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# Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem

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# CONTENTS

<b>PART 1: INTRODUCTION AND BACKGROUND</b> .....	4
<b>INTRODUCTION</b> .....	4
1.1 Purpose and Aims .....	4
1.2 Definitions.....	5
1.3 Strategic and Policy Context .....	6
<b>2. RATIONALE FOR ACTION</b> .....	7
<b>3. BACKGROUND</b> .....	8
3.1 Revisions to the Service Framework .....	8
3.2 Application of the Framework.....	9
3.3 Prudent Health and Social Care.....	10
<b>OVERARCHING PRINCIPLES OF THIS FRAMEWORK</b> .....	11
4.1 Holistic and Person Centred Care .....	11
4.2 Effective communication between Services, Service Users and their Families.....	12
4.3 Ensuring a Competent and Well Trained Workforce.....	13
4.4 Unambiguous Clinical Responsibility .....	13
<b>5. REQUIREMENTS</b> .....	15
5.1 Requirement 1 - Prevention and Early Intervention .....	15
5.2 Requirement 2 - A Competent and Well-trained Workforce .....	15
5.3 Requirement 3 - Ensuring Effective Clinical Leadership.....	16
5.4 Requirement 4 - Monitoring and Measuring Performance.....	17
5.5 Requirement 5 - Corporate Governance and Accountability .....	18
5.5.1 Responding to serious and untoward incidents (SUIs) .....	19
5.5.2 Safeguarding.....	19
5.6 Additional Service Aims .....	19
5.7 Meeting the needs of People with Protected Characteristics .....	20
5.7.1 Children and Young People.....	20
5.7.2 Expectant mothers .....	21
5.7.3 Over 50s.....	21
5.7.4 Carers and families .....	21
5.7.5 Prisoners' mental health .....	22
5.7.6 People with alcohol related brain damage (ARBD) .....	22
5.7.7 Veterans (former members of HM Armed Forces) .....	23

5.8 Welsh Language.....	23
5.9 Resolving professional differences of opinion.....	23
<b>APPENDICES</b> .....	<b>25</b>
<b>Appendix 1</b> .....	<b>25</b>
Key Definitions .....	25
<b>Appendix 2</b> .....	<b>27</b>
Together for Mental Health and Working Together to Reduce Harm: Mental Health and Substance Misuse Delivery Plans .....	27
<b>Appendix 3</b> .....	<b>30</b>
Substance Misuse and Mental health helplines .....	30
<b>Appendix 4</b> .....	<b>31</b>
Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) .....	31
<b>Appendix 5</b> .....	<b>32</b>
Case Studies .....	32
<b>Appendix 6</b> .....	<b>35</b>
Glossary.....	35
<b>Appendix 7</b> .....	<b>36</b>
References .....	36

# PART 1: INTRODUCTION AND BACKGROUND

## INTRODUCTION

### 1.1 Purpose and Aims

The framework is designed to inform and influence the delivery of integrated and collaborative practice in the delivery of mental health and substance misuse services for adults, children and young people. Responsibility for ensuring its implementation lies with managers, commissioners, planners and clinical leaders in health, social services, education and third sector services.

To fully realise the intent of this framework will require partnership arrangements across a broad range of services including housing and homelessness services and criminal justice agencies. Oversight and assurance will be provided by Substance Misuse Area Planning Boards (APBs) and Health Boards (HBs) via their lead role in local mental health partnership boards (LMHPBs). The framework is also intended to inform people who use these services, their carers, families and friends. Delivery of this framework is a key outcome in both '*Together for Mental Health*' and '*Working Together to Reduce Harm*', the Welsh Government's mental health and substance misuse strategies. Part two of the framework has been drafted specifically for use by front line clinicians providing unambiguous guidance which allows staff to quickly identify their responsibilities and the action they need to take in response to the requirements of the framework.

The emphasis of the framework is on reiterating the approach required to drive effective delivery, rather than evidencing the need for a collaborative approach in itself. The approach required is based upon the following core principles:

- **Interventions are delivered in a timely manner**
- **Services deliver holistic, recovery focused care and treatment matched to the needs of the service user**
- **Services ensure effective communication both within and between agencies and with service users, through locally agreed care pathways and treatment protocols including clear arrangements for the transition of children and young people from CAMHS to adult services**
- **Services are accessible and appropriate to the population they serve addressing the needs of those whose first language is Welsh and the needs of people with protected characteristics**
- **Services integrate and operate within the principles of co-production and prudent health and social care**
- **Services have effective leadership and well established governance and accountability systems to audit the improvement in the delivery of dual diagnosis services**

- **Services ensure unambiguous clinical responsibility for the delivery of effective care and treatment.**
- **Services ensure a competent well trained and supervised workforce**
- **Services enable ease of access to appropriate services for people with dual diagnosis.**

The framework highlights the broader principles of coproduction and prudent health and social care to ensure that services are efficient, effective and empowering, do no harm and maximise the use of existing resources to provide the minimum level of intervention required. It also serves to reinforce a recovery approach in both mental health and substance misuse services. Whilst the document addresses the broad continuum of dual diagnosis a specific framework providing a separate work stream on ARBD is being taken forward which will address the various issues associated with ARBD in more depth.

The co-occurrence of a mental health problem with substance misuse problems (dual diagnosis), whether severe or moderate in severity, may cause individuals and their families' significant distress. It also impacts on their ability to lead a fully satisfying life. In the most extreme circumstances the co-occurrence of these problems may lead to increased mortality by suicide, accidental fatal overdose, sepsis or liver disease and, in a very small number of cases, can become a factor in a person committing serious crimes. It can also lead to safeguarding issues, and can be a significant cause of homelessness and roofless-ness.

The Welsh Government remains firmly committed to substantially improving the outcomes of those with a dual diagnosis through driving improvements in collaboration between services. This requires health services, social services, third sector and, where appropriate, justice agencies to work with service users and their families and carers to improve the outcomes achieved through service interventions.

This document supports health professionals to work collectively to address the needs of those with a co-occurring problem. For the purpose of this framework the term dual-diagnosis is used to describe those with a co-occurring mental health and substance misuse problem (for full definitions see Appendix 1).

## **1.2 Definitions**

### Dual Diagnosis

Dual Diagnosis is a term used to describe the co-existence of two or more diagnosed disorders. This can lead to a narrow interpretation of need, leading to gaps in provision. For the purposes of this framework a broader definition of Co-occurring mental health and substance misuse problems, whether or not of sufficient severity to be considered as a diagnosable disorder has been used. However, for the purposes of brevity the phrase "dual diagnosis" is used throughout the framework but with the meaning of the broader and more inclusive definition.

### Determining whether a person has a severe mental illness

Through this framework reference is made to mental health services having an unequivocal role as the lead agency where a person has a severe mental illness.

There is no universally agreed definition of what constitutes a severe mental illness and in any case the application of a definition may result in an arbitrary determination of an individual's needs. Clinical judgement must be applied through careful and thorough assessment in determining whether a person has a severe mental illness or not. Where consideration has been given to setting out the determining factors in what may constitute a severe mental illness the following have been frequently been addressed and should be considered within clinical assessment. The diagnosed disorder, the duration of the disorder, the social and health care needs resulting from the disorder, the risk to the health and safety of the patient and of other people and the disabling effects of the disorder.

It is important to note that for many people with a dual diagnosis the mental disorder may be a personality disorder with or without another co-morbid mental illness.

The diagnosis of personality disorder should not lead to exclusion from mental health services on the grounds of its treatability. In fact the presence of personality disorder with a coexisting substance misuse problem may well be an indication of a level of risk requiring careful care and treatment planning.

These factors included in Appendix 1

### **1.3 Strategic and Policy Context**

Substance misuse frequently impacts on the wellbeing of the population and this framework's vision is to contribute to wider outcomes set out in both *Together for Mental Health* and *Working Together to Reduce Harm*.

