Dual diagnosis toolkit

Mental health and substance misuse

A practical guide for professionals and practitioners

TURNING POINT
TURNING LIVES AROUND

rethink
severe mental illness

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Foreword

Dual diagnosis is not a new issue. The relationship between mental health and problematic substance misuse has a long and complex history. However, it is only comparatively recently that practitioners and policy makers have acknowledged the huge scale of the problem and begun to tackle the complex task of delivering appropriate care. We have written this toolkit to support the practitioners who deliver that care.
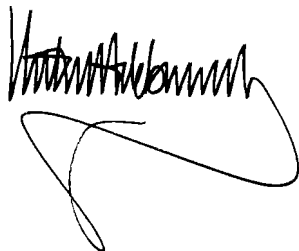
The core challenge is to co-ordinate disparate services to provide holistic care. There is usually little point in providing treatment unless we also recognise that people need homes, meaningful activity, adequate income, social networks and access to jobs and/or training. Whilst everybody accepts the principle of holistic care, in practice there are real barriers between services. That is why this toolkit is a deliberate attempt to build bridges and promote mutual learning.

Our purpose is to help a practitioner working in one field to develop a better understanding of other relevant service areas – the key issues, service frameworks, types of treatment, how to access them, and pointers to good practice.

As leading service providers, Rethink and Turning Point hope that our collaboration embodies the spirit of co-operation that we advocate. Only by working together can we provide care that is realistic and pragmatic and that genuinely enables people to move forward.

We hope you will find this toolkit both inspirational and useful.

"Co-ordinated personalised treatment and recognition of a person's need for a home, friends, money and meaningful activity are crucial. Taken together, these can be a passport to long-term recovery."

"Practitioners can be experts in their own field but unsure of how other relevant services work. We hope this toolkit will build bridges to promote understanding, co-operation and better outcomes for people affected."

Lord Victor Adebowale
Chief Executive, Turning Point

Cliff Prior
Chief Executive, Rethink

About the authors

This toolkit is a partnership between Rethink and Turning Point.

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Additional materials and case studies were researched and written by Liz Aram of The Forster Company.

Turning Point

Turning Point is the UK's leading social care organisation providing services for people with complex needs across a range of health and disability issues. It is the largest provider of substance misuse treatment services and a major provider of mental health and learning disability services. Last year, Turning Point had contact with almost 100,000 people through services in 200 locations in England and Wales. Turning Point provides services for people with concurrent mental health and substance misuse problems.

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Rethink

Rethink has more than 30 years experience of helping people with severe mental illness and their families recover a meaningful life. As well as running over 400 mental health services, Rethink has a network of more than 120 support groups across the country.

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Section one
Introduction

Who should use this toolkit?

This toolkit is written for frontline staff working with adult clients who have a combination of substance misuse and mental health problems. They may be working in a variety of settings in both the statutory and voluntary sectors. The impetus for the toolkit was the recognition that people working within substance misuse would benefit from a basic understanding of mental health services and vice versa.

In addition, workers in a broad range of community-based services also provide relevant care including people in social services, housing, probation, prison services, primary care, hospital wards and Accident and Emergency.

Whilst the toolkit is not specifically aimed at dual diagnosis specialists, it may be useful to them in providing references and signposts to further information. We also hope that specialists will provide a vital dissemination link to frontline workers.

Similarly, although the toolkit is not aimed at service users and carers, they may also find it useful. (Rethink has also produced a shorter leaflet that is aimed at carers.)

What does the toolkit contain?

The toolkit is both a practical guide and a reference source. It provides a basic introduction to key issues, service models and good practice in both substance misuse and mental health. The material is arranged so that busy practitioners can quickly identify the information they need without having to read the whole document.

Accompanying materials

The toolkit is part of a suite of materials designed to improve understanding and practice around dual diagnosis. These comprise:

Networking Tool for Practitioners
An A2 poster suggesting a range of relevant services and designed to support practitioners in identifying and accessing services in their area.

Suggestions Booklet
A4 booklet containing suggestions and explanatory notes to accompany the Networking Tool.

Families and Carers Leaflet
4 page leaflet produced in association with Adfam – a leading UK charity supporting families affected by drugs and alcohol. Designed as an introduction to dual diagnosis for families and carers and lists useful organisations.

To order copies of the Leaflet and Networking Tool call Rethink on 0845 456 0455 or download from www.rethink.org/dualdiagnosis. To order further copies of this Toolkit call Turning Point on 020 7702 2300 or download from www.turning-point.co.uk or call Rethink on 0845 456 0455 or download from www.rethink.org/dualdiagnosis

What is dual diagnosis?

"Dual diagnosis is a label they give you, but even at my most buoyant I think I've got more than two problems."

Service user

"In short, an individual's needs are often multiple rather than dual and include social as well as medical needs."

Lehman et al 1989 quoted by The Centre for Research on drugs and health behaviour

There is no common understanding about what is meant by "dual diagnosis". For the purposes of this toolkit, we have defined it as: 'the co-existence of mental health and substance misuse problems'.

For services, diagnostic labels have value in defining a client group and enabling the commissioning and delivery of care. However, practitioners should be aware that both service users and staff often see the label "dual diagnosis" as problematic.

"Dual" diagnosis can suggest that there are only two problems. In fact many people have multiple needs. These might include one or more medical problems and a range of social issues such as housing, income, employment and social isolation. In practice, people are usually only given a formal diagnosis of dual diagnosis if they have severe mental health problems (generally psychotic disorders) **and** severe substance misuse problems that meet the criteria for specialist services. The issue then arises of how to access appropriate care for people whose problems, whilst distressing, are not considered "serious" enough to meet the threshold for specialist care. For example someone who has serious substance misuse problems but "moderate" mental health problems (such as anxiety or depression) or vice versa.

The term "dual diagnosis" does not specify the disorders and so could potentially apply to a person with any two conditions eg a learning disability and a mental health problem.

A label of dual diagnosis can lead to stigma and barriers in accessing services. Paradoxically, it can also be a passport to services, especially when specialist care is in short supply. It is important to note that the label "dual diagnosis" does not indicate a specifically new condition but rather identifies that the person has concurrent issues.

How common is dual diagnosis?

In the UK it is estimated that a third of patients in mental health services have a substance misuse problem. At the same time, around half of patients in drug and alcohol services have a mental health problem (most commonly depression or personality disorder[1]). In a major study[2] of people involved in substance misuse treatment, one in five people reported recent psychiatric treatment. Prevalence amongst the prison population is high. A study[3] by the Office of National Statistics indicated that:

10% of male remand prisoners had moderate dependency
40% had severe dependency
79% of male remand prisoners who were drug dependent had two additional mental disorders

What is the relationship between substance misuse and mental health?

The relationship is complex, controversial and varies from individual to individual. '*The Dual Diagnosis Good Practice Guide*' from the Department of Health describes four possible relationships:

• A primary psychiatric illness precipitates or leads to substance misuse
• Use of substances makes the mental health problem worse or alters its course
• Intoxication and/or substance dependence leads to psychological symptoms
• Substance misuse and/or withdrawal leads to psychiatric symptoms or illnesses

There is a range of factors that may make some people more vulnerable to either or both problems. These include genetic make up, environment and behaviour. The triggers are also diverse and may include a range of adverse life events such as homelessness, relationship breakdown or bereavement.

There remains debate about the extent to which substance use can **cause** mental illness. Drug induced psychosis is one area of study as are the effects of cannabis. There is more agreement that substance misuse may **trigger** or **exacerbate** mental illness. However, in practice it may be difficult to identify whether use caused the problem or is merely associated with it. Substance misuse can also mask a mental health problem which is then revealed when use is decreased. For example, a person with anxiety or depression may use stimulants as a means of coping with their situation.

It is important to recognise that people's mental health and substance misuse problems may vary over time. For example:

• People may vary the type and amount of substances they use – eg they may stay clear of illegal drugs but use alcohol or cannabis occasionally
• They may react differently to the same substance depending on the supply, their environment or their general health
• Their mental health problems may fluctuate. For example they may have episodes of ill health followed by long periods of stability
• Fluctuating vulnerability – for example a person may be vulnerable to using alcohol during periods of mania

Case study

In her late twenties, Sally began experiencing deep periods of depression and unusual shifts in mood. She was diagnosed as having bipolar disorder in 1994, aged 32 and was prescribed lithium. During initial assessment, she admitted to often not taking her medication when she felt well and this, and her escalating cocaine use, resulted in multiple compulsory hospital admissions under Section 3 of The Mental Health Act. Sally reported low self-esteem due to difficult family dynamics and said that cocaine made her feel more confident, but also made her take risks, which frightened her.

Counselling and support began whilst Sally was in hospital. This built on Sally's wish to control her illness and lead a "more productive" life. Sally began to realise that, to help reach her goals she needed to take her medication. She acknowledged that it helped "keep me well" and that, if she experienced side effects, she could talk to her care team. She also recognized that her cocaine use exacerbated her mental illness and put her at risk of sexual and financial exploitation.

Sally was able to remain drug free while in hospital, but realized that on discharge, this would be more difficult to maintain. Cocaine had left "a hole" in her life and it was important to replace it with meaningful activity. She therefore attended relapse prevention sessions and life skills groups run by a local voluntary agency and also looked forward to the complementary therapies on offer. Sally remains drug free and has had no hospital admission for over a year. She is currently studying beauty therapy in the hope of working in the future.

Section two
The policy framework for dual diagnosis

In this section we alert practitioners to two frameworks for practice produced by the Department of Health and the Royal College of Psychiatrists. We also provide a brief summary of key areas of policy that are relevant to dual diagnosis. Fuller descriptions of these can be found in Appendix 2 on page 81.

Practitioners should be aware that policy tends to focus on people with more severe problems who have been given a formal label of dual diagnosis.

Frameworks for practice

We particularly refer practitioners to two sets of guidelines:

Dual Diagnosis Good Practice Guide

Published by the Department of Health, this summarises current policy and good practice with emphasis on the provision of mental health services for people with severe mental health problems and problematic substance misuse.

The guide clarifies lead responsibilities and sets out ways in which substance misuse and mental health should work with and support each other. Its key provisions include:

• The primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse should lie within mental health services. This approach is referred to as 'mainstreaming', and aims to lessen the likelihood of people being shunted between services or losing contact completely

• Substance misuse agencies (both alcohol and drugs) should provide specialist support, consultancy and training to mental health teams

• Where clients have less severe mental health problems, mental health services should provide similar support to substance misuse agencies

• Clear pathways of joint working and treatment should be developed in dual diagnosis strategic planning

Local Implementation Teams (from mental health) and Drug Action Teams (from substance misuse) are responsible for the implementation of the Guide's requirements.

Co-existing problems of Mental Disorder and Substance Misuse (dual diagnosis) - an Information Manual

This is a more detailed resource for practitioners published by the Royal College of Psychiatrists in 2002. It contains similar sections to those covered in this toolkit but provides greater depth of discussion and good practice detail. The manual can be downloaded free from: www.rcpsych.ack.uk/cru/complete/ddip.htm

Other policy and service frameworks

The Mental Health National Service Framework (NSFMH)

Published in 1999, the NSFMH sets out how services will be planned, delivered and monitored. Several areas are relevant to dual diagnosis including mental health promotion, primary care and specialist services.

Two approaches to care are also particularly relevant:

The Care Programme Approach (CPA) is a framework for inter-agency working. It seeks to ensure that clients have a proper assessment and that services are co-ordinated in line with client need.

Assertive outreach and crisis resolution services are proactive approaches to engaging with clients and managing problems.

Models of Care (MoC)

This is effectively the comparable framework for substance misuse services. Although it does not have the formal status of a National Service Framework, it has similar aims in terms of specifying how services will be planned, delivered and monitored.

MoC emphasises care co-ordination and meeting multiple client needs through an integrated pathway of care. To this end, it groups services into four tiers and outlines the relationships between them. The tiers are set out in this toolkit in the '*In Practice*' section on page 36.

The Mental Health Act 1983

This Act sets out the circumstances in which an individual can be detained (sectioned) in hospital for assessment and/or treatment for their mental disorder without their consent. The '*References and Resources*' section explains the sections that are most commonly used (see page 83). It should be noted that this Act is currently under review.

The Mental Health Act contains several different sections. More information is available from www.imhap.com

The National Alcohol Harm Reduction Strategy for England

Published in March 2004, this document sets out the Government's strategy for tackling the harms and costs of alcohol misuse in England. The strategy recognises the need for co-ordination of services and commits to working within the Models of Care framework on integrated care pathways.

Updated Drug Strategy

Published by the Drug Strategy Directorate at the Home Office in 2002, the strategy aims to reduce the harm that drugs cause to society, including communities, individuals and their families.

The Social Exclusion Report – Mental Health and Social Exclusion

Published in June 2004, this document examines how to attack the cycle of deprivation linked to mental health problems (including considering the role of substance misuse). Both the National Institute for Mental Health (England) (NIMHE) and the National Treatment Agency for Substance Misuse (NTA) have agreed to take forward work in this area recommended by the report.

Section three
Substance use

This section is designed to give practitioners an introduction to some of the issues and concepts involved in substance misuse. It includes:

• What is a drug?
• The nature of use and misuse
• Why do people misuse?
• Patterns of misuse
• How common is substance misuse?

In the '*In Practice*' section on page 33-35 we include details of a range of treatments available from substance misuse services.

In Appendix 1 on page 72 we include a description of the substances that are most commonly misused.

What is a drug?

Drugs have been described as: 'any substance that, by its chemical nature, alters the structure or functioning of a living being'.

This is obviously a very broad definition that takes in a wide range of everyday socially accepted substances (coffee, tea) right through to illegal class A drugs. Nevertheless, an inclusive description can have some value in helping practitioners understand patterns of use and difficulties of changing or reducing use:

> *"We try to get staff to think about their own addictions – how difficult it is to lose weight, to stop drinking so much tea or coffee, give up cigarettes, cut down on social drinking. How ready are they to give up experiences that are pleasurable? It helps them think about the complexity and difficulty of change."*
>
> **Dual diagnosis trainer**

However, of more immediate concern to the practitioner is to understand different patterns of use and when substance use becomes problematic.

What is the difference between drug use and misuse?

Many of us use legal drugs like caffeine, nicotine, or alcohol without much thought. Their use is socially acceptable and, in some circumstances, encouraged. We may even consume unwise levels or have a temporary dependency without having a long-term dependency problem. It is important to note that some people may also take illegal drugs occasionally without being dependent on them – eg a recreational cocaine user.

The line between use and misuse is a fine one and will vary from individual to individual. However, a useful working definition of use and misuse has been developed by the drugs agency, Drugscope:

> **Drug use:** this refers to the taking of a drug, either by swallowing, smoking, injecting or any other way of getting it into the bloodstream. Drug use is used to refer to drug taking that, although it has some risk, is not necessarily wrong or dangerous. The term does not imply that drug taking is wrong and is therefore preferred by many not wishing to value-judge the taking of drugs.

> **Drug misuse:** implies use outside medical use and which is harmful or done in a wrong way. It refers to use that is dependent or part of a problematic or harmful behaviour. This is preferable to the older term drug 'abuse' which can imply a moral judgement.

Why do people misuse substances?

"I'd just got out of prison. I got straight back on the 'gear' again, 'cos my missus, my kids, my home - everything had gone."

Service user

The reasons why people use will be as varied as the individuals themselves. Some may enjoy the experience, wish to improve their sex life or hope to lose weight. Others who are socially excluded may find a sense of community with other drug users. For some, drug taking may be an escape from too much pressure. For others, it may be that boredom; peer pressure or a lack of opportunity is a trigger. Either way, it can be all too easy to create a vicious circle whereby using to escape problems only creates more problems and hence a greater need to escape.

Some people use to counter the withdrawal effects of other drugs. For example, benzodiazepines after stimulants. Or they may combine drugs to enhance the effect – for example cocaine and ecstasy. Alternatively, people may take illegal drugs to counter the unpleasant side effects of prescribed medication - for example muscle spasms or movement disorders arising from mental health medication.

"In the environment where I am living, there are so many negative vibes, so many things to get you into trouble, so many things to keep you down and keep you like on a depressive vibe. You have to smoke something to keep you up."

Service user

"We say to people – you mustn't take your drugs because they're bad for you, they do bad things, they're from bad people. Here are our drugs – they're OK. But we don't really subjectively understand what the experience of taking psychiatric drugs is. Some have terrible side effects."

Drug worker

"Often the symptoms that the medication is addressing are not those that actually cause the client most distress. For example people can be more concerned about anxiety and mood than about hearing voices. So then they can turn to street drugs to help them deal with social situations or to take away the symptoms of medication."

Dual diagnosis nurse

The role of adverse life circumstances is also much discussed in relation to both mental health and substance misuse. Not only can deprivation in itself be a trigger but also there is generally greater availability of drugs in deprived areas. The relationships between these factors is complex and beyond the scope of this toolkit to explore in detail.

Workers should however be mindful that, paradoxically, contact with health and social services could also make people more vulnerable. For example, clients discharged from hospital in receipt of benefits may be soft targets for drug dealers. There is also a worrying increase in the availability of illicit drugs in psychiatric wards.

Patterns of substance use

When considering patterns, the key factor is the amount taken and the effect on the person rather than issues around legality.

The legal status of a drug does not necessarily indicate how harmful it can be. The Government estimates that there are 3.8 million dependent drinkers in England and Wales. This is six times as many as those who are dependent on Class A drugs.

It is also worth noting that 'harm' can apply not only to the direct damage to the person but also to the behaviour associated with using. For example, there are known links between both alcohol and drugs and crime.

Factors affecting use

A number of factors may influence people's use:

Environment/culture: Poor social support, lack of employment or meaningful activity or adverse work environment, peer pressure, family situation.

Mood: can fluctuate from optimism to low self-worth and despondency.

Plasticity: this means variability in the effects of a drug. For example, heroin has low plasticity so that effects will be broadly similar for everyone. In contrast, LSD has high plasticity because its effects are very variable.

Types of use

It will be helpful for practitioners to know some of the terms used by substance misuse services to describe different patterns of drug use: These are not rigid definitions and use can be problematic at any stage.

Experimental use can be seen as a normal developmental pattern. For example, it could apply to a school pupil inhaling solvents for the first time with friends. Other examples could include an ecstasy user who tried the drug once about 6 months ago and wants to try it again, or a person who has grown up with no drugs or alcohol but gets drunk with friends to see how it feels.

The numbers of those experimenting are steadily increasing and the age of first time use is decreasing. However, experimental use tends to be random and is usually sociable. It is important to note that it does not necessarily lead to dependency - the "slippery slope" theory is not borne out by research.

Recreational use differs from experimentation, in that it is both regular and controlled and can also be stopped at any time. It applies to both legal and illegal substances and is usually a sociable experience. Examples could include a person who smokes cocaine every other month with their partner or someone who drinks alcohol at the weekend who doesn't consider this to be problematic.

Polydrug use. This is use of more than one drug by the same individual, either in a drug "cocktail" or one after the other.

Dependent use describes a compulsion to continue taking a drug in order to feel good or avoid feeling bad. This term is preferable to "**addiction**" which has negative connotations.

Dependence is often described as either physical or psychological. Psychological dependence is central to the definition of drug dependence. Physical dependence is a common and often important, but not a necessary, element of drug dependence.

Psychological dependence usually includes a strong desire to take a drug even in the knowledge it is harmful, or in spite of negative consequences. In severe cases intense craving and prominent drug-seeking behaviours are present.

Physical dependency is characterised by the need to take a substance to avoid physical discomfort or withdrawal symptoms. This results from repeated, heavy use of drugs like heroin, tranquillisers and alcohol. This can change the body chemistry so that, without a repeat dose, a person suffers physical withdrawal symptoms – such as "the shakes" and flu-like effects. For some drugs physical withdrawals can play a much greater part in continuing to reinforce the dependence. For example, heroin has a much more prominent physical dependence syndrome than drugs such as cannabis, or even cocaine.

Usually both the psychological and physical dependence on drugs are due to direct biological effects of the drug on the brain and nervous system. Common effects of most drugs that cause psychological dependence are direct or indirect changes in the brain reward and pleasure pathways. Physical withdrawals tend to be due to more specific nervous system changes related to the particular drug involved.

