

DUAL DIAGNOSIS NETWORK

CITY OF LEEDS

CARE CO-ORDINATION PROTOCOL

Rationale

The partner organisations linked to the dual diagnosis network recognise that it is their collective responsibility to ensure that all individuals with co-existing mental health & drug / alcohol problems receive a service fit for their multiple needs, irrespective of where and how they present. The protocol describes locally agreed assessment, co-ordination and joint-work criteria.

Guidelines

Partners of the Dual Diagnosis Network should follow the three steps described below to offer care based on individual needs and utilising the resources within the network in a coherent way.

STEP 1: Initial Screening of overall needs

An initial screening will help practitioners to establish immediate risks and support needs. The key factors to assess at this stage are:

- Severity of Mental Health: mild – moderate – severe & enduring condition?
- Substance use Patterns: current use, dependence, perceptions & readiness / motivation to change.
- Housing & support networks: e.g. homelessness, engagement with supported housing, social networks.
- Risks: to self, to others, in relation to all of the above.

Key Question: *Can our service support the person's overall needs and manage associated risks?*

STEP 2: Using the Partnership Framework

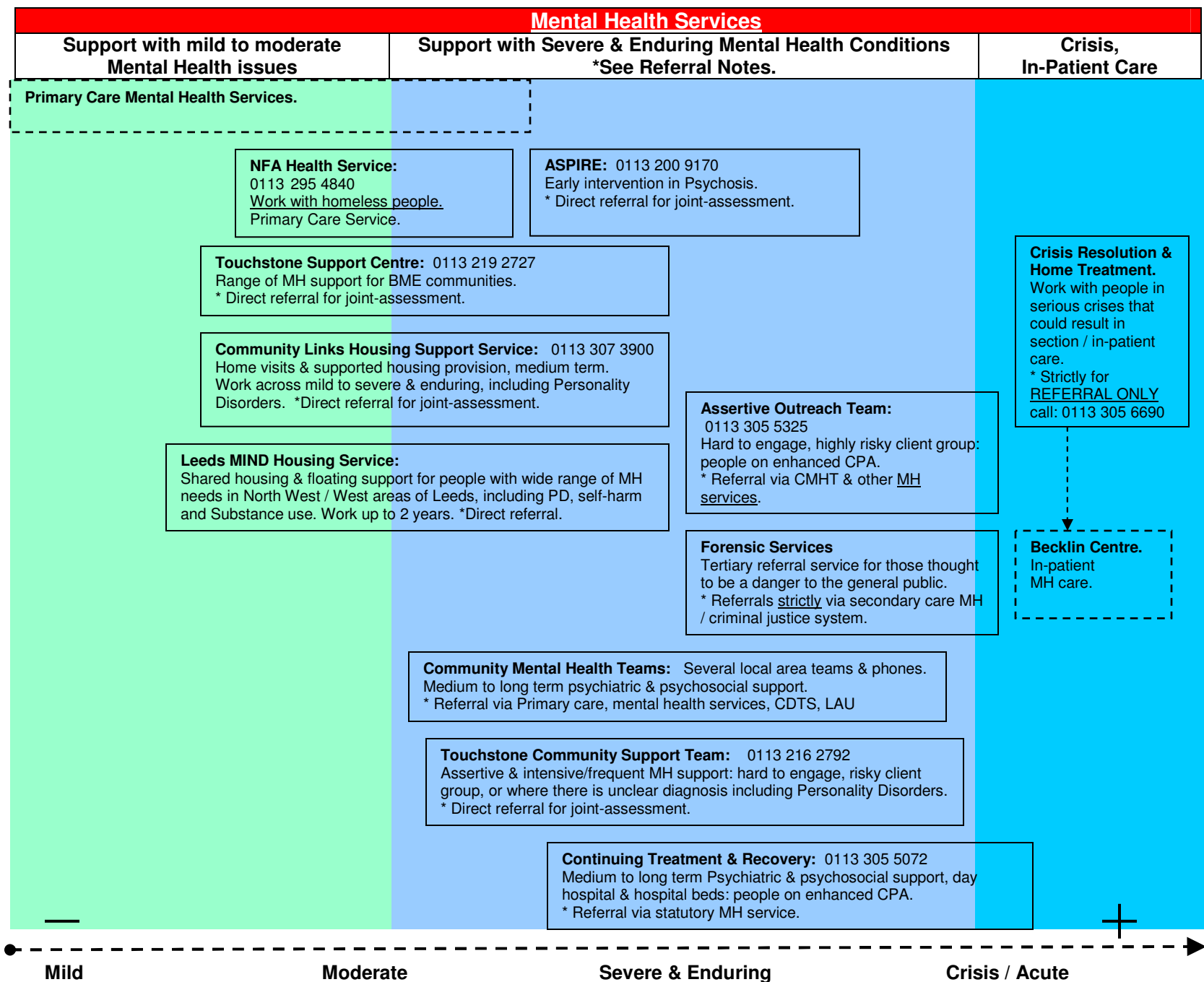
If following the initial screening your service considers:

- Consulting with another service
- Offering collaborative care with another service
- Referring on to another service

The framework below can assist in making decisions about which service to contact based on matching the assessed needs to the 'spectrum' of mental health and substance use presented on pages 2 and 3.

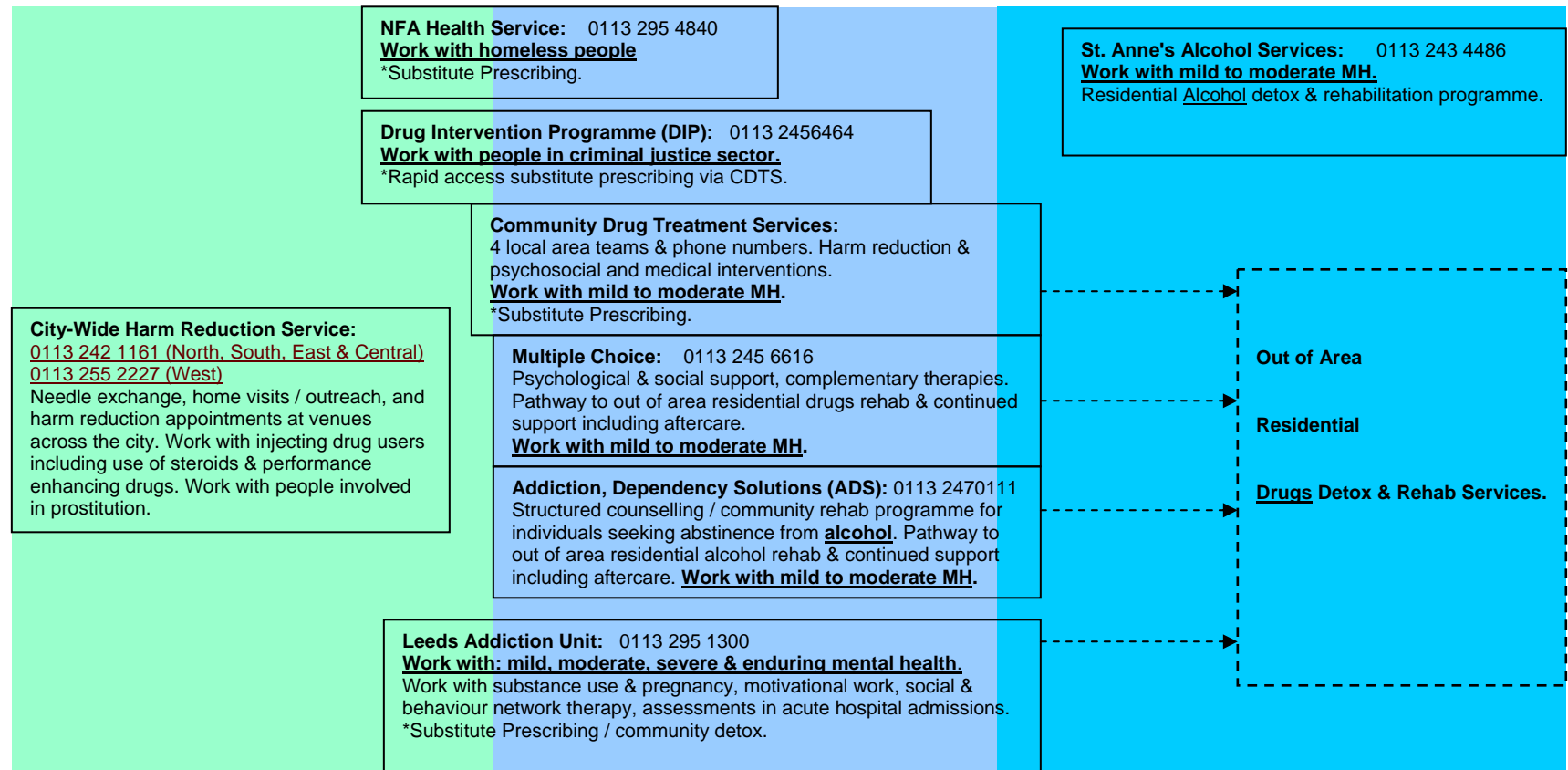
Key Question: *Which service(s) can offer support in relation to the person's needs?*