Ensuring that dual diagnosis is managed effectively are key actions within both the *Together for Mental Health* Delivery Plan (2012-2016) (action 11.3) and *Working Together to Reduce Harm: Substance Misuse Delivery Plan 2013-2015* (action 5.2).. These actions will remain and be strengthened within the new *Together for Mental Health* and *Substance Misuse Delivery Plans* which are scheduled to be published in late 2015, early 2016 respectively.

The Mental Health (Wales) Measure 2010 has expanded services available to those experiencing mental ill health by imposing additional statutory duties on health boards and local authorities. The Social Services and Wellbeing (Wales) Act 2014 has also introduced wellbeing duties on local authorities, health boards and their partners including seeking to ensure that people's care and support needs are met. These new legal duties serve to support implementation of the framework's intent. Further detailed information about the Mental Health (Wales) Measure and related policy and legislation is provided at Appendix 2.

## 2. RATIONALE FOR ACTION

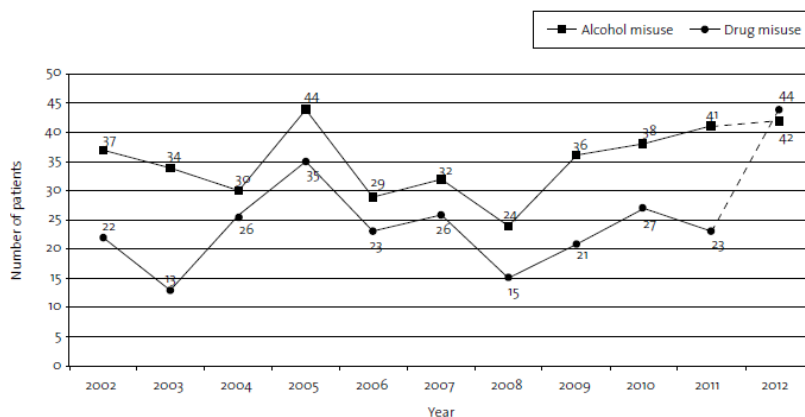
The prevalence of dual diagnosis and the implications it has for mortality, serves to highlight the importance of improving the coordination of services required to tackle these problems.

Data shows that:

- Up to three in four drug using clients have been reported as having mental health problems.
- More than half of people with substance misuse problems are also diagnosed with a mental disorder at some point in their lives.
- Alcohol is the most common substance misused.
- Where drug misuse occurs it often coexists with alcohol misuse.
- Approximately one third of people using mental health services in the UK, half of the people seen by substance misuse services, and 70% of prisoners will experience co-occurring mental health and substance misuse problems (Banerjee et al. 2002, Office of National Statistics (ONS), 1997). Compared to people with a mental health problem alone, those with a co-occurring substance misuse and mental health problem are;
  - likely to experience more severe mental health problems;
  - be at increased risk of suicide;
  - experience unstable housing
  - have financial difficulties
  - be less likely to engage with treatment interventions
  - more likely to fall through the gap between services (Banerjee, et al. 2002).

Dual diagnosis is a significant factor in terms of mortality. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (July 2014) identified that in Wales between 2001 and 2012 there were:

- 387 suicides in people known to services with a history of alcohol misuse, 48% of the total sample
- 275 patient suicides with a history of drug misuse, 34% of the total sample
- 460 patients who had a history of either alcohol or drug misuse or both, 56% of the total sample
- 119 patient suicides had severe mental illness and co-occurring alcohol or drug dependence/misuse (dual diagnosis), 15% of the total sample



**Fig 1 Patient suicide: number with a history of alcohol or drug misuse Wales 2001-2012 National Confidential Inquiry into Homicides and Suicides Annual Report 2014**

### 3. BACKGROUND

#### 3.1 Revisions to the Service Framework

This framework replaces the existing *Service Framework to Meet the Needs of People with a Co-occurring Mental Health and Substance Misuse Problem (2009)*. The context and treatment principles described in the original framework remain, for the most part, valid. The purpose in reissuing a revised framework is to encompass the key developments that have taken place since first publication and to drive consistent implementation across Wales.

It seeks to address the ineffective collaboration of the many services required to help people with a dual diagnosis. In 2010, Healthcare Inspectorate Wales (HIW) published a report "*Substance Misuse Services in Wales: Are they meeting the needs of service users and their families?*" which found that "the links between substance misuse services and mental health services were considered to be significantly under developed". A number of issues were cited as to why this is the case including:

- Unclear lines of accountability which resulted in a lack of responsibility for implementation.
- The concerns of both substance misuse and mental health services that joint working can result in one service shifting responsibility for service users onto the other.
- A lack of understanding about how service users with varying degrees of need should be treated and which agency would be expected to take the lead.
- Cultural assumptions surrounding both mental health and substance misuse service users, and the need to challenge those assumptions.

The original framework has therefore been revised to take account of:

- The implications of the *Mental Health (Wales) Measure 2010*.



- National criteria to be incorporated into jointly agreed local care pathways for each APB / LMHPB area.
- Lessons learned from case studies to illustrate how the framework is to be applied in a variety of situations.
- Training requirements.
- Clear lines of accountability and responsibility for implementing the framework.
- Prudent Healthcare principles
- Welsh Language needs of service users

### **3.2 Application of the Framework**

People with a dual diagnosis frequently have complex needs that require a co-ordinated approach from a range of primary and/or secondary care services, delivered in both statutory and non-statutory settings and where appropriate justice and housing agencies.

**This framework reiterates previously stated responsibilities, that adult mental health services should be the ‘lead’ service in cases where a service user has a severe mental illness.**

For people without a severe mental illness there should nevertheless be absolute clarity on which agency and individual is leading and co-ordinating their care. This should be discussed with, and fully understood by the service user and their family or carer (where appropriate). In these circumstances the lead agency will be determined by assessment and negotiation. The agency identified as the unequivocal lead shall inform the service user and other agencies of the role they have adopted.

Services are responsible for ensuring the seamless delivery of support to the service user. It must not be left to the service user to navigate between substance misuse, mental health and other related support services themselves. This principle is particularly important where service users are in transition between services, for example between Child and Adolescent Mental Health Services (CAMHS) and adult services and movement between criminal justice services into health and social care provision.

Whilst adult mental health, CAMHS and specialist substance misuse teams remain the key service providers, input from other providers such as housing, justice agencies and education are also important in delivering the comprehensive range of services required. In cases where the probation service is involved, Case Offender Managers may play a significant role in the formulation and of care plans and the delivery of interventions. Prison in reach mental health services and Counselling, Assessment, Referral, Advice and Through care (CARAT) services will need to address the provision of dual diagnosis interventions to prisoners and liaise with the relevant services on release. Without an integrated approach from the providers of the different service components, individuals with dual diagnosis are potentially at risk of falling between services or of receiving sub optimal support. This is of particular concern given that this client group is at increased risk of suicide and of causing harm to others including in a small number of cases homicide.

In order to deliver effective care, services have to be co-ordinated with clear treatment protocols and care pathways. This framework sets out guidance on the joint liaison/collaborative model of care that must be implemented by mental health and substance misuse services and the key criteria that all local care pathways must include. In developing care pathways services will ensure that prudent healthcare principles are applied using a stepped care approach, avoiding the duplication of services or unnecessary overlap in provision. The key worker and care coordinator role will also assist service users and their families to negotiate the pathway and where required enable access into services provided by the various agencies involved in delivering integrated mental health and substance misuse services.

**The importance of unambiguous clinical responsibility and access to appropriate services for people with dual diagnosis is crucial.** Staff working in adult mental health services and CAMHS must recognise that those with alcohol and drug problems may develop mental illnesses that require treatment. The implications of co-occurring problems on children who live in families with complex needs must be addressed. Partnership working with services such as the Integrated Family Support Service (IFSS) should be considered where indicated.