It is important to recognise that a range of individual biological, psychological and social factors can strongly influence development of drug dependence. The importance of these factors varies from person to person, and for some may be of greater importance than the simple biological drug effects in maintaining dependence of in contributing to relapse.

Other kinds of "behavioural addictions" are referred to such as work, gambling or sex addictions. The mechanisms involved are also complex and not fully understood. However, a range of individual biological, psychological and social factors are also involved including evidence of effects in brain reward pathways too.

Binge – describes a pattern which involves episodic use of a substance in large amounts over a condensed period of time (which may be a period of hours, days or weeks), followed by little or no use. Often the period between binges becomes shorter and substance use becomes heavier and more problematic. Possible examples of binge using might include: a drinker who once a month consumes large amounts of alcohol all weekend and who may have physical complaints, such as liver damage or alcohol poisoning. Or, a crack cocaine user who spends large amounts of money, perhaps on the day the benefits cheque comes through, and then doesn't use for some time.

Harmful use. This term should follow the ICD10 definition that 'there must be clear evidence that substance use was responsible for or substantially contributed to physical or psychological harm.' It is interchangeable with problematic use.

Examples include a drinker who consumes large quantities of alcohol every day. She develops a tolerance to alcohol and then needs larger quantities to feel intoxicated. She has regular binges of very heavy use that affect her job and relationships. She knows that her drinking is a problem but is ambivalent about getting help.

Chaotic use: This is often polydrug use, combined with other significant health issues eg HIV and liver damage, and mental health problems. It can be described as excessive use of substances over a prolonged period of time, with the user finding it very difficult to live without the substance or experiencing problems stopping or regulating use. Such individuals may not appear to care or be aware of the dangers of their use

Note, when working towards change, it is important that these definitions are identified and accepted by the user.

How common is substance misuse?

Estimates vary widely. The '*Updated Drugs Strategy*' refers to 250,000 Class A drug users with the most severe problems. However, other research conducted by York University indicated a range of 280,000-500,000 people in the UK. According to the '*Alcohol Harm Reduction Strategy for England*', 1.8 million adults currently drink at very heavy levels. It is important to realise that the number of people in treatment does not reflect the much larger number of people who are dependent.

Key findings from the British Crime Survey 2001/2

• Of all 16-59 year olds, 12% had taken an illicit drug and 3% had used a Class A drug in the last year. This equates to around four million users of any illicit drug and around one million Class A drug users in the last year
• Cannabis is the most frequently used drug, with around 3 million of 16-59 year olds having used it in the last year

Section four
Mental health

This section includes:

• A brief introduction to mental health problems highlighting some issues around diagnosis

• Descriptions of the main types of mental health problems giving prevalence figures and examples of symptoms

The treatments that are normally offered by mental health services are described in the '*In Practice'* section on page 39-42.

Most of us experience variations in our mental health from time to time. However for some people these variations are prolonged and can result in considerable disturbance to everyday life. This is the point at which a diagnosis of mental illness may be given.

It can be helpful to think of mental health in terms of a continuum. At one extreme would be positive wellbeing. This would include both medical and social factors and is a state of active good health rather than simply the absence of illness.

At the other end would be "serious and enduring" mental health problems. However, it is important to recognise that everyone is on this continuum and that most people fluctuate between different positions. Even people with "serious" conditions can have long periods of being well. This fluctuation is one of the reasons why many people feel uncomfortable about psychiatric labels and diagnoses. Such labels may not be a good predictor of somebody's health at a given time and may lead to stigma and preconceptions.

Where a diagnosis is given this is because a doctor or psychiatrist recognises a number of symptoms and attributes them to a particular illness. However, practitioners should be aware that diagnosis is not an exact science. In practice, some symptoms can point towards two or more illnesses and misdiagnosis can also occur. In other instances, conditions remain undiagnosed.

Types of mental illness

Anxiety disorders

According to the Mental Health Foundation, anxiety disorders are the most common form of psychiatric illness affecting around one in ten of the population.

Anxiety, worry and fear are feelings that everyone experiences from time to time. However, some people experience them with a severity that is out of proportion to the real threats around them. This can have a profound impact on their ability to function normally.

Diagnosis can be more complex in the event of dual diagnosis. On the one hand, anxiety disorders can be brought on by drink and drug use. On the other hand, people who have an anxiety disorder may use drink or drugs to deal with the symptoms.

The general symptoms of anxiety disorders are:

• Feeling worried a lot of the time
• Feeling tired
• Difficulties concentrating
• Being irritable
• Problems sleeping
• Heart palpitations
• Heavy and rapid breathing
• Dizziness
• Feelings of dread or impending doom

Anxiety disorders include:

• Generalised anxiety disorder
• Obsessive compulsive disorder
• Panic disorder
• Post traumatic stress disorder
• Social anxiety disorder
• Specific phobias
• Separation anxiety disorder

One particular form of anxiety disorder is Post Traumatic Stress Disorder (PTSD). This is a pattern of behaviour that can occur after a traumatic experience or witnessing life threatening events such as serious accidents, violent personal assaults, sexual abuse or terrorist incidents. People with PTSD often re-live the experience through nightmares and flashbacks, have problems sleeping and feel detached from reality. PTSD is complicated by the fact that it often occurs together with other mental health problems like depression, anxiety, memory problems and substance misuse.

Depression

The severity and length of depression can vary widely from a short-term reaction to an adverse event to a prolonged episode that interferes with the ability to function, feel pleasure or maintain interest.

It is estimated that one in five people will experience depression at some point in their lives and about one in 20 people have clinical depression.

Symptoms of depression include:

• Feelings of helplessness and hopelessness
• Feeling useless, inadequate, bad
• Self hatred, constant questioning thoughts and actions, an overwhelming need for reassurance
• Being vulnerable and over sensitive
• A loss of energy and motivation
• Agitation and restlessness
• Physical aches and pains

In severe depression these feelings may also include:

• Suicidal ideas
• Failure to eat or drink
• Delusions and/or hallucinations

Sometimes depression may be masked – for example, by alcohol or drugs.

Schizophrenia

One in 100 people will experience schizophrenia during their lifetime.

Although for some people the illness may be chronic and enduring, many do recover and live ordinary lives. People are most likely to experience schizophrenia between their late teens and early twenties.

The causes of schizophrenia are still unclear though there are a number of theories. In relation to dual diagnosis, practitioners should be aware that drug use has not been conclusively shown to cause schizophrenia (or other severe and enduring mental health problems). However, long-term use of certain drugs could increase the chance of some people developing mental health problems.

There are two groups of symptoms. These are known as "positive" and "negative". Positive symptoms mean that people have more experiences than normal whilst negative symptoms involve some loss of normal experience.

Positive symptoms

Hallucinations and illusions
Hallucinations are perceptions that occur without connection to an appropriate source.

The most common hallucination is hearing voices. However, they can occur in any sensory form: auditory (sound), visual (sight), tactile (touch), gustatory (taste) and olfactory (smell).

Voices are usually thoughts in the mind. They can describe activities taking place, carry on a conversation, warn of dangers, or even issue orders. They can seem so loud that the person believes that they are audible to others around them.

To a person with schizophrenia, the voices appear to come from an external source. However, using modern imaging techniques, it is possible to see changes in the speech area of the brain at the time when the person says they are hearing voices. Thus, for practitioners, there is an important point: a person hearing hallucinatory voices is not simply imagining something. A measurable experience is actually happening.

Delusions
Delusions are false personal beliefs that are not subject to reason or evidence and are not explained by a person's usual cultural beliefs.

They make take a variety of forms. For example, about one-third of people with schizophrenia have paranoid-type symptoms. These usually involve delusions of persecution, or false and irrational beliefs

that they are being cheated, harassed, poisoned or are the subject of a conspiracy. These people often believe that a member of their family or someone close to them is making this happen.

Another form is delusions of grandeur in which the individual may believe they are a famous or important person.

Sometimes people's delusions are quite bizarre. For example, believing that a neighbour is controlling their behaviour with magnetic waves; that people on television are directing special messages to them; or that their thoughts are being broadcast aloud to others. A person experiencing delusions may try to keep them secret, knowing that others would not understand. Other people can become overwhelmed and begin to act strangely in accordance with their delusions.

Negative symptoms

Negative symptoms are when the person experiences a degree of withdrawal from their normal life. For example, families may gradually realise that their relative's behaviour has been changing over a period of time in subtle ways. They may have become slower to think, talk and move, or indifferent to social contact. Their sleeping patterns may have changed so that they remain up all night and sleep all day. Body language may also be affected.

The overall result is a reduction of motivation, the effect of which varies from minor to severe. Negative symptoms are much less dramatic than positive, but they tend to be more persistent.

Recognising these changes can be particularly difficult if the illness develops during teenage years when it is quite acceptable for changes in behaviour to occur, particularly where the young person is experimenting with new freedoms and lifestyles.

Bipolar disorder/manic depression

Around one in 100 people experience bipolar disorder which is also known as manic depression.

The key symptoms are unusual shifts in mood, energy and ability to function. These are severe and quite different from the normal ups and downs of everyday life.

Bipolar disorder typically develops in late adolescence or early adulthood though it is frequently not recognised until the symptoms become severe. It is often a long-term illness that must be carefully managed throughout a person's life.

Many people have long periods between episodes when they are free of symptoms. About one third have some residual symptoms and a small minority have unremitting symptoms. Symptoms of a depressive episode are described under "depression" above.

Some of the symptoms of a manic episode include:

• Increased energy, activity, restlessness
• An overly high, euphoric mood
• Extreme irritability
• Racing thoughts and sometimes talking fast, jumping from one idea to another

- Reduction in the need for sleep
- Unrealistic beliefs in abilities and powers

People with mania are more likely to use drugs, particularly cocaine, alcohol and sleeping medications.

Sometimes severe episodes of mania or depression include psychotic symptoms. These are described in more detail under the symptoms of schizophrenia.

Schizoaffective disorder

About one in every 200 people develops schizoaffective disorder although it is thought that this may be an underestimate.

The term is applied when symptoms of manic depression and symptoms of schizophrenia present at the same time (or within a few days of each other). Usually this diagnosis is given when the symptoms of schizophrenia are more pronounced. Schizoaffective disorder usually begins in late adolescence or early adulthood.

Personality disorders

Approximately 10-13% of the population has a personality disorder.

We are used to thinking of "personality" as the characteristics that make us unique. However, the term "personality disorder" is used when those personal characteristics cause someone to have regular and long term problems in the way they cope with life and interact with other people. There are different types of personality disorders. '*The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*', identifies ten:

- Paranoid
- Schizoid
- Schizotypal
- Antisocial
- Borderline
- Histrionic
- Narcissistic
- Dependent
- Avoidant
- Obsessive-compulsive

An individual may have more than one. However, it is likely that some people experiencing these problems will never come into contact with mental health services. Others may easily be misdiagnosed – particularly because the symptoms may be more general than those of other mental disorders. In addition, some people may have other mental health conditions co-existing with personality disorders, but these are not always diagnosed. '*Co-existing problems of Mental Disorder and Substance Misuse (dual diagnosis) - an Information Manual*' suggests that some personality disorders are more relevant to dual diagnosis than others. These include paranoid, schizoid, anti-social and borderline.

The issue of diagnosis may become more complex where substance misuse is also involved. On the one hand, to achieve a diagnosis of personality disorder the person's symptoms must not be as a result of drug or alcohol use. However, drug and alcohol dependence is often seen as a symptom of personality disorders.

When making a diagnosis, the criteria that a psychiatrist will look for may include the following:

• Symptoms have been present for an extended period of time. They are inflexible and pervasive, and are not a result of alcohol or drugs or another psychiatric disorder. The history of symptoms can usually be traced back to adolescence or at least early adulthood

• The symptoms have caused and continue to cause significant distress or negative consequences

• Problems are seen in at least two of the following areas:

  • Thoughts (ways of looking at the world thinking about self or others, and interacting)
  • Emotions (appropriateness, intensity, and range of emotional functioning)
  • Interpersonal Functioning (relationships and interpersonal skills)
  • Impulse Control

Further discussion around personality disorders

In the past, some professionals thought that personality disorders were untreatable. Hence, commissioning of services has generally been poor or patchy. This has led to significant confusion and misunderstanding about the disorder as well as to poor or patchy commissioning of services. In order to clarify understanding, we have provided greater detail on the diagnosis and treatment of personality disorders. This information is intended to challenge myths about treatability and to alert practitioners to new guidance. It does not therefore, imply that personality disorder is a special case in terms of treatment.

Treatment and services

A problem with services is that they have traditionally been focused on providing crisis and acute care. However, many people with personality disorders do not reach the threshold of crisis and may consequently not receive support. They may be living in an isolated way in the community without receiving care and this can become a trigger for drug or alcohol use. However more recently, there have been advances in treatment and the Government has recently published guidelines: '*Personality Disorder, no longer a diagnosis of exclusion*' (see page 69 for further details). Treatment may include medication which is mainly used to calm anxiety and stabilise mood.

In addition, psychological approaches have been shown to be effective. These include cognitive behavioural therapy (CBT) and also longer term psychotherapy. Another more specific form of therapy is Dialectical Behaviour Therapy (DBT) which is a longer-term form of CBT that has proved effective for some people with certain types of personality disorder.

Research[1] has looked at the effectiveness of different approaches in different settings. This includes psychological treatments, drug treatments, service models and approaches, (including therapeutic communities) and features of good management.

Whilst there is increasing data on treatment, practitioners should be aware that there may be a shortage of services in their locality. Each area should now have a strategy for the treatment of people with personality disorders and it may be helpful to identify and work with relevant people.

Engagement

It is particularly important to establish a good working relationship from the start. Many people with personality disorders may have had bad experiences of engaging with services and of not receiving appropriate support. This can lead to a vicious circle whereby they express their frustration and are then regarded as "difficult" by services.

Working with symptoms

Personality disorders have traditionally been viewed in medical terms, and this presents challenges to services which provide treatment based on medication. It is important to develop a better understanding from a psychological point of view, with an emphasis on changing behaviour. Try to look at the various symptoms and review whether they can be treated.

Making assumptions

Personality disorder remains a controversial diagnosis and an area where there is still much confusion. In particular, there is debate about the label "dangerous and severe personality disorder". In practice, workers are unlikely to encounter clients with this label. It is a term used by the Home Office rather than a diagnosis given by psychiatrists. A tiny minority of people will receive this label, many of whom are already in a special hospital or criminal justice system. It is important to avoid making assumptions.

Mental Health

Section five
In practice

In this section we look at issues and good practice around delivering services. This includes:

- The assessment process
- Assessing and managing risk
- Understanding and using the Care Programme Approach
- Types of treatment offered by substance misuse services
- Types of treatment offered by mental health services
- Complementary therapies
- Stages in treatment
- Involving service users and carers in treatment
- Meeting diverse needs including black and minority ethnic populations, women, gay, lesbian, bisexual and transgender populations

The assessment process

This section considers the core principles involved in assessing a client's needs and some of the issues that arise in practice. Some of these are particularly relevant to dual diagnosis and others are more general. We then offer some suggestions for good practice.

Some core principles

Thorough, multi-disciplinary assessment is the first step towards providing an effective package of medical and social care.

Practitioners should aim to establish[1]:
- The chronology of presenting problems
- The relationship (if any) between them
- Whether the disorders require independent treatment, or
- Whether treating one will help alleviate the other

It is also important to gain an holistic picture of the client's current lifestyle, domestic arrangements and historical factors relating to this.

This information should lead to a practical care plan that recognises a range of needs and wishes.

Some issues in practice

Preoccupations with "what came first"

Many practitioners become preoccupied with establishing whether a person's substance misuse is primary or secondary to their mental health problem or vice versa. In a few instances, this may be clear, but as we have seen, it is likely to be difficult to distinguish. There is a danger that answering this question, and deciding which service should lead, will become the focus of an assessment instead of the client's needs.

Unfortunately, the assessment often initiates a process of shunting the client between substance misuse or mental health services, with neither taking overall responsibility or co-ordinating care. In some cases, this shunting process is also linked to budgetary considerations or it may simply depend on which agency

the client approached first. (Some of these issues are discussed further in the section on service delivery on page 57). In other cases, access to mental health services may be difficult as some mental health teams actively exclude people whose primary problem is drug or alcohol misuse.

Confusing symptoms

The symptoms of some psychiatric disorders can be very similar to the effects of substance misuse.

For example, it can be difficult to tell the difference between psychosis that is an ongoing mental health problem, and drug-induced psychosis that may disappear when the substance use is stopped. An extra layer of complication may occur if more entrenched problems have been caused by extreme or long-term substance misuse.

In practice, it may be that an initial diagnosis is made and then reviewed at a later date. However, even if detoxification may clarify the issue, appropriate treatment may not be available, there may be long waiting lists, or the client may be unwilling or unable to consider it.

Differences in culture between substance misuse and mental health

There can be difficulties if the assessing psychiatrist feels that the client should be clean from substance misuse before they can be properly assessed.

Awareness of holistic needs

In practice, assessments often concentrate on clinical needs and fail to address social needs such housing, employment, income or social networks. In fact, these factors are crucially relevant in terms of both the presenting problem and the treatment approach.

Clients and practitioners have different perspectives

There are many reasons why a client may perceive their issues differently from a practitioner. Many people with multiple needs have experienced social exclusion and/or trauma and their previous contact with services may have been negative. For these and other reasons, they may not acknowledge the presence or extent of their difficulties, or they may not see their substance misuse or mental ill-health as a problem.

Practitioners should also be aware of the importance of cultural, spiritual and religious differences. These are discussed later in this section under '*Meeting Diverse Needs*'.

In addition, practitioners should be aware that stigma or the fear of stigma may act as a barrier to accessing services.

Good practice suggestions for assessment

Consider the client's concerns

Many people find it difficult to approach services and, in practice, many quickly disengage. From the client's perspective, the assessment can look as if it is for the benefit of the service rather than for them. The process can also seem intimidating.

It is important to be pragmatic. The key objective is to encourage the client to engage. This may mean that the assessment does not take place on the first meeting but is delayed until the client has a better understanding of what the service is offering. Or it may mean doing the assessment in stages so that it seems less intimidating. There is a balance to be struck between, on the one hand, ticking every box and, on the other hand, ensuring that services have the depth of information they need to plan appropriate referrals and treatment.

Consider a range of needs

It is vital to identify the range of a person's needs for medical and social care. Practitioners should consider issues such as the person's domestic situation, food and shelter, access to primary care and child care considerations. In practice, these issues have a huge effect not only on the problem but on the person's ability and motivation to engage in treatment.

Avoid assumptions and keep an open mind

Try to avoid making hasty conclusions and do seek advice from senior colleagues when appropriate. Wherever possible, make your assessment on the basis of the client's needs rather than on what services are available.

Timelines can be a useful tool

Moore and Rassool[2] recommend the use of timelines. This involves noting the sequence of events for both substance misuse and mental health problems over a given time. This may be over a lifetime or a shorter period. Timelines can provide invaluable information and help indicate priorities for treatment actions. This exercise should be done in partnership with the client to encourage them to make links between issues in their lives.

Monitor regularly

Be aware of behaviour that gives cause for concern and regularly review the client's progress. This is especially important for clients with relapsing conditions. This may involve providing training for team members so that they are aware of signs of relapse.

Recognise positive achievements

Assessments often focus on weaknesses, deficits and risks and fail to acknowledge people's achievements and strengths.

By recognising the positive you can help to build esteem, encourage engagement and also influence people's coping strategies and treatment outcomes.

Factors that may influence a diagnosis

- The expertise/experience of the professional making the diagnosis
- The definition of the psychiatric disorder[3] that is used (professionals often disagree on this)
- The perspective of the assessment team, (whether from a mental health or substance misuse perspective)
- The population studied: for example, an urban situation where there is heavy substance use or a population of successful professionals

Assessing and managing risk

"Staff see problems such as aggression and intoxication, but they don't often look beyond. Often that is the client's only way of communicating – by being abrupt and aggressive."

Nurse

It is important to have proper assessment and management of risk. This is not only to protect clients and workers but also because this is an area where there is significant ignorance, fear and stigma. If risk factors are simply ignored then hidden perceptions can hinder the treatment process.

