Leeds Partnerships NHS
NHS Foundation Trust

Adult Mental Health Community Service
Leeds Partnerships NHS Trust

The service incorporates:

- Community Mental Health Teams (5 Sectors)
- Assertive Outreach Team (2 geographical teams)

Adult Mental Health Service – Leeds Partnerships NHS Foundation Trust

The CMHT provides the following services:

- Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.
- Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow-up.
- Any disorder where there is significant risk of self harm or harm to others (eg acute depression) or where the level of support required exceeds that which a primary care team could offer (eg chronic anorexia nervosa).
- Disorders requiring skilled or intensive treatments (eg CBT, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.
- Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983), except where these have been accepted by an AOT.
- Severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by an AOT or a specialised personality disorder team where there is one."

AOT is designed for people who:

- have a history of violence or offending
- are at risk of self-harm or self-neglect
- who have poor response to previous treatment
- who have dual diagnosis
- who have been detained under the Mental Health Act 1983 in past two years who have unstable accommodation or homelessness

Principles of the Service

- There is timely access to appropriate care and treatment.
- We should involve people who use the service and wherever possible their carers.
- The Care Programme Approach underpins all aspects of care.
- There is a focus on recovery and social inclusion.
- It is based on delivering interventions which are based on best evidence.
- Service users will receive the most appropriate support from the most appropriate mental health professional.
- The 10 Essential Shared Capabilities are at the core of service delivery (Appendix 10).
- We are striving to incorporate New Ways of Working.
- We will use a system of integrated care pathways to ensure consistent high standards of practice.
- We work in partnership with other statutory and non statutory agencies.

Dual Diagnosis definition from the LPFT DD Strategy 2010-12 (Draft)

- The term dual diagnosis within this strategy refers to a situation where an individual presents with concurrent needs arising out of mental health problems/mental illness and substance use.
- Substance use refers to the problematic, harmful or dependent use of substances including illicit and legal drugs as well as alcohol.
- Mental health problems/mental illness refers to a broad spectrum of problems ranging from common mental problems such as might be encountered within primary care settings, various types of emotional distress which may benefit from specialist care, through to severe and enduring mental illness as defined in the ICD10 (WHO1992)
- Leeds PFT is part of a district wide Leeds Dual Diagnosis Network. The network has a collective responsibility to ensure that all individuals with co-existing mental heath & drug / alcohol problems receive a service fit for their multiple needs, irrespective of where and how they present.
- The clinical role of the Leeds PFT within this Network will be to care for service users who have the most complex presentations of multiple diagnoses including physical health problems or people with sever and enduring mental health problems that have problematic, harmful or dependent use of substances.
- Leeds PFT will also provide expert knowledge and guidance in mental health/mental illness to the Dual Diagnosis Network as well as collaborative work in developing care pathways and models of care for people with dual diagnosis.

Lead Practitioner in Dual Diagnosis for clinical teams

- Each of the following teams will have a lead practitioner who will act as a central point for the team guarding dual diagnosis. The lead practitioner will be either a Registered Nurse or Doctor and be part of the district wide Leeds Dual Diagnosis Development Network. They will be expected to attend 80% of the dual diagnosis practice development sessions each year and will have completed the Leeds University Dual Diagnosis Module at (Academic) Level 3 or equivalent. (Equivalent to be determined by the Lead Clinician for the Leeds Addiction Service)

1. All in-patient care areas
2. All Community Teams
3. All Acute Day Treatment Units
4. A&E Liaison
5. Crisis Resolution and Home Treatment

- The Lead Practitioners will require the necessary training and supervision to meet their designated competency level. Each team will have different requirements regarding the role of the individual which may for example include prescribing. It is the role of the CSM to identify the scope of practice of each of the lead practitioners in association with the Associate Medical Director advised by the Lead Clinician for Addiction Services in Leeds. Where dual diagnosis prevalence is low a lead practitioner may provide cover to several teams.
- It is not considered practical to prescribe this role through this strategy as some lead practitioners may have a more educative role while others a more direct care role. Other member of the team may be skilled to the same level as the lead practitioners depending on the prevalence rates. E.g. it is likely that Assertive Outreach teams may have higher prevalence or rates of people with dual diagnosis in comparison to other teams and that teams operating in specific postcode areas i.e. Areas of high social deprivation, etc.

Lead Practitioner as a minimum should be able to:

- Act as a resource of information and advice for their team
- Update the team on policy and practice developments
- Network with dual diagnosis workers from other services and agencies through the Dual Diagnosis Development Network
- Improve shared care and communication between services
- Improve referral pathways
- Identify training needs in dual diagnosis for the service
- Possibly provide specialist clinical supervision in dual diagnosis