### **3.3 Prudent Health and Social Care**

Public services are required to deliver services that reflect the principles of prudent healthcare. In this context, these principles can be expressed as: delivering evidence based care, tailored to the specific needs of the individual; avoiding treatment where it may cause harm and is unlikely to benefit the service user or, is wasteful and maximising the use of resources by ensuring that the workforce is operating at the top of its competence. Therefore, where tasks can be delegated they should be, allowing senior clinical staff to deliver the interventions that only they have the competence to provide.

The framework fully embraces a co-production approach, ensuring that there is meaningful involvement of service users in the planning and delivery of services. Service users, and where appropriate their families, will be involved in establishing the outcomes to be achieved by the agreed interventions. Their care plan will ensure that a strengths based, recovery approach is used, recognising the resources that the service user and their family can contribute to its delivery.

The framework supports the delivery of efficient and effective evidence based care. Given the potential complexity of care and treatment that may be required in cases of dual diagnosis, services must ensure that there is no duplication of effort and that treatment is not avoided until a service user's condition has deteriorated to a point where intervention becomes essential and more expensive. Where treatment is delayed this frequently leads to a level of intervention in excess of that which would have been required had intervention been delivered in a timely manner.

This cultural shift is of relevance in work with people with dual diagnosis. The failure of services to work collaboratively with service users in the past has led to sub optimal care. This may be as a consequence of those in significant need being omitted from services due to the application of separate service criteria rather than a

criterion which recognises the associated risks and needs emanating from co-occurring conditions.

Alternatively services may engage separately with a person experiencing co-occurring problems leading to poor co-ordination of services and the potential for over provision. Prudent healthcare in this context requires the right service to intervene utilising the right practitioner at the right time and in the right way. Where more than one service is required to intervene this should be done collaboratively, making best use of resources, ensuring a proportionate response and avoiding duplication of effort and treatment. It is essential that people's physical health needs are addressed including their oral health in order to ensure the maximisation of health and social care services. For those people in specialist mental health services these needs should be addressed within the statutory care and treatment plan.

Involving service users and their carers (where appropriate) in determining the outcomes to be achieved from intervention and drawing upon their individual strengths and those present in their families and communities will further assist the delivery of effective and prudent care.

## **OVERARCHING PRINCIPLES OF THIS FRAMEWORK**

### **4.1 Holistic and Person Centred Care**

For people to receive the most effective and prudent treatment, holistic, person centred care and support must be core to their individual care plan. Where a person has an identified need for care and treatment from specialist mental health services this will be provided under Part 2 of the Mental Health (Wales) Measure 2010 using a statutory care and treatment plan. The plan will incorporate both interventions to address mental health problems and substance misuse problems and will ensure the seamless delivery of support to the service user. Where a person is not covered by the Mental Health (Wales) Measure 2010 other care plans (such as those in substance misuse services) should detail the outcomes agreed between the service user and those providing services. Regardless of whether a person is entitled to a care and treatment plan under Part 2 or not, their care, treatment and support should be matched to the assessed level of need and complexity. It should be holistic recognising the social aspects of service users' lives, such as accommodation, finances, relationships and social opportunities. It is crucial that these issues are assessed and that relevant statutory and third sector agencies are involved. Where practicable people should have their needs met within primary care. This may be for the duration of their treatment or, where there is a need for specialist intervention, upon referral back to primary care following treatment in specialist services, once the service user's condition has become stable. Specialist services should support the management of dual diagnosis in primary care.

Wherever possible services should be built around the individual's needs and recognition of their individual strengths and abilities. The service user must not be responsible for navigating substance misuse, mental health and other related support services. Providers must work with individuals to establish the goals they wish to achieve, help service users take responsibility for their contribution to

achieving these goals and discuss what options are available and what services and treatments can be provided.

Service users consistently report that the values and attitudes demonstrated by staff have a big impact on their experiences and can affect their outcome, this is recognised in one of the six Together for Mental Health high level outcomes: The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

It is important therefore that all staff providing support to people with mental health and substance misuse problems demonstrate empathy and understanding and treat service users with dignity and respect addressing the individual and where appropriate the protected characteristics of each individual. This should be embedded within any training that takes place and be evident in the culture within relevant organisations responsible for providing support.

#### **4.2 Effective communication between Services, Service Users and their Families**

For efficient care and treatment, it is vital agencies communicate effectively with each other and with service users and their families. This will involve, as a minimum:

- consultation between mental health and substance misuse services,
- the provision of high-quality assessment and referrals
- the provision of reports.
- proportionate joint care and treatment planning where necessary
- in more complex cases shared care arrangements between services, in consultation with the service user and where appropriate their family or informal carers.

Joint working may include the involvement of Probation Service Case Offender Managers, housing and homeless workers and third sector services. In planning and delivering care practitioners must ensure they fulfil their responsibility to share concerns where risks exist to the individual, their family or the wider public. There will be occasions when the requirements of individual safety or the safety of others makes the use of the powers within the Mental Health Act 1983 necessary, in these cases effective communication between services is critical.

Services should work together using a collaborative approach that recognises the benefits of multi-agency working and builds effective working relationships between organisations and individuals. This should include ensuring continuity where people move in transition between services. It is essential for services to have clear, written protocols in place, and jointly agreed care pathways which make clear the responsibilities of any organisation involved in delivering services. Roles and responsibilities should be clearly described, including the active participation of the service user and any carer and/or family members. Plans will ensure that only the minimum services required are deployed and that resources are used efficiently and effectively, avoiding duplication, overlap and the provision of unnecessary interventions. However, in cases where families have complex needs or where safeguarding issues are evident services need to address complexity and safety

referring to child protection, protection of Vulnerable adult and IFFS where appropriate.

### **4.3 Ensuring a Competent and Well Trained Workforce**

In both mental health and substance misuse services the workforce are the key assets and resources in the delivery of effective care and treatment. In order for the workforce to be effective it needs to be competent in both mental health and substance misuse practice. For many people their needs will be entirely met within primary care. As such GPs, Practice Nurses and staff in the local mental health support service will need to be considered in training to improve understanding of the management of dual diagnosis. These staff will frequently provide the first point of contact. **Where secondary care services are providing support and treatment there should be absolute clarity on which agency and individual is leading and co-ordinating the care. This should be discussed with, and fully understood by the service user and their family or carer (where appropriate).** Care co-ordinators must be competent to assist service users to negotiate the pathway of care and ensure that where services are required from a number of agencies that these services are available, proportionate to need and tailored to meet these needs. This can be achieved through training, some of which will need to be joint training, including statutory specialist mental health and substance misuse services, primary care staff and the third sector. It may also be achieved through the use of a consultancy approach where specialists share their knowledge, not just in training colleagues to work with dual diagnosis and complex presentations, but by offering direct advice and support in the management of individual cases. Formal agreement is required as to which service is leading the delivery of care and treatment. Where individuals have a severe mental illness and are in need of secondary mental health services, then mental health services will lead but substance misuse services will, where necessary, have an active and named professional input.

### **4.4 Unambiguous Clinical Responsibility**

It is acknowledged that psychiatric issues can arise in individuals with problems related to substance use, which will dissipate on effective treatment of their substance use and will not constitute a psychiatric diagnosis. Likewise people with a mental health problem may use alcohol and or other substances in a manner which causes problems but which as their mental health problem is treated may abate.

For many people a single agency will be able to meet their identified needs. This ability is significantly enhanced where a suitably trained workforce is available. However, for people with more complex needs or where significant risk is identified services will need to work collaboratively and where necessary may jointly manage a case. The decision regarding which service takes the lead in a service user's treatment should be determined on a case-by-case basis depending on the needs of the service user. However, where a service user has a severe mental illness, mental health services should always take the lead role, providing a care co-ordinator, and in collaboration with the individual, produce a care and treatment plan, unless substance misuse services formally agree that there are specific reasons why this

should not be the case. Where this is the case the reasons should be discussed with the client/service user and should be formally recorded.