Assessment of risk is essential for several reasons:
• It helps to establish a consistent approach
• It is key to the protection of the individual, professionals working with them and the wider community
• It enables the individual, practitioner and other professionals to work more effectively together and therefore helps to promote engagement

Some other factors to bear in mind in relation to risk include:
Clients are more likely to pose risk to themselves than to others. Practitioners need to be aware of the risk of self-harm and attempted suicide.

Practitioners may fear that asking about 'risky behaviours' or suicidal feelings might encourage the individual to engage in them. In fact, this is unlikely. Instead, by acknowledging people's thoughts, practitioners can work with them using techniques such as anger management programmes, individual therapy and group work.

For those with mental health problems, misuse of drugs or alcohol can contribute significantly to the risk of violence and disturbed behaviour. This is particularly true if misuse is combined with poor compliance with medication or treatment programmes.

Research shows that people who have a dual diagnosis are more likely to have a history of violence than people with mental health problems who are not using substances. However the link between substance misuse and violence is unclear but this may be due to disinhibition. The environment of misuse could also play a part since the illegality of many substances and associated crime may bring closer links with violent behaviour.

It is important that the risk assessment looks at the individual rather than generalised risk factors.

It is helpful for services to work together to develop protocols that enable a shared approach to risk assessment and management.

If yours is a referral only service, you may need to complete a full assessment before the client can use the service.

Include as part of the assessment process, a contingency plan for a deterioration in the client's substance misuse or a mental health crisis.

Suggestions for good practice in risk assessment

Comprehensive assessments

Assessment should be systematic and thorough and may therefore take more than one appointment.
It should consider four main elements:
- Suicidal (or self-harming) ideas, plans and intentions
- Ideas, thoughts and actions of harming other people
- Self-neglect
- Risks from others including exploitation

Threats to undertake violent acts either to self or others should always be taken seriously.

It is important to include past history as well as the client's current situation.

Developing assessment tools

There is no one recommended risk assessment tool for people with co-existing mental health and substance misuse problems. Therefore we recommend that practitioners look at existing tools in mental health and substance misuse and adapt them for this population. Some of the factors to consider include blood-borne viruses, compliance with medication and dangerous injecting techniques.

The importance of teamwork

This is essential both to support clients and workers. The 'team' should be multidisciplinary and should include relevant workers in a range of statutory and voluntary organisations.

For clients, such teamworking gives a greater sense of confidence that their multiple needs are being addressed. For staff, support is also important as the work is demanding and progress can often seem slow.

Clear lines of responsibility

When clear expectations and boundaries are established and communicated, this benefits all team members including the client. It also encourages compliance with treatment and medication.

In Practice

Information sharing and confidentiality

It is good practice to obtain consent from the client before sharing information. The client's wishes should only be overridden where there is a legal requirement, defined concerns about public interest or a serious risk to the client or others.

However practitioners should be aware that clients may be reluctant to permit information sharing. This may be because their drug use is illegal, or because they have had a previous negative experience of services, or even because of paranoia and anxiety relating to their psychological difficulties. In consequence it is important to treat these issues with sensitivity. Try to explain why information is shared ie to ensure that factual, relevant information is available to deliver the best possible care. Reassure the client that their privacy will be respected. Ensure that they have the information to which they are entitled.

The importance of information sharing cannot be over-emphasised when assessing future risk of an individual.

It may be useful to include family and friends in the list of possible sources of information.

You will need to have protocols for sharing information that should apply across a range of services and departments and in both the statutory and voluntary sectors.

For further information, see '*Morgan S: Clinical Risk Management, A Clinical Tool and Practitioner Manual*' published by the Sainsbury Centre for Mental Health.

The Caldicott Report

The Department of Health's '*Caldicott Report (1997)*' identified weaknesses in the way parts of the NHS handled confidential patient data and so set out guidelines in order that:

1. Sharing of confidential information should be **justified**
2. Confidential information should only be shared when **absolutely necessary**;
3. The **minimum** information should be shared
4. Access should be on a **strictly need to know basis**
5. Everyone handling confidential information should be **aware of their responsibilities**
6. Everyone involved should understand and **comply with the law**

The report also recommended that a senior manager/s within an organisation should take responsibility to ensure patient data is kept secure and called this role a "Caldicott Guardian".

At present, compliance with these guidelines is mandatory for NHS providers and local authorities and is good practice for other agencies in order to meet the requirements of the Data Protection Act (1998).

Practical advice about how to implement the Caldicott Guidelines and the use and protection of patient information is outlined in the '*NHS Confidentiality Code of Practice (2003)*'. More information is available from: www.dh.gov.uk/PolicyAndGuidance/InformationTechnology/PatientConfidentialityAnd CaldicottGuardians/fs/en

Regular reviews

The nature and likelihood of risk is not constant. It can be exacerbated by some factors, restrained by others and can change over time. Therefore it is important to review assessments regularly - at least every 6 months and if possible, every 3 months.

Traditionally, reviews are often consultant led. However, it is increasingly recognised as good practice to carry out reviews in less clinical environments. For example substance misuse workers could attend reviews in out-patient departments, or mental health staff could go to substance misuse services or other community centres. It is also good practice for the client to attend.

Good quality documentation

It is essential that assessments, meetings and discussions about a client are recorded alongside care plans, and suicide prevention plans if appropriate. Other team members should know where this is stored in case of emergency. There should be at least a daily handover to update colleagues about each client in residential settings, where there are concerns about risk.

Staff training

All staff should receive training about risk assessment and management, at induction and on an ongoing basis.

In Practice

Understanding and using the Care Programme Approach

It is important for practitioners in all relevant services to be aware of the Care Programme Approach (CPA). This provides the basic framework for ensuring that a range of agencies work effectively together to provide integrated packages of care.

The CPA was developed by the Department of Health and is the accepted framework for working with people with mental health needs. Its key provisions for inter-agency working are:

• A systematic assessment of health and social care needs
• An agreed care plan, detailing responsibilities within the team
• A care co-ordinator whose role includes keeping in touch with the service user and monitoring arrangements
• A regular review (at least every 6 months), making changes as necessary. This may be more frequent, depending on an individual circumstances, eg whether in-patient or out-patient

When using the CPA it is good practice to ensure that all parties have the relevant documentation. This means practitioners in all the services involved with the client. In addition, service users and their identified carers should also be given a summary copy of their CPA care plan. By law, services must apply the CPA to all the clients of working age who are accepted into mental health services. There are however, two levels of activity:

Enhanced – for those with severe mental illness with a high level of risk to themselves or others.
Standard – for those who have lower level mental health problems or needs. Their care may be co-ordinated by the primary care team.

It should be noted that there is a similar framework within substance misuse. Models of Care (see page 36 for explanation) provides for Enhanced Care Co-ordination and Standard Care Co-ordination.

The CPA is a valuable framework and is effective when it is implemented, regularly reviewed and when teams work well together.

In practice however, co-ordinating care between disparate agencies and across professional disciplines can be problematic. People may have different professional views and it can be hard to co-ordinate diaries to get all the appropriate people together. Hence, reviews can sometimes be delayed.

In addition, when services are under pressure, clients who are on standard CPA may not be seen as a priority and so may not be seen as regularly as they should be by the team. Others clients may have significant needs but not fulfil the criteria for accessing support, or they may simply be undiagnosed.

In this way, many people with co-existing mental health and substance misuse problems can fall through the CPA net. Others, may technically be under the care of a psychiatrist or community psychiatric nurse (CPN), but may not actually engage with them.

If these people are in contact with services, it is more likely to be with voluntary sector agencies or housing agencies. In such situations, it is essential that casework is co-ordinated as much as possible with regular meetings of all partners. If the person is not seeing a psychiatrist or CPN, it is important to find out if they have a key worker and what other support is available to them. This could include day services or crisis intervention, primary care and support from family and friends.

The key point to remember in practice is that, although CPA is the official mechanism for joint working, it may not always be in place. However, collaboration is still vital and should be pursued even if it is on a less formal basis.

The role of the key worker

The concept of a key worker is central to both the CPA and Models of Care. This person may be the central co-ordinator of a package of care.

The key worker may be located in a range of agencies but the core task is to ensure that all involved in providing a particular package of care understand their own roles, responsibilities and boundaries and how these relate to the roles of other workers and agencies.

The core tasks of the key worker are to:

• Help to set realistic and achievable goals
• Help to make best use of available assistance
• Develop an integrated package of care and support
• Promote the client's independence & empowerment

This may involve liaison, sharing information, organising services, advocating, advising, supporting, handling conflict, writing reports and monitoring resources.

A carer's perspective

John is a carer for his son, Philip who started using drugs in 1980 and was diagnosed with schizophrenia in 1984.

When Philip first started using drugs, it was four years before we realized there was an underlying mental health problem. The two issues were closely interlinked. I realized he was using drugs to counter not just the psychosis but also the effects of the medication he'd been given. He'd say, "I need some stuff after the medication – it makes me brain dead." The medication would inhibit his dopamine levels and slow him down so he would take amphetamines to speed up again.

I think it's important that staff help carers to be more aware of the physical effects associated with dual diagnosis. That includes not just street drugs and medication but the physical effects of mental illness such as reduced motivation and effects of substance misuse in terms of lack of appetite and energy. This is really important in understanding someone's behaviour and helping them to cope. For example, we used to make extra portions of our food, freeze them and then take them to Philip because otherwise he wouldn't eat.

Another huge issue is support for carers in dealing with difficult behaviour. It can be very hard to manage a person who is on a short fuse, impulsive or even suicidal. Staff are experienced in handling such situations but carers are given little advice.

Housing is also a big issue because of the stigmatising behaviour of mental health services. The figures give a very high prevalence for dual diagnosis yet few housing projects are prepared to take clients with mental health and substance misuse problems. Where are they meant to go? Often parents get caught up in subsidizing their housing and then find they are stuck with doing this as no-one else will pick up the tab.

I've been a carer for a long time. I've got used to hunting down the information I need on the web. However, services could do much more to involve us and use us as a resource. The reality is, we are an essential part of the care team.

In Practice

Care Planning

Care planning is crucial to both the CPA and Models of Care.

A care plan sets out the essential steps in a person's care and describes the expected treatment. Typically it is structured, multi-disciplinary, and task-oriented. It should always be developed with the active participation of the client.

A care plan should include:
• The treatment goals and milestones to be achieved
• Treatment interventions specifying which agency and professional is responsible
• A specification of how information will be shared: which information will be given to which agencies and under what circumstances
• An engagement plan – this is particularly for people who have found it difficult to engage with services
• Consideration of any relevant issues relating to the client's culture and ethnicity
• A review date

The plan should also take account of any risk assessments.
(Adapted from '*Models of Care*' developed by The National Treatment Agency).

Person-centred Planning

Workers often look at what services are available and try to fit the client into these. The idea behind person-centred planning is to start with the client and their needs and wishes and to match these with what is available. It may include involving their family or friends where appropriate.

Being person-centred means:

• More than an exercise on paper, it's a culture where clients come first
• Considering how clients are involved in meetings about their own support, which may involve for example, provision of advocates and or interpreters or changing the location or time of the meeting. Meetings should be informing and empowering for the client
• Ensuring that people's personal histories are recorded in ways which are meaningful to them and their families. Regular staff changes, or a change in service provision should not mean that the process has to start again
• Considering funding streams which enable a person-centred approach, for example, direct payments

Summary of good practice recommendations

When a client is under CPA, reviews must be regular and multi-disciplinary.

Information should be kept up to date and circulated within the team.

A client and their identified carer should be given a summary copy of their CPA care plan.

Support systems should also be in place for those not under CPA, including contact with a key worker.

A care plan is central to CPA. This should also actively involve the client, and other professionals as necessary and be regularly reviewed.

Treatment

The value of treatment

Research has consistently found that there are clear benefits from treatment in terms of reduction, of drug use, abstinence and reduced criminal activity.

The evidence also shows that the faster the person gets into treatment, the more likely they are to stick with it and hence to achieve a better outcome. In practice, the success of treatment will depend on a number of other factors including the motivation of the person, the severity of their dependence and mental health problems, the extent to which their social care needs (eg housing, income) are met and the extent to which they have supportive social networks.

When considering the "success" of treatment, practitioners should be aware that there are a range of possible goals. Whilst abstinence may be an appropriate target for some, for others it may be unrealistic. Some other goals that may be appropriate include:

- Harm reduction: reducing the risks associated with drug taking. This includes both risks to the individual and to society. It could involve programmes such as supervised consumption, needle exchanges providing clean works for injecting, programmes to address wider health needs such as reducing the risk of HIV or hepatitis
- Stabilising consumption. This is obviously helpful in its own right but may also enable people to meet the criteria for other treatment programmes
- Education: improving people's awareness of risky behaviour, their understanding of any additional mental illness, their understanding of how the care system works and how to access support
- Addressing people's social care needs and possibly some of the triggers for substance misuse

The most important factors to consider are:
- Ensuring that treatment should address a broad range of needs including both health and social issues
- Planning treatment on the actual needs and situation of the individual not following some abstract preconception of "success"

In Practice

Types of treatment offered by substance misuse services

The categories below describe broad approaches to treatment. Within each category there may be a number of specific service models.

Detoxification

The aim of detoxification is to eliminate substances from the body. It is often a gradual process and can involve the use of substitute medication to alleviate physical withdrawal symptoms. The substitute is usually given in progressively smaller amounts.

For opiate withdrawal, there are different types of medication. The most frequently used are methadone, Subutex, Britlofex or Naltrexone. Alcohol withdrawal is aided by benzodiazepines of which Librium is the most popular. Vitamins such as B complex can also help to aid physical recovery. For stimulant users there is currently no substitute medication that has been confirmed to be effective. Sometimes antipsychotics may be offered but in general, support focuses on approaches such as support, structured counselling, and additional complementary therapies (including acupuncture) as well as other health and nutrition programmes.

There are different types of detoxification programmes and services should review these in terms of the client's need. Factors to consider are the average amount of substances consumed, the length of time the client has been dependent and their physiological and psychological condition. Variations in treatment may include the length of the programme and the setting – for example at home, in the community or residential.

Detoxification should not be seen as complete in itself but as preparation for further treatment. Once physical dependence has been reduced, a client is likely to require ongoing support to address the effects of psychological dependence and the issues underlying their misuse.

It may also be that detoxification enables services to assess underlying mental health problems and offer appropriate treatment.

Substitute prescribing

This is where a substitute prescribed drug is provided – usually under supervision. There are several reasons why this may be done:

• To reduce and eventually stop misuse as described above
• To stabilise use
• To reduce the risks involved in drug use. For example, a prescription drug is a known quantity whereas street drugs can vary widely in their purity and strength

Currently the most common substitute drug is methadone which is used for opiate dependence. It is generally provided in community settings with an accompanying package of support and therapy. A small number of doctors in the UK are licensed toto prescribe pharmaceutical heroin (diamorphine) for the management of dependence. Buprenorphine is also increasingly being used.

In Practice

Harm reduction

There is a range of interventions including education/advice and needle exchanges where people can obtain safe injecting equipment. This approach goes beyond drug and alcohol use and can also consider practical steps to address other issues in a person's life – often through a care plan. This might include arranging housing appointments, debt counselling, and looking at wider health needs. The health needs might include considerations of risks arising from substance misuse such as HIV and Hepatitis as well as generic check ups.

Counselling and psychological treatments

There is a wide variety of talking treatments that are provided to both individuals and groups in a range of settings. These include individual counselling, group work therapy, structured day programmes, self-help groups (Narcotics Anonymous, Alcoholics Anonymous etc), outreach and drop-ins and criminal justice interventions.

A range of approaches is also used in mental health services. These are described in more detail under '*Mental Health Treatments*' on page 39-42.

Some talking treatments focus on enabling the client to explore their issues in a non-judgemental setting. Others will provide practical support to explore issues such as the underlying factors influencing substance misuse and practical coping strategies that the client can adopt. Other aspects of counselling techniques may be used in assessing issues and needs (eg motivational interviewing as described on page 46).

Residential rehabilitation programmes

These programmes offer people the opportunity to leave their normal setting and live for a time in a safe, structured therapeutic environment. This can provide a valuable opportunity to maintain abstinence and improve health and lifestyle.

A short term programme may last between six and 12 weeks and may include detoxification as the first stage. A long-term programme may last between 12-52 weeks and does not usually provide detoxification.

Research demonstrates that residential treatment offers many benefits. However, "drop out" is also common, particularly in the first two weeks. Unfortunately there is very little residential treatment available that is specifically geared to people with a dual diagnosis.

In Practice

Accessing Treatment for substance misuse

Some services allow clients to refer themselves. Others require a referral from a service or professional such as a GP, accident and emergency services, community drug projects, mental health professionals or through a number of criminal justice initiatives.

The underpinning framework for substance misuse is known as Models of Care. This groups services into four levels or "tiers". The table below, adapted from Models of Care, gives a summary of the tiers and their main referral routes.

Tier No.	Tier Title	Type of service, with examples	Main routes of access
1	**Non-substance misuse specific services**	Work with a wide range of clients including those who misuse drugs or alcohol, but their sole purpose is not drug or alcohol treatment eg: • Primary care • Housing services • A&E • General psychiatric services • General probation services	• Self-refer • Referred by other agency
2	**Open access substance misuse service**	Provide drug and alcohol services described as low-threshold, often short-term eg: • Drug related-advice and information • Open access or drop in services • Needle exchange, outreach services • Low-threshold prescribing • Drug misuse specific assessments and care management	• Self-refer • Referred by other agency
3	**Structured community–based specialist drug misuse services**	• Structured counselling and therapy • Structured day programmes and aftercare programmes • Community based detoxes, and prescribing. Treatment programmes for offenders	• Self-refer • Referred by agency, primarily from Tier 2
4a	**Residential substance misuse specific services**	Aimed at those with high levels of need • In-patient drug detox and stabilisation services, crisis centres • Substance misuse rehabilitation services • Services for people with co-existing mental health and substance misuse disorders	• Self-refer (some instances) • Referred by specialist, primarily from Tier 3
4b	**Highly specialist non-substance misuse specific services**	Eg specialist psychiatric units and forensic services	• Referred by specialist, primarily from Tiers 2/4

In Practice

Geoff's story

Geoff is dependent on alcohol and has been using heroin for 23 years. He also has a diagnosis of depression. He has been in contact with many services over the years but for the last 15 years he has been coming to the Kaleidoscope project in Kingston on Thames. This project offers a community base combined with a range of services including methadone maintenance and reduction, needle exchange and detoxification.

My wife and I were both drug addicts. We had four children and we lost them because of the drugs and the drink. The youngest are in care. My older son died four years ago. He had a girlfriend who gave him methadone and after three days he went to sleep and didn't wake up. It was terrible – it still feels like yesterday. I'm also an alcoholic – my liver's gone and I've got Hepatitis C.

I think Kaleidoscope is perfection. That's a strong thing to say but I've been around a lot of services. This place is like my home. I come every day – it's not exciting but it's pleasurable to talk to people. You get your methadone and then go to the café. There's lots of other people who have been coming for a long time. They all know me, they're my friends. They ask about my kids – they've watched them grow up. You have access to the medical staff if you want them but they don't hassle you. They watch you but from afar – it's not in your face. The Hep C makes me sleepy. If I'm slumped over they would come over and say - are you OK?

It's like there's this strong network of people – nurses, social workers, staff, other users. People treat you with respect. They are interested in what's happening for you.

The dual diagnosis worker's perspective

In many ways Kaleidoscope is unique. At the heart of it is the networking and sense of community. So many drug misusers have nothing to do and nowhere to go in the daytimes. Here the café is at the centre of everything. People meet and talk and that helps us to informally keep an eye on how things are going as well as to deliver more formal interventions. As we see it, people need those kinds of networks as a basis for working on the drugs.

Interventions via the criminal justice system

As many substances are illegal, a significant number of people with co-existing mental health and substance misuse problems come into contact with the criminal justice system.

The Government's '*Updated Drug Strategy*' emphasises interventions at various stages of the criminal justice system - from police custody, to courts and probation, prison and through care. The aim of the Criminal Justice Interventions Programme (CJIP), is to improve integration between different agencies and interventions so that clients receive beginning-to-end support.

There are a number of specific programmes that are relevant to this client group:

Diversion

It is government policy to 'divert' people with mental health problems who have become involved with the criminal justice system to health and social services whenever this would be appropriate. This can be done at the police station, at the court, or from prison. If the person is detained under the Mental Health Act, various sections of the Act enable a person to be diverted from the criminal justice system. (See Home Office Circulars 66/90 and 12/95 for further details.)

