

A large, abstract, colorful graphic occupies the bottom-left portion of the cover. It consists of various overlapping, textured shapes in shades of blue, green, yellow, orange, red, and purple, creating a vibrant, multi-colored pattern.

*Mental Health Policy
Implementation Guide*

Dual Diagnosis Good Practice Guide



The Gift by John Roberts

My life so far has been quite diverse; I have travelled, been a family person, homeless and I am currently using the Creativity Centre. The Centre saved my life, changed my world and gave me the opportunity to express myself in various ways including painting, which I sometimes enjoy.

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Reflections is the publication supporting the promotion of 'Art Works in Mental Health', a new project that aims to encourage creativity in people who have been affected by mental illness and to promote understanding. We are launching a search for such art to showcase in a variety of ways, including a series of national exhibitions, for non profit purposes.

Entry is open to anyone who has experienced mental illness themselves or has been affected by the mental illness of someone they care about.

You can use a wide variety of media such as painting, drawing, photography, writing, sculpture, pottery and ceramics. Full details are in the application pack. If you are interested, or you know someone who might be, please contact 0870 609 0034, or log on to www.artworksinmentalhealth.co.uk

Art Works in Mental Health is sponsored by Pfizer Ltd and collaborating organisations involved in the project are Breakthrough, Coventry Healthcare NHS Trust, Depression Alliance, NSF, The Northern Centre for Mental Health, South London and Maudsley NHS Trust, PriMHE (Primary care Mental Health Education) and Priority Healthcare Wearside.

The Department of Health wishes to acknowledge the major contribution of the Sainsbury Centre for Mental Health in partnership with Alcohol Concern and Dr Alison Lowe (Barnet, Enfield and Haringey Mental Health Trust) to the production of this guidance, and the whole of the Dual Diagnosis Steering Group in overseeing it.

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Foreword

By Professor Louis Appleby

National Director of Mental Health

Supporting someone with a mental health illness and substance misuse problems – alcohol and/or drugs – is one of the biggest challenges facing frontline mental health services. The complexity of issues makes diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide.

One of the main difficulties is that there are a number of agencies involved in a person's care - mental health services and specialist rehabilitation services, organisations in the statutory and voluntary sector. As a result care can be fragmented and people can fall down the cracks.

The guidance provides a framework within which staff can strengthen services so that they have the skills and organisation to tackle this demanding area of work. Our key message is that substance misuse is already part of mainstream mental health services and this is the right place for skills and services to be. Mental health services must also work closely with specialist substance misuse services to ensure that care is well co-ordinated.

We have also highlighted some existing examples of excellent services working well now. This guidance and the services mentioned, demonstrate the importance of effective leadership at a local level and rigorous training programmes to help staff maintain high standards of service delivery.

In addition, it is evident that we have been held back by a lack of research in this field. I am pleased to say that this area of practice is being prioritised by major funding bodies for future research.

I commend this guidance to you and am confident it will be a very useful tool for developing effective services in the future.

LOUIS APPLEBY

Executive Summary

- 1 This guide summarises current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse. The substances concerned include legal and illegal drugs, alcohol and solvents, but not tobacco. It represents an addition to the Mental Health Policy Implementation Guide which supports implementation of the NSF for Mental Health. However, it differs somewhat in style and content from the rest of the implementation guide: it provides more detail on emerging policy, practice and the evidence base because service models for dual diagnosis are at an earlier stage of development.
- 2 It is aimed at all those who commission and provide mental health and substance misuse services. Local Implementation Teams (LITs) are charged with implementing the policy requirements described in this guide, working in partnership with Drug Action Teams (DATs).
- 3 Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care. **This should be delivered within mental health services.** This policy is referred to as “mainstreaming”. Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. “Mainstreaming” will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively.
- 4 “Mainstreaming” will only work if the following policy requirements are delivered:
 - local services must develop focused definitions of dual diagnosis which reflect local patterns of need and clarify the target group for services;
 - these definitions must be agreed between relevant agencies;
 - where they exist specialist teams of dual diagnosis workers should provide support to mainstream mental health services;
 - all staff in assertive outreach teams must be trained and equipped to work with dual diagnosis;
 - adequate numbers of staff in crisis resolution, early intervention, community mental health teams and inpatient services must also be suitably trained;
 - all health and social care economies must map services and need;
 - small and time limited local project teams including mental health and substance misuse specialists working to the LIT should prepare the focused definition together with care pathways and clinical governance guidelines;
 - all services, including drug and alcohol services, must ensure that clients with severe mental health problems and substance misuse are subject to the Care Programme Approach and have a full risk assessment.

- 5 The guide summarises good practice in relation to assessment and treatment and sets out a programme for local implementation of the service model. It is concluded that integrated care – delivered by one team – appears to deliver better outcomes than serial care (sequential referrals to different services) or parallel care (more than one service engaging the client at the same time). However more UK based research is required and well organised parallel care can be used as a stepping stone to integration. Integrated treatment in this country can be delivered by existing mental health services following training and with support from substance misuse services.
- 6 In order to develop comprehensive services delivering integrated care for this group, local project teams will, as well as preparing the protocols described above, need to:
- seek input from all the relevant local stakeholders;
 - formulate a local strategy for service change;
 - devise a training strategy.

In addition, all mental health provider agencies should designate a lead clinician for dual diagnosis issues and all health and social care economies should designate a lead commissioner.

1. Background

1.1 Introduction

- 1.1.1 Historically, substance misuse and mental health services have evolved separately. Few services currently exist which explicitly deal with clients with both substance misuse and mental health problems. These clients have tended either to be treated within one service alone, which has meant that some aspects of their cluster of problems have not been dealt with as well as they might, or have been shuttled between services, with a corresponding loss of continuity of care. Some potential clients or patients have almost certainly been excluded from all the available services. The provision of integrated care for people with a combination of mental health problems and substance misuse requires a radical rethink of the way services are organised – they need to be organised around the user rather than around social, professional or service constructions of “abnormal” behaviour.
- 1.1.2 A fundamental problem is a lack of clear operational definitions of “dual diagnosis”. In many areas a significant proportion of people with severe mental health problems misuse substances, whether as “self-medication”, episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problem such as depression or anxiety. Sweeping up all these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues. Integrating services therefore requires a clear and locally agreed definition of dual diagnosis supported by clear care pathways (care coordination protocols). It is essential to acknowledge that gatekeeping by specialist services is a valid activity which enables them to focus their efforts, and agreed and justifiable gatekeeping practice with clear accountability should ensure that clients are included in the right services, rather than excluded from services they desperately need.
- 1.1.3 **This guide is focused on people with severe mental health problems and problematic substance misuse.** Services will often have developed their own local definitions of severe mental health problems. Many of these will be based on the five “SIDDS” dimensions of severity, informal and formal care, diagnosis, disability and duration. Risk of harm to self or others, or of severe self neglect are also relevant. An appropriate response to this client group forms an important part of local and national strategies to prevent suicide.
- 1.1.4 It is vital to state at the outset that this guide covers the problematic use of all types of substances whether licit or illicit. Crucially it includes alcohol – the most commonly misused substance – and other substances which may be purchased legally such as solvents, as well as illegal drugs including opiates, stimulants and cannabis. **All references to substances in this guide include alcohol and other licit substances.** Tobacco is not however included, although there are important public health issues associated with tobacco use which services should not ignore, and an association between tobacco use and both mental health problems and other substance misuse. The guide also covers non-dependent but nonetheless problematic substance misuse.

1.2 Defining Dual Diagnosis

- 1.2.1 The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:
- a primary psychiatric illness precipitating or leading to substance misuse
 - substance misuse worsening or altering the course of a psychiatric illness
 - intoxication and/or substance dependence leading to psychological symptoms
 - substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.
- 1.2.2 Services need to be clear at the outset which individuals they intend to provide interventions for. Defining the population of people who experience these dual problems, and identifying those sub-groups for whom your service has responsibility are necessary steps in this process. Though little consensus is evident in the literature regarding such definitions Figure 1 presents one approach. The horizontal axis represents severity of mental illness and the vertical axis the severity of substance misuse. Case examples in each of the quadrants are also provided to aid clarity. This guide focuses on clients falling within the top right hand quadrant although a proportion of clients falling in the bottom right hand quadrant may also require some of the interventions and approaches described in this guide. Guidance on how to develop a focused definition of this group is contained in Section 4.4.
- 1.2.3 It is not acceptable for services to automatically exclude people with personality disorder. For the purposes of the model in Figure 1, personality disorder is seen as a separate dimension – which can coexist with a mental health problem or a substance misuse problem, or both. A diagnosis of personality disorder does not necessarily predict poor treatment outcome.

1.3 Prevalence

- 1.3.1 It is hard to assess the exact levels of substance misuse both in the general population and in those with mental health problems. UK data from one national survey and from local studies generally show that:
- increased rates of substance misuse are found in individuals with mental health problems affecting around a third to a half of people with severe mental health problems
 - alcohol misuse is the most common form of substance misuse
 - where drug misuse occurs it often co-exists with alcohol misuse
 - homelessness is frequently associated with substance misuse problems
 - CMHTs typically report that 8-15% of their clients have dual diagnosis problems although higher rates may be found in inner cities.
 - Prisons have a high prevalence of drug dependency and dual diagnosis.
- 1.3.2 Relevant epidemiological studies are listed in the bibliography.