In some cases it may be appropriate for one agency to take the lead and the other to provide advice on elements of an individual service user's treatment. In other cases it may be necessary for both agencies to be heavily involved and for a 'link worker' to be assigned. It may also be appropriate for both services to treat the service user at the same time, ensuring that the service user's treatment is regularly discussed between services.

Although all agencies should implement a joint liaison / collaborative model of care, it is accepted that geographic, demographic and local service configuration issues could result in small regional differences in how the model is applied. To ensure that a collaborative approach is being employed, each APB together with its LMHPB is required to jointly agree a local care pathway for the treatment of service users with a co-occurring mental health and substance misuse problem, as well as having a jointly agreed written protocol. These pathways will be published locally through health boards and local authorities and on the Welsh Government's website.

The importance of unambiguous clinical responsibility and access to appropriate services is crucial, as is the need for adult mental health services and CAMHS to recognise that those with alcohol and drug problems can also develop mental illnesses that require treatment.

## **PART 2: SERVICE DELIVERY FRAMEWORK**

### **5. REQUIREMENTS**

In order to ensure that a collaborative approach is delivered within local services, LMHPBs and APBs will produce jointly agreed local care pathways and protocols (to be published by local health boards, local authorities and on the Welsh Government's website).

Whilst mental health, CAMHS and specialist substance misuse teams remain the key service providers, input from other providers such as housing agencies and education are also important in delivering the comprehensive range of services required. Every person using secondary mental health services is entitled to a holistic care and treatment plan, which should cover the 8 areas of life prescribed in Part 2 of the Measure involving other support services where appropriate. Without an integrated approach from the providers of the different service components, individuals with dual diagnosis are potentially at risk of falling between services or of receiving sub optimal support. This is of particular concern given that this client group is at increased risk of suicide and of causing harm to others including in a small number of cases committing homicide.

To deliver on the intentions within this framework, services will need to ensure that the following requirements are being met:

#### **5.1 Requirement 1 - Prevention and Early Intervention**

Services are expected to take preventative measures to reduce health and social problems whenever possible. Co-occurring mental health and substance misuse problems are no exception. Where preventative approaches are available at a population level or within primary care, these approaches should be used, in line with the principles of prudent healthcare and a recovery focused approach. Where prevention is not possible then services should, seek to intervene as early as is practicable to minimise the impact of mental health and substance misuse problems. Where people attend primary care with a common mental health problem, services should explore with that individual their alcohol and drug use. In this context this may mean a person receives preventative advice and support. Should this be insufficient they may receive treatment within primary care for either their mental health problem, their substance misuse problem or for some support with both problems, ensuring early intervention where a co-occurring problem begins to emerge.

#### **5.2 Requirement 2 - A Competent and Well-trained Workforce**

All staff in mental health and substance services will require training in managing co-occurring problems and to augment their training in the field of either recognising and managing common mental health problems or recognising and managing substance misuse problems respectively where necessary.

Training and ongoing clinical supervision are key to ensuring that individuals and teams are confident, adequately equipped, skilled and sufficiently supported to work effectively with individuals with a dual diagnosis using a recovery approach. Any training being delivered should have regard to national occupational standards or other relevant qualifications. Co-occurring conditions are commonplace in both fields of work which means the skills should now be mainstream and part of day to day work. Managerial and clinical support structures should be in place for all individuals working with clients with co-occurring problems. Staff working in mental health and substance misuse teams requires the skills and knowledge necessary to identify, assess and address the needs of this population as part of their routine work.

Services will be required to ensure that the delivery of training and supervision is at a sufficiently senior level. Training in substance misuse treatment should be delivered to all members of the psychiatric service and equivalent training in mental health issues for substance misuse workers.

Team managers will identify the training needs of all their staff which must then be reflected in relevant training plans. Much of the training can be provided by the involved services – e.g. substance misuse teams can provide training with regards substance misuse to mental health organisations and community mental health team staff can provide training on issues of mental health to substance misuse services in statutory and non statutory settings. Joint training also promotes good communication and builds effective working relationships. There should also be consideration given to the training needs of other services, such as to housing, homelessness, education and criminal justice agencies, and thought given to wherever possible taking issues forward in a shared, collaborative and multi-agency way. Where gaps in knowledge exist external organisations will provide the relevant training.

The Welsh Government will ask health boards to conduct an audit of numbers of staff who have had formal training in relevant areas with the aim that at least 70% of staff will be able to demonstrate that they have undertaken formal training in the year 2015/16. The intention is to increase that percentage over future years to achieve the aspiration for all staff working within the service, to have been trained by 2018. These audits will form a part of the annual reports provided to Welsh Government by APBs and LMHPBs.

This framework will be augmented by quality standards for training in meeting the needs of people with dual diagnosis. Services will be required to ensure that local training meets the requirements of these quality standards.

### **5.3 Requirement 3 - Ensuring Effective Clinical Leadership**

The provision of health and social care is delivered by a number of agencies within frequently complex systems and involving large numbers of individuals. Clinicians need to have a clear understanding of the various pathways and systems of care to be able to function effectively. They must be comfortable working both with, and



within the various pathways and systems in order that service users reap the benefits of evidence based care.

In order to ensure effective clinical leadership, each clinician needs to have clear lines of responsibility and accountability embedded into every day working practices. Clinical leaders are required to be exceptionally skilled and have a sound knowledge base and work within the Clinical Leadership Competency Framework. They need to be innovative and lead by example.

The success of the implementation of this framework will require, for many, a change in culture. Values, attitudes and working practices will need to be challenged and this will need to be led by senior clinicians and managers throughout each organisation. Ultimately the accountability for implementing this framework will lie with each chief executive. However, arrangements will vary across agencies within the NHS. For example, responsibility for ensuring that pathways and systems are put in place and that the needs of service users with co-occurring problems are appropriately met may be devolved to the appropriate clinical director or their equivalent. This needs to be supported by the heads of nursing and other senior managers who are responsible for specific areas. The availability of regular, ongoing clinical supervision is essential for all staff engaging with service users with complex needs. This is particularly relevant when dealing with client's whose engagement in treatment and compliance with medication will present particular challenges for staff.

Staff at all levels within the NHS and other organisations will require education and support in order to ensure a change in culture is managed effectively. Staff will be supported through annual appraisals, personal development, regular clinical supervision and training. Similar arrangements should be in place for social services and third sector bodies although the scale may vary.

#### **5.4 Requirement 4 - Monitoring and Measuring Performance**

All service commissioners and providers, including the third sector, will be expected to ensure a robust programme of clinical audit and governance is in place, which ensures that duties under the Mental Health (Wales) Measure 2010 are met and sufficiently address the needs of individuals with a dual diagnosis . They will ensure that as a minimum:

- Duties under the Mental Health (Wales) Measure 2010 are appropriately met by health boards and local authorities.
- Jointly-agreed local care pathways and protocols are in place for every area and are regularly reviewed. Copies of pathways must be provided to, and will be published by, Welsh Government.
- Joint audits are planned and undertaken every two years (as a minimum) and must include an audit of effective clinical leadership, resolution of professional differences of opinion and delivery of competency based training.

- Members of statutory and non statutory substance misuse and mental health services' staff are appropriately trained to recognise and respond to people with dual diagnosis in line with the requirements stated under section 6.3 'competency based training'.
- Service users are actively involved in the design and evaluation of local services through the joint audit systems.
- Appropriate aggregated outcome data is made available (this should be through existing data reporting systems such as TOPS/Mental Health Core Data set, HONOS, self-assessment through 'Service User Lens', etc.).
- Appropriate information technology systems are introduced to improve interagency information sharing and to effectively capture and analyse data on service activity, outcomes and partnership working. The Community Care Information System being rolled out across Wales from 2015 should be considered as a means of achieving these aims.