Arrest Referral

Upon arrest, drug-misusing offenders are asked if they would like access to a drug worker who will then encourage them to take up appropriate treatment. Participation is voluntary and it is not an alternative to prosecution or the due process of law. In some cases, offenders may be referred by the courts.

Drug Treatment and Testing Orders (DTTOs)

These are stand-alone community sentences available on the advice of probation officers and the court. The CJIP seeks to manage offenders as they pass through the criminal justice system. The Criminal Justice Act (2003) will create a single generic community sentence made up of specific elements which will replace all existing community sentences, including the DTTO. Sentences will be drawn from a 'menu' of options, including different types and levels of drug treatment and can be tailored to meet the individual needs of the offender.

Within DTTOs, attention has been restricted to criminal justice and substance misuse treatment systems and has not adequately addressed ties with mental health care services. DTTOs have not anticipated the high proportion of offenders experiencing mental health problems. In practice, most areas have felt that drug users with mental health problems are unsuitable for a DTTO.

The National Audit Office's report '*DTTOs, the Early Lessons, (2004)*' recommended that health assessments for appropriate treatment might be considered for people with co-existing problems for whom DTTOs were not considered suitable.

Treatment in prisons

Intensive Treatment Programmes are designed for prisoners with moderate to severe drug misuse problems and related offending behaviour.

Other prison-based services include voluntary drug testing and detoxification. These are available in all local and remand prisons.

The foundation of the prison drug treatment framework is the ***Counselling, Assessment, Referral, Advice and Through care (CARAT)*** services. These aim to meet the non-clinical needs of the great majority of prisoners and provide low threshold, low intensity and multidisciplinary interventions.

Through care is support for a drug misuser from the point of arrest to sentence and beyond. ***Aftercare*** is support after release from prison, or completion of a community sentence, or completion of treatment. This support should include help with housing, financial management, family relationships, learning new skills and employment.

Interventions via the Mental Health Act

The Mental Health Act can be used to provide compulsory assessment and treatment for people experiencing mental illness and substance misuse problems. It cannot, however, be used for people whose only presenting problem is substance misuse. A number of civil sections can be used including sections 2, 3, 4, and section 5 (see '*The Mental Health Act 1983*' on page 83 of this toolkit). Treatment provided is primarily for the mental illness. When the criteria for admitting someone under a section are no longer fulfilled, the person cannot be held.

Types of treatment offered by mental health services

In general, medication plays a more significant role in mental health treatment than in substance misuse treatment. However, psychological and social approaches are also important, either on their own or in conjunction with medication. The key is to adopt an holistic approach that reflects clients' needs such as housing and occupation/employment.

Medication cannot cure mental illness but it is becoming increasingly successful at controlling symptoms. In the past, the action of medication has often been crude leaving people with many side effects. Whilst many people still struggle with side effects, drugs have generally improved and there is a wider choice and fewer side effects.

Types of medication

There are four main types of medication:

• Antipsychotics
• Anti-depressants
• Anxiolytics
• Mood stabilisers

Antipsychotics

Antipsychotics are generally used to treat psychotic disorders such as schizophrenia, schizoaffective disorders and mania. They are sometimes used for psychotic depression or personality disorders or, in low doses, for people with severe anxiety disorders.

There are two types of antipsychotics: older typical and newer atypical. The older typical are the most researched and, until now, the most prescribed. Common side effects are sedation and movement disorders. Important side-effects reported include tremors, shakiness and abnormal movements in limbs. These side effects can be disturbing, both for the person taking the drug and for others.

Newer atypical antipsychotics are better at treating the negative symptoms of psychotic illnesses and are less likely to induce movement disorders. The side effects recorded so far include weight gain, sexual problems, and diabetes.

Anti-depressants

Anti-depressants are used to treat depression and the depressive phases of manic depression. There are four types of anti-depressant:

• Tricyclic
• Selective serotonin re-uptake inhibitors (SSRIs)
• Mono-amine oxidase inhibitors (MAOIs)
• Others

All of these work in a similar way to improve mood. However, they can have varying side effects. Common effects include dry mouth, sexual problems, drowsiness, weight gain and nausea.

In Practice

Anxiolytics

Anxiolytics are used to relieve anxiety. Benzodiazepines are the most frequently prescribed. The most common side effects are drowsiness and dizziness. Anxiolytics are highly addictive and should only be prescribed for a short time for severe problems.

Mood stabilisers

Mood stabilisers are given to people with bipolar disorder, severe depression and some people with personality disorders. There has recently been an increase in the number of mood stabilising drugs though many of the old prescriptions are established as safe and effective. The side effects are different for each medication.

Types of psychosocial therapy

The benefits of "talking treatments" have long been recognised. These approaches are particularly important for people with dual diagnosis where psychosocial problems may have led to mental illness or drug and alcohol use.

Approaches that are particularly relevant include:
• Counselling
• Cognitive therapy
• Psychotherapy
• Family intervention
• Dialectical behavioural therapy
• Art therapy
• Drama therapy
• Group therapy

Most of these approaches focus on talking and listening. However, art and drama are more practical and involve a creative approach to tackling difficult issues. Clients may benefit from receiving an assessment from a psychologist to decide which approach is most suitable.

Counselling

Some people may become confused because they wrongly think that 'counselling' is the generic term for all talking therapies. In fact, in this context, counselling is a specific intervention.

Counselling offers a space where clients can share their problems with a trained professional. A very basic distinction between counselling, cognitive approaches and psychotherapy is that counselling tends to be essentially supportive, cognitive tends to focus on practical problem solving, and psychotherapy tends to be more exploratory. In practice, the distinctions may be somewhat blurred and many therapists may use a range of strategies.

Counselling is offered in a wide variety of settings. It is characterised by being supportive, allowing the client an opportunity to express their feelings and concerns without feeling either judged or directed. In this way, it seeks to empower clients to make their own decisions.

Cognitive therapy

Cognitive therapy is a relatively short-term, focused and practical approach used for a range of problems. The focus is on how clients are thinking, behaving, and communicating today rather than on early childhood.

There are three commonly used approaches:

• Cognitive behaviour therapy
• Cognitive analytic therapy
• Dialectical behaviour therapy

Cognitive therapy is often provided by a psychologist but it can also be used by doctors, nurses, counsellors and social workers. Sessions are usually weekly and last for approximately an hour.

Psychotherapy

Psychotherapy tends to be more exploratory than cognitive therapy and is likely to probe more deeply into underlying issues. It provides a safe, formal and professional space where the client can explore difficult, and often painful emotions and experiences such as anxiety, depression, trauma, or even the loss of meaning in life. Psychotherapy aims to help the individual to increase their capacity for choice and become more autonomous and self determined. It may be provided for individual adults, children, couples, families or groups.

Psychotherapy is good for treating:

• Anxiety
• Panic attacks
• Emotional problems
• Personality disorders
• Stress
• Insomnia
• Depression
• Bipolar disorder
• Relationship problems
• Psychological sexual problems

Psychotherapy is:

• An active process of participation
• Offered within a set time frame – for each session and usually with an agreed number of sessions in the first instance if it is offered in an NHS setting
• Aimed at addressing current problems and also teaching problem solving skills
• Aimed at reducing current symptoms and helping clients to prevent similar situations arising in future

Whilst psychotherapy is not always able to treat severe mental illness it can be helpful in:
• Increasing compliance with medication
• Enhancing social and occupational abilities
• Improving ability to deal with stressors in society

In Practice

- Decreasing denial and encouraging acceptance of the disorder
- Decreasing the trauma associated with the disorder

There are a range of approaches within the broad heading of psychotherapy and more information can be found at www.psychotherapy.org.uk

Family intervention

A family intervention is designed to help a client by bringing together family members, friends, co-workers and other supporters. Using a skilled and professional facilitator, the therapy can explore issues, processes and needs in a dynamic, honest and supportive way. This intervention can be very successful in encouraging the client to seek treatment.

Family interventions were originally developed to help families with a range of addictive problems. More recently, they have also been used to help families to cope with schizophrenia. Family intervention consists of psycho-education, behavioural problem solving, family support and crisis management. Some interventions are conducted with one family, others may bring several families together. They vary in a number of ways – for example in including or excluding the patient, in the length of the intervention and accordingly to the severity of the problem being addressed.

Art therapy

Art therapy uses a range of media, images, creative processes and responses to the creative process. Through these, it seeks to illuminate the client's development, abilities, personality, interests, concerns and conflicts. It can be powerful in helping clients to find different artistic 'languages' to understand and express their issues. The creative process is underpinned by a framework of developmental and psychological theory. This draws on a wide range of counselling approaches.

Art therapy is used to treat a wide range of psychological issues. It is used for individuals, couples, families, groups and communities and with adults, children and adolescents. Art therapists are trained in both therapy and art and often work as part of clinical teams.

Drama therapy

Similarly to art therapy, drama therapy tries to give clients a different medium to explore and express their issues. It is an active, experiential approach that helps clients to tell their story, express feelings, explore their inner life, build relationships and achieve personal growth. It also helps in relieving symptoms, solving problems, setting goals, developing life skills and achieving resolution of conflicts.

Drama therapists are trained in theatre arts, psychology, psychotherapy and drama therapy.

Complementary therapies

Complementary therapies are used throughout the world to treat drug and alcohol dependence as part of an holistic package of care.

The most frequently used are auricular (ear) acupuncture, shiatsu and reflexology. There are no substitute drugs for cocaine and cannabis and acupuncture is one of the few alternatives that most users accept. Although there is equivocal evidence supporting the specific effectiveness of acupuncture it is used for people dependent on opiates, cocaine/crack and alcohol. Clients report that the treatments help to alleviate anxiety, stress and physical pains, reduce substance cravings, promote relaxation, strengthen emotional and mental energy and aid sleep.

There has been little research into the effectiveness of complementary therapies in relation to dual diagnosis. The limited literature focuses on acupuncture and less severe mental ill health. However, in addition to some of the benefits outlined above, people with mental health issues also say that they enjoy the opportunity to relax in an holistic, rather than "medical" environment.

Complementary therapies also appear to play a valuable role in engaging clients and in sustaining contact with services.

Stages in treatment of dual diagnosis

Whilst all services could point to different phases in clients' progress, the concept of having clearly defined stages in treatment is more common in substance misuse. The reasons for this go beyond the scope of this toolkit. However, in very general terms, it relates to the fact that people with substance misuse problems may not see themselves as "ill" in the same way as people with a clearly medical problem such as cancer.

Hence, there is a need to positively reach out and engage with clients, and particular skills and techniques associated with different stages in treatment.

Osher and Kofoed (1989)[1] have identified four stages in a long-term process that is particularly relevant to people who have co-existing mental health and substance misuse problems. In practice, each person will be different. They may move back and forward between stages and their progress from one to the other will vary. The four stages are:

• Engagement
• Persuasion (Working towards change)
• Active Treatment
• Relapse Prevention

We will look at each of the four stages in turn and consider the '*Cycle of Change*' and Motivational Interviewing at Stage 2 (Persuasion).

Stage one: engagement

Engagement has been described as forming a therapeutic alliance with a client. This first step is crucial to later stages in both achieving participation and ensuring that care is truly person-centred.

Practitioners should never underestimate the difficulties that clients can face in contacting services. Common problems are:

• Difficulty in acknowledging a substance misuse or mental health problem
• The likelihood of increased stigma
• Worries about disclosing confidential information – who will have access to it and how it may be used
• Negative and sometimes traumatic experiences of services in the past. For example if a person with mental health problems has been admitted to hospital against their will
• Fears that children may be taken away by social services
• A loss of control and concerns about the medication that may be used
• Feeling intimidated by 'the system' with its numerous assessments. Doubting that "professionals" will be willing or able to help

Traditionally substance misuse services have operated on the basis that it is the client's responsibility to make contact with services and attend appointments and that this is a measure of their commitment to change.

However clients with co-existing mental health and substance misuse problems tend to find it difficult to engage with services. They have a history of "dropping out", failing to keep appointments and not adhering to treatment programmes. Hence a more assertive approach is required. This may take some time and involve considerable persistence and patience.

Factors that promote engagement

The following guidelines will help to promote engagement:

• Motivate clients to see the benefits of the treatment process - this requires a clear idea of what they need and value
• Have a non-confrontational, empathic and committed approach
• Offer help with meeting initial needs such as food, shelter, housing, clothing
• Provide assistance with benefit entitlements
• Provide assistance with legal matters
• Involve family or carers wherever possible
• Meet clients in settings where they feel safe. This may be more constructive than expecting them to come to services

One model of engagement outlined in the '*National Service Framework for Mental Health*' is the assertive outreach team. In this model, staff persistently and pro-actively contact patients.

Assertive outreach is commonly used to describe specialist teams with strict referral and operational criteria. However, features of assertive outreach are used by a broad range of professionals in other non-statutory settings. This may include home visits, or to getting to know family members and developing links with other agencies.

Many clients of assertive outreach services have dual diagnosis issues and these may be combined with other issues such as homelessness or contact with the criminal justice system.

In Practice

Case studies

The following case studies illustrate issues and practice around engagement and include perspectives from service users and workers. They are drawn from a voluntary sector community outreach service that uses principles based on assertive outreach.

A is a client who is "anti professional". She says she does not want or need any support. Staff have been successfully supporting her for over a year by "popping round" at various times and knocking on her door. A is very concerned about people coming into her home and rarely invites workers in in. However, she will usually engage in lengthy conversations on her doorstep. She will occasionally make contact via card or letter. This is generally an indicator that she would like a visit, though the card never actually asks for this.

B finds any social contact difficult as he would rather shut himself away and not "bother". He will not answer the telephone yet likes prior notice of visit times. As he often changes the time or day of a visit, this proved a block to working with him. After mutual discussion, it was agreed that "talking" between visits should be via email. This is working well as B can contact staff at his pace and feels in control. The e-mails now often let workers know if he is feeling low, it also helps with his feelings of not wanting to talk at particular times as he can choose to e-mail at a time best for him.

Initially, C did not welcome or recognize the value of 'social' support. He felt if the doctors couldn't do any more for him then he wouldn't get any better and just had to put up with his illness. At first he often cancelled visits but gradually over several months, with persistence and long conversations about the benefits of being able to get out, he is now able to meet others and actual talks at meetings about the benefits of outreach work in the voluntary sector.

Stage two: working towards change/persuasion

This stage is about building motivation and working towards change. In this section, we discuss two helpful approaches that are widely used in substance misuse.

The Cycle of Change
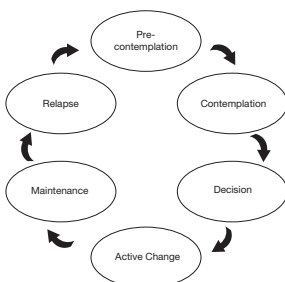
Prochaska and Diclemente (1983)

This makes the point that change is not an instant decision but rather one which involves a person going through a number of stages. The model helps practitioners to see what stage the client has reached and their readiness to change and to adjust the treatment accordingly.

Pre-contemplation: before the individual has recognised the need for change.
Contemplation: the individual recognises the problem and considers doing something about it. However, there is still ambivalence about change.
Decision: actually decides to do something about the problem behaviour.
Active change: the individual attempts to change the behaviour by seeking outside help (treatment).
Maintenance: the individual tries to maintain the changes made.
Relapse: a return to the levels of activity before treatment.

Motivational Interviewing

This is a form of counselling that aims to change behaviour. It is often used by specialist therapists. However, practitioners at all levels will find the approach helpful.

It involves presenting factual information in a non-judgmental way and inviting the client to give their views. The facts might include both standard statistics and personal data. For example, the general effects of substance misuse on mental health and specific results of the person's urine analysis.

The practitioner takes the role of an active listener who reflects back the client's responses. In this way, the client is helped to see aspects of their life that are problematic and how the use of substances exacerbates their difficulties.

There are five general principles:

- **Express empathy**
  Acceptance facilitates change
  Skillful reflective listening is essential
  Ambivalence is normal

- **Develop discrepancy**
  Awareness of consequences is important
  A discrepancy between present behaviour and important goals will motivate change
  The client should present the arguments for change

- **Avoid arguments**
  Arguments are counterproductive
  Defending breeds defensiveness
  Resistance is a signal to change strategies
  Labelling is unnecessary

- **Roll with resistance**
  Momentum can be used to good advantage
  Perceptions can be shifted
  New perspectives are invited but not imposed
  The client is a valuable resource in finding solutions to problems

- **Support self efficacy**
  Belief in the possibility of change is an important motivator
  The client is responsible for choosing and carrying out personal change
  There is hope in the range of alternative approaches available

The following table illustrates areas where the interviewer can easily go wrong and suggests some practical solutions.

<table>
<tr><td>Potential interviewer errors:
• Question-answer trap
• Confrontational-denial trap
• The expert trap (offering your solutions)
• The labelling trap
• Premature focus trap
• The blaming trap</td><td>Five early strategies:
• Ask open ended questions
• Listen reflectively
• Affirm
• Summarise
• Elicit self motivational statements:
     problem recognition
     expressions of concern
     intentions to change
     optimism about change</td></tr>
</table>

Stage three: active treatment

At this stage, the client is persuaded of the benefits of treatment and works with a range of practitioners to achieve agreed goals. It is important that the client is actively involved rather than a passive recipient and that the inputs of a range of care agencies is co-ordinated.

Factors involved in active treatments

Continuous assessment
Frequent reviews of progress and interventions are important. If a person is not engaging with a particular aspect of treatment, it may be better to re-visit this at a later stage.

Setting goals
These should be:
• Negotiated – reflecting both the professional judgement of the treatment team and the client's perspective and commitment
• Clear and measurable
• Realistic – avoid being over-ambitious
• Broken down into short-term targets to encourage a sense of achievement

In considering goals, it is important to include two broad areas:
• Enhancing people's coping skills
• Building their social skills and networks

Education and awareness
It is important that clients understand what their diagnosis means and are informed about the medication they are taking. This includes what it does, side-effects, contraindications with other substances they are using and effects on mental health. Practitioners should be aware that many clients lack this information and may feel unable to ask their psychiatrist.

Clients should be included in discussions and should be supported in developing questions to take to their next appointment. In this way they can feel more confident and involved in their care. Access to independent advocacy may be helpful.

Psychological interventions can also play a valuable role in education and can help a person to understand their situation and choices.

In Practice

Stage four: relapse prevention and management

Relapse should be anticipated in both substance misuse and mental illness. However, it is important that both the worker and client see this as an opportunity to learn and to develop preventative strategies.

Clients can be helped to identify situations in which they will become vulnerable to substance misuse or mental distress and can agree actions they will take in response. For example, if a person experiences anxiety around social interactions they may be helped by anxiety management or social skills training.

Other interventions that may be helpful include cognitive behavioural therapy, assertiveness training and relaxation techniques. In addition, meaningful activity is also very important. This might include voluntary or paid work, sport or hobbies. Such activities offer alternatives to usual patterns and can help to develop new social networks.

Factors involved in relapse prevention:

Identify high risk situations
This involves monitoring early warning signs and developing coping strategies.

Access to services
This may involve reviewing opening hours, considering crisis intervention and how mental health services can provide long term continuity of care.

Considering social factors
For example, housing, family and social situation.

Considering routines
Looking at whether a change of routine could be helpful – for example through education, voluntary work or leisure activities.

In Practice

Involving service users, families and carers in treatment

"Involving service users and their carers in their treatment and in service development is not an optional extra. The expert knowledge which they bring is a vital part of the resources which any service planners must have at their disposal."

Treated as People, SSI (2004)

Much of this toolkit has stressed the importance of partnership working between many agencies and different disciplines. Equally crucial is the role and involvement of the client and, where appropriate, their families and carers. Involvement should take places at all stages:

In treatment
This includes working with practitioners on short-term and long-term goals, and being present at review and other important meetings.

In the planning, delivery and development of existing services
Views can be expressed through a variety of ways, for example "suggestion boxes" at services, service user representatives, patient surveys or user forums.

In the planning and commissioning of future services
This is usually on a more formal level by consultation or involvement as part of a planning group.

Within services, the extent to which users are involved will vary. Some organisations are run by and for users. Others work in partnership with clients or describe themselves as working on behalf of clients.

The key point is that participation must be genuine and not tokenistic or superficial.