Figure 1: The scope of co-existent psychiatric and substance misuse disorders

| Severity of problematic substance misuse | |
|---|---|
| <p>e.g. a dependent drinker who experiences increasing anxiety</p> <p>Severity of mental illness</p> | <p>High</p> <p>e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation</p> |
| <p>Low</p> <p>e.g. a recreational misuser of 'dance drugs' who has begun to struggle with low mood after weekend use</p> | <p>High</p> <p>e.g. an individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health</p> <p>Low</p> |

1.4 Patterns of drug and alcohol use

- 1.4.1 Research findings concerning the substances most commonly used by people with mental illness are equivocal. A propensity to use stimulants as a possible mechanism for alleviating negative symptoms in schizophrenia has been reported. However, the Epidemiological Catchment Area study (USA) and British studies have identified alcohol and cannabis to be the drugs most frequently used by individuals with mental health problems.
- 1.4.2 It seems unlikely that psychiatric diagnoses alone are meaningful predictors of which substance, if any, an individual will misuse. Alcohol is readily available and is therefore unsurprisingly the most commonly used substance. Other drug use may simply be dependent upon local availability, and the network of contacts that a potential user might establish. Currently cannabis appears to be the most commonly misused illicit substance by people with mental health problems in the UK. However, researchers in the substance misuse field are consistently reporting an increase in the availability of cocaine and of a resurgence in heroin use in some cities.
- 1.4.3 The Office of National Statistics study of the prevalence of mental disorder amongst prisoners demonstrated high rates of drug use and dependence prior to coming into prison. 10% of male remand prisoners had a moderate drug dependency and 40% severe dependency. High levels of comorbidity were also common. 79% of male remand prisoners who were drug dependent had two or more additional mental disorders.

- 1.4.4 American researchers have also found multiple drug misuse to be typical in urban samples of psychiatric clients with resultant chaos and debilitation for the person concerned. Clinical experience suggests this phenomenon is also widespread in the UK.

1.5 Clinical Implications

- 1.5.1 Substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes including:

- Worsening psychiatric symptoms
- Increased use of institutional services
- Poor medication adherence
- Homelessness
- Increased risk of HIV infection
- Poor social outcomes including impact on carers and family
- Contact with the criminal justice system.

Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide.

- 1.5.2 Of equal importance are those ailments that result more directly from the administration of substances regardless of a coexistent mental illness. Intravenous drug misuse, for example, can result in venous or arterial thrombosis, blood-borne infections including HIV and Hepatitis B and C, and cardiac disease. Smoking substances, particularly crack and heroin, can result in respiratory diseases including pneumonia and emphysema. Long term alcohol use is also associated with such debilitating conditions as Korsakoff's syndrome, delirium and seizures. To overlook or neglect substance misuse in the course of mental health treatment will result in poor treatment outcome.

- 1.5.3 Despite the above a range of effective interventions is available. While the risks are greater where substance misuse and mental health problems coexist there is no reason for a pessimistic approach. Most clients can and will achieve positive outcomes with the right treatments and support.

Key Points

- the relationship between psychiatric illness and substance misuse is complex
- services are advised to generate focused definitions which reflect the target group for whom their service is intended
- defining target client groups and agreements on provision must be achieved through inter-agency collaboration across mental health and substance misuse services, both statutory and voluntary, and the criminal justice system
- expect substance misuse to be usual rather than exceptional among people with severe mental illness
- alcohol is the most commonly misused substance by people with mental illness
- misuse of illicit substances will reflect local availability, of which mental health services should develop an awareness
- substance misuse is strongly associated with increased rates of violence and suicidal behaviour
- significantly poorer clinical outcomes are expected among psychiatric clients who also misuse substances: nonetheless an optimistic approach to treatment is both warranted and appropriate

2. Policy

2.1 Historically there has been little attempt to provide a policy framework for people with dual diagnosis and separate strands of policy have focused on either mental health problems or addiction. It is now clear, as in so many areas, that “joined up thinking” is required at a policy level if integrated care is to be delivered to people with a dual diagnosis. This section seeks briefly to summarise an emerging policy framework which is focused on “mainstreaming” the care of people with severe mental health problems and substance misuse within mental health services which should take the lead responsibility for the care of this group. This model does not mean a reduction in the role of drug and alcohol agencies. On the contrary, what it means is introducing a clearer way of working across drug and alcohol agencies and mental health agencies involving the definition of clear care pathways so that:

- drug and alcohol services provide specialist support, “consultancy”, and training to mental health services to support “mainstreaming” of clients with severe mental health problems (top right hand quadrant of Figure 1) without which people will continue to receive poorly integrated or episodic care;
- mental health services offer the same sort of packages of support to drug and alcohol services so that they can deal effectively with people with less severe mental health problems (top left hand quadrant of Figure 1).

This is not “new work” for either set of agencies – they are already dealing with the clients concerned. It is about achieving a more rational and effective framework for tackling the pool of morbidity covered by the term “dual diagnosis”.

2.2 The table below summarises the current policy framework for dual diagnosis by listing the key national strategy documents, the lead agencies for implementation and the relevant policy and care guidelines:

| | Mental health | Drugs |
|-------------------------------|---|--|
| Strategy | National Service Framework (NSF) | Tackling Drugs to Build a Better Britain (TDBBB) |
| Implementation responsibility | Local Implementation Teams (LITs) | Joint Commissioning Group working through the local Drug Action Teams (DATs) |
| Guidelines | Mental Health Policy Implementation Guide | Drug Misuse and Dependence – Guidelines on Clinical Management (1999), Models of Care for Substance Misuse Services (2002) |

2.3 Mental health policy

2.3.1 The National Service Framework for Mental Health emphasised the importance of a number of issues in tackling dual diagnosis:

- **Mental health promotion.** In relation to alcohol brief primary care interventions such as an assessment of alcohol intake with feedback can help reduce excess consumption. Stronger links between drug and alcohol services and community mental health services are needed to help reduce suicide in the client group.
- **In primary care** assessment of individuals with mental health problems should consider the potential role of substance misuse. Primary care clinicians should know how to access specialist services.
- **Secondary care** should meet the needs of people with dual diagnosis through existing mental health and drug and alcohol services.
- **The Care Programme Approach (CPA)** should be applied to people with dual diagnosis whether they are located in mental health or drug and alcohol services and this must start with a proper **assessment**.
- **Assertive outreach and crisis resolution services** will be foci for work with the group and must be equipped to take opportunities and tackle challenges. **Long term engagement** will be key to success.

Other recent policy statements have also emphasised these points as well as drawing attention to the importance of **staff training** and supervision in substance misuse.

2.3.2 The White Paper – Reforming the Mental Health Act – published in December 2000 signalled new legislation which will determine the scope and limitations of compulsory powers. It will be applied in a way that ensures that everyone with a serious mental disorder is looked at as an individual.

2.4 Drug policy

2.4.1 *'Tackling drugs to build a better Britain'* (DH 1998) represents current UK drug policy. This strategic document has 4 aims:

- to help young people resist drug misuse in order to achieve their full potential
- to protect communities from anti-social and criminal behaviour
- to enable people with drug problems to overcome them and live healthy and crime-free lives
- to stifle the availability of illegal drugs on our streets.

2.4.2 Drug Action Teams (DATs) have been established to ensure the strategy is translated into practice. These teams are local partnerships established on local authority boundaries, and consisting of senior representatives of health, social services, criminal justice, education and housing agencies. Each DAT receives a central government grant towards administration and coordination costs. From April 2001, new funds have been made available to increase drug treatment. This is in the form of a pooled budget, which can only be spent with the agreement of the DAT. Health authorities or PCTs will act as the bankers for these funds. Most DATs have established a Joint Commissioning Group consisting of the commissioners and budget holders from each DAT membership organisation. Their role is to coordinate their spend of mainstream resources as well as work on behalf of the DAT to administer the new pooled budget. The DAT role mirrors that of the LIT for mental health. The effective representation of mental

health services on DATs and of drug and alcohol services on LITs is a necessary step to provide comprehensive services for individuals with a dual diagnosis. Contact details for DATs can be found at www.doh.gov.uk/drugs/drugactionteams.htm.

2.4.3 *Drug Misuse and Dependence – Guidelines on Clinical Management* (DH 1999), which underpin the UK drug strategy have also been published. Emphasis is placed on the rights of individual drug users to receive appropriate treatment and on the responsibility of all doctors to address drug-related problems. ‘Shared-care’ arrangements between specialist drug services and other providers are recommended. A central role for general practitioners is emphasised and health authorities have been charged with ensuring structures are in place to adequately support primary care staff. In some areas these structures will already be present facilitating greater involvement of primary care in the management of people with a dual diagnosis.

2.4.4 The UK drug strategy is also supported by legislative developments. *The Criminal Justice and Court Services Act* came into effect in 2001 and requires all offenders, including suspects, to be liable for drug testing at each stage of the criminal process. The Act requires the court to take positive drug test results into account when determining whether or not to grant bail. ‘Drug Treatment and Testing Orders’ (DTTOs) are now being introduced as one response to those offenders, or suspects, who are identified as having a drug problem. This legislation provides a potential mechanism for individuals with a dual diagnosis to enter mental health and/or substance misuse services.