### **5.5 Requirement 5 - Corporate Governance and Accountability**

Local corporate accountability for implementation lies with the health board's executive director with responsibility for the operational delivery of adult mental health services in partnership with their local authority colleagues. They must establish local implementation and delivery mechanisms within the work programme of the APB, and the LMHPB. Each of these two partnerships requires an identified board member to act as a lead for the implementation and delivery of this framework.

The delivery plans for both the LMHPBs and APBs should act as the primary delivery vehicle for the local implementation of this framework. Good communication between mental health and substance misuse services should result in effective joint working protocols and joint planning. These plans will be scrutinised to ensure that the actions intended to deliver this service framework are appropriate, achievable and consistent with the expectations defined elsewhere in this document.

Health boards and their local authority partners' progress against the delivery of the framework should be reported to APB's and LMHPB's. These Boards will be expected to report through their annual reports and other performance management arrangements progress in implementing this framework to the Department of Health and Social Services in Welsh Government.

It is crucial that planned actions for delivery have taken into account the following:

- All extant policy, guidance and legislation relating to both mental health and substance misuse services
- The views of local service users and carers
- The views of local clinicians and service managers
- The interface between the provision of services for individuals with a dual diagnosis and other health and social care and criminal justice services. The

assessment of planned actions and future services for people with these co-occurring problems within the context of a local equality impact assessment

- The United Nations Convention on the Rights of the Child (UNCRC)
- The Human Rights Act (HRA)
- The Equality Act (2010)

### **5.5.1 Responding to serious and untoward incidents (SUIs)**

Partnerships and frontline services are expected to utilise the expertise, scrutiny, analysis, advice and recommendations of their Harm Reduction Group (HRG) and/or Local Intelligence Network (LIN) in order to respond and act upon any serious incident (including fatal and non fatal drug poisonings). Where co-occurring problems are identified as present, both the APBs and LHBs will be required to demonstrate how the advice and recommendations emerging from the HRG and or LIN will be delivered. The formal requirements for reporting serious untoward incidents (SUIs) within the NHS should be adhered to.

### **5.5.2 Safeguarding**

People with a dual diagnosis frequently pose significant risks to themselves or others. This may be a risk posed to children or adults in their care or for whom they have some responsibility. Considering the risk a person may pose to themselves or to other people must be considered in the formulation of any plan of care. For children, the impact may not be one of significant risk but the consequences of parental mental health and substance misuse problems may render them children in need. On occasion, this raised risk is not necessarily identified in considering eligibility to receive a service. This combination of a failure to reach the threshold of services and raised risk can lead to particular safeguarding issues. Services need to ensure that guidance on the protection of children and vulnerable adults are followed in the management of people with a dual diagnosis. Services must implement their safeguarding requirements in line with the Social Services and Wellbeing (Wales) Act 2014.

## **5.6 Additional Service Aims**

In addition to the five requirements above, all substance misuse and mental health services should ensure :

- A comprehensive staged approach to recovery including, where appropriate, assertive outreach, motivational interventions and provision of appropriate clinical care to clients to manage both mental health and substance misuse problems. Individuals must also have access to relapse prevention and services should facilitate the reintegration of individuals back into the community following hospital discharge or residential rehabilitation.
- People are managed at a level of care, primary or secondary, appropriate and proportionate to their need. Services should form appropriate links with the

criminal justice services including the police, courts, prison and probation services addressing the requirements contained within the Wales Reducing Re-offending Strategy 2014-2016 and the Welsh mental health crisis care concordat. Additionally where possible, broad based interventions should include social, housing, education and employment components.

- A clear local definition of dual diagnosis is agreed together with a clear description of which service users will be treated. Services should also have a common referral criteria and process.
- All individuals have access to the services that they need. This includes access to out-reach services, community treatment, home visits, inpatient and outpatient service user treatment, and day care provision. This also includes services that are rapidly available and flexible to individual need.

## **5.7 Meeting the needs of People with Protected Characteristics**

Mental health and substance misuse services should be tailored to meet the needs of their local population.

This includes taking into account the specific needs of people with the protected characteristics considering as a minimum any particular requirements related to their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Responding to these needs can have a huge impact on an individual's potential to be engaged by services. Organisations need to be culturally aware in order to be able to provide the most appropriate support. Consideration should be given to the need for resources produced in braille and in the foreign languages used within a local population and to the use of signers and interpreters where appropriate

### **5.7.1 Children and Young People**

Substance misuse in children presents particular issues requiring consideration and a tailored response according to their clinical or other needs. The legal status of children and young people, particularly in regard to safeguarding and consent also requires specific consideration.

Adolescence is typically an age of experimentation and risk taking into which substance misuse may present as a short period of experimentation. When more long term, entrenched substance misuse occurs in adolescence it is invariably associated with, if not precipitated by, considerable complex additional difficulties necessitating a coordinated multiagency response from education, local authority children's services, third sector, health professionals (from CAMHS, sexual health, school nursing and GP etc.) and occasionally youth justice professionals. Frequently young people do not readily engage with traditional statutory service models. Instead they present with chaotic behaviour, which when addressed may resolve their initial substance misuse problem.

Particular attention is required in meeting the needs of young people with co-occurring problems when they move from CAMHS services (for children and young people up to the age of 18) into adult services. In cases of relatively simple care this can be a point where services let young people down allowing them to fall out of service provision. Where they have complex problems associated with co-occurring problems safeguards to ensure the range of care needs are met during and after transition must be in place.

Service development should be based on a local needs assessment. Where this hasn't been undertaken the National Treatment Agency have developed a framework which suggests that a mapping exercise for specialist young person's substance misuse treatment systems should be undertaken against the description of the client profile in relation to referrals, throughput, re-referral, discharge and transitional arrangements.

### **5.7.2 Expectant mothers**

A healthy pregnancy maximises the chance of having a healthy child. Pregnancy and the first year of life shape the emotional and physical development of future generations. The effective treatment of expectant mothers with a dual diagnosis is frequently a safeguarding issue and must be a priority for services. Where such issues are identified, referral to specialist midwifery services should be made (where available) and provisions included in the care plan to minimise the harm to both the expectant mother and unborn baby. 'A Strategic Vision for Maternity Services in Wales' sets out Welsh Government expectations of NHS Wales in delivering safe, sustainable and high quality maternity services.

### **5.7.3 Over 50s**

The *Integrated Assessment, Planning and Review Arrangements for Older People (anyone 50 and over)* guidance requires that I health boards and local government in Wales, work with local communities and third sector partners, to ensure they have integrated well-being, assessment, care and support planning and review arrangements specifically to support older people. This includes any specialist and professional assessments, such as substance misuse, forming an element of a wider integrated assessment. For more information on this please refer to the *Integrated Assessment, Planning and Review Arrangements for Older People Guidance*.

### **5.7.4 Carers and families**

It is important to fully engage with and involve carers of people with a dual diagnosis as early as possible, subject to usual requirements around consent. Carers may feel excluded by health and social care professionals from the care and treatment provided by statutory services. This is particularly so when a carer or family disclose to professionals that the person is exhibiting symptoms of relapse. Practitioners should ensure that they follow the requirements of the Carers Strategies (Wales) Measure 2010 and from 2016 the Social Services and Wellbeing Act 2014.

