



**Public – To be published on the Trust external website**

# **Title: Management of co-occurring mental illness and substance use (Dual Diagnosis)**

**Ref: CLIN-0051-v8**

**Status: Ratified**

**Document type: Policy**

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# 1 Introduction

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Alcohol and drug use are very common among people with mental illness and vice versa. Research shows that mental health problems are experienced by the majority of drug (75%) and alcohol (85%) users in community substance use services. A history of alcohol or drug use is also recorded in 54% of all suicides in people experiencing mental health problems and people with co-occurring conditions have a heightened risk of physical health problems and early death. (Health matters: reducing health inequalities in mental illness. Public Health England Dec 2018)

Substance use can be very common in multiple disadvantaged communities (for example those involved in the criminal justice system), further adding to difficulties they have in traditional services engaging with them. Despite the shared responsibility that NHS and local authority commissioners must provide treatment, care and support, people with co-occurring conditions are often excluded from each other's services.

Individuals with co-occurring mental illness and substance use problems (Dual Diagnosis) often have complex assessment and treatment needs. Substance use is common in many patients who present to mental health services and mental health problems are common in drug and alcohol.

Individuals with dual diagnosis often experience higher risks and poorer outcomes than other patients, such as:

- high risk of relapse and hospitalisation,
- high risk of suicide, drug-related death, and crime
- poor outcomes,
- poor physical health,
- high risk of dropping out of services; and
- higher overall treatment costs.

Supporting people with co-occurring mental illness and substance use is a key chapter within the Trust Clinical Journey. This policy is critical to the delivery of Our Journey to Change (OJTC) – the next chapter and our ambition to support people to lead their best possible lives. It helps us deliver our three strategic goals as follows:

- This policy supports the trust to co-create high quality care by ensuring that people access the care that is right for them, delivered in a flexible and compassionate way.
- This policy supports TEWV to be a trusted partner by supporting joint working with alcohol and drug use services to meet the needs of individual with co-occurring conditions.

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## 2 Why we need this policy

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### 2.1 Purpose

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The policy refers to all patients of the Trust with concurrent mental illness and/or learning disability and substance use needs.

The purpose of this policy is to:

- comply with CQC standards, (including CQC Brief Guide: Substance Misuse Services – People in Vulnerable Circumstances), NHS Resolution standards, Department of Health Guidance (including Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use conditions), NICE guidance NG58, CG120, QS188, and Local and National Guidance,
- ensure that all staff are aware of the care and management of dual diagnosis policy and to provide guidance for staff when working with people who have a Dual Diagnosis,
- set out standards for joint working and for liaison between Mental Health and Substance use services and for referral and assessment; and
- set out the duties and expectations of staff within Mental Health services.

### 2.2 Objectives

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By adhering to this policy, the Trust will ensure that patients are managed in line with national standards of good practice and that patients are not discriminated against due to their mental health needs being perceived as drug or alcohol induced. This Policy supports this by setting out the expectation that patients:

- receive care based upon their needs, provided by the service (or services) best placed to meet those needs,
- have an appropriate keyworker / care co-ordinator or lead professional allocated
- receive care delivered in a collaborative manner from a care plan if multiple providers are involved; and
- are cared for by staff in mainstream substance use and mental health services who are competent and capable of responding to dual diagnosis needs.

## 3 Scope

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The policy refers to all patients of the Trust with concurrent mental illness and substance use needs.

### 3.1 Who this policy applies to

- This policy applies to all clinical staff within the Trust.