This is an important subject and beyond the scope of this toolkit to cover in depth. However some brief core principles include:

- Ensuring that relevant information is accessible and provided in user-friendly formats and languages
- Providing access to independent advocacy where appropriate. This should ensure that people understand their treatment and available options and are able to express opinions and preferences
- Making adequate resources available to support users. This could include both "human resources" such as facilitators or translators, and finance to cover transport and other expenses
- Giving regular feedback on actions suggested by users so that they know their views are taken seriously
- Encouraging users to participate. It is important that users are clear about why and how they will be involved and how this may affect outcomes
- Developing a culture that recognises and encourages the rights of service users to participate as fully as possible in decisions about their care and evaluate the services they receive

Meeting diverse needs

In principle, if care were truly person-centred then it would not be necessary to include chapters on diversity. In practice, it is useful to be aware that there are broad groups of people whose needs are not always appreciated or met within current services. In this section, we focus on three broad areas of diversity:

• Black and minority ethnic groups
• Women
• Gay, lesbian and transgender issues

Black and Minority Ethnic Groups

Although there are some local studies, data on substance misuse among ethnic minorities in the UK is sparse, and there is a danger of making estimations and broad generalisations.

The special issues relating to members minority ethnic groups with mental health problems are well known. A recent inquiry into the death of David Bennett (2004)[1] highlighted many of the problems:

• Misdiagnosis. For example, a disproportionate number of people from non-white ethnic groups are given a diagnosis of schizophrenia. In addition, psychiatrists can sometimes attribute mental health conditions to "drug induced psychosis". In Afro-Caribbean communities this often relates to the use of cannabis
• Institutional racism
• Disproportionate detention under the Mental Health Act
• The prevalent use of restraint
• Over-reliance on medication and less access to talking treatments

Good Practice Recommendations

Avoid making assumptions

It is easy to make assumptions around gender, race or sexuality, and create stereotypes, which can cloud our judgments. Minority ethnic communities are themselves diverse, each with distinct identities and with different ideas about both mental health and substance misuse.

Develop cultural awareness

Psychiatry was developed by white, male Europeans, and diagnoses can reflect this. Standard means of expression in one culture may be misinterpreted in another, perhaps leading to misdiagnosis. For example, people from some Asian cultures may look down as a sign of respect, which could be misinterpreted as shyness or evasiveness. People from an African or Afro-Caribbean culture may look at and speak to their listener directly, which could be misinterpreted as being aggressive.

Develop understanding of other models of health and illness

Different cultures will have different models of health and wellbeing and a variety of approaches to treatment. For example, some cultures have a more holistic approach in which there is less distinction between the person and the disease or between medicine and religion.

Whilst not abandoning European approaches, it is important to explore the client's understanding and beliefs and to address issues that they see as relevant to their psychological health.

In some cultures people will describe their psychological state in terms of physical symptoms, e.g. in some Asian cultures depression might be described as a chest pain. It may take careful questioning to separate the mental health problem from any medical problems.

Be aware of stigma

Many people with mental health and substance misuse issues experience stigma and feelings of shame and isolation but this can be more severe for people from ethnic minority communities. In addition to racism and exclusion within the wider community, there may also be stigma within their own community.

For refugees and immigrants, there may be barriers to working with UK services. For example, services may be seen as intimidating or alien and it may be culturally difficult to ask for help outside the family or community.

There is a need to match the type of contact to meet the needs of different clients.

In Practice

Recognise generational issues

The experience of people who were born in the UK will be different to elders who were immigrants. For example, first generation immigrants potentially face huge changes in financial and social status and family role. Their children however, may face cultural or identity conflicts and tensions in their position as carer or interpreter for their parents.

Understand differences in substance use

Substances and methods of use vary between different ethnic groups. For example, injecting is seen as 'dirty' and injectors are 'junkies', among people from the African and Afro-Caribbean communities who have historically tended to smoke and pipe drugs.

People from ethnic minorities may use drugs or alcohol with other members of their cultural and ethnic origin to re-establish a sense of community and to help overcome isolation and marginalisation. Some drugs have a cultural significance - for example, khat chewing among members of the Somali, Yemeni and Ethiopian communities. Practices and patterns can be very regional.

There are also significant differences of use between men and women. For example, women may misuse in the home because they rarely go out and feel socially isolated.

Making services more culturally appropriate

The workforce

There is a perception that services are run for and by white people. Ideally mental health and substance misuse teams should reflect the cultural and ethnic diversity in their local area. Strategies should be in place to recruit, retain and promote qualified and ethnically diverse staff at all levels.

It is also important to recognise and address racism where it exists. All staff should receive ongoing training in cultural awareness.

The range of treatment offered

Some services have a "European focus" with emphasis on prescribing and appointments. Treatment is much more than this and should offer a broad menu of options to meet the wide range of identified needs. In addition to psychological therapies, social support and access to ancillary services, complementary therapies such as acupuncture, aromatherapy, massage, hypnotherapy and meditation are found to be helpful. These have benefits to all clients, but can be particularly attractive to black and minority ethnic groups, for whom such treatments are more commonplace.

The delivery of services

To help overcome stigma, many agencies working with black or Asian clients provide services through telephone counselling. Others will see clients away from their home area. It is also important to consider gender specific services, especially for Asian clients. Other measures to consider include: different opening times, satellite clinics, clinics in other healthcare/community settings. Where possible, attention should be given to the décor of waiting areas and counselling rooms. Services should be developed in consultation with local communities to establish effective access and a suitable environment.

In Practice

Women

There are significant differences between men and women in relation to dual diagnosis. These apply to both the nature of their problems and the way in which they present to services. The needs of women and the implications for services are briefly considered below.

Childhood abuse

Women who misuse substances are significantly more likely than other women (or men) to have experienced sexual, physical and/or emotional abuse as children. It is important that these issues are addressed and also that there is greater provision of women only services where appropriate.

Physical violence

Rates of domestic violence amongst women are high. Refuge estimates that one in four women experience domestic violence at some point in their lives. Therefore it is important to consider provision of alternative, secure accommodation.

Medical illness

It has been shown that women with co-existing problems also have high rates of medical illness (Brunette 97[1]) and practitioners should be alert to these needs.

Issues around engaging with services

It is known that fewer women present to services than men. However, this may only be partially due to a lower prevalence of dual diagnosis. It could be that women are not seeking help or that services are not appropriate for their needs (Crome 97[2]). Women are more likely to present at mental health or primary care services and to refer to psychological difficulties rather than substance misuse problems. Some of the barriers to accessing help may be:

- Male dominated provision, with few women-only services or facilities for child care
- Poor knowledge amongst staff about child protection issues
- Weak links with social services which can lead to uncoordinated and poorly planned joint working
- Fear that children will be taken into care
- Childcare responsibilities may make it difficult to attend appointments
- Stigma

Good practice recommendations

- Better training about the particular issues faced by women
- Expansion of designated sessions and women only services
- Recruitment of more female staff

Lesbian, Gay, Bisexual and Transgender issues

There are a number of issues which are particularly relevant to lesbian, gay, bisexual and transgender (LGBT) communities. It is important to understand some of the extra pressures that some LGBT people may face and how these can impact upon a single, or dual, diagnosis.

Internal pressures

LGBT people face an internal pressure to identify their sexual orientation or gender difference to themselves before discovering whether they are able to accept this difference. Then there is pressure around whether to "come out" and publicly declare their difference. Not to do so may result in internalising the situation, leading to depression, low self-esteem or self harm, whilst "coming out", may open the person to increased discrimination, homophobia or hate crime.

Stigma

Misunderstanding and stigma, reinforced through negative media and discrimination, can lead people to adopt various coping mechanisms. These can include drug and alcohol use or engagement in compulsive or risky sex. Living a "double life" is still common – for example, being out with a group of friends but not at work.

Psychological distress and/or substance misuse

It is important to treat everyone as individuals and to avoid making assumptions. However, a report[1] published in 2003 by Mind drew similar conclusions to US reports in finding that (in their sample) gay men and lesbians reported more psychological distress than heterosexuals. This was despite similar levels of social support and quality of physical health. The same report, (and others), discovered higher levels of substance misuse among lesbians and gay men than amongst heterosexuals. Many findings are collated in a scoping study[2] for the Home Office downloadable from the www.drugs.gov.uk website.

Engagement with services

Of further concern are the experiences of some members of the LGBT community within services. Among lesbian and gay individuals, the Mind report highlights a reported lack of empathy and rapport by practitioners. This can impact on a service user's choice about accessing services at all for fear of actual or perceived homophobia. There may also be fears around levels of disclosure, engagement and success should they choose to attend.

Good practice recommendations

Prioritise increased awareness of LGBT issues

This can be both within services or by personal research. Training should include the possible links between sexual orientation and mental wellbeing, and the increased risk of substance misuse within some LGBT communities.

Proactive sharing of good practice

Agencies should pro-actively seek to share good practice and work in partnership with specialist LGBT organisations. The experience and opinions of LGBT service users should be monitored. Targeted interventions and campaigns should then be considered to address any gaps in access to treatment.

Include LGBT issues in organisational policy

Organisations should ensure their policies include awareness of differing needs of people from LGBT communities and consider monitoring sexual orientation at assessment or triage stage.

In Practice

Section six
Structures

Service Delivery

"People with a dual diagnosis, are in effect, a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can just fall below the threshold of all the 'helping' services. For example, they may have mild ideas of suspicion but may not be clearly psychotic. They may have been to prison but not long enough to be followed up by probation. They may have been squatting with friends, but not technically homeless. There may be no clear reason why social services should allocate a social worker. As a result, they have a dreadful quality of life, even though they may have six or seven major problems, they may receive either no help, or just bits and bobs of help without clear co-ordination."

Psychiatrist

Although this toolkit is focused on practical issues, there are also underlying issues around the structure and culture of services that have a significant impact on both workers and clients. Therefore, in this section we consider:

*   The challenges of delivering an holistic approach
*   Some ideas for better integration between services
*   Identifying and meeting training needs
*   Some good practice examples

The challenges of delivering an holistic approach

The basic underlying principle of supporting people with a dual diagnosis needs to be client-centred. This produces challenges at all levels - from strategic, to operational planning, to delivery at the front line. These challenges arise because most clients have a range of issues including physical health and social care needs. Whilst it can be easy to talk about the concept of holistic care, in practice it can be difficult to co-ordinate inputs across many disparate services with their own cultures and policy frameworks. We have already seen that there are problems in joint working between mental health and substance misuse. However, a truly holistic approach would also need to involve social services and a range of providers in both the statutory and voluntary sectors.

In this section we look at some of the issues around social care. We then consider issues between mental health and substance misuse.

Social care

In practice, it is often the social issues such as poverty, unemployment, housing and social isolation that have the greatest impact on a person's ability to engage with treatment. For example, housing is a major issue. Those who are homeless or have insecure housing tend to have greater difficulties in attending appointments and taking medication regularly. They may also suffer social isolation that exacerbates their mental health problems and increases their vulnerability to substance misuse and poor general health.

One study shows that homeless people with mental illness and substance dependency were five times more likely to lose contact with caring agencies as those who were not similarly dependent. Conversely, suitable housing can bring about increased stability, an improvement in engagement and treatment outcomes, promote recovery, lessen the likelihood of relapse and encourage social interaction.

Sadly, there is a huge shortfall in supported housing for many vulnerable groups and those with complex or multiple needs can find it extremely difficult to access and maintain suitable accommodation.

> *"Dual diagnosis patients are often the bed blockers – no-one will take them after hospital. Services like housing and day centres shy away. They want people who are drug-free."*
>
> **Mental health nurse**

A wide range of other social factors may also be relevant to this client group. The illegal nature of some drug taking may lead to a criminal record, which in turn makes it hard to find a job or meaningful daytime activity. People may become socially isolated and lose contact with friends or relatives. Poverty and problems with benefits can lead to rent arrears and then put housing in jeopardy. On top of this, people from ethnic minorities can face a range of cultural barriers.

Issues between health and substance misuse services

> *"Dual diagnosis clients are everybody's business, but nobody's priority. Substance misuse and mental health are two parallel universes with totally different cultures and commissioning practices."*
>
> **Clinician and researcher**

> *"There seem to be two conflicting models at work here. In mental health services, people can be seen as sick, their responsibility is taken away from them and gradually they become reliant on the services. In substance misuse services, current thinking is that people need to take responsibility for their own drug use and the problems that has brought on. These two models don't really come together. If you're the client in the middle of this, you may be receiving very contradictory messages".*
>
> **Clinician and researcher**

There is a range of issues at both a strategic and operational level:

- **Substance misuse and mental health operate differently**
  Although there is some joint thinking at a strategic and commissioning level, the two services still function differently at a planning, funding and operational level. This means that people with multiple needs are often passed from one service to another or fall through the gaps completely. A recent study by Turning Point and the IPPR '*Meeting Complex needs, The Future of Social Care, 2004*' has highlighted that, although the commissioning process has four distinct elements: assessment, planning, commissioning and monitoring, all four are rarely fulfiled.

- **Different cultures/ideologies**
  Although practice varies, substance misuse and mental health services are based around different treatment philosophies and so have developed in very different ways.

  Substance misuse services place more emphasis on a psycho-social perspective and offer treatment based on these ideas. It is generally necessary for the service user to be motivated and capable of engaging in treatment. Mental health services often adopt a more medical model of treatment and, if necessary, have powers under the Mental Health Act to provide treatment to an individual, even if they do not wish it.

  It is understandable that these different ideologies translate into different ways of operating. For example, Community Psychiatric Nurses are based in the locality and visit people in their homes whilst most substance misuse services tend to expect a client to attend an appointment.

- **Rigid professional boundaries and lack of training**
  Practitioners in either field may regard this client group as outside their professional remit. They may feel they lack the necessary understanding, skills or resources or that they have not received appropriate training. Others may feel that their particular specialism is being challenged. There will always be a need for specific and distinct skills, but this should not preclude collaboration with other practitioners.

- **Lack of clarity about roles and responsibilities**
  This can lead either to a duplication of work (for example with assessments) or a failure to take appropriate action.

- **Pessimism about outcomes**
  People who have co-existing needs are undoubtedly challenging to work with. Several studies have found poor records of compliance with treatment and worsening of psychiatric symptoms in comparison with people who have a single diagnosis.

It is important to recognise these factors. However practitioners should note that the difficulties might arise precisely because multiple needs cross professional structures. Hence the problems may arise from the services rather than the individual. Other studies have shown that treatment and care does work for this client group.

> *"People in mental health can see people's continuing use of drugs as sabotaging the care they are receiving. They forget to ask the reasons why people start or relapse."*
> **Worker in substance misuse**

> *"We need to have realistic goals for ourselves just as much as for clients. Sometimes it feels like taking down a wall with a teaspoon. We need to remember that change can happen even if can take years."*
> **Dual diagnosis trainer**

Structures

Ideas for better integration between services

Greater integration needs to be approached at both a strategic policy level and in terms of operating structures and practices on the ground.

Strategic level

- Links between government policies: For example, it would be helpful to link the current work of separate departments on social exclusion and mental health, guidance on personality disorders, delivery of services to people from different ethnic groups and changes to the Supporting People framework. The Social Exclusion Unit at the Office of the Deputy Prime Minister has made some encouraging moves in this direction as has the development of the National Institute for Mental Health in England (NIMHE)

- Co-ordinating commissioning and planning: It is essential that those planning, commissioning and delivering services are clear about the nature and extent of need. There is a need to develop clear commissioning protocols that promote co-ordinated care. At the same time, these processes need to be flexible to recognise local need and to identify which agency is best placed to provide which service in a given area

- Promoting mutual understanding: practitioners can do much here to understand what different services do, how to access and refer, set up systems and processes for interagency working and ensure that case working across agencies is working effectively. (The Networking Tool provided as part of this pack is intended to support practitioners in this process. See page 1 for details of how to order.) Informal networking between practitioners can also be extremely useful in building relationships and understanding

> *"What would be helpful is to share good practice about service development. There's the high-level policy advice and now some guidelines about working with individuals. The gap is – how have different services put the policy into practice? What works best in different areas? And, importantly, what hasn't worked. I often wish we had more courage to be honest about what doesn't work and then we could learn from that."*
>
> **Worker in mental health**

Operational level

This section looks specifically at opportunities for greater integration between substance misuse and mental health.

The Department of Health's '*Dual Diagnosis Good Practice Guide*' states that the primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse lies with mental health services. It describes three current models of service delivery in the UK:

- **The serial model:** "implies treatment of one condition before the other"
- **The parallel model:** "implies concurrent, but separate treatment of both conditions (by different teams)"
- **The integrated model:** "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"

The favoured approach is to work towards the integrated model. Services are recommended to agree a definition of dual diagnosis based on local need and to use this to guide service development.

There are several possible service models:

- **Dedicated dual diagnosis teams**
  In this model, all workers receive specialist training and lead the provision of dual diagnosis care. Whilst this is recommended in some circumstances, there can be difficulties. The model may be too expensive and too specialised to address a range of issues. Some people may be excluded because they do not meet the strict criteria for access.

  At the same time, there can be problems with heavy caseloads and staff burnout. This is particularly true if there are unrealistic expectations that this team should be responsible for all dual diagnosis clients.

- **Training of specialist dual diagnosis workers**
  Here the specialists would be placed within generic services and would spread expertise about dual diagnosis issues.

- **Networks of clinicians with expertise in dual diagnosis issues**
  These would be placed within teams where there are high levels of need.

  The choice of model will depend on service structures and situation locally. Every model has benefits and disadvantages.

- **Case Management**
  Whatever model is used, effective caseworking is central and this needs skilled caseworkers with capped caseloads[1].

As Checinski[2] points out, whatever model is chosen, some individuals will not fit into it. Therefore it is important to have a strong keyworker system to broker a range of care. He sees this as a "virtual team" with a client and keyworker at the centre and a network of relevant agencies around them. Depending on the needs of the individual, this might include mental health nursing, substance misuse teams, psychiatry, clinical psychology, the primary care trust and the local authority providing housing and education. Checinski concedes that this has the advantage of flexibility, but not the cohesion of a "physical team".

Good practice recommendations

Map existing service provision and agencies

A wide range of additional agencies may be relevant to this client group including A&E, social services, primary care, housing associations, police, probation and other criminal justice agencies, specialist agencies working with diverse issues. It is recommended that a dual diagnosis steering group be formed to map out the full range of possible services. (A Networking (mapping) Tool is provided in association with this toolkit. Please see page 1 for details of how to order this.)

Structures

Good liaison and partnership between agencies

It is important to build relationships with a range of services, to understand their referral criteria and the care and support they provide. It is essential that practitioners are aware of acute inpatient services as well as those based in the community.

"Informing other professionals about what services are on offer, where they are based and how to refer can be as valuable as drug and alcohol awareness."

Senior Team Leader, Community Drug Project

Multi-agency approach

This requires joint ownership of goals as well as clarity about the roles and responsibilities of each agency. An agreed care plan is central to this approach (see page 30 on the '*Care Programme Approach*'). It is important that the treatment goals agreed for each individual are clarified between agencies and that they are felt to be realistic.

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

Pathways for referral

When the joint working as described above is still not able to support a particular individual, there should be a clear pathway for referral to more appropriate agencies.

Clear plan for ongoing care

An agreed strategy for continuing care is important in minimising relapse and maximising outcomes.

Identifying and meeting training needs

"Yes, we need skills training but we also need to work on changing staff attitudes. People in substance misuse are reluctant to work with "mad" people and people in mental health are nervous about working with substance misuses. Actually there are strong parallels with client work – we need to listen empathetically, to understand what workers are afraid of, what the barriers are and roll with that resistance. Just as with clients, one session won't do it – it will need time and ongoing support."

Dual diagnosis trainer

"We urgently need more dual diagnosis specialists on the wards to bridge the knowledge gaps. The levels of skills and knowledge are very low."

Dual diagnosis nurse

The Department of Health's '*Dual Diagnosis Good Practice Guide*' recommends that services undertake an audit of training needs. It also suggests core competencies that are relevant to all staff in all settings. These are:

• 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

Training should be based on case discussion and debate that is relevant to the particular team's working practice. Wherever possible, services should promote internal sharing of information and expertise.

There should be an ongoing rolling programme to ensure that training is informed by the most recent research.