The Mental Health (Wales) Measure 2010 has introduced an additional duty upon Health Boards and local authorities to undertake an assessment of a person's need for specialist mental health services where they seek such assessment, without requiring referral from a G.P or other agency. The duty covers those people over the age of 18 who have been discharged from secondary care services within the previous three years. Since this duty was introduced approximately 100 people a month in Wales have made such a request. Reminding service users of these duties and keeping their carers informed that the service user has the option to request an assessment is important. Carers and families should have access to appropriate information and be supported to have further learning opportunities to develop skills for dealing with a person's symptoms. There is a good evidence base that family interventions can reduce relapse and improve outcomes for those with serious mental illness.

#### **5.7.5 Prisoners' mental health**

In prison settings this framework requires the prison mental health in-reach service and the Counselling, Assessment, Referral, Advice and through care (CARATs) to work in partnership to ensure that the needs of prisoners with a co-occurring mental health and substance misuse problem are met. This is underpinned by Welsh Government policy implementation guidance in relation to prisoners with mental health problems, in which access to treatment services for substance misuse features strongly. Where a Prisoner has a history of a relapsing serious mental illness associated with substance misuse, services should highlight any public safety or safeguarding issues with community services prior to discharge to ensure that these risks can be addressed upon release from custody. Prisoners who have received services from prison mental health in reach services become eligible patients under Part 3 of the Mental Health (Wales) Measure 2010.. Services should also ensure that duties under Section 60 of the Housing (Wales) Act are met. Section 60 requires to the provision of advice and assistance to people leaving prison or youth custody.

#### **5.7.6 People with alcohol related brain damage (ARBD)**

Early identification and diagnosis of ARBD is important, all relevant health and social care professionals should be fully trained and competent to assess these conditions.

Where they do not already exist, links should be established and formalised between local substance misuse treatment services (both statutory and voluntary sector) and specialist psychiatric and psychological services for ARBD.

Clear care pathways from diagnosis to ongoing assessment and treatment for ARBD should be developed and a lead ARBD clinician identified within each health board across Wales.

Dementia services must ensure that they are accessible to those with ARBD which will include young onset dementia services for clinically appropriate cases. Support from specialist services for those with comorbid substance misuse and ARBD should be in place as with any other mental health condition. A separate work stream on ARBD is being taken forward which will address the various issues associated with ARBD in more depth.

### **5.7.7 Veterans (former members of HM Armed Forces)**

Veterans have a higher incidence of dual diagnosis problems than the non-veteran population. The Armed Forces Covenant requires NHS services to provide Veterans with priority treatment (subject to the clinical needs of others) in respect of treatment relating to a condition resulting from their service in the Armed Forces. These needs will frequently be met by Veterans' services, such as the Veterans NHS Wales service and third sector providers. However, for some veterans referral to general mental health or substance misuse services will be required and services will need to respond in an appropriate manner to supplement specialist Veterans' services. Services should also ensure that duties are met under Section 60 of the Housing (Wales) Act to provide advice and assistance to people leaving the armed forces of the Crown in order to prevent homelessness and to secure accommodation.

The Welsh Government Substance Misuse Treatment Framework 'Improving Access to Substance Misuse Treatment for Veterans' outlines actions which could be taken to improve Veterans' access to substance misuse treatment.

As part of the local needs analysis underpinning their commissioning strategies, area planning boards are required to review their existing local care pathways with a view to ensuring that access to substance misuse treatment for Veterans is improved. Likewise ensuring that read codes used to routinely collect service user data to identify veterans will need to be consistently applied. This review will need to take into account local factors and service availability (including the treatment of co-occurring mental disorders), alongside the requirement to ensure priority treatment for veterans is in place in accordance with Welsh Government policy.

### **5.8 Welsh Language**

All organisations in the public sector have a responsibility to comply with the Welsh Language (Wales) Measure 2011, which imposes duties on bodies to use the Welsh language, enabling Welsh speakers to use their chosen language.

"More than just words", the strategic framework for Welsh language services in health, social services and social care, complements the Measure. It emphasises the need for people working in services to recognise many people can only comfortably and effectively communicate their care needs through the medium of Welsh. This is particularly important in mental health services where people may find it difficult to discuss their distress and emotional difficulties through the medium of a language which is not their first language it is therefore important to deliver appropriate services to meet their linguistic needs. Therefore, the framework requires substance misuse and mental health services to operate within these legal obligations and ensure that services are accessible in Welsh and that clients have the right to access services in Welsh should they wish to do so.

### **5.9 Resolving professional differences of opinion**

Despite the presence of agreed clinical pathways and service protocols, professionals will not always agree which services and interventions are required for an individual with a dual diagnosis. In the majority of cases these issues are resolved by discussion and negotiation between the professionals concerned this may be achieved through a multidisciplinary meeting drawing together the specialist mental health and substance misuse services. Professional challenge is a positive activity a

sign of good professional practice, functional organisations and effective multi-agency working. However professional disagreements may arise including tensions between services. In order to avoid these and the consequent delays in service delivery that may emerge from such professional disagreements each health board should establish a locally agreed protocol for resolving these professional differences.

Professional differences of opinion should always be resolved in a constructive and timely manner. Where there is a difference of opinion between providers regarding whether a service will become involved in the co-ordination of assessment, care planning, intervention and treatment of a service user, negotiation in the management of the case must take place at the operational level prior to escalation. In such circumstances the views of the service user and where appropriate their family or carer should be sought and taken into consideration.

Differences of opinion may be escalated through the management structure of each practitioner if necessary. If this, in turn, is ineffective the matter should be referred to the clinical director or equivalent (health board) and head of service (local authority). Should the difference of opinion arise between statutory and non-statutory providers and the situation is not resolved through the line management structure, commissioners of the non-statutory service provider will be involved. The escalation process, including responsible individuals, should be clearly stated in locally agreed protocols.

In the event that the disagreement relates to allocation of a care co-ordinator or lead professional, the relevant managers will review the case and decide which provider is best placed to provide effective care for the service user. The service user will remain engaged by the services with which they were in contact at the time the disagreement arose, until the matter is satisfactorily resolved. Local services will identify the managers responsible for adjudicating in any cases where professional or organisational disputes arise.



# **APPENDICES**

## **Appendix 1**

### **Key Definitions**

#### **Substance misuse**

Substance misuse refers to the problem use of prescribed or illicit drugs, and/or alcohol.

**Dimensions of a definition of Severe Mental Illness (as described with the Department of Health Document “Building Bridges”).**

#### **SAFETY; has four components**

- Unintentional self-harm, e.g. self-neglect;
- Intentional self-harm;
- Safety of others
- Abuse by others, e.g. physical, sexual, emotional, financial

#### **INFORMAL AND FORMAL CARE has two components**

- Help from informal carers, including friends and relatives;
- Help from formal services, such as day centres, paid staff voluntary services, hospital; admissions, medication and detention under the Mental Health Act 1983

#### **DIAGNOSIS may include:**

- Psychotic illness;
- Dementia;
- Severe neurotic illness;
- Personality disorder;
- Developmental disorder

**Disability with impaired ability to function effectively in the community, which may include problems with:**

- Employment and recreation;
- Personal care;
- Domestic skills;
- Interpersonal relationships.

**DURATION of any of the above, for periods which may vary between six months and more than two years**

## **Dual Diagnosis and co morbid mental health problems**

Dual diagnosis or co-morbidity refers specifically to the co-existence of diagnosed mental health problems (irrespective of severity) and substance misuse but also a range of other conditions.

Co-occurring substance use and mental health problems is used more generally to acknowledge that not all mental health problems have been diagnosed, nor are all forms of substance use considered to be problematic.

Co-occurring substance misuse and mental health problems has therefore been adopted for use in the development of this service framework. Taken together these problems give rise to significant impairment and disability for which people affected need advice, support and services, in order to follow a more integrated life course. The severity and nature of a person's problem are liable to change over time. Each problem, however, would be significant enough to merit planned care on its own.