### 3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and Trust Board	Ensuring there are effective arrangements for Care and Management of Dual Diagnosis within the Trust.
Care Group Director	Ensuring policy/procedure is implemented in respective services.
Service Manager	Ensuring policy/procedure is adhered to within their areas of accountability.
Clinical Staff	<p>To adhere to the principles and standards laid out in this policy.</p> <p>Use a harm minimisation-based approach to care and work collaboratively with other providers in devising and implementing a care plan with patients with dual needs. This will be developed and reviewed with the patient whenever possible.</p> <p>Engage in ongoing professional development and lifelong learning relating to the care of those with dual needs.</p> <p>Must meet Foundation Training standard which supports awareness of their role with clients who have co-existing dual diagnosis needs.</p>
Chief Pharmacist	As the Accountable Officer for Controlled Drugs (CDs), the Chief Pharmacist has overall responsibility for all aspects of the safe and secure management of CDs within the organisation. This appointment is a statutory requirement as identified by the Controlled Drugs (Supervision and Management of Use) Regulations 2006.
Local Security Management Specialist	Supporting staff to implement a zero-tolerance approach Provide support to staff after incidents to ensure lessons are learned

<p>Dual Diagnosis Advocates:</p>	<p>Advocates will be at team level, and it is envisaged that there will be at least one per team, however, teams may opt to have more based on need and interest.</p> <p>Advocates ARE NOT a default role to be allocated a dual diagnosis caseload. They will have job planned activity in relation to dual diagnosis consisting, of several of the following components:</p> <ul style="list-style-type: none"> <li>• Supporting the sharing of knowledge and training focused on dual diagnosis and team development in dual diagnosis.</li> <li>• Advising complex cases where there is a dual diagnosis need, seeking supervision/wider consultation as required.</li> <li>• Supporting the Team in partnership working with local drug and alcohol recovery services and services which support the needs of those with dual diagnosis.</li> <li>• Completing Audit in line with local, care group and trust wide directions and standards.</li> <li>• Providing advice on Harm Minimisation approaches for those at risk of drug and alcohol related harm (including, the management of Naloxone).</li> </ul> <p>Area specific input may include:</p> <p><b>Urgent Care</b> – advise and support around drug testing and working with TEWV approved drug dogs, supporting the commencement of dual diagnosis assessment by drug and alcohol recovery services while an inpatient through multi-agency partnership links.</p> <p><b>Planned Care</b> - Maintaining links with local drug and alcohol recovery services to support joint care planning, multi-agency working and joint training opportunities.</p>
<p>Dual Diagnosis Specialists:</p>	<ul style="list-style-type: none"> <li>• Specialists will either be in a specific senior clinical dual diagnosis roles or have a dual diagnosis functionality within their substantive role which is both clear and job planned. This would be agreed within their appraisal and job planning processes.</li> <li>• Specialists may have a functionality at team level (due to the nature of the team) or have a system wide element to their role. Their experience and training will be reflective of this position, and they will be expected to continue their development around dual diagnosis as part of their appraisal.</li> </ul>
<p>Dual Diagnosis Leaders:</p>	<ul style="list-style-type: none"> <li>• Leaders will be part of the organisation wide strategic dual diagnosis leadership set, attend and actively contribute to dual diagnosis trust wide leadership activities and actions.</li> </ul>

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## 4 Policy

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### 4.1 Our Ambition for Drug and Alcohol

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We will work with people with co-existing substance use issues and not exclude anyone from accessing mental health services based on concurrent substance use. Staff will have the confidence and competence to support people who use substances including those with addictions and have access to expert advice when needed. Services will respond effectively and flexibly to presenting needs. We will work together with partners in primary care, local authorities, and the voluntary sector to improve access to services which can minimise harm, improve health and enhance recovery (and be guided by those with lived experience)

#### 4.1.1 Our Approach

We will adhere to the following principles:

**This is everyone's job.** We will work jointly with alcohol and drug use services to meet the needs of individuals with co-occurring conditions. We will support and treat substance use guided by expertise (internal and external) when needed. Equally we will support drug and alcohol agencies in understanding and managing mental illness.

**No wrong door:** People with co-occurring conditions often endure a lot of uncertainty, repeat traumatisation and chaos in their lives. This requires us to adopt a flexible, trauma informed and attachment-focused approach. We cannot be rigid about when we see people or what we are seeing them for. It takes time to build trust and so we accept that individuals may contact mental health services at multiple and unpredictable points in their lives and their care journey.