Ongoing supervision and continuing professional development is vital. Peer support networks and increased joint training can help to achieve this.

Given the issues discussed above in relation to culture, it is important that training addresses attitudes and perceptions as well as practical skills.

Structures

Training in relation to client need

The CASA Multiple Needs Service (MNS) suggests relating the need for specialist training to levels of client need. It outlines three levels of need:

• People with coexisting needs who would be able to use existing (generic substance misuse and mental health) services effectively if the workers in these services had additional training around dual diagnosis issues

• People whose mental health needs are best met within mental health agencies, but whose substance misuse is such that they also require the help of a specialist substance misuse counsellor

• People with serious and multiple needs, whose lifestyles have become chaotic and self-destructive, and who require sustained and intensive specialist support from people who are specialists in dual diagnosis

(See article: '*Perspectives on Multiple Needs CASA MNS 1998*')

Raising expectations

Training can also help to address negative attitudes to clients and low expectations for outcomes.
It is also important to address low expectations with clients themselves.

Good practice examples

The following provide practical examples of how dual diagnosis issues are being addressed at a local level.

Barnet Dual Diagnosis Steering Group

This group has recently been set up by Turning Point's dual diagnosis lead at a community drug and alcohol project in Barnet called 'The Crossing'.

Its main purpose is to consolidate and improve referral pathways and systems of support for clients with co-existing substance misuse and mental health problems.

The group brings together primary leads of services working with dual diagnosis from voluntary and statutory agencies. It currently includes a lead consultant psychiatrist from Barnet, Haringey and Enfield Mental Health Trust, two social work department managers, the clinical drug and alcohol service manager, the Dual Diagnosis coordinator and clinical psychologist, the senior team leader of the community drug and alcohol service, the A&E psychiatric liaison nurse and will include a service user.

A number of problems in meeting client need were identified:

• Difficulty of agreeing a local definition of "dual diagnosis"
• Different views from psychiatry and substance misuse services on who should be responsible for a given person's package of care
• Confidentiality – there were no existing protocols about information sharing or referrals
• Time to attend meetings– many professionals had conflicting priorities

Many of the solutions were focused around better dialogue between a wide range of healthcare managers and practitioners. Each party became clearer about their own role and that of other agencies. As a result, referral and through care pathways became clearer, more consistent and more appropriate for the individual. There is also a locally agreed definition of dual diagnosis.

Another valuable improvement has been the extent to which service users and their representatives have been able to influence policy and practice. An example of this is described below.

Improving liaison between A&E and community services

A statutory psychiatric liaison team provides all-day and evening cover five days a week in the accident and emergency (A&E) department in Barnet hospital. The team consists of a co-ordinator and two nurses. The coordinator attends the dual diagnosis steering group in Barnet and is part of the community mental health team. Consequently the co-ordinator is well placed to refer and liaise with all mental health services.

The psychiatric liaison workers also have excellent links with other community and clinical services, including substance misuse. When making a referral to substance misuse services, the psychiatric liaison workers use standardised letters and include a copy of the assessment carried out in A&E. This details fully the reason or incident that brought the person to A&E and provides contact details of other professionals or agencies involved in the person's care. This is useful in pursuing letters or reports that may be relevant to compiling a risk assessment and also helps to foster joint working.

A copy of the Care Plan is also attached to the referral. This will include a plan to attend The Crossing, or another agency, for support regarding their substance use. A letter is then sent out from the substance misuse service, inviting the client to attend their service for a more comprehensive assessment or a specific type of support that is offered.

Patients from A&E are regularly referred to The Crossing's drop-in service and Barnet Drug and Alcohol Service (the clinical substance misuse service), where an initial/triage assessment is carried out. Every week during one of these drop-ins, a dual diagnosis co-ordinator, employed by Barnet Drug and Alcohol Service, attends the drop-in to provide support with the high volume of 'dual diagnosis' clients.

This is a good example of effective joint working between substance misuse services and between statutory and voluntary agencies.

The psychiatric liaison co-ordinator has invited substance misuse services to provide training to community mental health team staff. This has included community psychiatric nurses, mental health social workers, A&E and other hospital staff. The training covers both issues relating to drugs and/ or alcohol and the services available. Reciprocal training has also been arranged.

Turning Point: Druglink Hammersmith and Fulham Complex Needs Service

Druglink Hammersmith and Fulham is a street agency providing a wide-range of project-based and outreach services to people affected by their own problematic drug use. It also offers advice and support to families, friends and other professionals. The Complex Needs Service was developed in 2002 to meet the needs of a growing number of clients with severe and enduring mental health problems, complicated by substance misuse and often further compounded by physical and/or learning disabilities.

This client group had high and multiple levels of need, but were 'falling through the gaps' between mental health and substance misuse services whilst staff lacked the confidence and training to provide adequate help.

The service provides individual sessions based on psycho education and cognitive behavioural therapy, alongside a series of life skill workshops and complementary therapies. To ensure accessibility and maximise engagement, it is flexible in terms of times and locations. It provides satellite services at supported accommodation projects as well as in-reach into in-patient psychiatric wards and home visits. The service is currently led by one specialist Complex Needs Worker. This person shares expertise locally by offering training, support and consultancy to a wide range of professionals from both specialist and generic services.

Resulting improvements include better communication and relationships between agencies in the borough, clearer pathways and continuity of care, and greater support for clients and workers. It is also demonstrating successful collaborative working with a diverse range of services in difficult situations. For example providing a multi-agency in-reach service to long-term in-patients to enable a seamless transition from hospital into the community.

A whole person approach to a range of needs

Mark is typical of the clients coming to Turning Point's Housing Link service in Hemel Hempstead. He had clinical depression and had just completed his third residential alcohol detox. He was in an impossible situation, trying to stay alcohol free whilst living in a shared house with people who were still using drugs and alcohol. Rent arrears were intensifying his problems. Although registered with the council housing department for alternative accommodation, he was considered a 'low priority'.

Carol, a Support Worker, worked with Mark over 18 months to address a number of issues. Partnership working is considered vital to empower clients and equip them with the skills they need for the future. The first task was for Mark to claim Disability Living Allowance and other benefits to which he was entitled. Through applying for back dated Housing Benefit, Carol was able to support Mark to clear his rent arrears, this enabled him to move more quickly. She also liaised with the Council and Housing Association providing his current housing to eventually secure his own flat.

Mark had not been in contact with a GP or the Community Mental Health Team for several years. So, to address his anxieties about explaining his needs and engaging with other services, Carol accompanied him to initial appointments if requested. He realised that living on his own would bring different challenges and Carol helped him to find out about local drop in services as well as pottery and art classes. She also encouraged him to renew contact with his family.

Carol continued to visit regularly for several months and Mark was able to access the service again to help him through a difficult period some months later.

Action points for practitioners

- Use the networking tool provided with this toolkit to identify the range of relevant services in your area
- Check that you have up to date contact details for these together with descriptions of the service provided and details of their referral criteria and procedures
- Agree a local definition of dual diagnosis
- Look at the protocols that exist for inter-agency working and do a reality check. Do the protocols describe what actually happens or are there gaps in practice?
- Involve service users and carers in mapping people's actual experiences of services against the theoretical models. Use this to identify actions and develop a clear plan for ongoing care that is shared with all services
- Where there are gaps/problems alert your managers and/or arrange a multi-agency meeting to discuss the issues so that each party understands their role and that of other agencies
- Do a training needs audit within your team and act upon identified needs. Consider reciprocal training between mental health and substance misuse services

References and resources

In this section we provide:

• References for the preceding chapters
• A description of the most commonly used substances
• A fuller description of the policy context for dual diagnosis
• Suggestions for further reading
• Useful addresses

References

Section one: Introduction

1 *Dual Diagnosis Information Manual - Co-existing problems of Mental Disorder and Substance Misuse,* The Royal College of Psychiatrists (2002)

2 J. Marsden et al. *Psychiatric symptoms among clients seeking treatment for drug dependence. Intake from the National Treatment Outcome Research Study, 176 Br, J. Psychiatry 285-289 (2000)*

3 Quoted in *Dual Diagnosis Good Practice Guide (2002),* Department of Health

Section three: Substance Use

References used throughout this section:

The Druglink Guide to Drugs (2004), Drugscope
(Available from Amazon.co.uk. ISBN 1-904319-16-5 Price: £8.50)

Co-existing Problems of Mental Disorder and Substance Misuse (Dual Diagnosis) - an Information Manual (2002). The Royal College of Psychiatrists (www.rcpsych.ac.uk/cru/complete/ddipPracManual.pdf)

British Crime Survey information available at: www.homeoffice.gov.uk/rds/bcs1.html

Patterns of Substance Misuse

National Alcohol Harm Reduction Strategy (2004), Department of Health

Section four: Mental health problems

Bateman, A. and Tyrer, P. (2002) *Effective management of personality disorder*, Department of Health

Personality disorder

No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder, National Institute for Mental Health in England (NIMHE) (2003) (www.dh.gov.uk/mentalhealth/personalitydisorder.pdf)

The Personality Disorder Capabilities Framework NIMHE (2003) (www.nimhe.org.uk/downloads/personalitydisorders.pdf)

Psychological interventions

A useful resource is '*Recent Advances in understanding mental illness and psychotic experience*'. (Available at the British Psychological website www.bps.org.uk)

Involving users, families and carers

There may be a local user group or organisation in your area that can provide advice.

National information includes:

• The Joseph Rowntree Foundation findings: '*Increasing user involvement in voluntary organisations*' July (2003). Ref 723 www.jrf.org.uk

• A Fair Day's Pay: A guide to benefits, service user involvement and payments. Mental Health Foundation, July (2003). Price: £8 (free to unwaged)

The Sainsbury Centre for Mental Health has also begun a pilot entitled *Service User Empowerment and Leadership Programme.*

Making services more culturally appropriate

BME communities

1 http://image.guardian.co.uk/sys-files/Society/documents/2004/02/12/Bennett.pdf

Wanigaratne S, Unnithan S and Strang J *Substance misuse and ethnic minorities*: *issues for the UK* (published in *Psychiatry in Multicultural Britain: (2001)* p. 243-263)

For further information on the Department of Health's Strategy: *Delivering Race Equality: a Framework for Action* and other key documents see www.nimhe.org.uk/priorities/black.asp

Women

Brunette, MF and Drake, RE (1997) *Gender differences in patients with schizophrenia and substance misuse*. Compr Psychiatry Mar-Apr 38(2):109-16

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

For further information on the Department of Health's Women's Mental Health Strategy *Mainstreaming Gender and Women's Mental Health* and other key documents see www.nimhe.org.uk/priorities/women.asp

Lesbian, gay, bisexual and transgender

Lesbian

1 *Mental Health and Social Wellbeing of Gay Men, Lesbians, and Bisexuals in England and Wales* –
  Principal Authors: Professor Michael King and Dr Eamonn McKeown, Mind (2003) (www.mind.org.uk)

2 Richard Dyter and Philip Lockley *Drug Misuse Amongst People from the Lesbian, Gay and Bisexual
  Community: A Scoping Study*, Home Office (2003) (www.drugs.gov.uk)

Further resources for LGBT issues include:

DeAngelis, T., *New Data on lesbian, gay and bisexual mental health*. Monitor on Psychology Vol 33 (2002)

PACE, a Lesbian, Gay and Bisexual Mental Health Organisation
Tel: 020 7697 0014
www.pacehealth.org.uk
pace@dircon.co.uk

Antidote, Specialist LGBT Substance Misuse Service
Tel: 020 7437 3523
antidote@turning-point.co.uk

Queery – searchable LGBT community database for other referrals
www.queery.org.uk

Section six - Structures

Rankin J & Regan S (2004) *Meeting Complex Needs: The Future of Social Care*, Turning Point/IPPR
Price: £9.95

1 *Keys to Engagement*, Sainsbury Centre (1998)

2 Checinksi K: Treatment Strategies and Interventions. Chapter 10 in *Dual Diagnosis: Substance Misuse
  and Psychiatric Disorders* G. Hussein Rassool, Blackwell Science (2002).

Section five: In Practice

Assessment

1 *Co-morbidity of substance misuse and mental disorders* available from
www.nelmh.org/content_show.asp?c=17&fid=663&fc=008001

2 Moore K & Rassool GH: A Synthesis of Addiction & Mental Health Nursing:
*An Approach to Community Interventions. Chapter 8 in Dual Diagnosis: Substance Misuse
and Psychiatric Disorders,* Blackwell Science (2002)

The Diagnostic and Statistical Manual Four.
(Available from Amazon Price: £55.95)

Managing risk

Assessment and Management of Risk of Harm in Clients with Dual Diagnosis.
(Published by Alcohol Concern in association with Drugscope, March 2002. Price: £10)

Types of treatment provided by substance misuse services

Much of the information in this section comes from *Treatment Works*, an initiative involving the major
voluntary substance misuse agencies in the UK. More information and resources are available from
www.treatmentworks.co.uk

Treatment via the criminal justice system

This information is adapted from the Home Office website. More details are available from:
www.drugs.gov.uk/NationalStrategy/CriminalJusticeInterventionsProgramme

Stages in treatment

Osher, FC and Kofoed, LL, (1989) *Treatment of patients with psychiatric and psychoactive substance abuse
disorders*. Hospital and Community Psychiatry 4 (10), 1025-30

Active treatment

*Co-existing Problems of Mental Disorder and Substance Misuse (Dual Diagnosis) - an Information Manual
(2002)*. The Royal College of Psychiatrists. (www.rcpsych.ac.uk/cru/complete/ddipPracManual.pdf)

Factors involved in relapse prevention

Also see above

Miller WR & Rollnick S (1991) *Motivational Interviewing: preparing people to change addictive behaviour*.
New York, Guildford Press

Prochaska J & DiClemente C (1986) *Towards a comprehensive model of change*. In W Miller and N Heather
(Eds) *Treating addictive behaviours: Processes of change*. New York, Plenum Press

Appendix 1

The most commonly used substances and their effects

It is important to remember that the effects of any substance will vary from one individual to another. This will depend on the quality and quantity of the substance and the person's age, gender, weight, mood, culture, expectations and state of physical and mental health. Street drugs are almost always cut (mixed) with other substances to bulk out the drug and maximise profit. As a result, the appearance and potency of drugs varies widely. Unless a sample of a drug is tested it is not possible to know exactly what it is.

With many drugs, regular users may develop tolerance. They may then require more of the substance to achieve the same effect. Users may alter their method of use to increase potency – for example from snorting to injecting. Users appear not to become notably physically dependent, but may become very strongly psychologically dependent.

Injecting involves additional health risks such as blood borne viruses including HIV and Hepatitis B and C; infection from sharing needles; septicaemia and damage to the heart valves. Some effects may prove fatal, especially if combined with other substances.

The following information covers the principal legal and illegal substances under these headings:

• Description
• Legal status/class
• Method of use
• Signs: description of common symptoms. (Note: these will vary and not all will be experienced)
• Sought after effects
• Adverse effects

Stimulants (uppers)

Some stimulants are very strong – for example cocaine and amphetamines. Others like caffeine and nicotine are relatively weak. However it is smoking that causes the most severe long-term health problems.

Overall effects of stimulants

Stimulants force the release of the body's own energy chemicals and stimulate the reward/pleasure centre. They also constrict blood vessels, speed the heart and raise blood pressure. Prolonged use of the stronger stimulants depletes energy resources, and triggers intense craving.

Stimulants can also cause or mimic mania, anxiety and/or depression or paranoid psychosis. Users appear not to become physically dependent, but may become psychologically dependent. Cocaine and amphetamine withdrawals can resemble a major depression. The direct effects of the stronger stimulants, combined with the exhaustion of withdrawal can cause or mimic a bipolar illness that includes manic delusions and then depression. Cocaine causes the most rapid stimulation and subsequent comedown of all the stimulants.

Amphetamines - *speed, whizz, sulph, uppers*

A white powder or tablets.

Use: swallowed, sniffed, smoked or injected (by crushing the tablets).

Legal status: Prescription only medicine, Controlled drugs. Class B.

Signs: increased alertness and dry mouth, excessive fluid intake.

Sought after effects: elevation of mood, boost of confidence, energy levels or wakefulness, suppression of appetite.

Adverse effects: initial pleasurable rush followed by anxious feelings, exhaustion (leading to excessive sleep) and depression, irritability, and paranoia. Heavy users may experience severe weight loss and psychosis, hallucinations and delusions and may become aggressive.

Anabolic steroids - eg *nadralone, dianabol, durabolin, primobolin, stanozolol, winstrol*

These are synthetic drugs similar to natural hormones. They promote protein build up and therefore muscle gain.

Use: swallowed as tablets or injected. They should be taken in cycles of a number of weeks of using/not using but multiple mixtures and on-going use is common. Widely available in gyms.

Legal status: Prescription only medicines. Class C.

Signs: muscle growth and deepening of the voice.

Sought-after effects: to build up muscle size and body strength.

Adverse effects: Can be associated with mental health problems (eg mania and depression). They affect mood and can cause aggression and paranoia. Use is prevalent amongst young men who may have emotional problems and are drinking heavily. There is a high level of injecting, but users do not perceive themselves as drug users and do not engage with substance misuse services for clean equipment bringing associated dangers of injecting. There is also a recent trend in injecting insulin. There is an increasing supply of counterfeit products which do not attract the same controls for quality or dose as for licit steroids.

Cocaine - *charlie, coke, snow, foot, lady, C*

A white powder, usually 'cut' or mixed with other fillers.

Use: sniffed, injected, smoked or eaten.

Legal status: Class A.

Crack cocaine - *rocks, ready wash, ice, base*

Irregular lumps, looking like sugar, whitish in colour.

Use: crushed then heated and the fumes inhaled.

Legal status: Class A.

Signs: same as above, but effects can be more pronounced.

Sought after effects of cocaine and crack cocaine: a rapid intense high, Makes the user more confident and talkative. The high is only short lived leaving the user craving more. Can stimulate the sex drive.

Adverse effects: anxiety and exhaustion, long periods of sleep, irritability, depression and paranoia. Sudden rise in blood pressure and slowing of heart rate. Overdose can cause sudden heart attack or strokes after prolonged use. Highly addictive. As tolerance grows, the margin narrows between a dose producing euphoria and one that is fatal. Heavy users may experience psychosis, hallucinations and delusions and may become aggressive.

Many cocaine and crack users also take other drugs, including heroin. In some parts of the country, users are engaging in the highly dangerous practice of injecting a mixture of heroin and cocaine (known as snowballing or speedballing). Alcohol is often involved too. When alcohol is mixed with cocaine, a third substance – cocaethylene - is formed. This substance lasts longer in the body, is more toxic, and causes more harm, especially to the cardio-vascular system. **(Taken from Know the Score: Crack and Crack Cocaine, produced by the Scottish Executive see www.knowthescore.info)**

Khat – *(also spelled Quat, Qat and Kat)*

Leaves from the Catha Edulis plant - most powerful when fresh.

Use: users usually chew leaves or shoots for several hours and swallow the juice.

Legal status: the Khat plant is legal, but its active ingredients cathinone and cathine are Class C.

Signs: irritability, increase in spitting, talkativeness.

Sought after-effects: Mild euphoria, hallucinations.

Adverse effects: dependence can develop and heavy use can be problematic. Increased aggression, hallucinations, nausea, vomiting. Continued use can lead to cycles of sleeplessness and irritability and can in the longer-term lead to psychiatric problems such as paranoia and possibly psychosis.

Khat acts as a social lubricant in mostly Muslim countries, with links to (especially) the Yemen, Ethiopia or Somalia. Effects start after approximately 30 minutes with stimulation and talkativeness. This is followed by a relaxed and introspective state that can last up to 5 hours, often with an inability to sleep. This is then followed by periods of lethargy, irritability and general hangover.

Khat is also often used with tobacco. This brings additional associated risks such as respiratory problems. Mouth ulcers and problems in the digestive tract are also common among users.

Sedative-Hypnotics (Anti-anxiety drugs)

Sometimes called anxiolotics or minor tranquillisers, these drugs are used medically (on prescription) and are also abused for their effects. When used to treat anxiety, they are called minor tranquillisers/sedatives and when used to treat sleeping problems, they are known as "hypnotics" or sleeping tablets.

