem may result in discharge from BSMHFT but treatment continuation by CGL).

Treatment may discontinue from both services, with the service user being transferred to an alternative third-party service based upon their remaining needs.

Pathway exit and transitions between services and other agencies will be coordinated by the lead practitioner.

Service users will not be discharged until there has been discussion between both services.

Exits will also incorporate those relating to non-successful treatment outcomes e.g. ‘dropping out’ of treatment (although efforts will be made to re-engage through outreach), treatment suspensions (e.g. following violent/abusive conduct) and prolonged periods of imprisonment. In relation to shorter periods of imprisonment, (three months or less within BSMHFT) the services will continue to retain service user engagement concomitant with the through-care ethos whilst the service user is in prison and again continue with their treatment post-release.

Appendix A: Pathway between BSMHFT services and CGL Substance Misuse services

Substance Misuse services will treat patients with substance misuse problems and will advise on substance misuse issues, they will coordinate and treat, from the addiction's perspective, all complex, higher risk, multiple needs individuals for the Birmingham area.	Substance Misuse Services will make a referral for BSMHFT services through the BSMHFT Single Point of Access (SPOA). SPOA will triage the referral prior to formal allocation to a BSMHFT service in the interests of ensuring the individual is passed to the right team first time.	BSMHFT teams will coordinate and treat individuals, based upon complexity of mental health need (as per the Care Clusters), which will include trauma/personality disorders, thereby avoiding 'exclusion by diagnosis.' Decisions will also be made as to the urgency of the referral. This should be negotiated with the referrer. Birmingham Healthy Minds will case manage and treat individuals who come under the Care Cluster for their services.	When it is identified that the individual fits the criteria for BSMHFT services, then the assessment will be ideally undertaken jointly by a staff member from both BSMHFT services and Substance Misuse Services. In exceptional circumstances where it is not possible to undertake a joint assessment within a reasonable period, the agency that received the referral will undertake the assessment and the lead practitioner from that agency will then liaise with the partner agency to progress their assessment.

Following the assessment process, a decision will be made as to how the individual's needs are to be best met. This process is likely to involve discussion within the Team ,COMPASS Clinician and with a Senior Practitioner from Substance Misuse Services, and will be guided be care clusters in BSMHFT. The decision may be one of the following:

If no service from either agency is appropriate; the assessor will inform the referrer (and GP, where GP is not the referrer) and the individual in writing in terms of the decision rationale and signpost to the appropriate agency.	That treatment should be provided either by BSMHFT or by CGL as a single treatment provider.	That treatment should be provided by BSMHFT or CGL, but with support from the other service.	Both BSMHFT and CGL joint work the case. A lead practitioner will then be agreed for the case from one service.

Where BSMHFT services are identified as the lead provider the Care Coordinator will undertake the full remit of their role in supporting the individual. The service will work jointly with CGL to develop an escalation process to manage disputes effectively.	Pathway exit and transitions between services and other agencies will be coordinated by the lead practitioner. Individuals will not be discharged until there has been discussion between both services.

Appendix B

Notes: 1/ Individuals who are within A and B Level regarding their mental health needs, are likely to be subject to the CPA Programme. It should be noted that although Substance Misuse Services may provide the lead practitioner in B2 and B3 (refer 2/ below), they will not initially provide CPA Programme Coordination, Therefore if an individual requires this, the lead practitioner will be provided by BSMHFT Mental Health services.
2/ In all other cases where there is a potential overlap as to which agency is to provide the lead practitioner, e.g. in B2 and B3, the decision will be based upon which need is the greater i.e. if this is mental health, then Complex Care Mental Health will provide the lead practitioner but if the greater need is addictions, then Substance Misuse Services will provide the lead practitioner.

An objective framework for decision making to meet individual needs. ***For adults of working age with dual diagnosis issues***	1 **LIMITED** NEEDS ARISING FROM SUBSTANCE USE E.g. single substance misuse (drugs or alcohol); intermittent or lower quantity/frequency use; non-injector; 'lower' level of concern re physical/mental health or wider social complications as a result of the substance misuse.	2 **MODERATE** LEVEL OF NEEDS ARISING FROM SUBSTANCE USE E.g. polysubstance misuse; higher quantity/frequency use; injector; 'medium' level of concern re physical/mental health or wider social complications as a result of the substance misuse.	3 **HIGH** LEVEL OF NEEDS ARISING FROM SUBSTANCE USE E.g. polysubstance misuse; high quantity/frequency use; injector; 'serious' level of concern re physical/mental health or wider social complications as a result of the substance misuse. '
A **HIGH LEVEL OF NEEDS ARISING FROM SEVERE MENTAL HEALTH PROBLEMS** High risk to physical safety of self or others, either intentional or unintentional. Positive evidence of abuse or exploitation. Very disabling or distressing problems with thinking, feeling or behaviour. Very disabling problems with activities or in relationships with other people. Serious lack of basic amenities, resources or living skills. Very disabling problems with activities or in relationships with others	BSMHFT Secondary Care Mental Health services lead with support from CGL Addiction Services	BSMHFT Secondary Care Mental Health services lead, with support from CGL Addiction Services	BSMHFT Secondary Care Mental Health services lead with support from CGL Addiction Services
B **MODERATE** LEVEL OF NEEDS ARISING FROM MENTAL HEALTH PROBLEMS Definite indicators of risk to physical safety of self or others, either intentional or unintentional. Definite risk of abuse or exploitation. Marked lack of basic amenities, resources or living skills. Disabling or distressing problems with thinking, feeling or behaviour. Disabling problems with activities or in relationships with other people. Disabling problems with activities or in relationships with others	Primary or Secondary Care Mental Health services. Lead, with support from CGL Addiction Services	BSMHFT Secondary Care Mental Health services lead, with support from CGL Addiction Services lead with support from BSMHFT Secondary Care Mental Health services	BSMHFT Secondary Care Mental Health services lead with support from CGL Addiction Services OR CGL Addiction Services lead with support from BSMHFT Secondary Care Mental Health services
C **LIMITED NEEDS ARISING FROM MENTAL HEALTH PROBLEMS REQUIRING SHORT TERM INTERVENTION** Minor or no concern of risk to physical safety of self or others, either intentional or unintentional. Minor or no concern of risk of abuse or exploitation. Minor or no concern with basic amenities, resources or living skills. Minor or no disabling or distressing problems with thinking, feeling or behaviour. Minor or no problems with activities or in relationships with other people. Minor or no problems with activities or in relationships with others	Primary Care lead, support from CGL Addiction Services	CGL Addiction Services lead, support from Primary Care	C Addiction Services lead with support from Primary Care

Appendix C
Specialist Treatment Pathway for Dual Diagnosis