**Making every contact count:** Treatment for any of the co-occurring conditions is available through every contact point as is support for physical or social concerns. This will also help to build trust.

**Consultation to the system approach:** Where direct intervention by either mental health or substance use services is limited or not possible, a joint working and consultation stance will be held, with a focus on advice, consultation, and support to each other with the person held at the centre of their care.

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#### 4.1.2 How will we achieve our ambitions?

We will:

- Develop a network of expertise in dual diagnosis across the Trust in order that all clinical staff will have access to an identified staff member who has enhanced dual diagnosis capabilities. All localities and specialties will determine the number of practitioners with enhanced dual diagnosis knowledge.
- Develop local substance use clinical networks linking key stakeholders at place. Dual diagnosis practitioners are expected to regularly attend and actively contribute to the local substance use clinical network. Services will give staff protected time to attend these networks and dual diagnosis related duties will be specified in the staff's job description and regularly reviewed during appraisal.
- Ensure community hubs incorporate easy access to substance use services through partnership, co-created at place.
- Educate staff in core skills in substance use, use of the dual diagnosis pathways, appropriate interventions, motivational interviewing, and harm minimisation (including other family members and in particular children)
- Have access to dedicated workers, including substance use peer workers in our hospitals and as part of our crisis response.
- Develop and embrace harm minimisation and harm reduction practices such as making naloxone available to those at risk of opioid overdose.

#### 4.1.3 Assessing patients who are under the influence of alcohol or drugs.

Crisis, Access, Liaison, Street Triage and Liaison and Diversion teams are often asked to see patients who are intoxicated with alcohol or drugs. It is often difficult or impossible to conduct a comprehensive assessment of these patients and they often lack capacity to consent to being assessed and managed by mental health services.

A structured test is available to assess and document capacity for these patients. If there is a chance that the person will regain capacity to make a decision, then it may be possible to put off a decision until later. Professionals will need to assess if there are any arrangements possible to secure the patients safety until they are able to be assessed.

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## 4.2 Managing illicit substances or alcohol on Trust premises, including in in-patient services

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The Trust Position Statement must be displayed in inpatient areas – see [Appendix 3](#)

The Trust has a zero-tolerance policy for the use or possession of illicit substances (including non-prescribed medication) on Trust premises. The Trust does not tolerate the use, possession or supply of alcohol, illicit substances including psychoactive substances (previously known as legal highs) on Trust premises. If you suspect that anyone is in possession of an illicit substance you must follow:

- [Management of substance use on Trust premises \(including Inpatient settings\) policy](#)
- [Dual Diagnosis Clinical Link Pathway \(CLiP\)](#)
- [Policy for the Searching of Patients, Patients Property, Patient Areas and Visitors](#)
- and contact the police as required.
- [Criminal Incident Reporting Procedure](#)
- [Controlled Drugs Standard Operating Procedures](#)

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## 4.3 Reviewing and preventing drug related deaths and incidents

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The Trust patient safety department will identify serious incidents in which dual diagnosis appears to be a factor.

A yearly focused review of these incidents will be carried out to identify common themes and lessons learned. The findings will be used to inform service development needs in this area.

## 5 Definitions

Term	Definition
Dual Diagnosis	Used for patients with mental health problems and co-occurring substance use. Although the term Dual Diagnosis has been criticised for different reasons by patients and professionals it is still commonly used in research and national guidelines. The trust will therefore continue to use the term 'Dual Diagnosis' alongside 'Mental illness and Co-occurring Substance use'.
Problem Drug Use	In the UK, the Advisory Council on the Misuse of Drugs (ACMD) characterises problem drug use as a condition that may cause an individual to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption, and/or dependence (ACMD, 1998).
Dependence	Strong desire or sense of compulsion to take a substance, a difficulty in controlling its use, the presence of a physiological withdrawal state, tolerance of the use of the drug, neglect of alternative pleasures and interests and persistent use of the drug, despite harm to oneself and others (WHO, 2006). Dependence is diagnosed according to DSM-IV or ICD-10 criteria.
Dual Diagnosis Practitioners	Staff with enhanced levels of knowledge and training in dual diagnosis. The term Dual Diagnosis Practitioners replaces the term Dual Diagnosis Leads that was used in previous policies.