## Appendix 2

### **Together for Mental Health and Working Together to Reduce Harm: Mental Health and Substance Misuse Delivery Plans**

Ensuring substance misuse co-occurring with mental health problems is managed effectively is a key action within both the *Together for Mental Health* Delivery Plan (2012-16) (action 11.3) and *Working Together to Reduce Harm: Substance Misuse Delivery Plan 2013-15* (action 5.2).

The delivery of this action is reliant on collaborative working between mental health and substance misuse services, and both delivery plans impose a number of specific requirements on a range of key partners. Effective management is dependent on LMHPBs and SMAPBs working together to establish clear protocols and operate integrated pathways between mental health and substance misuse services. Furthermore, LMHPBs and SMAPBs are required to ensure all relevant staff are trained to recognise and respond to people with co-occurring substance misuse and mental health problems and have a clear understanding of protocols and integrated care pathways in place.

Together for Mental Health, the Welsh Government's mental health and wellbeing strategy for the period 2012-22, incorporates six high-level outcomes, all of which focus on improving the lives and prospects of the individual service user to better realise their 'recovery and enablement':-

- a. The mental health and wellbeing of the whole population is improved.
- b. The impact of mental health problems and / or mental illness on individuals of all ages, their families and carers, communities and the economy more widely, is better recognised and reduced.
- c. Inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced.
- d. Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions.
- e. Access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result.
- f. The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

**Working Together to Reduce Harm** is the Welsh Government's ten-year strategy (2008-2018) that aims to reduce the harms associated with the misuse of alcohol, drugs and other substances in Wales. The strategy has four priority areas:

1. Preventing harm by helping children young people and adults resist or reduce substance misuse by providing information about the damage that substance misuse can cause to their health, their families and the wider community.
2. Supporting substance misusers to improve their health and maintain recovery by enabling, encouraging and supporting substance misusers to reduce the harm that they are causing to themselves, their families and communities and ultimately return to a life free from dependent or harmful use of drugs and alcohol.
3. Supporting and protecting families by reducing the risk of harm to children and adults as a consequence of the substance misusing behaviour of a family member, e.g. a parent, partner, adult relative or child.
4. Tackling availability and protecting individuals and communities via enforcement activity to reduce the harms caused to individuals and communities by substance misuse related crime and anti-social behaviour, by tackling the availability of illegal drugs and the inappropriate availability of alcohol and other substances.

Substance misuse frequently impacts on the wellbeing of the population and this framework vision is to contribute to wider outcomes set out in both Together for Mental Health and Working Together to Reduce Harm.

Success will be measured by improved outcomes for people with co-occurring mental health and substance misuse problems. The auditing of protocols and pathways put in place by LMHPBs / SMAPBs and the proportion of clients with co-occurring problems referred to either appropriate mental health or substance misuse services. Service user feedback from local audits will be used to assess the existence of such arrangements and improved outcomes.

### **The Mental Health (Wales) Measure 2010**

Since the publication of the previous treatment framework Wales's specific mental health legislation has been made. The *Mental Health (Wales) Measure 2010* has expanded services available to those experiencing mental ill health by imposing additional statutory duties on health boards and local authorities. These new legal duties should serve to support implementation of the framework's intent.

Part One of the Measure requires health boards and local authorities to establish local primary mental healthcare support services. These services expand the capacity of primary care services to address issues relating to mental ill health and provide assessment, advice, information and treatment for those with mental health problems; this includes those with a co-occurring substance misuse problem. In order to underpin this requirement, an all Wales curriculum for primary mental health workers was developed by Public Health Wales. The curriculum confirms the values according to which primary care services should operate; holistic, individualised care which recognises the impact of wider issues, including, in this context, possible substance misuse. These two steps should improve the culture and capacity within

primary care, helping professionals to better identify and tackle substance misuse in those people with mental ill health not believed to be of sufficient severity to require a referral to secondary care.

Parts two, three and four of the Measure are each concerned with secondary mental health services. Part two, places a duty on health boards and local authorities to ensure all those receiving secondary mental health care services have a holistic care and treatment plan in place. Developing the plan is the responsibility of an appointed care co-ordinator, working whenever possible with the service user to agree goals that are meaningful to the individual and designed to address any wider issue that might impact on that individual's mental wellbeing. In formulating a plan, eight specified "areas of life" should be considered with at least one of these being formally addressed in the care and treatment plan.

The code of practice for Parts two and three of the Measure describe the assessment and care and treatment planning process. For a care and treatment plan to be effective and meaningful for people with dual diagnosis as with other conditions, it should set out how an individual with mental ill health and a history of substance misuse is to receive help and targeted support and should be regularly reviewed. For relevant service users the care and treatment plan provides the mechanism that allows for the identification of such concerns including any risks, and for formalising arrangements relating to ongoing treatment by both mental health and substance misuse services together with any others that may be required. The code of practice to parts two and three of the Measure also requires that a person's personal care needs and physical wellbeing needs are identified when planning care. Outcome-focused, care and treatment planning must therefore effectively consider the broad range of factors which impact on an individual's wellbeing. Just as poor mental health or substance misuse can affect an individual's physical health, relationships, employment prospects, ability to interact socially and lead a fulfilling life, so too does the reverse apply; a lack of employment, poor accommodation and social isolation can compound mental ill health and accelerate those habits which are harmful to one's wellbeing.

## **Appendix 3**

### **Substance Misuse and Mental health helplines**

#### **Wales Drug and Alcohol Helpline (DAN 24/7)**

DAN 24.7 is a free and bilingual telephone helpline providing a single point of contact for anyone in Wales wanting further information or help relating to drugs or alcohol.

The helpline will assist individuals, their families, carers, and support workers within the drug and alcohol field to access appropriate local and regional services.

Services available include:

- Initial assessment to establish an individual's needs
- Referral to local and regional drug and alcohol services
- Information on drugs and alcohol, and their effects
- Information and contact details for local GPs, needle exchanges, dentists and other associated health services
- Information on other suitable helplines
- A wide range of brief interventions including motivational interviewing, harm reduction and overdose management

<http://dan247.org.uk/>

Freephone: 0808 808 2234

Text DAN to: 81066

#### **Community Advice and Listening Line (CALL)**

CALL offers emotional support and information/literature on Mental Health and related matters to the people of Wales. Anyone concerned about their own mental health or that of a relative or friend can access the service.

The service provided by CALL consists of two parts. Initially the caller is offered emotional support through listening and allowing them to express their feelings regarding any crisis or situation.

Callers are also provided with information from the CALL database and can be provided with contacts for agencies, statutory and voluntary, local to the caller. Free literature is also provided on a range of symptoms, mental health problems and the services provided by particular agencies.

C.A.L.L. Helpline offers a confidential listening and support service. The Mental Health Helpline service is available 24 hours a day, 7 days a week

<http://www.callhelpline.org.uk/Default.asp>

Freephone 0800 132 737

Text help to 81066

## **Appendix 4**

### **Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT)**

The WIISMAT was developed for use by services in partnership with adult service users.

It is designed in two parts. Part one contains seven core sections and part two five annexes. Part one is to be completed during the initial phase of engagement with the service user, and it is at the discretion of practitioners which of the five annexes may also be required following this initial engagement. As with statutory care and treatment planning, the WIISMAT should be used on a case-by-case basis, in a way that is proportionate to need and which reflects the complexity of the case.

The five annexes which serve to collate detailed information on individual need are:

- Annex A: Motivation and Self Concept
- Annex B: Psychological Examination/Observation
- Annex C: Physical Examination/Observation
- Annex D: Social Inclusion Issues in Relation to Drug and/or Alcohol Misuse
- Annex E: Family History

The in-depth assessment is undertaken by a professional assessor with the outcomes reflected in a service user's Care Treatment Plan (CTP). Mechanisms which ensure the aligning of CTP and WIISMAT outcomes are crucial to successful collaborative working between the services responsible for mental health and substance misuse.