2.4.5 Substance misuse services systematically monitor drug misuse patterns. All doctors who treat individuals for problematic drug misuse should provide information on a standard form to the National Drug Treatment Monitoring System based on their regional area. Although data sent to central government contain no identifiable information, data sent to the regional centres retain the client’s initials, date of birth and gender in order that records can be matched (for instance, to avoid double counting). As this data cannot be considered as fully anonymous, doctors or workers recording personal information about clients attending drug treatment services are asked to ensure that:

- clients are individually informed and understand how information about them may be used;
- clients understand that they can ask that their information is not passed on, although obviously it is hoped that most clients can be reassured that their information is important and will be used very carefully;
- a record of this action is made locally.

A report should be made when a person first presents with a drug problem or re-presents after a gap of six months or more. Regional contact numbers for database centres are available on Manchester University’s Website (www.medicine.man.ac.uk/epidem/dmru) and are also provided in the British National Formulary.

2.4.6 On 1 April 2001 the National Treatment Agency, a new special health authority, was created with the aim of increasing the number of drug misuse clients treated and raising the effectiveness of their treatment. The Agency will:

- develop and promulgate evidence based standards for treatment provision and commissioning;
- take action to reduce variations in the availability and standards of treatment;
- ensure the treatment field is able to deliver these improvements;
- develop providers and commissioners.

It will do this by developing work programmes around:

- performance management and development;
- commissioning;
- development of the knowledge base;
- policy management and development.

The NTA is currently still in the process of recruiting staff and starting its work programmes, but NTA colleagues have been fully involved in the discussions supporting preparation of these guidelines.

2.5 Primary care

2.5.1 Standard Two of the NSF makes clear the need for primary care services to be able to assess the needs of people with mental health problems, and to access the appropriate services. Assessment of the physical health needs of these people lies entirely within the remit of primary care, and as described above, the physical health consequences are significant e.g. a third of people with dual diagnosis will be sero-positive for either HIV, Hepatitis B or Hepatitis C.

2.5.2 Accessing the service from primary care is also an issue when an individual may be in need of services from both the CMHT, and the drug or alcohol services. There exists a great opportunity for individuals to fall between two stools; with one service believing that the other is providing a service, when in fact neither are doing so. Some PCTs are beginning to address this potential difficulty by developing clear care pathways. However, the opportunities offered through commissioning a comprehensive mental health service from PCTs are significant, providing that a robust commissioning process is in place, with appropriate training and resources.

2.6 Secondary care

2.6.1 A few areas with very high morbidity and a special commitment to this issue are providing specialist teams which deliver services exclusively to people with severe mental health and substance misuse problems. Where such teams exist they need to adopt a model of “outreach” working or “consultancy” so that they can support mental health services effectively. This model will not be appropriate in all areas of the country – and this is unlikely to be an economical or an effective approach where comorbidity is at average or below average levels. In such areas assertive outreach teams are likely to have the highest level of contact with the client group, while inpatient, crisis resolution, early intervention and generic community services will also have significant contact. The standard model will therefore be to mainstream people with dual diagnosis so that:

- all staff in assertive outreach teams are trained and equipped to work with people with dual diagnosis, with appropriate support and professional supervision;
- adequate numbers of staff in the other teams and settings mentioned above are similarly trained and equipped and can be readily identified by other staff as such. All staff require some basic knowledge of substance misuse issues to allow them to make appropriate referrals or seek help when required;
- one or more staff within such services develop a major specialism in dual diagnosis and service level agreements are set up with drug and alcohol services which ensure appropriate skills and knowledge are available (and such agreements must be reciprocal).

All health and social care economies will need to conduct a local mapping exercise to determine the local level of need in dual diagnosis, and the scope of existing services, as a basis to determine whether mainstreaming, or exceptionally, the provision of a dedicated service, is required. More details of the needs assessment process, which must include the criminal justice system, can be found in section 4.2 below. A local plan to meet the identified need must then be completed, led by a small project team, but involving the key stakeholders along the lines described in section 4.3 below.

- 2.6.2 All services, including drug and alcohol services, must ensure that clients with severe mental health problems and substance misuse are subject to the Care Programme Approach. All clients within this group must have a full risk assessment which addresses issues outlined in section 3.1.3 below. All clients must also have a copy of their care plan detailing the service they can expect to help them with their substance misuse problem.
- 2.6.3 The DH is producing detailed policy guidance in respect of substance misuse in general psychiatry wards and day care settings and this is referred to in more detail in section 4.6 below. Local policies based on this guidance must be developed.
- 2.6.4 All services working with people with comorbidity are intended to be covered by the Mental Health Information Strategy and those responsible for implementing the strategy will need to take account of the particular focus on confidentiality issues which these services require. However, the principles of patient confidentiality remain the same whether patients are suffering from mental health problems with or without concurrent substance misuse. Local services will need to develop guidelines for information-sharing, and monitor how they work as part of clinical governance.

2.7 Commissioning

2.7.1 The commissioning of these services needs to take account of two key policy developments:

- Mental health services will increasingly be commissioned by Primary Care Trusts (PCTs) as *Shifting the Balance of Power* is implemented;
- Drug and alcohol treatment services will also increasingly be commissioned by PCTs but in collaboration with other agencies working together on a Joint Commissioning Group and with oversight from the local DAT in respect of drug services.

As a consequence great care will need to be taken locally to ensure coherent commissioning across DATs and PCTs. Specifically, LITs and DATs must coordinate their service development plans and the cross-members on both groups must take personal responsibility for ensuring that this happens. However, given that mental health services deal with the majority of clients falling within the ambit of these guidelines and that these guidelines form a supplement to the PIG, LITs should take lead responsibility for ensuring commissioning plans reflect these guidelines. It is proposed later in the document that the detailed work locally should be undertaken by a small, expert, project team reporting to the LIT.

2.7.2 The Health Advisory Service has produced some standards for mental health services in dual diagnosis which can usefully inform commissioning and these standards are compatible with these guidelines. In addition, the Substance Misuse Advisory Service have also produced Commissioning Standards for Drug and Alcohol Treatment and Care.

Key Points

- Mainstream mental health services have a responsibility to address the needs of people with a dual diagnosis
- Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health services
- All staff in assertive outreach must be trained and equipped to work with dual diagnosis
- Adequate numbers of staff in crisis resolution and early intervention teams, CMHTs and inpatient settings must also be so trained
- They must be able to link up with each other and with specialist advice and support, including from drug and alcohol agencies
- All local health and social care economies must map need including for those in prison
- Project teams must be set up and must agree a local plan to meet need which must contain an agreed local focused definition, care pathways/care coordination protocols and clinical governance guidelines
- All clients must be on the CPA and must have a full risk assessment regardless of their location within services
- LITs should take the lead in implementing these guidelines ensuring that commissioning is coordinated across PCTs and DATs

3. Assessment and treatment approaches

3.1 Assessment

3.1.1 Since substance misuse among those with mental health problems is usual rather than exceptional and results in poorer treatment outcomes, it is necessary to consider its presence in all assessments undertaken by mental health services. To do otherwise may result in misdiagnosis, over treatment with psychiatric medication and the neglect of appropriate interventions. The often covert nature of substance misuse, combined with the symptoms of mental health problems, can make this task challenging. The purpose of the assessment, its confidential nature and any exceptions to this confidentiality should be made explicit to the individual, and their consent sought for any screening procedure. Different approaches will be necessary for the following components in the assessment process:

- detection and screening
- specialised assessment
- risk assessment.

3.1.2 Detection and screening

Assessment of all individuals with mental health problems should actively consider the potential role of substance misuse. Detection and screening can be conducted through self-report methods, laboratory tests and from collateral data sources.

3.1.3 Specialised assessment

Specialised assessments are undertaken to determine the nature and severity of substance misuse and mental health problems, and to identify corresponding need. The more comprehensive and focused the assessment the better the understanding will be of the relationship between the two disorders. Since substance misuse can itself generate psychological and psychiatric symptoms, assessment of this relationship should be longitudinal and open to revision. Box A presents the necessary components of a specialised assessment.

Box A Assessment components

- Identification and response to any emergency or acute problem
- Assessment of patterns of substance misuse and degree of dependence/withdrawal problems
- Assessment of physical, social and mental health problems
- Consideration of the relationship between substance misuse and mental health problems
- Consideration of any likely interaction between medication and other substances
- Assessment of carer involvement and need
- Assessment of knowledge of harm minimisation in relation to substance misuse
- Assessment of treatment history
- Determination of individual's expectation of treatment and their degree of motivation for change
- The need for pharmacotherapy for substance misuse
- Notification to the National Drug Treatment Monitoring System

A range of validated assessment instruments to enhance clinical techniques are available. See Hasin et al (1996), Rosenberg et al (1998), Maisto et al (2000), Appleby et al (1996) and Marsden et al (1997) in the reference section.