## 6 Related documents

- [Trust Clinical Journey](#)
- [Management of substance use on Trust premises \(including Inpatient settings\) policy](#)
- [Dual Diagnosis Clinical Link Pathway \(CLiP\)](#)
- [Policy for the Searching of Patients, Patients Property, Patient Areas and Visitors](#)
- [Safety and Risk Management Policy](#)
- [Controlled Drugs Standard Operating Procedure](#)
- [Criminal Incident Reporting Procedure](#)
- [Personalised Care Planning Policy](#)

## 7 How this policy will be implemented

- This policy will be published on the Trust intranet and Trust website
- Where applicable line managers will ensure staff are made aware of this policy and any procedural changes

### 7.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Bulletin produced highlighting key changes and taken through Quality Standards Groups, Clinical Networks and IDGs	Inform staff of changes to policy	Within 1 month after policy implementation	Head of Clinical Strategy	Minutes of meetings
Policy distribution via Policy update	Staff informed	Once policy approved and ratified	Policy Team	Included in Policy Update

## 7.2 Training needs analysis.

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Level 1 All practitioners (working with patients)	Completion of dual diagnosis e-learning package	< 1 hour	Once
Level 2 Job planned as Dual Diagnosis advocates (working to support their Team and patients)	Regular attendance and active contribution to local dual diagnosis networks - Reflections on practice as part of Continuing Professional Development (CPD) - Completion of dual diagnosis and substance use training	Depending on individual and role	To attend local dual diagnosis networks at least twice a year.
Level 3 Specialist (working within their Team and system level)	- Enhanced dual diagnosis knowledge and experience this could be either qualifications or though substantial clinical practice in the field. - Regular attendance at local dual diagnosis networks - Enhanced level practitioners will usually have a significant part of their job role dedicated to substance use/dual diagnosis work or have been within such a role within the last 10 years.	Depending on individual and role	To be completing CPD dual diagnosis focused activities yearly.
Level 4 Collective Leadership Care Group and /or Trustwide (Locality and trust level)	A member of the collective leadership set, trust wide, will have experience and training in dual diagnosis and will be part of the collective strategic leadership around dual diagnosis for the Trust.	Active member of dual diagnosis leadership set contributing yearly to the strategic direction in the organisation.	As required.

## 8 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Number and skills of staff with enhanced dual diagnosis capabilities	Audited every 2 years. Trustwide Lead for Dual Diagnosis	Executive Clinical Leaders Group
2	Compliance with Clinical Link Pathway (Dual Diagnosis)	Audited every 2 years Trustwide Lead for Dual Diagnosis	Service Improvement and Development Groups

## 9 References

- [Health matters: reducing health inequalities in mental illness. Public Health England Dec 2018](#)
- NICE NG58, Coexisting severe mental illness and substance misuse: community health and social care services <https://www.nice.org.uk/guidance/ng58>
- [CG120 Coexisting severe mental illness \(psychosis\) and substance misuse: assessment and management in healthcare settings](#)
- [QS188 Coexisting severe mental illness and substance misuse | Quality standards | NICE](#)
- [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking \(high-risk drinking\) and alcohol dependence](#)
- Drug misuse and dependence - UK guidelines on clinical management (Orange Book), available on [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/673978/clinical\\_guidelines\\_2017.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf)

- [‘CQC Brief Guide: Substance Misuse Services – People in Vulnerable Circumstances](#)
- [Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use Conditions](#)

## 10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	07 April 2026
Next review date	07 April 2029
This document replaces	CLIN-0051-v7 Management of coexisting mental illness and substance misuse (Dual Diagnosis)
This document was approved by	Executive Clinical Leaders Sub-Group
This document was approved	18 March 2026
This document was ratified by	Executive Directors Group
This document was ratified	07 April 2026
An equality analysis was completed on this policy on	11 August 2025
Document type	Public
FOI Clause (Private documents only)	n/a

