

# 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](http://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](http://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](http://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](http://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](http://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](http://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).*