3.1.4 Risk assessment

Routine risk assessment protocols need to address specific factors relevant for individuals with a dual diagnosis. The severity of substance misuse, including the combination of substances used, is related to the risk of overdose and/or suicide. Exploration of the possible association between substance misuse and increased risk of aggressive or anti-social behaviour forms an integral part of the risk assessment, and should be explicitly documented if present.

3.1.5 Specific groups

Certain groups of individuals are emphasised in the literature as warranting specific attention including:

Young people – substance misuse is a major contributory factor in the development of mental health problems in the young. For example, early onset of substance misuse is linked with higher rates of major depressive disorders and it is estimated that a third of young people committing suicide are intoxicated with alcohol at the time of death.

Homeless people – studies have identified high levels of concurrent substance misuse and mental health problems among groups of homeless people and rough sleepers. Homelessness almost trebles a young person's chance of developing a mental health problem. Assertive outreach to these groups and in-reach to hostels are necessary.

Offenders including prisoners – both mental health problems and substance misuse play a major role in youth offending, and their combination together with low adherence to medication may lead to a higher

risk of violence among adults with severe mental health problems. These factors together with the introduction of legislation to support the UK's drug strategy will necessitate partnerships with the criminal justice system and in-reach to detained offenders or suspects. Prisoners have high levels of mental disorder and substance misuse so a close working relationship between prisons, their drug services and community drug and mental health services is vital.

Women – Significant differences between men and women have been found in their patterns of substance misuse and psychiatric co-morbidity:

- women who misuse substances are significantly more likely than other women or men to have experienced sexual, physical and/or emotional abuse as children
- substance misuse lifestyles can impact on women's sexual health and establish a pattern of re-victimisation
- women are more likely to present at mental health or primary care services for psychological difficulties rather than for any associated substance misuse problem
- women therefore tend to access alcohol and drug services later than men, and this may explain their more severe presentation
- women may have children, or want children, and this can deter them from contact with statutory services for fear of their children being removed.

The complexity and severity of need among women with a dual diagnosis requires the development of tailored services that are both attractive to women and relevant to their needs. More specifically, services must be informed and sensitive to the needs of childhood sexual abuse survivors. A women's mental health strategy is currently being developed.

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. Reference should be made to the DH strategy for black and ethnic minority mental health expected later in 2002.

3.2 Treatment approaches

3.2.1 As with severe mental illness, substance misuse is often a chronic relapsing condition. It is important that staff hold a realistic and longitudinal view of treatment in which different approaches may be necessary during different stages of the process. American researchers have described the following stages of treatment:

- engagement
- motivation for change (persuasion)
- active treatment
- relapse prevention.

3.2.2 Engagement

Engagement is concerned with the development and maintenance of a therapeutic alliance between staff and client. The strength of this alliance will depend, in part, on the value a client attributes to

the service. This can be enhanced by the style of interaction, which should be non-confrontational, empathic and respectful of the client's subjective experiences of substance misuse. The therapeutic alliance will also benefit from meeting a client's immediate needs rather than focusing on the cessation of substance misuse. Typically, individuals who misuse substances may have deficits in basic living requirements such as food, housing, shelter, clothing and physical health.

3.2.3 Motivation

Building motivation in clients has been termed 'persuasion' in the American literature and draws upon the principles of Motivational Interviewing. Its purpose is to strengthen a client's motivation and commitment to change whilst avoiding confrontation and resistance. A variety of simple techniques can be used for this purpose including:

- education about substances and the problems that may be associated with misuse including the effects on mental health
- presentation of objective assessment data (e.g. liver function tests, urinalysis)
- balance sheets on which the client lists the pros and cons of continued use/abstinence
- exploration of barriers to the attainment of future goals
- reframe problems or past events emphasising the influence of substance misuse
- reviewing medication and the use of an optimal medication regime.

With each of these examples the approach should remain non-confrontational and empathic. Thus, assessment data are fed back not to frighten and coerce the individual into change but to invite them to consider the data and offer their own interpretations. The task for staff is to actively listen and reflect back to the client those aspects of their behaviour that appear problematic, thereby nudging the decisional balance in favour of change.

3.2.4 Active treatment

3.2.4.1 It may take many months before a client is ready to receive active treatment interventions for their substance misuse. It is important at the outset to agree the anticipated goal of treatment and to integrate treatment of mental health problems and substance misuse. If it is unrealistic to aim for abstinence it may be more appropriate to consider intermediate goals that represent reductions in the harm incurred from drug and alcohol misuse whilst not focusing prematurely on complete cessation.

3.2.4.2 Evidence based interventions specifically designed for this client group have yet to be reported in the UK although guidelines on the clinical management of substance misuse are available and should be implemented. American researchers have identified components which they believe are critical for the effective treatment of these dual conditions although these too lack specificity:

- integrated treatment
- staged interventions
- assertive outreach
- motivational interventions
- individual counselling
- social support interventions

- long-term perspective.

Services will need to ensure that they remain aware of new evidence as it emerges.

3.2.5 Relapse prevention

Given the chronic relapsing nature of substance misuse it is important once a client has reduced their misuse, or become abstinent, to offer interventions aimed at the prevention and management of future relapses to problematic substance misuse or to mental health problems. The principles and strategies of 'relapse prevention' for substance misuse and the management of relapses to psychosis are recommended for this purpose. This approach aims to identify high-risk situations for substance misuse and rehearse coping strategies proactively. Attention is also given to the development of action plans should the client return to damaging substance misuse.

It is rare that clients pass through these treatment stages in a linear fashion. Some will enter treatment ready to begin change whilst others, having made progress, will relapse to earlier stages. It is also possible that a client will be in different stages at the same time in relation to their mental health problems and substance misuse. Flexibility and adaptation are essential skills for a workforce charged with providing treatment and care for this client group.

3.2.6 Other interventions

The analysis set out above is not intended to exclude a range of other interventions and forms of support which are relevant across mental health services generally, some of which may be particularly relevant for people with comorbidity. Particular attention needs to be given to pharmacological management, social support and building self esteem, social skills and the ability to participate in work or leisure through services such as occupational therapy, welfare advice and employment services.

Key points

- assessment of substance misuse forms an integral part of standard assessment procedures for mental health problems
- services need to develop routine screening procedures and, where substance misuse is identified, the nature and severity of that misuse and its associated risks should be assessed
- an awareness of specific groups for whom these dual conditions generate specific needs must inform the assessment process
- treatments should be staged according to an individual's readiness for change and engagement with services
- staff should avoid prematurely pushing clients towards abstinence but adopt a harm reduction approach
- an optimistic and longitudinal perspective regarding the substance misuse problem and its treatment are necessary
- a flexible and adaptive therapeutic response is important for the integrated management of these dual conditions
- attention must be paid to social networks of clients, to meaningful daytime activity and to sound pharmacological management

4. Implementation

4.1 Service models

4.1.1 Background/history

- 4.1.1.1 Three broad types of service model have been described in the literature: serial, parallel and integrated. The former implies treatment of one condition before progressing to treatment of the other condition. This approach is problematic for those with severe mental illness who also misuse substances since the two conditions are likely to be mutually interactive.
- 4.1.1.2 The parallel model implies the concurrent but separate treatment of both conditions. This approach can also be problematic since it may require the individual to attend different services and engage with different therapeutic structures and approaches. However, liaison across mental health and substance misuse services may make this model more viable if it enables treatment for both conditions to be delivered on one site. Dual diagnosis services with this liaison role have begun to emerge in the UK. The successful application of this approach also brings the added benefit of imparting knowledge and skills across specialisms.
- 4.1.1.3 The integrated model also implies the concurrent provision of both psychiatric and substance misuse interventions, but requires the same staff member (or clinical team), working in a single setting, to provide relevant psychiatric and substance misuse interventions in a co-ordinated fashion. This approach originates in America where 'hybrid' case managers and services, with the necessary repertoire of skills, have been developed. Subsequent US evaluations of this model have tended to conclude that integrated treatment is more effective than either parallel or serial treatment for this client group.
- 4.1.1.4 The need for hybrid staff and services reflects in part the distinct funding and training systems to which US psychiatric and substance misuse services are aligned. In the UK, whilst acknowledging the need for integrated treatments delivered from a single site, this challenge may be met without needing to establish new hybrid services. Sectorised community services provided by CMHTs and assertive outreach/home treatment teams are important components for the delivery of integrated services.

4.1.2 The way forward

- 4.1.2.1 There are a number of models which could achieve, or at least move services towards, achieving integrated care. Possible steps forward include:
- closer links between substance misuse and psychiatric services e.g. nominating a liaison substance misuse specialist for each sector team and developing agreed care pathways;
 - training and supervision, at a sufficiently senior level, in substance misuse treatment for all members of the psychiatric service, and equivalent training in mental health issues for substance misuse workers;
 - augmenting existing mental health teams with a specialist dual diagnosis worker who will work alongside care coordinators on clients with these dual problems but will also impart advice and support to the rest of the team. Such workers must be able to access suitable supervision and peer support.

In order to support service change it will be essential for each service provider to identify a **lead clinician** with specialist knowledge of the area, who can be a focus for advice to the project team which has to implement this guidance. This could, for example, be a nurse consultant, dual diagnosis having been identified as a priority area within the nurse consultant initiative.