Dual Diagnosis Partnership Framework



Dual Diagnosis Partnership Framework

Drugs & Alcohol Services		
Harm Reduction, Motivational work, Pathway into structured treatment	Structured drugs treatment, *Substitute prescribing	Residential Detox & Rehab



Spectrum of readiness / motivation to change and to engage with structured treatment

STEP 3: Treatment Models & Care Co-ordination

Treatment Models

Key Question: *What type of care should be offered and who should co-ordinate this?*

A) Integrated Care

When a single service can offer support around mental health and substance use simultaneously. This may be done in consultation with another service. This is the recommended treatment modality to maximise engagement and consistency of care. Should be offered when:

- Needs & risk can be managed by a single service in the short-term.
- When there is a likelihood of disengagement if many services are involved.
- Engagement & support in the short-term can prepare someone for engagement with other services and long-term support via collaborative care.

B) Collaborative Care

When 2 or more services are involved in care, in order to address overall needs.

Where a service user is not involved with CPA, it is crucial that co-ordination as described below is established: A care plan with common goals should be agreed; including appointments for reviews involving service user & carers where appropriate. A nominated practitioner should act as a care co-ordinator, which involves: regular contact with the service user and the organisation of joint-assessment and review meetings. All involved parties should have a copy of the agreed plan.

Co-ordination Guidelines

- **Referring on:** It is preferable for the first service coming into contact with a service user to take responsibility for assessing which service(s) and what care model would be most suitable. As possible, a joint-assessment meeting is a preferable way to refer on. It is unacceptable to refer on to another service without following up to ensure that suitable care has been offered.
- **Collaborative Care:** It is preferable for the first service coming into contact with a service user to take on the care co-ordination role. This may be negotiated between services involved, in agreement with service user. However, it may be more appropriate for specific services to co-ordinate care in certain scenarios:
 - If severe & enduring MH** → Secondary Care MH service via CPA / Enhanced CPA.
 - If mild to moderate MH** → Drug & Alcohol service.
 - If criminal justice involvement** → Drug Intervention Programme (DIP).
 - If supported housing or homelessness** → housing or homelessness service.

Note: *Different recommendations to those described above apply to acute mental health care and forensic services. Contact Crisis Resolution & Home Treatment team for specific guidelines in crisis situations. CR&HT service staff do not care co-ordinate.*

* *Forensic services only receive referrals through secondary care and criminal justice services.*

Time Scales

- Partner services must refer to their own specific targets regarding time-scales for assessment and intervention. Information regarding these time-scales must be communicated to service users and to other services involved in care, in order to clarify expectations and to inform decisions about referral and treatment.
- More information about specific time-scales can be found in detailed services directory.

Sharing of Information & Monitoring

- Information should only be shared on a 'need to know' basis and strictly in compliance with duty of care. There is an expectation that consent to share information is sought from the service user; although this may differ in *exceptional circumstances* such as crisis / high risk scenarios (refer to your own service's confidentiality policy).
- Consent to share information will be re-considered / up-dated at regular review meetings.
- Services will keep confidential databases to keep track of service users who are offered care based on the guidelines set out in this Dual Diagnosis protocol.

SUMMARY FLOWCHART: DUAL DIAGNOSIS CARE CO-ORDINATION