Benzodiazepines are the most frequently prescribed sedative-hypnotics. They were developed as safer alternatives to barbiturates but tolerance, addiction, withdrawal and overdose still occur. There are also other problems with the millions of depressant drugs prescribed by doctors including polydrug use, cross tolerance and cross dependency. Dependency on benzodiazepines is extremely dangerous. Stopping use abruptly if dependent (usually 3 weeks or more) should be avoided and medical advice sought.

Tranquillisers – *temazepam – (te)mazzies, eggs, jellies, mogadon – moggies*
Pills, tablets, capsules in a variety of shapes and colours.
Use: swallowed or injected.
Legal status: Prescription only medicine. Controlled drugs. Illegal to possess without a prescription.
Benzodiazepines and minor tranquillisers (Class C).
Signs: see adverse effects.
Sought after-effects: increased relaxation and calmness.
Adverse effects: higher doses cause drowsiness, reduced co-ordination and concentration, anxiety and epilepsy.

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Depressants (downers)

Overall effects of depressants

Overall, downers, particularly where there is excessive use, can cause or mimic a depressed mood. They may cause loss of motivation and interest in surroundings, other people or oneself leading to self-neglect and even self-harm, including attempted suicide. Effects are particularly dangerous if combined with other drugs. Excessive sleep may be one of the characteristics of a major depression.

It is easy to overdose on downers, particularly where there is alcohol use. Where there has been regular or heavy use of downers, it is important that the person does not suddenly stop. Rapid withdrawal (especially combined with a withdrawal from alcohol) can cause serious problems including tremors, sweating, cramps, transitory hallucinations, stomach pains and even seizures or deliriums tremens called DTs.

Alcohol – *booze, bevy, pop*
Use: is taken orally. Alcohol is absorbed in the bloodstream and its effects depend on its strength and the individual. Food will delay absorption.
Use is common among people with mental health problems.
Legal status: Can be bought by adults 18+ (or drunk outside a pub by children 5+) Need a license to sell.
Signs: include slow or slurred speech, poor co-ordination (see adverse effects below).
Sought after effects: if a person is not at risk (e.g pregnant, in recovery, or with mental or physical health problems) there are some benefits.
In general, sedation, muscle relaxation and lowered inhibitions and increased confidence accompany low to moderate use.

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Adverse effects: with high doses, a range of effects occur from decreased alertness and exaggerated emotions to shock, coma and death. Effects are directly related to the amounts, frequency and duration of use and also depend on the tolerance of the user. Depending on a drinker's habits and susceptibility, organ damage, particularly liver damage, nutrition deficits and sexual problems can occur. Alcohol affects co-ordination and reactions, so users are prone to accidents. It is also the leading cause of birth defects in those cases where a cause can be attributed.

The effects of withdrawal from alcohol can be severe and requiring medical supervision for detoxification. These include hallucinations, seizures and DTs and in some cases death.

Chronic drinking
As defined by the Department of Health, chronic drinkers are those who drink large amounts regularly. (Around a quarter of the population drink above the former weekly guidelines of 14 units for women and 21 units for men). Excessive, chronic drinking causes tolerance and tissue dependence. Withdrawal symptoms can occur upon cessation of drinking. Altered body chemistry can lead to dependence.

Binge-drinking
This is taken to mean drinking to get drunk or drinking substantially above recommended daily guidelines in one session.

Cannabis - *dope, draw, blow, resin, grass, skunk*
Like tobacco or a dark brown resin
Cannabis can have hallucinatory effects and stimulant properties, but is regarded mainly as a depressant or relaxant.
Use: smoked, eaten or drunk as an infusion.
Legal status: controlled drug Class C.
Signs: blood-shot eyes, hunger pangs.
Sought after effects: some users experience an intense feeling of relaxation. If eaten, effects last longer than when smoked.
Adverse effects: can include lethargy, demotivation, panic, paranoia and short term memory loss. Heavy use, particularly if strong varieties such as some forms of skunk are used regularly, can lead to psychosis. There are also health risks associated with smoking.

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GHB – *GBH, Liquid E, Liquid X*
A colourless liquid, with a slightly salty taste. Sometimes sold as 'liquid ecstasy', but is not related to ecstasy.
Use: by body-builders and on the club scene.
Legal status: controlled drug – Class C
Signs: similar to alcohol, with the user appearing drowsy or drunk.
Sought-after effects: slows body actions, euphoria.
Adverse effects: as dosage increases, euphoria is replaced by powerful sedative effects, with reports of nausea, vomiting, muscle stiffness, confusion and sometimes at high doses, convulsions, coma and respiratory collapse.

Hallucinogens

The most commonly used hallucinogens are LSD, MDMA ("ecstasy"), PCP, mescaline and psilocybin mushrooms (magic mushrooms).

Overall effects of hallucinogens

Hallucinogens cause intensified sensations, mixed-up sensations (visual input becomes sound), illusions, delusions, hallucinations, stimulation and impaired judgement and reasoning. LSD is very potent and can cause delusions. On some occasions, users can experience a "bad trip", which can be very frightening both for the user and any onlooker. Flashback may occur for a considerable length of time after the original "trip". Magic mushrooms cause nausea and create hallucinations. Mescaline used in sacred rituals and ceremonies cause more hallucinations than LSD, and designer hallucinogens like ecstasy are similar to amphetamines but also have calming and psychic effects. PCP, an animal tranquilliser, causes mind-body dissociation and a sensory deprived state. Ketamine ("Special K"), a powerful anaesthetic, is becoming more popular and has a potential for causing hallucinations and other 'psychotic' outcomes.

Hallucinogens generally are unpredictable and can trigger a latent mental illness. They can also cause or mimic delusional hallucinations and paranoia associated with a major psychosis.

Ecstasy (or MDMA) - *E, adam, XTC, doves*
Tablets, powder and capsules in many shapes and colours.
Use: usually swallowed, sometimes can be injected and occasionally snorted.
Legal status: Class A.
Signs: increased energy, slurred speech.
Sought after effects: 20-60 minutes after use, user experiences euphoria which plateaus for 2-3 hours before wearing off. Feelings of empathy, meaningfulness and relaxation.
Adverse effects: tiredness, confusion, anxiety, depression and paranoia. Sudden death through overheating and dehydration or drinking too much water. A minority experience liver damage and strokes. Some users report panic attacks, paranoid psychosis and depression. Dependence is possible if taken frequently.

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LSD - *acid, tabs, trips*
Small tablets or printed squares of paper impregnated with the drug.
Also comes in liquid form.
Use: swallowed or sucked, can be absorbed through bodily membranes such as the eyes or anus.
Legal status: Class A.
Signs: being detached from reality, giggly, unable to communicate coherently, slurred speech, lack of co-ordination.
Sought-after effects: to induce an altered state of consciousness. LSD distorts shapes, colours and sense of time, producing hallucinations, laughter or exhilaration.
Adverse effects: can include flashbacks, anxiety and paranoia. Can precipitate relapse in those already susceptible to schizophrenia. Users often underestimate the length of a trip and feel exhausted physically and psychologically after a 12-36 hour experience. A lack of control and ability to stop the experience can frighten users.

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Mushrooms - *shrooms, silly simons, mushies*

Mushrooms, a variety of wild growing fungi, native to the UK, such as the Liberty Cap. International varieties are becoming more widely available through specialist shops and the internet. The key constituent is psilocybin.

Use: eaten raw, cooked or drunk as an infusion.

Legal status: if prepared for use may be a controlled drug.

Signs: being detached from reality, giggly, unable to communicate coherently, slurred speech, lack of co-ordination, vomiting.

Sought after effects: similar to LSD, but the trip is often milder and shorter.

Adverse effects: can include stomach pains, sickness and diarrhoea. Misidentification can lead to users eating poisonous varieties which can prove fatal.

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Opiates and opioids

Opiates and opioids are natural, semi-synthetic, and synthetic derivatives of the opium poppy. The principal opiates and opioids are heroin, codeine and morphine. Others include methadone and other analgesics (painkillers), which are widely used.

Heroin - *junk, smack, skag, H, gear, brown*

Sold illicitly as a powder, usually brown, but can be white.

Use: can be injected, swallowed or smoked – after heating it over a flame and then inhaling through a tube such as an empty pen. The most common street use is mixing it with water and injecting it. Diverted pharmaceutical tablets may be swallowed or crushed and injected.

Legal status: prescription only medicine. Class A.

Signs: slow shallow breathing, drowsiness and constricted (small) pupils, watering eyes & nose, itching, fidgeting.

Sought after effects: provide powerful relief from physical pain (for which they are used medically) and also of psychological pain. It induces euphoria, which may wear off but use continues to avoid withdrawal symptoms.

Adverse effects: running nose and eyes, irritability, tremors, chills. Sudden withdrawal leads to cramps, sweating and diarrhoea and "goose bumps." Dependence develops after repeated use over several weeks. Not all users are dependent, but heroin is difficult to manage recreationally. Tolerance develops quickly.

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Methadone - *doll, red rock, juice, 'script'*

Usually in the form of white tablets or liquid.

Use: swallowed or sometimes in injectable form.

Legal status: prescription only medicine. Class A.

Signs: slow shallow breathing, drowsiness and constricted (small) pupils, watering eyes & nose, itching, fidgeting.

Sought after effects: the effects are similar to heroin, however methadone tincture cannot be injected which helps to reduce the associated risks of this practice. Provide powerful relief from physical pain (for which they are used medically) and also of psychological pain. It induces euphoria, which may wear off but use continues to avoid withdrawal symptoms.

Adverse effects: Some people are sick the first time they take drugs like Methadone. For women, use can cause irregular periods (although conception is still possible). It can cause constipation.

Methadone is usually prescribed as a substitute for heroin either to stabilise or reduce use. It is also regarded as equally and sometimes more addictive than heroin. Sold illicitly either through selling on prescriptions or diverted from legal sources, it may be used when heroin is difficult to obtain. Many opiate users who are prescribed methadone may often seek street heroin to top up their dose either because the prescription is not high enough or the effects are not strong enough. Dose management, appropriate to each individual, is therefore extremely important.

Other substitute drugs for opiate dependency may also be used such as Subutex, with less of a buzz or sense of euphoria that methadone provides. Naltrexone is an antagonist, it prevents the neuro-receptors in the brain from picking up the effects of opiate drugs.

Volatile Substances

More than 100 commercially available products are now used to get high. They include: lighter fuel, glues, rubber cement, tippex™ fluid, nail polish remover, magic markers, petrol, paint and paint thinners, cleaning fluids, aerosols, fire extinguishers - the list is endless.

Overall effects of volatile substances

The inhaled vapours are absorbed through the lungs and pass rapidly through the blood to the brain. They act on the central nervous system, sometimes as a stimulant but generally as a depressant, putting a clamp on that part of the brain (the cortex) which is believed to "check" primitive instincts. "Disinhibition" results.

General body functions like breathing and heart rate are depressed and there is a "stoned" feeling lasting from a few minutes to half an hour. Headaches, sickness and dizziness are not uncommon, particularly for novices. Continued or deep inhalation causes disorientation, drowsiness, numbness and perhaps unconsciousness - much like the effects of medical anaesthetics. The experience is said to be like that of being drunk and can produce euphoria, aggression, deep melancholy, giggling and raised libido.

Alkyl nitrites (amyl, butyl and isobutyl)
- "*Poppers*", *rush, locker room, hard core*
Clear yellow liquids.
Use: fumes from the liquid are inhaled. Effects are short lived.
Popular on the dance scene and in clubs.
Legal status: Pharmacy medicine.
Signs slurred speech, poor co-ordination.
Sought-after effects: an initial rush followed by light-headed feelings.
Used to facilitate sex (often among the gay community).
Adverse effects: fainting, loss of balance, headaches and nausea.
Swallowing the liquid can be fatal but is rare.

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Solvents - (*brand names*)
Off the shelf products.
Use: sniffed or inhaled.
Signs: watering eyes and nose, poor co-ordination, slurred speech.
Sought-after effects: "to get high"
Adverse effects: use is most common among early teens (12-15) and is often short term, but can be very dangerous. Continued use can lead to numbness or unconsciousness, propellant gasses can freeze the vocal cords causing asphyxiation. Associated dangers include accidents, choking on vomit or heart failure. Long-term use can impair visual and bladder function.

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Appendix 2

The policy context for dual diagnosis

There has been increasing recognition of the extent of co-existing mental health and substance misuse problems in recent years. This is reflected both in legislation and frameworks affecting service delivery. Whilst acknowledging that co-existing disorders occur on a spectrum, it should be noted that the focus of many policies is on people with more severe problems who have been given a formal diagnosis of dual diagnosis.

This section summarises the main initiatives, but is not intended to be a critique of policy.

The Mental Health National Service Framework 1999

The ten year National Service Framework for Mental Health (NSFMH) published in September 1999 sets out how services will be planned, delivered and monitored. It is relevant to all providers, the NHS, social services and voluntary and independent agencies. Seven standards set targets for the mental health care of adults up to age 65. These span 5 areas – health promotion and stigma, primary care and access to specialist services, the needs of those with severe and enduring mental illness, carers' needs and suicide reduction.

In relation to dual diagnosis, the Framework emphasises the following:

Under mental health promotion:
• Development of specific programmes to combat discrimination and social exclusion of vulnerable groups, including individuals with mental health and alcohol and drug problems
• Brief primary care interventions such as assessments of alcohol intake, which can reduce excess consumption
• Stronger links between drug and alcohol services and community mental health services to help reduce suicide

Under primary care:
• Assessments of individuals with mental health problems should consider the potential role of substance misuse

Under specialist services:
• The needs of people with dual diagnosis through existing mental health and drug and alcohol services.
• People with severe mental illness who have high rates of psychological or physical morbidity should receive appropriate and responsive care. Services should ensure that crises are anticipated or prevented wherever possible
• The Care Programme Approach (CPA) is a framework for inter-agency working set out by the Department of Health. It should be applied to people with dual diagnosis whether they are located in mental health or drug and alcohol services. The programme must start with a proper assessment (see page 30)
• Assertive outreach and crisis resolution services are seen as the main focus for work with people who have dual diagnosis. These must be adequately resourced and trained. Training for all staff, particularly in substance misuse and long-term engagement with clients, is identified as important

See www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009598&chk=jmAMLk

Models of Care

This sets out a national framework for the commissioning of an integrated drug treatment system for adult drug misusers in England. Published by the National Treatment Agency (NTA) in partnership with the Department of Health, Models of Care has similar status to a national service framework. Its aim is to support Drug Action Teams (DATs), joint commissioners and providers to develop an efficient and effective treatment and care system for all drug misusers. It groups services into four tiers (see page 36).

Models of care places considerable emphasis on care co-ordination and on meeting the multiple needs of a person misusing drugs or alcohol through an integrated care pathway. This involves links between substance misuse treatment provision and other generic health, social care and criminal justice services. Care plans are designed to ensure that a client's care is co-ordinated, comprehensive and has continuity. All commissioners of drug treatment services are expected to plan and commission services based on the system outlined in Models of Care.

See www.nta.nhs.uk

Dual Diagnosis Good Practice Guide

Published by the Department of Health in May 2002, this is the most relevant document concerning dual diagnosis. It summarises current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse.

This toolkit makes frequent reference to the guide but the key points are summarised below:

The primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse should lie within mental health services. This approach is known as 'mainstreaming' and aims to lessen the likelihood of people being shunted between services or losing contact completely.

In addition, substance misuse agencies (both alcohol and drugs) should provide specialist support, consultancy and training to mental health teams.

Mental health services should offer similar support to substance misuse agencies to enable them to effectively treat those with less severe mental health problems.

Clear pathways of joint working and treatment should be developed in dual diagnosis strategic planning.

Local Implementation Teams (from mental health) and Drug Action Teams (from substance misuse) are responsible for the implementation of the Guide's requirements.

See www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/ PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009058&chk=sCQrQr

The Mental Health Act 1983

This Act sets out the circumstances in which an individual can be detained in hospital for assessment and/or treatment for their mental disorder without their consent. A person cannot be detained by reason only of dependence on alcohol or drugs. They must also have a mental health disorder at a level at which they are considered to present a danger to themselves or others. Some people with co-existing conditions are being excluded from compulsory treatment. The draft Mental Health Bill proposes that the so-called exclusion clauses are dropped from legislation.

See www.markwalton.net/guidemha/index.asp?

The National Alcohol Harm Reduction Strategy for England

Published in March 2004, this document sets out the Government's strategy for tackling the harms and costs of alcohol misuse in England. The strategy states that binge drinkers and chronic drinkers are at particular risk of harm. It identifies particularly vulnerable groups such as ex-prisoners, street drinkers, young drinkers and those who are likely to experience other problems such as mental illness and drug use, which may compound multiple needs. It does not recommend specific actions for such groups. However, it is envisaged that measures to help them will be encompassed in the four main ways to tackle alcohol related harm. These are: improved education and communication; better identification and treatment of alcohol problems; tackling crime and anti-social behaviour; and closer working with the drinks industry.

The strategy recognises that treatment for a person's alcohol problems may fail due to lack of co-ordination and links with other services. It therefore contains a commitment to work with the National Treatment Agency to develop guidance within the Models of Care framework on integrated care pathways for vulnerable groups.

See www.strategy.gov.uk/su/alcohol/index.htm

Updated Drug Strategy

This was published by the Drug Strategy Directorate at the Home Office in 2002.

The Government's drugs strategy has the overarching aim of reducing the harm that drugs cause to society, including communities, individuals and their families. Key targets include: reduction of the use of Class A drugs and the frequent use of illegal drugs by young people; and the increase of problem drug users in treatment. It places particular emphasis and funding on expanding interventions within the criminal justice system.

The Strategy acknowledges that those with complex needs find it difficult to access the help they need. However, it does not explicitly mention any specific measures to improve provision for poly-drug users or those with co-existing mental health needs.

See www.homeoffice.gov.uk/drugs/strategy/index.html

The Legal Framework

There are two main statutes regulating the availability of drugs in the UK: the Misuse of Drugs Act, and the Medicines Act.

The Misuse of Drugs Act 1971

This is intended to prevent the non-medical use of certain drugs. For this reason it controls not just medicinal drugs (which will also be in the Medicines Act) but also drugs with no currently recognised medicinal uses. Drugs subject to this Act are known as "controlled" drugs. The law defines a series of offences, including unlawful supply, intent to supply, import or export (all these are collectively known as "trafficking" offences), and unlawful production. The main difference from the Medicines Act is that the Misuse of Drugs Act also prohibits unlawful possession. To enforce this law the police have the special powers to stop, detain and search people on "reasonable suspicion" that they are in possession of a controlled drug.

The Act divides drugs into three classes:

Class A: These include cocaine and crack (a form of cocaine), ecstasy, heroin, LSD, methadone, processed magic mushrooms and any Class B drug which is injected.

Class B: These include amphetamines, barbiturates, and codeine.

Class C: These include benzodiazepines, anabolic steroids, GHB and minor tranquillisers. Cannabis (in herbal or resin form) was reclassified to Class C in January 2004.This means that possession carries a reduced maximum sentence. The police have been issued with guidance advising them not to arrest for simple possession unless there are aggravating factors such as when the drug is being smoked in areas which minors frequent eg schools and youth clubs. However, the police will retain the power to arrest if they think it is appropriate, regardless of aggravating factors.

Use/production of drugs on work premises

Section 8 of the Misuse of Drugs Act

The current law makes it a criminal offence for people to knowingly allow premises they own, manage, or have responsibility for, to be used by any other person for:
• production or attempted production of any controlled drug
• supply or attempted supply of any controlled drug
• preparation of opium for smoking
• smoking of cannabis, cannabis resin or prepared opium

Professionals can be prosecuted if they knowingly allow any of these things to occur on work premises, which they 'occupy'. The same legal obligations could apply to people with regard to their own homes. The law requires that if staff become aware of the use or supply of illicit drugs on their premises, they must take reasonable action to prevent this continuing.

An amendment to Section 8(d) was passed in 2001, to extend this section to cover the administering or use of any controlled drug, so that it extends to crack and heroin.

However, in order to strengthen the laws on drug dealing, particularly in crack, Part 1 of the Anti-social Behaviour Act (2004) creates powers for the police and the courts to close down premises where there has been Class A drug use, production or supply, together with serious nuisance or disorder. In the light of these powers, although the amendment (Section 8d) to the current Misuse of Drugs Act has been passed, the Government is delaying its implementation to see if it will be necessary and is due to review the situation in 2005. Until then, the restrictions under Section 8 remain, as outlined in the bullet points above.