4.1.2.2 Service models which could be adopted, depending on local need, include:

- dedicated dual diagnosis teams which support services in dealing with the most challenging clients, working in “outreach” or “consultancy” mode and which are a focus for more general advice, support and training on dual diagnosis;
- developing an assertive outreach team to specialise in dual diagnosis led by an expert team leader;
- developing a local network of clinicians with expertise in dual diagnosis who will be located in teams and inpatient settings with high levels of comorbidity. They would provide support and supervision to each other and act as a resource for the settings in which they work. The lead clinicians and networks must be linked to senior management and mechanisms must be in place for reviewing workloads and negotiating competing priorities.

4.1.2.3 Some possible models are illustrated by the good practice service cameos in boxes D, E, F, and G. These models are not, of course, mutually exclusive, but the more focused teams may only be required in areas of high prevalence. Local agencies must together develop a local service model which delivers on the policy priorities set out in Section 2 above, but which takes account of local needs and circumstances. While the exact local service model cannot be specified precisely, box B contains a list of dos and don'ts from the literature and operational experience and box C a list of key questions which must be answered locally. The rest of this section is concerned with issues and tasks which must be dealt with locally in order to formulate and implement the service model.

Box B: Dos and Don'ts

Don'ts

- Serial models of care are likely to fail to deliver integrated care or efficiency
- Parallel models may also fail although a stepwise progression from a parallel to an integrated model may make sense for many services
- Isolated dual diagnosis specialists will become burned out or disconnected from wider knowledge and developments
- Pump-priming voluntary agencies to tackle the issue in isolation is likely to fail
- One off training interventions will have limited value
- Specialist teams focusing exclusively on their own case loads will not be able to support mental health or drug and alcohol services more widely

Dos

- Agree the local definition, care pathways and service model
- Provide supervision for all specialist staff whether they form part of a specialist team or not
- Adopt a planned and comprehensive approach to training, tiered according to training needs in different settings
- Support supervision and training with local networks of experts across the statutory and independent sector
- Ensure specialist teams and staff work on an outreach/consultancy model
- Ensure liaison with relevant generic agencies (e.g. primary care, homelessness organisations, prisons)

Box C: Questions to be answered locally

- How big is the client group, what are their needs and where are they located, based on existing knowledge?
- What mental health and substance misuse services are currently available?
- What are the local staffing and training needs?
- What is the relevance of geography, demography and local substance misuse patterns?
- What are the goals of the service?
- How will the service model be formulated and implemented?
- How will the service respond to the needs of women, offenders, people from ethnic minorities, young people and homeless people?
- How will commissioning be coordinated?
- What are the elements of the local training strategy?
- What is the availability of housing for the client group and how can housing agencies be engaged?
- How can primary care, DATs, LITs and the independent sector contribute and be involved?
- How will clinical support and supervision be provided to dual diagnosis workers wherever they are located
- What cultural shifts are needed locally and how will they be achieved?
- What are the managerial and infrastructure issues?

4.2 Data collection and needs assessment

4.2.1 Agencies are not encouraged to carry out lengthy exercises to establish local prevalence. The process is fraught with problems of definition and many agencies do not currently monitor dual diagnosis at all. It is recommended for the present that local services proceed on the basis of perceived need, having taken soundings as widely as possible, and agree improved data collection methods with partner organisations for future needs assessment. DATs and LITs are an important resource in both respects. Equally important for any future needs assessment are the views of frontline staff regarding difficulties and gaps in services, and the experiences and preferences of service users and their carers. Substance misuse services will be able to provide information on patterns of substance misuse within the local community.

4.2.2 There are large gaps in current services, and particularly in continuing support for clients. More specifically, service users nationally identify the following gaps:

- access to mental health services and advice in informal settings (e.g. day support services, drop ins);
- access to specialist services, especially psychiatric services, within general day support services;
- longer stay residential services;
- day support – both dry and those that can tolerate substance use – available 7 days a week;

- someone to talk to;
- housing support;
- residential rehabilitation places which will accept people with dual diagnosis.

It will be important to talk to service users locally to see whether there are specific local gaps which need to be addressed.

Box D: The Kingston CDAT Dual Diagnosis Service

The Kingston Community Drug and Alcohol Team (KCDAT) launched their dual diagnosis model of joint working with mental health services in 1998. It represents a local attempt to respond to the growing gap between substance misuse services and mental health services.

Aim of the model: To provide a set of interventions from mental health and substance misuse services concurrently in a flexible but coordinated way in the spirit of joint working to engage, stabilise and treat people with dual diagnosis.

The definition: A dual diagnosis client is defined as an individual with concurrent needs arising out of their mental disorder(s) and their substance misuse, past or present. People with personality disorder or who are currently sober or drug free but who are at high risk of relapsing may be included.

The model: Each CMHT, rehabilitation service and assertive outreach team has identified a CDAT link clinician. The main tasks of the link person are:

- to respond to all requests for joint assessments of dual diagnosis clients either in the community or hospital
- to attend allocations meetings, identify cases requiring joint assessment, advise mental health services on treatment strategies, feedback on jointly worked cases and discuss CDAT cases requiring mental health support
- to attend other relevant meetings such as CPA meetings.

Intervention philosophy: CDAT is proactive in outreaching to clients in partnership with mental health. It has moved away from a traditional “no motivation – no service” model. There is a four stage approach:

- assessment, including risk assessment
- education
- harm reduction
- abstinence and relapse prevention.

Agreement: There is a written protocol between the two services covering:

- definition
- the model
- basic principles
- interventions
- referrals
- joint assessments
- allocation
- joint working
- closure
- disagreements
- resources
- clients on acute wards and in residential units
- evaluation.

Box E

The Haringey Dual Diagnosis service is a **newly funded, consultant led multi- disciplinary service, which functions along a model of addiction liaison into mental health**. The service offers **tiered interventions** based on a comprehensive assessment including

- re-evaluation of mental health symptoms in the light of addictive behaviour;
- short term interventions focused around harm minimisation;
- longer term work along the lines of assertive outreach but addressing substance misuse issues.

The service is also able to offer psychiatric style liaison into addiction services and **to facilitate the movement of patients** between addiction services and mental health services together with the **sharing of information and expertise across these boundaries and developing training for both groups of staff**. The service does not “take over from mental health” but **works in collaboration** with other professionals. The service is focused on people with severe mental health problems and substance misuse issues. Patients with personality disorder are not excluded as long as they are in contact with mental health services.

Box F: The COMPASS Programme

The COMPASS Programme began developing in 1998. It represents an “integrated shared care” approach to meet the unmet needs of those with severe mental health problems who use alcohol and drugs problematically within Northern Birmingham Mental Health NHS Trust. The service model aims to achieve integration of treatment both at the clinical and service level. The main focus of the COMPASS Programme is to train and support staff within mental health settings, particularly assertive outreach teams, to deliver integrated treatment. Where more specialist input is required this is achieved via shared care agreements and protocols between mental health and substance misuse services. The COMPASS Programme team is thus a specialist multidisciplinary team that trains and supports existing mental health and substance misuse services to provide integrated treatment. Clients with mental health problems remain engaged with and case managed by mental health services, and if necessary care is shared with substance misuse services.

The team consists of six multidisciplinary staff involved in a number of activities:

- Training for assertive outreach staff in the delivery of a manualised integrated treatment approach (Cognitive-Behavioural Integrated Treatment), followed by on-going regular weekly support and joint-working to aid the delivery of the intervention from the COMPASS Programme team.
- Provision of specialist assessments and a brief motivational enhancement intervention in conjunction with case managers/inpatient staff in mental health and substance misuse services.
- A rolling two -level training programme for primary care mental health and inpatient staff addressing basic awareness issues and training in screening/detection and delivery of a brief motivational enhancement intervention.
- Improving links and pathways of care between mental health and substance misuse services.
- Systematic research evaluation of the effectiveness of the integrated treatment approach.

Box G: The Mid Cheshire Dual Diagnosis Team

A specialist Dual Diagnosis Team was established in July 1999. The Team operates within the structure of the Substance Misuse Service, based in the Mental Health Directorate.

The Team

The Team comprises of two specialist nurses and one approved social worker, and is managed by a clinical co-ordinator. There is sessional input from a consultant psychiatrist with a special interest in substance misuse.

The locality

The Mid-Cheshire area is a large mixed rural and urban area comprising 600 sq. miles with a population of around 270,000. Mental health services are based within three localities across the district, with a CMHT in each local.

Target group

The client groups targeted are those with a severe and enduring mental illness that are misusing substances. As the service has developed, a 'tiered' approach has been adopted, and the team also provides specialist input to clients with less severe mental health problems and/or personality disorder who misuse substances. This work is carried out in collaboration with colleagues within the CMHT and/or drug and alcohol services using a 'shared care' model.

Model of Intervention

The team has developed within an assertive outreach framework, as many clients do not respond to more traditional treatments. A flexible, client-centred model is the focus of intervention. Following screening, a specialist assessment is undertaken, which may, given the nature of the client group, take an extended period of time to complete. This is especially evident with difficult to engage clients in order to fully assess their complex needs. A number of validated tools are used, the assessment and management of risk is considered a central and critical factor in this process.

Collaboration with a wide range of agencies is vital to the overall process, and ultimately the successful intervention and outcomes for service users.

