

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 Pathways Guide

If following the initial screening your service considers:

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

The Dual Diagnosis care pathways guide can assist in making decisions about which service to contact based on matching the assessed needs to specific services. The pathways guide is a directory containing basic information about a range of services that come into contact with people with complex needs. It also contains some locally agreed decision rules and guidelines to support referral and interagency liaison.

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

The pathways guide can be accessed on-line at: <http://dual-diagnosis.org.uk/doc/DDpathways.pdf>

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. This 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 or 'Shared' Care

When 2 or more services are involved in care, in order to address overall needs. Normally co-ordinated under CPA Framework. 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, joint-assessment 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 or 'shared' care:** 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 mental health problems** → Secondary Care Mental Health service via CPA.
 - If mild to moderate mental health problems** → Drug / Alcohol treatment service.
 - If criminal justice involvement** → Drug Intervention Programme (DIP).

If homeless → homelessness service until a suitable engagement with the above services is achieved.

Notes: *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 the time-scales for specific services can be found in the Dual Diagnosis care pathways guide.

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.

Acknowledgements

This protocol was initially developed in 2007 in consultation with representatives of numerous mental health and substance misuse services through the Leeds Dual Diagnosis Working Group. It was approved by the Dual Diagnosis Strategy Group in 2008.

This version has been revised in August 2009 to ensure consistency with local service developments and to be used in conjunction with the Care Pathways Guide.

SUMMARY: Quick guide to screening, inter-agency liaison and care co-ordination

STEP 1: Screening

- Screening of overall needs –as a minimum– should consider: mental health history & current symptoms, substance use history & current patterns, housing status / housing needs, risk history & current risks, physical health needs.
- Services that are NOT mental health specialists can use brief questionnaires to gather information about mental health before considering referral options:
[Brief Mental Health Triage](#)
[Depression Questionnaire](#)
[Generalised Anxiety Questionnaire](#)
- Services that are NOT drugs treatment specialists can use a range of standardised assessment tools to establish patterns & severity of substance use:
[AUDIT](#), [DUDIT-E](#), [DAST](#),
[Clinician-rated alcohol & drug scales](#)

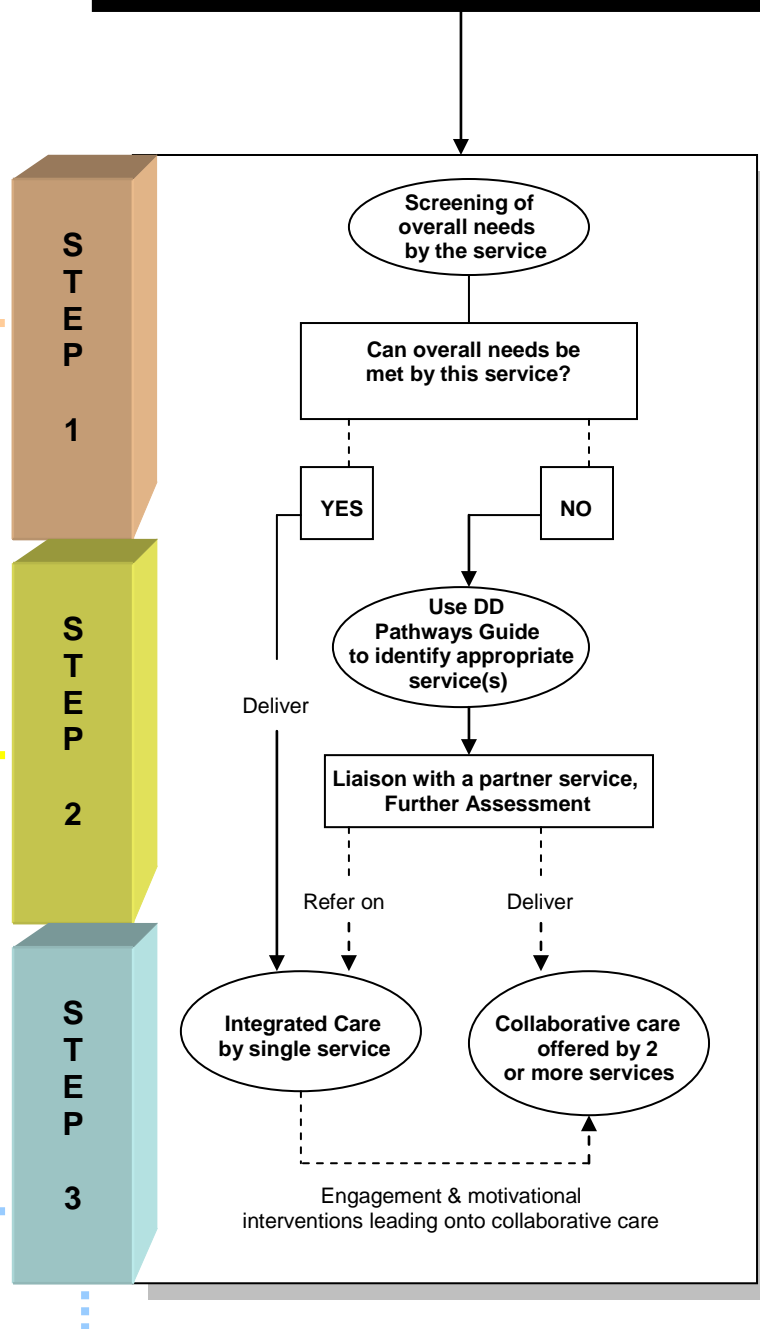
STEP 2: Using the Pathways Guide

- The pathways guide is essentially a directory with brief descriptions of various services that often come into contact with people with Dual Diagnosis issues.
- Information gathered through initial screening should be used to **'match' specific client needs to specific services**. The pathways guide clusters services in different 'Sections' to facilitate the process of 'matching'. Some guiding questions to help in this process are:
 - Is the person in crisis? → See section A.
 - Presenting symptoms of common mental disorders? → See section B.
 - Presenting symptoms of severe mental disorders? → See section C.
 - Requiring drug / alcohol related interventions? → See sections D & E.
 - Homeless or requiring support with housing? → See sections F & G.

STEP 3: Care Models

- The Department of Health's Dual Diagnosis good practice guide (2002) describes *integrated care* as a best practice model: where treatment is offered concurrently for mental health, substance use and other related needs during the same period of care.
- In some cases, clients may access *integrated care* within a single specialist service, and this approach is often preferred by service users and maximises engagement and continuity of care.
- In other cases, care may be offered following a *collaborative* or *shared care* model: where two or more services are involved in offering different aspects of care & support. The defining feature of *collaborative care* is the delivery of services under a shared and explicit care plan describing the aims, expectations and roles of the different services/people involved. Care co-ordination under CPA can be taken as a model for this approach.

A service comes into contact with a person with combined mental health & addiction problems



CARE CO-ORDINATION

In accordance with local care co-ordination guidelines, where more than one organisation is involved, care should be co-ordinated by a named service. There are specific conditions based on which specific services would take on the role of care co-ordination:

CONDITION	CARE CO-ORDINATOR
Severe mental disorder (and combined addiction)	Secondary care mental health team (e.g. CMHT, AOT, etc.)
Common mental disorder (and combined addiction)	Community Drugs Treatment Service
Involvement in criminal justice sector (and dual diagnosis)	Criminal Justice service (e.g. DIP, forensic services)
Homelessness (and dual diagnosis)	Homeless team (e.g. NFA, Street Outreach Team)