The Medicines Act 1968
This covers the manufacture and supply of medicinal products (mainly drugs) of all kinds.
It divides drugs into three categories:

• Prescription only – can only be sold or supplied by a pharmacist working from a registered pharmacy. The drug must have been prescribed by a doctor

• Pharmacy medicines – can be sold without a prescription, but only by a pharmacist

• General sales list – can be sold without a prescription by any shop, but certain advertising, labelling and production restrictions apply

The information on these two pages has been adapted from Drugscope and Release. Both organisations can provide more detailed information and advice. (See 'Useful Addresses' for details).

Further Reading

Dual Diagnosis: Substance Misuse and Psychiatric Disorders G. Hussein Rassool Blackwell Science (2002)
Available from Amazon
Price: £24.99

Advances in Quality Care – Spotlight on health/dual diagnosis "looking after myself"
Cassette tapes from Rethink conference: National Schizophrenia Fellowship in Partnership with Alcohol Concern and SCODA: 10 November (1998)

Meeting Complex Needs: The Future of Social Care.
Rankin, J and Regan, S
Available from Turning Point www.turning-point.co.uk

Counselling and Psychotherapy Resources Directory
Published annually by British Association for Counselling, 1 Regent Place, Rugby, Warwickshire, CV21 2PJ. Tel: 01788 550899

Does severe mental illness run in families?
Genetic counselling for schizophrenia and allied disorders
Rethink Fact Sheet 9

Drug Problems: Where to Get Help
ISBN 190431905X
Drugscope (see '*Useful Addresses*')
Price: £20
A comprehensive listing of drug treatment agencies in England. These include the major national and regional organisations, Drug (and Alcohol) Action Teams and drug user organisations. It covers advice and information, harm reduction, counselling, prescribing, rehabilitation and aftercare services, as well as specialist provision for young people

Factsheets are periodically published in Drugscope's magazine Druglink. For a full listing of resources see Drugscope's website

Dual diagnosis – mental illness and drug/alcohol problems - Rethink Fact Sheet 7

Dual diagnosis of severe mental health problems and substance abuse/dependence: a major priority for mental health nursing. K Gournay, T. Sandford, S. Johnson, G. Thornicroft (1997)
Journal of Psychiatric and Mental Health Nursing

Drug misuse and mental health: learning the lessons on dual diagnosis. A report of the All Party Parliamentary Drugs Misuse Group (2000)

Mental Health and Social Exclusion (2004)
ISBN 185112-7178
Available free from ODPM Publications Tel 0870 1226 236 or downloadable from www.socialexclusionunit.gov.uk/

Integrated treatment for dual disorders: a guide to effective practice.
Mueser K.T., Noordsy D.L., Drake R.E., Fox L. London Guilford Press (2003)

Keys to engagement: review of care for people with severe mental illness who are hard to engage with services
The Sainsbury Centre for Mental Health (see '*Useful Addresses*')

The National Electronic Library for Health is a useful website, with a comprehensive mental health section:
www.nelmh.org

New Guide to Medicines and Drugs (2001), British Medical Association
ISBN 0-751-327-379
Published by Dorling Kindersley Ltd. UK

Perspectives on multiple needs: working with individuals who experience mental health and substance misuse problems
The CASA Multiple Needs Service September (1998)

Street drugs: the facts explained, the myths exploded Andrew Tyler (1995)
ISBN 0-340-60975-3
Hodder & Stoughton

Substance Use: Guidance on good clinical practice for Nurses working within mental health. Coyne, P. Lambert, E. Carroll, J. (2004) London. ANSA/Department of Health (forthcoming)

Substance misuse and mental health co-morbidity (dual diagnosis): standards for mental health services. Abdulrahim D. Health Advisory Service (2001)

Rethink's publications and factsheets are available from the Rethink National Advice Service. They include information on:

• Schizophrenia
• Bipolar Disorder
• Anxiety disorders
• Schizoaffective disorder
• Depression
• Personality disorders
• Treatments

and many other topics affecting people with mental health problems. The Rethink Diversion Toolkit is also a useful resource

Turning Point has published a number of reports exploring issues which are often relevant to people with multiple needs. These include:

• Getting it right for young people: a vision for young people's social care (2003)
• Waiting for Change: treatment delays and the damage to drinkers (2003)
• Routes into treatment: drugs and crime (2004)

These are available free from Turning Point

Useful Addresses

Addaction
67-69 Cowcross Street
London EC1M 6PU
Tel: 020 7251 5860
Fax: 020 7251 5890
Website: www.addaction.org.uk
E-mail: info@addaction.org.uk

Addaction helps individuals and communities to manage the effects of drug and alcohol misuse and has over fifty projects in England within communities and prisons.

Adfam
Waterbridge House
32-36 Loman Street
London SE1 0EH
Tel: 020 7928 8898
Open 10am - 5pm Monday-Friday, answering machine at all other times.
National charity for families of drug users. Offers confidential support and information. Callers can ring as often as they need and Adfam will call people back if the cost of a call is a problem.
Fax: 020 7928 8923
Website: www.adfam.org.uk
E-mail: admin@adfam.org.uk

Adult Children of Alcoholics
Tel: 020 7229 4587

A fellowship of men and women who have been raised in an alcohol environment and who need support.

African Caribbean Mental Health Association (ACMHA)
49 Effra Road Suite 37
Brixton
London SW2 1BZ
Tel: 020 7737 3603
Fax: 020 17924 0126

The African Caribbean Mental Health Association comprises a community mental health centre that provides a wide range of care services to the black community. They also address the problem of racism in the care and treatment of black people.

Al-Anon Family Groups (UK and Eire)
61 Great Dover Street
London SE1 4YF
Tel: 020 7403 0888 (Open 24 hours a day, 365 days a year)
Website: www.al-anonuk.org.uk

For families and friends of alcoholics. Al-anon Family Groups provide understanding, strength and hope to anyone whose life is, or has been, affected by someone else's drinking.

Alcohol Concern
Waterbridge House
32-36 Loman Street
London SE1 0EE
Tel: 020 7928 7377
Fax: 020 7928 4644
E-mail: contact@alcoholconcern.org.uk
Website: www.alcoholconcern.org.uk

Alcohol Concern is the national agency on alcohol misuse. They work to reduce the incidence and costs of alcohol-related harm and to increase the range and quality of services available to people with alcohol-related problems. The Mental Health & Alcohol Misuse Project provides fact sheets, a newsletter and web pages to share good practice among clinicians and professionals. For more information contact Slade Carter (scarter@alcoholconcern.org.uk).

Alcoholics Anonymous
Tel: 020 7352 3001 (Open 10am-10pm 7 days a week, 365 days a year)
Website: www.alcoholics-anonymous.org.uk

Alcoholics anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. Out-of-hours answering machine. A.A. will return messages. Will provide a comprehensive list of private clinics around the country for drug, alcohol and other addictions on request.

Association of Nurses in Substance Misuse
PO Box 146
Yelverton
Tavistock PL20 7ZJ
Tel: 0807 241 3503
Website: www.ansa.uk.net
E-mail: ansa@fsmail.net

ANSA welcomes all professionals who work in the area of substance abuse.

British Association for Counselling and Psychotherapy
BACP House
35-37 Albert Street
Rugby
Warwickshire CV21 2SG
Tel: 0870 443 5252
E-mail: bacp@bacp.co.uk
Website: www.bacp.co.uk

The British Association for Counselling and Psychotherapy provides training and a register of registered practioners across the country

CASA Multiple Needs Service
75 Fortess Road
London NW5 1AG
Tel: 020 7428 5954
Fax: 020 7428 5953

CASA was developed to address the gaps in service provision for people who experience mental health and substance misuse services. It adopts an holistic approach to these problems, working with the whole person and their presenting difficulties. The Multiple needs Service (MNS) has worked with clients in Islington and Camden since late 1995. It also offers specialist training nationally.

Carers UK
20-25 Glasshouse Yard
London EC1A 4JS
Tel: 020 7490 8818
Carersline: 0345 573 369
Fax: 020 7490 8824

Carers UK is the national voice of carers. They provide advice for carers across the UK.

Chinese Mental Health Association
Oxford House
Derbyshire Street
London E2 6HB
Tel: 020 7613 11008 (9am-5.30pm Monday-Friday)
Fax: 020 7729 0435

The Chinese Mental Health Association is a voluntary organisation and registered charity set up to help Chinese people who are sufferers of mental illness. The association aims to promote mental health education in the Chinese community and to raise awareness amongst the mainstream healthcare providers regarding Chinese mental health issues.

Cocaine Anonymous
Tel: 020 7284 1123 (Open 24 hours a day, 365 days a year)
Website: www.cauk.org.uk
Cocaine Anonymous is a fellowship of men and women who use the 12 step, self-help programme to stop using cocaine and all other mind-altering substances. There are meetings all over the country.

Council for Involuntary Tranquilliser Addiction (CITA)
Cavendish House
Rooms 15 & 17
Brighton Road
Waterloo
Liverpool L22 5NG
Helpline: 0151 949 0102 (10am-1pm Monday-Friday)
Fax: 0151 284 8324

CITA helps patients and families to cope with addiction to benzodiazepines and other prescribed drugs especially anti-depressants, and with withdrawal. In addition to the helpline, CITA has a list of self help groups across the country.

Drinkline
Freephone: 0500 801 802
Tel: 020 7332 0202 (Open 11am-11pm Monday-Friday, dial and listen service 24 hours a day)

Drinkline is the National Alcohol Helpline. They provide information and self-help materials, help to callers worried about their own drinking, support to the family and friends of people who are drinking and advice on where to get help.

Drug and Alcohol Women's Network
31 Great Sutton Street
London EC1V ODX
Tel: 020 7253 6221 Monday/Tuesday/Thursday 9.30am-5.30pm

Set up to help and support women working in the field of drugs and alcohol. The Greater London Association of Alcohol Services is also at the same address. This aims to create and support a network of alcohol services in London.

DrugScope
32 - 36 Loman Street
London SE1 0EE
Tel: 020 7928 1211
Fax: 020 7928 1771
Website: www.drugscope.org.uk
E-mail: info@drugscope.org.uk

DrugScope provides information and publications on a wide range of drug related topics. The information service is open from 10am-4pm Monday-Friday on 08707 743 682.

FRANK (formerly the National Drugs Helpline)
Freephone: 0800 77 66 00
Confidential, daily 24 hour service:
Website: www.talktofrank.com

Campaign from the Department of Health and the Home Office, supported by the DfES. Information and advice on drugs to anyone concerned about drugs and solvent/volatile substance misuse, including drug misusers, their families, friends and carers. Information and advice is available in several languages.

Health Information Service
Freephone: 0800 66 55 44

An information-only service, run by the NHS. 10am-5pm Monday-Friday, answering machine outside these hours. The service operates on a local basis. Calls are automatically routed to your nearest local office. A general health information service, but it provides details of addiction units and self-help groups around the country.

Hearing Voices Network
91 Oldham Street
Manchester M4 1LW
Tel: 0161 834 5768
Fax: 0161 228 3896
Website: www.hearing-voices.org

The Hearing Voices Network offers information, support and understanding to people who hear voices and those that support them.

JAMI
Jewish Association for the Mentally Ill
16a North End Road
Golders Green
London NW11 7PH
Tel: 020 8458 2223
Fax: 020 8458 1117
Website: www.mentalhealth-jami.org.uk/

JAMI provides essential daycare, social work, counselling advice, information, and social activities for people suffering from severe mental health problems, their families and carers.

Kaleidoscope Project
40-46 Cromwell Road
Kingston upon Thames
Surrey KT2 6RE
Tel: 020 8549 2681

In addition to a methadone maintenance and reduction service, needle exchange, day programme and recreation, counselling, crèche and detoxification unit, the Kaleidoscope Project runs professional training courses in drug awareness and education.

Manic Depression Fellowship (MDF)
Castle Works
21 St. George's Road
London SE1 6ES
Tel: 020 7793 2600
Fax: 020 7793 2639
E-mail: mdf@mdf.org.uk
Website: www.mdf.org.uk

The Manic Depression Fellowship works to enable people affected by manic depression to take control of their lives. It does this through supporting and developing self help opportunities for people affected by manic depression, providing an information service, influencing the improvement of treatments and services to promote recovery and tackling discrimination. It has a number of self help groups across the UK.

MIND (National Association for Mental Health)
Granta House,
15-19 Broadway
Stratford
London E15 4BQ
Tel: 020 8519 2122
Help Line: Mind info-line: 020 8522 1728 / 0845 766 0163
E-mail: contact@mind.org.uk
Fax: 020 8522 1725

Mind is a leading mental health charity in England and Wales, working for a better life for everyone with experience of mental distress. As well as printed information, Mind has a very comprehensive website offering advice, information and background briefings on a wide range of mental health issues and mental health problems (add including dual diagnosis).

Mental Health Foundation
7th Floor, 83 Victoria Street
London SWIH 0HW
Tel: 020 7802 0300
Fax: 020 7802 0301
Website: www.mentalhealth.org.uk
E-mail: mhf@mhf.org.uk

The Mental Health Foundation is a leading UK charity providing research and community projects to improve support for people with mental health problems and people with learning disabilities. It provides information on specific mental health problems, where to get help, treatment and rights.

Narcotics Anonymous
Tel: 020 7730 0009 (10am-10pm 365 days a years. Out of hours answering machine, calls will be returned)
Website: www.ukna.org

NA is a fellowship of men and women for whom drugs had become a major problem. Using the 12 step self-help model recovering addicts meet regularly to help each other stay clean. The have meetings all over the country.

National Asian Drinkline
Tel: 0990 133480 (Counselling 1pm-8pm Monday-Friday, dial and listen service 24 hours a day, 365 days a year)

National Association of Children of Alcoholics
PO Box 64
Fishponds
Bristol BS16 2UH
Freephone: 0800 358 3456 (Open 9am-5pm Monday-Friday. Out of hours answering machine. Calls will be returned)
Fax: 0117 924 8005

The National Association for Children of Alcoholics offers advice, information and support to children of alcoholics. They also work with professionals who deal with children of alcoholics.

National Institute for Mental Health in England (NIMHE)
Blenheim House
West One
Duncombe Street
Leeds LS1 4PL
Tel: 0113 254 3811
Website: www.nimhe.org.uk
E-mail: Ask@nimhe.org.uk

NIMHE aims to improve the quality of life for people of all ages who experience mental distress. They help all those involved in mental health to implement positive change, provide a gateway to learning and development, offer new opportunities to share experiences and one place to find information. Through NIMHE's local development centres and national programmes of work (eg on dual diagnosis, personality disorder and women) they support staff to put policy into practice and to resolve local challenges in developing mental health.

Overcount Drug Information Agency
20 Brewery Street
Dumfries
Scotland DG1 2RP
Tel: 01387 770 404 (8am-9pm, answering machine at other times. All calls will be returned)

A unique agency offering information on over the counter drugs. Run by David Grieve, this is a free, independent and confidential service for anybody who fears that they may be addicted, or for friends and family wishing to know more about over the counter drugs.

Release
388 Old Street
London EC1V 9LT
Helpline: 020 7729 9904
Administration: 020 7729 5255
Legal and Drugs Helpline: 020 7729 9904 (10am-5.30pm, Monday-Friday)
Website: www.release.org.uk
E-mail: ask@release.org.uk

Release is a national organisation committed to informing and advising the public about drugs, the law and human rights.

Rethink severe mental illness
30 Tabernacle Street
London EC2A 4DD
Tel: 0845 456 0455
Fax: 020 7330 9102
E-mail: info@rethink.org
Website: www.rethink.org
Carers' website: www.rethinkcarers.org

Rethink has more than 30 years experience of helping people affected by severe mental illness and their families recover a meaningful life. As well as running over 400 mental health services, they have a network of more than 120 support groups across the country.

Rethink National Advice Service
28 Castle Street
Kingston upon Thames
Surrey KT1 1SS
Tel: 020 8974 6814 (Mon, Wed, Fri 10am-3pm; Tues and Thurs 10am-1pm)
E-mail: advice@rethink.org

The Rethink National Advice Service provides information and advice on all aspects of mental illness and issues affecting people with mental illness to people with mental illness, their carers, friends and family and professionals.

Revolving Doors

Unit 29, The Turnmill
63 Clerkenwell Road
London ECIM 5NP
Tel: 020 7253 4038
Fax: 020 7553 6079
Website: www.revolving-doors.co.uk

Revolving Doors Agency is the UK's leading charity concerned with mental health and the criminal justice system. It runs practical schemes in police stations, prisons and courts to support people who have "fallen through the net" of mainstream services. It uses this experience to provide project development support to other agencies and to conduct research and policy work at local and national level.

Sainsbury Centre for Mental Health

134-138 Borough High Street
London SWI 1LB
Tel: 020 7403 8790
Fax: 020 7403 9482
Website: www.scmh.org.uk

The Sainsbury Centre for Mental Health is a charity that works to improve the quality of life for people with severe mental health problems. It carries out research, development and training work to influence policy and practice in health and social care.

SANE

Ist Floor, Cityside House
40 Adler Street
London E1 1EE
Tel: 020 7375 1002
Fax: 020 7375 2162
SANELINE: 0845 767 8000
SANE is one of the UK's leading charities concerned with improving the lives of everyone affected by mental illness.

Survivors Speak Out

34 Osnaburgh Street
London NW1 3ND
Tel: 020 7916 6991

Survivors Speak Out is a nationwide organisation for people who are defined psychiatric system survivors. This is a campaigning organisation trying to bring change through survivor contact and empowerment, by putting people in touch with each other.

Tasha

(Tranquillisers, Anxiety, Stress, Help Association)
Tel: 020 8560 6601 (6pm-12am only, 365 days a year)
Website: www.tasha-foundation.org.uk

The TASHA foundation provide confidential information, support, training and counselling to individuals affected by mental health difficulties and problematic benzodiazepine usage.

Turning Point
New Loom House
101 Back Church Lane
London E1 1LU
Tel: 020 7702 2300
Website: www.turning-point.co.uk
E-mail: info@turning-point.co.uk

Turning Point is the UK's leading social care charity providing services for people with complex needs across a range of health and disability issues primarily substance misuse, mental health and learning disability. It has residential and community-based services in 200 locations in England and Wales. Turning Point provides services for people with concurrent mental health and substance misuse problems.

UK Council for Psychotherapy
United Kingdom Council for Psychotherapy
167-169 Great Portland Street
London W1W 5PF
Tel: 020 7436 3002
Fax: 020 7436 3013
Website: www.psychotherapy.org.uk
E-mail: ukcp@psychotherapy.org.uk

The UKCP promotes psychotherapy for the public benefit, research and education in psychotherapy its dissemination as well as protection of the public through high standards of training and practice in psychotherapy. They publish the National Register of Psychotherapists annually and only psychotherapists who meet the training requirements and abide by its ethical guidelines are included.

Young Minds (Children's Mental Health Charity)
2nd Floor, 102/8 Clerkenwell Rd
London EC1M 5SA
Tel: 020 7336 8445
Helpline: (Parents' information service) 0800 018 2138
Fax: 020 7336 8446
Website: www.youngminds.org.uk
E-mail: enquiries@youngminds.org.uk

Young Minds is the national charity committed to improving the mental health of all children and young people.

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Turning Point

New Loom House
101 Back Church Lane
London E1 1LU
Tel: 020 7702 2300
Website: www.turning-point.co.uk
E-mail: info@turning-point.co.uk

Registered Charity Number: 234887
Registered Social Landlord and Company Limited by Guarantee in England and Wales (no.793558).

Turning Point is the UK's leading social care charity providing services for people with complex needs across a range of health and disability issues primarily substance misuse, mental health and learning disability. It has residential and community-based services in 200 locations in England and Wales. Turning Point provides services for people with concurrent mental health and substance misuse problems.

Rethink severe mental illness

30 Tabernacle Street
London EC2A 4DD
Tel: 0845 456 0455
Fax: 020 7330 9102
Website: www.rethink.org
E-mail: info@rethink.org

Registered Charity Number: 271028
Company Registered in England Number: 1227970

Rethink has more than 30 years experiwence of helping people affected by severe mental illness and their families recover a meaningful life. As well as running over 400 mental health services, we have a network of more than 120 support groups across the country.