LEEDS DUAL DIAGNOSIS JOINT WORKING PROTOCOL

Rationale

The partner organisations linked to Leeds Dual Diagnosis Network recognise that it is their collective responsibility to ensure that all individuals with co-existing mental heath & substance use difficulties receive a service fit for their multiple needs, irrespective of where and how they present. The protocol describes locally agreed assessment and joint-working criteria.

Guidelines

Partners of the Leeds 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

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

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. TOPS, GAD7 & PHQ9 screening tools may be used to aid this process – See http://www.dual-diagnosis.org.uk/?cat=34
- Substance use Patterns: current use, dependence, perceptions & readiness / motivation to change. AUDIT, ASSIST and Leeds Dependency Questionnaire screening tools may be used to aid this process – See http://www.dual-diagnosis.org.uk/?cat=34
- Housing & support networks: e.g. homelessness, engagement with supported housing, social networks.
- Risks: to self, to others, in relation to all of the above.

N.B – Practitioners should use clinical experience to consider if the mental health symptoms yielded by initial screening can be better explained by alcohol/drug misuse. And, if the alcohol/drug use was addressed first would it be likely to help address the mental health symptoms, would they change or get worse. Support and advice should be sought from specialist services and/or dual diagnosis link workers if required.

STEP 2: Treatment Models & Lead Agency

Key Question: What type of care should be offered and who should lead the co-ordination of Joint Working?

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; it 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 too 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 (Joint Working): When 2 or more services are involved in care, in order to address overall needs. Where possible this should be co-ordinated under the CPA Framework, however if a service user is not involved with CPA, it is crucial that a nominated agency takes the lead in co-ordinating care as described below.

1. A care plan with common goals should be agreed; including appointments for reviews involving service user & carers where appropriate.
2. A nominated lead practitioner should co-ordinate care, which involves regular contact with the service user and the organisation(s) involved, joint-assessment and review meetings.
3. All involved parties should have a copy of the agreed plan.

STEP 3: Using the Pathways Guide

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

If following the initial screening your service cannot support the person's overall needs and manage associated risks consider:

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

The Dual Diagnosis Pathways Guide and locally agreed protocols can assist in making decisions about which service to contact based on matching the assessed needs to specific services.

The Pathways Guide contains –

- A comprehensive directory which includes information such as contact details, referral and exclusion criteria about a range of services that come into contact with people with coexisting mental health and substance use difficulties.

- Service mapping against the Dual Diagnosis Quadrant - Services included in the Pathways Guide have been mapped against the Department of Health Dual Diagnosis Quadrant. The quadrant provides a simplistic guide to identify which services may be able to offer support based on severity of substance use and mental health difficulties.

- The Crisis Thermometer which identifies appropriate and inappropriate referrals during crisis situations.

A number of locally agreed protocols and link working partnerships have been developed to improve joint working and improve access to treatment between specific services. These include –

- Forensic/Forward Leeds Referral Protocol
- Assertive Outreach/Forward Leeds Joint Work Protocol
- Common Mental Health Problems Best Practice Joint Work Protocol

The pathways guide and local protocols can be accessed on-line at:
http://www.dual-diagnosis.org.uk/?cat=6

Essential Guidance

- **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. When possible joint-assessment is the 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 (Joint Working)**: This may be negotiated between the services involved, in agreement with service user. However, it may be more appropriate for specific services to co-ordinate care in certain scenarios. In that scenario they would take the role of lead agency:

Lead Agency

If severe & enduring mental health problems – Secondary Care Mental Health Service/Forward Leeds Specialist Team

If mild to moderate mental heath problems – Forward Leeds/Primary Care Mental Health.

If criminal justice involvement – Drug Intervention Programme/Integrated Offender Management

If homeless or only housing services involved – homelessness/housing service until suitable engagement with the above services is achieved.

Essential Guidance -

If a service does not formally care-ordinate e.g. via CPA, the expectation remains that a named service will still take the lead role in liaising between the relevant services involved in a persons care.'

Different recommendations to those described above may apply to acute mental health care and forensic services. Contact LYPFT Single Point of Access if clarification is required and for specific guidance in crisis situations.

Forensic services only receive referrals through secondary care mental health 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.

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 should 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 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 January 2012 and September 2015 and agreed by the Dual Diagnosis Working Group to

ensure consistency with local service developments and to be used in conjunction with the Care Pathways Guide.

DD Working Group Member Organisations –

BARCA
CRI
IAPT Leeds
Forward Leeds
Leeds Adult Social Care
Leeds Mind
Leeds Survivor Led Crisis
St Anne's Community Services
St Georges Crypt
West Yorkshire Probation Service
WY-FI
Zip
Community Links
DISC
Foundation Housing
Joanna Project
Leeds Housing Concern
Leeds Involving People
Leeds + York Partnership Foundation Trust
St Martins Healthcare Service
Touchstone
Volition

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