Training and Consultancy

The team has a strong commitment to the training and development of multiprofessional colleagues who practice within acute and community mental health services. Research suggests that there is a growing need to address the issues of substance misuse within a mental health setting. A dual diagnosis training strategy is being developed to support all staff within the Mental Health Unit. This is being developed as part of a research study, which is due for completion January 2002. Team members also provide advice, information and supervision to staff within generic services in order to raise awareness and challenge stereotypical perceptions that sometimes become apparent in respect of substance misuse in general.

Liaison

The team has recently established a nurse liaison post from the in-patient mental health service. The post is part-time but provides rich training and development experience that can be further developed within the in-patient unit, and cross fertilisation of information and knowledge can be shared with colleagues.

4.3 Developing local service plans

The local service plan must be based around the needs assessment. A possible process for developing a service plan might be as follows:

- set up a local project team. This needs to be small and focused. It must contain a lead commissioner, provider manager, clinical representative from mental health services and drug and alcohol services (one of whom is a lead clinician), and representatives from the LIT and the DAT. However, one person may fulfil more than one of these roles so the group need number only 4 to 6 people. The team will need administrative support to write documents, set up meetings etc. This team will be accountable for delivering the plan and for leading on implementation. It will be time limited and will cease to exist when certain implementation milestones are reached. It will report to the LIT;
- bring together the required planning information. This will include the needs assessment, a map of current services, information about national policy, relevant statements of local policy (e.g. the HImP), and an assessment of current gaps in services (both quality and quantity);
- this document could then form the basis of a stakeholder meeting to discuss the way forward, based on initial questions formulated by the project team. A list of possible stakeholders for dual diagnosis services forms Box H. There is a balance to be found in such meetings between keeping the meeting to a reasonable size and ensuring that all possible stakeholders are present. Box H suggests the division of stakeholders into core stakeholders who must own the strategy and those with an interest who need to be informed and involved as far as possible. Who is in what group or what meetings must however be decided locally;
- formulating the basic strategy. This will need to be very simple and might consist of say three points – examples might be
 - construct agreed local care pathways by a certain date;
 - train all assertive outreach staff in substance misuse by a certain date;
 - producing information for users and carers including an easily comprehensible guide to services.

The strategy should emerge from the planning information and stakeholder group. All strategies will have to include the agreed local definition of dual diagnosis and other necessary agreed documentation;

- operationalising the strategy by producing a short written plan identifying the philosophy and values of the service, service goals and concrete steps to be taken to deliver the strategy. This will also need to address the issues covered in the rest of this Section. The plan must be produced by the project team which will feed back the draft to the wider stakeholder audience. Box I contains a check list of the key points which will need to be agreed across the relevant agencies. Annexed to the plan should be a map of services;
- getting the strategy signed off by the relevant agencies/boards.

Box H: Stakeholders in dual diagnosis services

Core

Users/clients
Carers
Strategic Health Authorities
Primary Care Trusts
NHS Trusts providing mental health or substance misuse services
Independent sector
Social services
Clinicians (includes GPs) and clinician's groups
DATs
LITs
Addiction/drug and alcohol teams
Prisons
Support services for vulnerable people

Those with an interest

Housing authorities
Housing providers
The Benefits Agency
Police
Probation services
Employment services
Local politicians and community leaders
The local media
Educational institutions

Box I: Issues to be covered by inter-agency protocols

- what each agency does and can offer for the client group
- common assessment tools and procedures
- agreed care pathways, including referral arrangements, assessments, service provision and arrangements for discharge from hospital or prison
- confidentiality/data sharing
- standardised data collection
- discharge arrangements for all services
- joint training plans
- risk assessment.

4.4 Service goals and definition of dual diagnosis

The first step in defining and implementing the local service model is to set service goals. The service goals state simply what the service is trying to achieve in terms of therapy and of relationship with other services. This could cover:

- what the service will offer clients
- care pathways
- therapeutic goals
- what the service offers other agencies.

Related to this, a short focused definition of dual diagnosis is required. There is no reason why a pragmatic approach should not be adopted if this can be agreed by the partner agencies. An example of the approach used by the specialist dual diagnosis team in Haringey forms box J.

Box J: Definition of Dual Diagnosis for Assessment by the Dual Diagnosis Team in Haringey

If referred by mental health services, a diagnosis of mental illness presumed to be of a severe and enduring nature which will bring the patient into contact with statutory mental health services in the borough, and the suspicion of a substance misuse problem. The substance misuse may include problematic use of drugs or alcohol, it may include over-the-counter medications, and it may include prescribed medications.

If coming from a substance misuse service we would expect a clear diagnosis/description of substance misuse problems and some information about the mental health difficulties that have been perceived.

4.5 Care Pathways

4.5.1 The care pathways for dual diagnosis clients – or care coordination protocols – will follow on naturally from the agreed definition. The production of these pathways should be taken forward by the project team and probably led by the local lead clinician. Once a draft has been formulated the protocol can be consulted on with the wider stakeholder group. The protocol should then be linked in and disseminated through the wider activities of the relevant agencies including clinical governance frameworks, training programmes and local information and dissemination strategies.

4.5.2 It will be important that the care pathway addresses the key role and contribution of each of the local provider agencies concerned, which typically might include:

- specialist mental health provider
- drug and alcohol services (statutory and voluntary sector)
- primary care
- more generic organisations (e.g. homelessness and youth organisations)
- prisons.

It is important that all the main provider organisations are covered by the protocol, and involved in its development and dissemination/implementation. In order to be successful in doing this it will be important that each understands its own role and what it will get from the other agencies. This may best be approached in terms of understanding what morbidity/problems already have to be dealt with by each agency and how specialist services can best help more generic agencies. For example, primary care and voluntary organisations may find it easier to accept prioritisation by specialist services if they believe the most difficult clients will be dealt with effectively and if support and advice is available when required. Similar principles apply to relations between specialist dual diagnosis teams, drug and alcohol services and general mental health services. The care pathways developed need to reflect broader principles of joint working already developed as part of Health Improvement Plans and plans prepared by DATs and LITs.

- 4.5.3 In developing care pathways it is important not to assume that mental health issues are already being dealt with appropriately in specialist mental health services. Substance misuse issues can overlay and confuse diagnosis. Equally, mental health issues can confound diagnosis and treatment within drug and alcohol services. The work on care pathways needs to relate to clinical governance and to training strategies described below. Care pathways should flag up the need to review both diagnoses when dual diagnosis is suspected.

4.6 Addressing acute inpatient care

- 4.6.1 Illicit drug use is a widespread problem within acute in-patient units, including psychiatric intensive care units. The presence of significant numbers of individuals within these units with dual diagnoses presents a number of challenges to staff which need to be addressed as part of the implementation programme. In-patient staff have generally received little training in the area of dual diagnosis. The resultant lack of knowledge, coupled with the pressure upon the staff to maintain a drug free in-patient environment, can lead to a lack of understanding and tolerance towards dually diagnosed patients. Individuals who have a dual diagnosis can be perceived as 'non-compliant', and responsible to some extent for their own ill health. Obviously this militates against effective therapeutic collaboration between staff and these individuals.
- 4.6.2 Patient focused strategies to prevent substance misuse can also militate against therapeutic collaboration. The withdrawal of leave and confinement to the ward is stressful for patients, and the resulting boredom and frustration may make substance misuse more attractive. The use of contracts with patients, where discharge from the ward, is presented as a sanction in the instance of substance misuse can also be counter productive, resulting in patients perceiving staff as being unaware of their concerns and difficulties. If discharge is used as a sanction, this can result in the withdrawal of services from needy and vulnerable individuals. Often discharge is found to be an empty threat, as the statutory frameworks prevent the unplanned discharge of patients with complex needs.
- 4.6.3 In order to address these issues, a number of strategies are required. The knowledge and skills of staff in dealing with dual diagnosis should be enhanced through training. Staff require organisational support through the development of clear and comprehensive policies and procedures regarding positive risk taking, and illicit drug use with the in-patient unit and such frameworks must be based on the relevant DH guidance which will be issued in 2002. The policy framework should be supported by collaborative relationships with the police, housing department and local substance misuse services. Staff working with this client group require regular good quality clinical supervision.

4.7. Training strategy

- 4.7.1 The training strategy for any given area should be based on the training needs of staff in both the statutory and independent sector. The training needs of staff will vary according to which part of the service they work in. For example, staff working in assertive outreach teams will require intensive training on the assessment, engagement and management of individuals with a dual diagnosis, whereas training for in-patient staff may focus on the detection and assessment of substance misuse with less emphasis on longer term treatment options.
- 4.7.2 Training should be available to all staff who routinely come into contact with people with a dual diagnosis including those working in community mental health teams, inpatient services, assertive outreach teams, early intervention teams, crisis resolution teams, primary care, mental health services for older people, independent mental health projects, accommodation services, day care services, statutory drug and alcohol services and independent drug and alcohol service providers. Training must include medical as well as nursing, social work, psychology, occupational therapy and non-professionally qualified staff. Considerable effort may be required in some services to ensure all professional groups are involved with the training strategy and key representatives of each profession need to be involved with strategy development. Failure to access medical staff in particular to the training will fundamentally weaken its impact.
- 4.7.3 Training should incorporate three main strands: interagency collaboration and information exchange through interagency training, theoretical and skills based training and practice development and supervision. These three strands should form different levels of the integrated training strategy and will be detailed below.