### Change record

Version	Date	Amendment details	Status
v7	20 Dec 2023	Full revision to align with Dual Diagnosis Chapter within Our Clinical Journey to Change	To be withdrawn
v8	07 Apr 2026	Changed title from Management of coexisting mental illness and substance <b>misuse</b> (Dual Diagnosis) to Management of co-occurring mental illness and	Approved pending ratification

		<p>substance <b>use</b>, to reflect both the Department of Health &amp; Social Care Guidance published 10 Dec 2025 (Co-occurring mental health and substance use delivery framework) and the Royal College of Psychiatry Paper May 25 titled Co-occurring substance use and mental health disorders</p> <p>Updated language throughout document from Substance <b>misuse</b> to substance <b>use</b>. Language is important and can be used to reduce stigma and negative bias when discussing addiction. Substance misuse elicits negative associations, punitive attitudes and individual blame. (National Institute of Drug Abuse <a href="#">Words Matter - Terms to Use and Avoid When Talking About Addiction   National Institute on Drug Abuse (NIDA)</a>). Support the “Stigma Kills” campaign</p> <p>Changed service user to patient throughout document as recommended by equality and diversity</p> <p>Updated Section 2.1 to include more specific detail regarding which standards/legislation the policy helps us to comply with. Changed NHSLA to NHS Resolution.</p> <p>Updated Section 3.2 roles and responsibilities to include Chief Pharmacist, Local Security Management Specialist, Dual Diagnosis Advocates, Specialists and Leaders. Clinical staff also updated to reflect personalised harm minimisation approach to care planning with patient and other care providers.</p> <p>Section 6 updated references to reflect changes to some policy titles. Also updated as required throughout the policy</p>	
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		<p>Updated 7.2 Training Needs Analysis to reflect Trust Dual Diagnosis Plan Updated Section 9 references and include links</p> <p>Removed reference to 3-year plans from OJTC</p> <p>Appendix 1 Section 3 Equality Impact Assessment, updated sources of information list to be more specific</p>	
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## Appendix 1 - Equality Analysis Screening Form

Section 1	Scope
Name of service area/directorate/department	Trustwide clinical services
Title	Management of co-occurring mental illness and substance use
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	<p>The purpose of this policy is to:</p> <ul style="list-style-type: none"> <li>• comply with CQC standards, (including CQC Brief Guide: Substance Misuse Services – People in Vulnerable Circumstances), NHS Resolution standards, Department of Health Guidance (including Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use conditions), NICE guidance NG58, CG120, QS188, and Local and National Guidance,</li> <li>• ensure that all staff are aware of the care and management of dual diagnosis policy and to provide guidance for staff when working with people who have a Dual Diagnosis,</li> <li>• set out standards for joint working and for liaison between Mental Health and Substance use services and for referral and assessment; and</li> <li>• set out the duties and expectations of staff within Mental Health services.</li> </ul>
Start date of Equality Analysis Screening	July 2025
End date of Equality Analysis Screening	11 August 2025

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	This Policy benefits patients and carers and ensures that they are not discriminated against due to their mental health needs being perceived as drug or alcohol induced – the policy describes the principles by which staff will work with our patients and carers in a supportive and compassionate, person-centred way. Our staff are able to access training as well as advice and guidance from dual diagnosis p[practitioners and partner organisations. Our clinical Journey to Change includes a chapter on Dual Diagnosis which recognises the trust ambitions to work with and not exclude people with co-existing substance use issues.
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	<ul style="list-style-type: none"> <li>• Race (including Gypsy and Traveller) NO</li> <li>• Disability (includes physical, learning, mental health, sensory and medical disabilities) NO</li> <li>• Sex (Men and women) NO</li> <li>• Gender reassignment (Transgender and gender identity) NO</li> <li>• Sexual Orientation (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) NO</li> <li>• Age (includes, young people, older people – people of all ages) NO</li> <li>• Religion or Belief (includes faith groups, atheism and philosophical beliefs) NO</li> <li>• Pregnancy and Maternity (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) NO</li> <li>• Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners) NO</li> <li>• Armed Forces (includes serving armed forces personnel, reservists, veterans and their families) NO</li> <li>• Human Rights Implications NO (Human Rights - easy read)</li> </ul>
Describe any negative impacts / Human Rights Implications	Dual diagnosis can lead to stigmatisation, not only in general public but also among professionals. Stigmatisation can lead to negative attitudes, poor outcomes and