### **The Implications of the Measure and WISMAT on Assessment and Care Planning**

The associated code of practice for part two of the Mental Health (Wales) Measure 2010 requires all people in receipt of secondary mental health services for mental ill health to have a proportionate care and treatment plan - produced by an appointed care co-ordinator in discussion and collaboration with the service user, carer(s) and mental health service providers.

The first Together for Mental Health Annual Report published in December 2013 points to the impact of this work: 94% of secondary service users are now in possession of a valid care and treatment plan, and the emphasis going forward is to improve the quality of these care and treatment plans.

### **The Wales In-Depth Integrated Substance Misuse Assessment Toolkit (WISSMAT) qualifying criteria**

The WIISMAT is not universally applied in Wales and is under review. Some agencies have opted not to use the toolkit in assessing need, however where it is being used this should be proportionate to the degree of complexity in any individual case. It is a matter for professional judgement as to the whether the use of the WIISMAT is required or whether some other form of care planning should be used.

Where a person is in receipt of secondary mental health services these services will take the lead and the statutory care and treatment will be used as the core plan.

## **Appendix 5**

### **Case Studies**

#### **Case Study 1**

Client A is a 36 year old woman who has been accessing substance misuse services for 10 years. She is prescribed oral Methadone (60 mgs daily), supervised at a local chemist, and has periods when she uses both crack cocaine and heroin intravenously. She has a previous history of low mood which has been managed by her GP.

Client A became increasingly distressed when her partner was sent to prison for drug related offences. She developed the idea that her flat had become infested by insects put in her flat by an external force and that her life was in danger. She saw bugs and heard noises which she thought were the insects burrowing into her furniture. She became increasingly distressed with suicidal ideation and began using neat bleach on her skin. She threw out all of her furniture leading to complaints from neighbours and was not reassured when her housing provider decontaminated the house.

A meeting of professionals was arranged and a joint assessment undertaken with the local CMHT. It was agreed that she had developed a psychotic disorder and was a risk to herself. Client A was reluctant to work with mental health services, but did agree that, if her substance misuse key worker was present to support her, she would be assessed. She agreed to take oral anti-psychotic medication which was monitored by the CMHT, and the teams worked together to arrange a move of accommodation. Her symptoms improved, although she continued to intermittently use crack cocaine. She requested discharge from mental health services at a care and treatment review. It was agreed that substance misuse services would alert the CMHT if she developed any of her early warning signs of relapse so that an urgent reassessment could be made. Six months later her symptoms recurred. The plan was followed and she agreed to take medication. An ongoing joint care plan between both teams was also agreed. She reports that it was the support of her substance misuse key worker that helped her to accept input from the CMHT.

#### **Case Study 2**

Client B is a forty year old woman who initially came to the community drug and alcohol team (CDAT) with a presentation of extensive use of prescription analgesics which were used to manage chronic back pain. Following comprehensive assessment it was highlighted that she was registered with many different GP practices and was using a number of different prescriptions to access the analgesia.



Client B was treated by a specialist prescribing service. Her access to her prescriptions was stopped and she was given a comparable dose of subutex (substitute medication for opiate dependence) instead. She was also referred to the pain specialist nurse, who holds clinics on a regular basis within CDAT, for assessment of pain management. A consequent plan was put in place, which was developed in conjunction with Client B.

Alongside the stabilisation onto substitute medication, Client B's psychological and mental health needs were considered. It was identified that she had struggled with negativity and destructive behaviour patterns for many years and it was important that any intervention offered would be appropriate to manage her needs. She was referred to the pathways to recovery psychosocial interventions group (lifestyle balance model). This is a 12-week group programme, supported by weekly one to one sessions that are delivered within substance misuse services for those with substance misuse and low to moderate mental health problems. The programme includes sessions on understanding substance dependence, staying safe, managing craving and urges, building relationships and social networks, understanding mental health, overcoming negative thoughts, breaking destructive behaviour patterns and creating a road map to success.

Client B attended the pre-group session where the fundamentals and outline of the programme were explained. She committed to attending the programme and after about four weeks of attending the programme understood her substance dependence, how to manage triggers cravings, negative thoughts and beliefs. During this time her pain was also managed more effectively.

Since completing the programme, Client B has reviewed her lifestyle and has pursued her goal of fostering rescue greyhounds. Following on from this she has now been discharged from the service having successfully learned how to manage her pain issues and no longer needs to self-medicate.

### **Case Study 3**

Client C is a 36 year old woman with a long history of poly substance misuse. She has been known to her local complex needs addiction service for many years, initially with a history of solvent use, moving on to intravenous heroin use (for which she received a prescription of methadone and, more recently, IV use of mephedrone). She has also been known to the community mental health team with a diagnosis of schizoaffective disorder. She has had several admissions under the Mental Health Act including one to the psychiatric intensive care unit. She has a chronic injecting abscess at the top of her left leg, going into her groin with an associated chronic anaemia. She repeatedly refuses to go into hospital for medical treatment but will allow district nurses to dress the wound and is assessed as having capacity each time. The consultant physician has arranged for her to have blood samples taken in her local GP surgery, and has agreed a fast track onto the unit should she change her mind about admission.

She is currently receiving intensive input from the Community Mental Health Team (CMHT) with regular Community Psychiatric Nurse (CPN) visits and an antipsychotic depot injection every two weeks. She has a good relationship with her CPN and trusts him. She is no longer on prescription methadone and only rarely uses heroin, but has daily use of injected mephedrone. The complex needs addiction service have been unable to engage her in psychosocial interventions as she is unmotivated to change and does not keep to appointments. However, the service retains links with the CMHT and acts in a consultative role with the understanding that, should she wish to engage, a treatment place can be made available quickly. Links are also maintained via the needle exchange co-ordinator within the complex needs service where Client C obtains her injecting equipment.

Professionals involved in her care have concerns over her vulnerability. She is a sex worker and has admitted that she does not practice safe sex. In addition, she has a number of associates who use mephedrone with her and she has admitted that she gives them her bank card to draw out money which they then spend on drugs. Her CPN has observed them removing a significant sum from an ATM. Client C refuses a referral to Protection of Vulnerable Adults (POVA).

Due to the concerns over her health, the professionals involved in her care meet every 2 to 3 months to review the situation. The meeting takes place at her GP surgery and also includes representatives of the CMHT (both medical and nursing), the complex needs addiction service (usually the consultant) and district nursing. In between meetings members of the team communicate via phone and email when there are changes to presentation and other causes for concern.

Her mental health largely remains stable although she continues to voice some delusional beliefs relating to previous admissions to hospital. Although there are considerable risks being held with this service user, the close working and communication between services ensures that all professionals are involved in regular reviews and any acute changes can be communicated quickly and dealt with in a timely manner.

## Appendix 6

### Glossary

LMHPBs	Local Mental Health Partnerships Boards
SMAPBs	Substance Misuse Area Planning Boards
APBs	Area Planning Boards
HBs	Health Boards
ONS	Office of National Statistics
SMI	Severe Mental Illness
CAMHS	Child and Adolescent Mental Health Services
GMS	General Medical Services
SUIs	Serious and Untoward Incidents
LIN	Local Intelligence Network
HRG	Harm Reduction Group
CARATs	Counselling, Assessment, Referral, Advice and Through care
ARBD	Alcohol Related Brain Damage
WIISMAT	Wales Integrated In-depth Substance Misuse Assessment Tool
CTP	Care Treatment Plan
CMHT	Community Mental Health Team
CDAT	Community Drug and Alcohol Team
CPN	Community Psychiatric Nurse
HIW	Healthcare Inspectorate Wales
BME	Black Minority Ethnic
POVA	Protection of Vulnerable Adults

## Appendix 7

### References

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