Interagency training should provide the foundation of the training strategy and the aim should be to foster closer working alliances between teams, services, prisons and all agencies, whether statutory or independent sector, for mental health and substance misuse. Inter-agency training should provide a forum for representatives from each service to come together to discuss current working practice with respect to dual diagnosis, share information about their capacity to work with this client group and come to a consensus on local working definitions around dual diagnosis. The Interagency training agenda should seek to meet the following training needs

- Raise awareness of mental health issues and therapeutic responses
- Raise awareness of drugs related issues and therapeutic responses
- Raise awareness of the relationship between substance misuse and mental health problems
- Challenge negative attitudes and prejudices around both mental health problems and substance misuse
- Increase staff confidence and reduce fear and anxiety in relation to working with people with complex needs
- Joint/ shared training on assessment and referral
- Knowledge of other relevant services and referral criteria
- Cross cultural and gender issues
- Accessing users views
- Scope and limitations of compulsory powers under mental health legislation.

Educational resource

Video: 'Pillar to Post'

'Pillar to post' features people with a dual diagnosis and a range of experts who describe the difficulties faced both by services and service users. A model of good practice is presented, which shows how by working flexibly and with the service user's agenda, progress can be made with people who once felt they had been written off by services.

'Pillar to Post' has been produced by Mind in Croydon and can be purchased through their web site www.mindincroydon.org.uk

Theoretical and skills based training should be informed by a simple training audit of the needs of each team or part of the service with respect to dual diagnosis. Training should be tailored to meet the individual needs of each part of the service and whilst certain features will be core business, care should be taken to ensure that the training can remain reflexive, where possible using case discussion or debate that is relevant to the teams' working practice. Training will need to adopt a two tiered approach as individuals working within mental health services will by definition need a higher emphasis on training around substance misuse and vice versa for individuals working in substance misuse services. However, it should not be assumed that those services would not benefit from some top-up training around their core business, particularly in relating it to dual diagnosis, as individual levels of knowledge may be variable within teams. Where possible whole teams should be trained together to ensure a cohesive approach is adopted and that team members share an understanding of the theoretical basis of the approach so that they can support each other in their daily work. The following represent core training needs for those working with individuals with dual diagnosis:

- Knowledge of dual diagnosis
- Drug and alcohol awareness
- Assessment skills for substance misuse
- Assessment skills for mental health problems
- Risk assessment and management
- Knowledge of the management of substance misuse problems
- Knowledge of the management of mental health problems
- Engagement skills
- Care Co-ordination
- Motivational enhancement strategies including Motivational Interviewing
- Relapse Prevention for substance misuse
- Early warning sign monitoring and relapse prevention for mental health problems.
- Mental health legislation

However, the evidence base on effective interventions is developing all the time, and services will need to remain alert to the need for further training in the light of new research.

Practice development and supervision will form the final point of the training triad. Staff will need to be supported in the implementation of the practices gleaned from the training. Ongoing supervision is crucial to ensure that new ideas are embedded in daily work and that staff feel supported in their practice. In areas where specialist dual diagnosis services exist, supervision can be provided by these services to the generic services. Where such specialist services do not exist, peer support networks are crucial to ensure individuals do not feel overwhelmed and de-skilled in the face of changing or bolstering their practice. Peer supervision networks should be set up during the training sessions and must be supported at management levels by ensuring that time is allocated for reflection on practice. Information regarding barriers to practice should be collected from individuals/ peer supervision groups and fed back in to the service planning groups around dual diagnosis.

- 4.7.4 The turnover in both mental health services and substance misuse services is high so it is important that any training initiative forms part of an on-going rolling programme. The aim of this is to ensure that new staff recruited into the service have access to the same basic training as their colleagues at both the multi-agency level and the theoretical and skills based levels.
- 4.7.5 Services should endeavour to use in house training capacity whenever possible. Specialist substance misuse staff can contribute to the training of mental health staff and vice versa. This will ensure that trainers have local knowledge about the services that will serve clients with a dual diagnosis and will help to form personal links between the services. A specified staff member will be needed to take on the co-ordination role for the training programme to ensure high quality and that equity of access is maintained. Placements and secondments to other services, or exchanges across mental health and substance misuse services may also be of great value.
- 4.7.6 The new Workforce Development Confederations will have a key role and responsibility for the development of the existing and future workforce in the delivery of effective practice in dual diagnosis. This requires an integrated approach, across health and social care as well as hospital and community boundaries, in examining the skills and competence required of the multidisciplinary workforce. The recently published Sainsbury Centre for Mental Health document 'The Capable Practitioner', commissioned by the DH Workforce Action Team, provides a framework of the knowledge, attitudes and skills required of the workforce to implement the NSF and the NHS Plan. This Framework can provide a basis for examining local training need against national policy priorities.
- 4.7.7 In conjunction with the assessment of local need for training in effective dual diagnosis approaches, development of strategic partnerships with education providers is necessary to improve responsiveness of education programmes to this neglected area of need. One of the key challenges for education providers is how to access the very limited pool of expertise available nationally in the design and delivery of dual diagnosis educational programmes. The Confederations have a vital role here in making resources available to facilitate the strategic links between local learning and education facilities, regional development centres and national organisations with expertise in this area.
- 4.7.8 If training on the scale that is required nationally is to be achieved, then it is crucial that the Confederations are engaged with investing in developing greater training opportunities for the existing mental health practitioner workforce. This should also extend to working with both professional bodies and the higher education institutions to examine ways that the graduates of the future can also be equipped for practice in this area.

4.8 Commissioning

- 4.8.1 It is likely that the skills and knowledge to develop better dual diagnosis services will lie mainly with local providers (i.e. NHS Trusts, social services and the independent/voluntary sector). It will be crucial that local commissioners draw on this expertise and commitment to deliver service improvement. A critical first stage will be to identify a lead commissioner (i.e. usually a single person) who could be located within a PCT, Strategic Health Authority or Social Services Authority. It may not always make sense for each PCT to commission dual diagnosis services individually, so some sort of agreement about lead PCTs, pooling or an SHA lead may be required. It might be helpful to use Health Act flexibilities to appoint a lead commissioner, create a pooled budget, or to give specific responsibility for dual diagnosis work to an existing joint commissioning board, and these sorts of options – designed to give clarity and accountability – should be considered locally.
- 4.8.2 Once designated, the role of a lead commissioner might vary according to the level of local commitment and development by providers. If necessary however, he or she should be able to participate in or coordinate the planning process described above, whilst drawing on the expertise locally which is required. The key task will be to use the local plan described above as a basis for joint commissioning across the Strategic Health Authority/PCT(s) and DAT. This lead commissioner must be part of the project team which carries the work forward from the outset.

Key points

- the development of comprehensive services for this client group is a priority
- integrated care appears to confer superior outcomes over serial or parallel treatment although further well designed research is required
- integrated treatment in the UK can be delivered by existing mental health services following training and with close liaison and support from substance misuse services
- the choice of approach should be informed by local factors with input from all major stakeholders and must deliver the policy priorities set out in Section 2
- all mental health provider agencies must designate a lead clinician for dual diagnosis issues
- all health and social care economies must set up a project team to lead work on implementing this guide and must designate a lead commissioner
- the team must produce and agree a local focused definition, care pathways and other required protocols/agreements
- a two tiered training strategy delivering basic training across all staff in relevant services and advanced training and supervision to particular staff must be formulated and implemented

References

Section 1: Background

- Appleby, L. (2000) Safer services: conclusions from the report of the National Confidential Inquiry. *Advances in Psychiatric Treatment* **6** 5-15
- Baker, S. (1999) *Dual Diagnosis: A report on eight mapping projects*. London: Alcohol Concern
- Banerjee, S., Clancy, C. and Crome, I. (eds) (2001) *Co-existing problems of mental disorder and substance misuse: an information manual*. London: Royal College of Psychiatrists Research Unit: Report to the Department of Health 2001.
- Crawford, V. (2001) *Co-existing Problems of Mental Health and Substance Misuse ('Dual Diagnosis'): A Review of Relevant Literature*. London: Royal College of Psychiatrists
- Duke, P., Pantelis, C., McPhillips, M. and Barnes, T. (2001) Comorbid non-alcohol substance misuse among people with schizophrenia: Epidemiological study in central London. *British Journal of Psychiatry* **179** 509-513
- Farrell, M., Howes, S., Bebbington, P. et al (2001) Nicotine, alcohol and drug dependence and psychiatric comorbidity. *British Journal of Psychiatry* **179** 432-437
- Farrell, M., Howes, S., Taylor, C., et al (1998) Substance misuse and psychiatric co-morbidity: An overview of the OPCS national psychiatric morbidity survey. *Addictive Behaviours* **23** 909-918
- Menezes, P., Johnson, S., Thornicroft, G. et al (1996) Drug and alcohol problems among individuals with severe mental illnesses in South London. *British Journal of Psychiatry* **168** 612-619
- Mental Health Foundation (1999) *The fundamental facts: all the latest facts and figures on mental illness*. London: Mental Health Foundation
- Mueser, K., Bennett, M., Kushner, M. (1995) Epidemiology of substance use disorders among persons with chronic mental illness. In: Lehman, A. and Dixon, L. (eds.) *Double Jeopardy: Chronic mental illness and substance use disorders*. Chur, Switzerland: Harwood Academic
- Phillips, P. and Johnson, S. (2001) How does drug and alcohol misuse develop among people with a psychotic illness? A literature review. *Social Psychiatry and Psychiatric Epidemiology* **36** 269-276
- Regier, D., Farmer, M., Rae, D. et al (1990) Comorbidity of mental disorders with alcohol and other drug use. *Journal of the American Medical Association*. **264** 2511-2518
- Scott, H., Johnson, S., Menezes, P., et al (1998) Substance misuse and risk of aggression and offending among the severely mentally ill. *British Journal of Psychiatry* **172** 345-350
- Ward, M. and Applin, C. (1998) *The Unlearned Lesson*. London: Wynne Howard Books