exclusion from getting the same level of care than other people without a comorbid problem.

The ageing cohort of heroin users is one of the factors identified as a cause of the rise in drug related deaths, due to deteriorating general health and increased susceptibility to overdose (Non-fatal overdose among people who inject drugs in England: 2017 report) and reduced life expectancy

Those aged over 65 are particularly vulnerable to the effects of drugs and alcohol due to presence of coexisting medical disorders and greater likelihood of drug-drug interactions. Comorbidity can be a key factor, with increased risk with age of suffering from chronic pain, insomnia, bereavement, loneliness and mood. There is a cohort of older people presenting with alcohol dependency and opiate dependency.

Those described as 'late onset users' may have begun using substances regularly only later in life, sometimes following stressful life events or lifestyle changes that typically occur later in life (such as retirement, marital breakdown, social isolation, increasing morbidity or bereavement). The latter group tends to be a larger but less visible population of older drug users typically using prescription or over-the-counter medicines.

Although pregnancy is not considered a disorder or even a problem in itself there is often a lot of fear and anxiety of patients accessing support for dual diagnosis due to stigma and concerns regarding safeguarding of baby or any children within the home

Evidence from children and young people's alcohol and drug treatment data shows high levels of self-harm, domestic violence and sexual exploitation among children and young people, with very low referral rates from mental health treatment into alcohol and drug treatment, younger persons drugs of choice tend to be alcohol, cannabis, new psychoactive substances

There is a high prevalence among prison populations with the 2009 Bradley report recognising that co-existing alcohol and drug use and mental health issues are the norm rather than the exception among most offenders. Prisoners are also at increased risk of self-harm and suicide, multiple disadvantage (substance use,

	<p>homelessness and criminal justice involvement), over half (55%) had a diagnosed mental health condition.</p> <p>It is recognised that some groups with diverse needs have problems with certain addictions and can experience difficulties in accessing services. Over recent years access to services has been greatly improved e.g. by women only clinics or initiatives that work with Black and Minority Ethnic (BME) or lesbian, gay, bisexual, and transgender community (LGBT) communities, gypsy and traveller groups, we must be aware of the differing needs of these client groups</p>
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<b>Section 3</b>	<b>Research and involvement</b>
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	NICE guidance, UK guidelines on clinical management, clinical audit, Our Clinical Journey to Change, Research
Have you engaged or consulted with patients, carers, staff and other stakeholders including people from the protected groups?	No – this Policy builds upon the previous version which was discussed with peer mentors who are actively involved and support development of projects to support patients with drug and alcohol use within TEWV. It also supports the Trust Clinical Journey to Change chapter regarding Dual Diagnosis which was co-produced.
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	There will be further engagement with partner agencies and peer/patients via the consultation process
Describe any positive impacts / Human Rights Implications	The Trust Clinical Journey states that we will work with people with co-existing substance use and not exclude anyone from accessing mental health services

	<p>based on concurrent substance use. This Policy support this ambition as it requires that patients:</p> <ul style="list-style-type: none"> <li>• receive care based upon their needs, provided by the service (or services) best placed to meet those needs,</li> <li>• have an appropriate key worker, care co-ordinator or lead professional allocated,</li> <li>• receive care delivered in a collaborative manner from a care plan if multiple providers are involved; and</li> <li>• are cared for by staff in mainstream substance use and mental health services who are competent and capable of responding to dual diagnosis needs.</li> </ul>
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<b>Section 4</b>	<b>Training needs</b>
As part of this equality analysis have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	<p>Service managers - to determine number of dual diagnosis leads as well as their training, development and support needs</p> <p>Specialist level - Specialists will usually work on the consultant level with a significant part of their job role dedicated to substance use /dual diagnosis work. and advise dual diagnosis leads.</p> <p>Dual diagnosis leads Advise frontline staff in managing patients with dual diagnosis Staff that have: This level can be achieved via two different routes:</p> <ul style="list-style-type: none"> <li>- Regular attendance and active contribution to local dual diagnosis networks</li> <li>- Completion of enhanced level dual diagnosis or substance use training</li> </ul> <p>All practitioners who regularly work with dual diagnosis patients completion of dual diagnosis e-learning module every 3 years</p>
Describe any training needs for patients	None
Describe any training needs for contractors or other outside agencies	None

## Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
<b>1. Title</b>		
Is the title clear and unambiguous?	y	
Is it clear whether the document is a guideline, policy, protocol or standard?	y	
<b>2. Rationale</b>		
Are reasons for development of the document stated?	y	
<b>3. Development Process</b>		
Are people involved in the development identified?	y	
Has relevant expertise has been sought/used?	y	
Is there evidence of consultation with stakeholders and patients?	y	Based on Clinical Journey to Change chapter which was co-produced
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
<b>4. Content</b>		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
<b>5. Evidence Base</b>		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	
Are supporting documents referenced?	Y	
<b>6. Training</b>		
Have training needs been considered?	Y	

Are training needs included in the document?	Y	
<b>7. Implementation and monitoring</b>		
Does the document identify how it will be implemented and monitored?	Y	
<b>8. Equality analysis</b>		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	AH 11 Aug 2025
<b>9. Approval</b>		
Does the document identify which committee/group will approve it?	Y	
<b>10. Publication</b>		
Has the policy been reviewed for harm?	Y	no harm
Does the document identify whether it is private or public?	Y	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
<b>11. Accessibility</b> ( <a href="#">See intranet accessibility page for more information</a> )		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	N/A	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	

## Appendix 3 – Trust position Statement



**Tees Esk & Wear Valleys NHS Foundation Trust is committed to protect the welfare of all patients admitted to this ward.**

1.	<p>TEWV is committed to:</p> <ul style="list-style-type: none"><li>• Offering all patients an opportunity to discuss their substance use issues with their named nurse and a package of care tailored to their needs which are clearly laid out in an intervention plan.</li><li>• Providing safe and effective care to those who use our services as well as a safe environment for staff to work.</li></ul>
2.	<ul style="list-style-type: none"><li>• No alcohol, non-prescribed or illegal substances (this includes psychoactive substances previously referred to as “legal highs”) are to be brought in or used on the ward. Please be aware that prescribed drugs or those bought over the counter can also be harmful if used against medical advice. Our staff may consider any substance, even unidentified, as presenting a possible cause of harm and treat it as a harmful substance].</li></ul>
3.	<ul style="list-style-type: none"><li>• Any patient found to have returned to the ward under the influence of such substances or brought them into the ward will have their future plans discussed with their Consultant and Care Co-ordinator/ Key Worker. This may lead to discharge from the hospital.</li></ul>
4.	<ul style="list-style-type: none"><li>• Any visitor found to have brought in such substances (for their own use or for others) or to be observed under the influence of such substances may have their right to visit the ward withdrawn. In the case of illegal drugs, this will be reported to the Police.</li></ul>
5.	<ul style="list-style-type: none"><li>• Any illicit substances found on the ward will be disposed of and may be reported to the police. Sniffer dogs may also be requested for planned or random searches of wards if this is felt to be required.</li></ul>
6.	<ul style="list-style-type: none"><li>• Any non – illicit drugs or alcohol found or handed in to staff may be disposed of, subject to any requirement to hand over to the police for evidence preservation.</li></ul>