Weaver, T. (1999) *Dual Diagnosis: The Co-Morbidity of Psychotic Mental Illness and Substance Misuse. Executive Summary No. 63*: Centre for Research on Drugs and Health Behaviour, Imperial College, London

Weaver, T., Rutter, D., Maden, P., Ward, J., Stimson, G. and Renton, A. (2001) results of a screening survey for co-morbid substance misuse amongst patients in treatment for psychotic disorders: prevalence and service needs in an inner London borough. *Social Psychiatry and Psychiatric Epidemiology* **36** 399-406

Wright, S., Gournay, K., Glorney, E. and Thornicroft, G. (2000) Dual diagnosis in the suburbs: prevalence, need and in-patient service use. *Social Psychiatry and Psychiatric Epidemiology* **35** 297-304

Section 2: Policy

Abdulrahim, D., Annan, J., Cyster, R. et al (2001) *Developing an Integrated Model of Care for Drug Treatment: Promoting Quality, Efficiency and Effectiveness in Drug Misuse Treatment Services*. London: DoH, National Treatment Agency (forthcoming)

Anon (2002) *Assessment and Management of Risk of Harm in Dual Diagnosis Clients*. London: Alcohol Concern and Drugscope (*in press*)

Anon (2000) *Drug Misuse and Mental Health: Learning Lessons on Dual Diagnosis*. Report of the All-Party Parliamentary Drug Misuse Group.

Department of Health (2001) *The Mental Health Policy Implementation Guide*. London: DH

Department of Health (2001) *Shifting the balance of power within the NHS*. London: DH

Department of Health (1999) *Drug Misuse and Dependence: Guidelines on Clinical Management*. London: The Stationery Office

Department of Health (1999) *The National Service Framework for Mental Health*. London: DH

Department of Health (2000) *Reforming the Mental Health Act*. London: DH

Tackling Drugs to Build a Better Britain: the Government's 10-year Strategy for Tackling Drug Misuse. London: HMSO, 1998

Health Advisory Service (2001) *Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis): Standards for Mental Health Services*. London: HAS

Section 3 Assessment and treatment approaches

Anon (2002) *Assessment and Management of Risk of Harm in Dual Diagnosis Clients*. London: Alcohol Concern and Drugscope (*in press*)

DH (2002) *Guidance in respect of substance misuse in mental health in-patient and day care settings*. London: DH (forthcoming)

Appleby, L. (2000) *Safer services: conclusions from the report of the National Confidential Inquiry*.

Advances in Psychiatric Treatment **6** 5-15

Appleby, K., Dyson, V., Altman, E. et al (1996) Utility of the chemical use, abuse and dependence scale in screening patients with severe mental illness. *Psychiatric Services* **47** 647-649

Bellack, A. and DiClemente, C. (1999) Treating substance abuse among patients with schizophrenia. *Psychiatric Services* **50** 75-80

Bulik, C., Prescott, C. and Kendler, K. (2001) Features of childhood sexual abuse and the development of psychiatric and substance use disorders. *British Journal of Psychiatry* **179** 444-449

Carey, K. (1995) Treatment of Substance Use Disorders and Schizophrenia. In Lehman, A. and Dixon, L. (eds.) *Double Jeopardy: Chronic mental illness and substance use disorders*. Chur, Switzerland: Harwood Academic

Crawford, V. (2001) *Co-existing Problems of Mental Health and Substance Misuse ('Dual Diagnosis'): A Review of Relevant Literature*. London: Royal College of Psychiatrists

Crome, I (1997) Gender differences in substance misuse and psychiatric co-morbidity. *Current Opinion in Psychiatry* **10** 194-198

Crome, I. (1999) Substance misuse and psychiatric co-morbidity: towards improved service provision. *Drugs: Education, Prevention and Policy* **6** 151-174

Department of Health (1999) *Drug Misuse and Dependence – Guidelines on Clinical Management*. London: The Stationery Office

Drake, R. and Mercer-McFadden, C. (1995) Assessment of substance use among persons with chronic mental illnesses. In Lehman, A. and Dixon, L. (eds.) *Double Jeopardy: Chronic mental illness and substance use disorders*. Chur, Switzerland: Harwood Academic

Hasin, D., Trautman, K., Miele, G. et al (1996) Psychiatric Research Interview for Substance and Mental Disorders (PRISM): Reliability for Substance Abusers. *American Journal of Psychiatry* **153** 1195-1201

Health Advisory Service (2001) *Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis): Standards for Mental Health Services*. London: HAS

Maisto, S., Carey, M., Carey, K. et al (2000) Use of the AUDIT and the DAST-10 to identify alcohol and drug use disorders among adults with a severe and persistent mental illness. *Psychological Assessment* **12** 186-192

Marsden, J., Gossop, M., Stewart, D. et al (1997) The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome. *Addiction* **93** 1857-1868

Marlatt, G. and Gordon, J. (1985) *Relapse prevention: maintenance strategies in the treatment of addictive disorders*. New York: Guilford Press

Miller, W. and Rollnick, S. (1991) *Motivational Interviewing: Preparing people to change addictive behaviour*. New York: Guilford Press

Osher, F. and Kofoed, L. (1989) Treatment for patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry* **40** 1025-1030

Raistrick, D. and Heather, N. (1998) *Review of the Effectiveness of Treatment for Alcohol Problems*. Unpublished report for the DH

Rosenberg, S., Drake, R., Wolford, G. et al (1998) Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness. *American Journal of Psychiatry* **155** 232-238

Ryrie, I. (2000) Coexistent substance use and psychiatric disorders. In: Gamble, C. and Brennan, G. (eds.) *Working with Serious Mental Illness: A manual for clinical practice*. London: Bailliere Tindall

Scott, H., Johnson, S., Menezes, P., et al (1998) Substance misuse and risk of aggression and offending among the severely mentally ill. *British Journal of Psychiatry* **172** 345-350

Swanson, A., Pantalon, M. and Cohen, K. (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. *Journal of Nervous and Mental Disease* **187** 630-635

Westermeyer, J. (1995) Ethnic and Cultural Factors in Dual Diagnosis. In Lehman, A. and Dixon, L. (eds.) *Double Jeopardy: Chronic mental illness and substance use disorders*. Chur, Switzerland: Harwood Academic

Section 4 Implementation

Anon (2000) *Drug Misuse and Mental Health: Learning Lessons on Dual Diagnosis*. Report of the All-Party Parliamentary Drug Misuse Group.

Baker, S. (1999) *Dual Diagnosis: A report on eight mapping projects*. London: Alcohol Concern

Drake, R., Essock, S., Shaner, A. et al (2001) Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services* **2** 469-76

Drake, R. and Noordsy, F. (1994) Management for people with coexisting severe mental disorder and substance use disorder. *Psychiatric Annals* **24** 427-431

Health Advisory Service (2001) *Substance Misuse and Mental Health Co-Morbidity (Dual Diagnosis): Standards for Mental Health Services*. London: HAS

Johnson, S. (1997) Diagnosis of severe mental illness and substance misuse: a case for specialist services? *British Journal of Psychiatry* **197** 171 205-208

Scott, H., Sathymoorthy, G., Minghella, E. et al (2000) *Evaluation of Services Funded by the Department of Health, Drugs and Alcohol Specific Grant Programme*. London: Sainsbury Centre for Mental Health

Appendix: Membership of Dual Diagnosis Steering Group

The preparation of this guidance was commissioned from the Sainsbury Centre for Mental Health in partnership with Alcohol Concern and Dr. Alison Lowe of Barnet, Enfield and Haringey Mental Health Trust. The work was led by Dr. Andrew McCulloch.

The Dual Diagnosis Steering Group has overseen the development of this guidance, contributing comments on drafts and advice on examples of good practice. The membership of this group is listed below:

Sue Baker

Jenny Bywaters (Chair)

Ilana Crome

Richard Ford

Jood Gibbins

Anne Gorry

Kevin Gournay

Hermine Graham

Angela Greatley

Graeme Kerr

Cheryl Kipping

Don Lavoie

Cath Moran

Paul O'Halloran

Mary Piper

Mark Prunty

Malcolm Rae

Carolyn Steele

Phil Willan



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