QUICK GUIDE FOR JOINT WORKING:

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
  GAD7 + PHQ9
- Services that are NOT drugs treatment specialists can use a range of standardised assessment tools to establish patterns & severity of substance use:
  AUDIT, ASSIST.

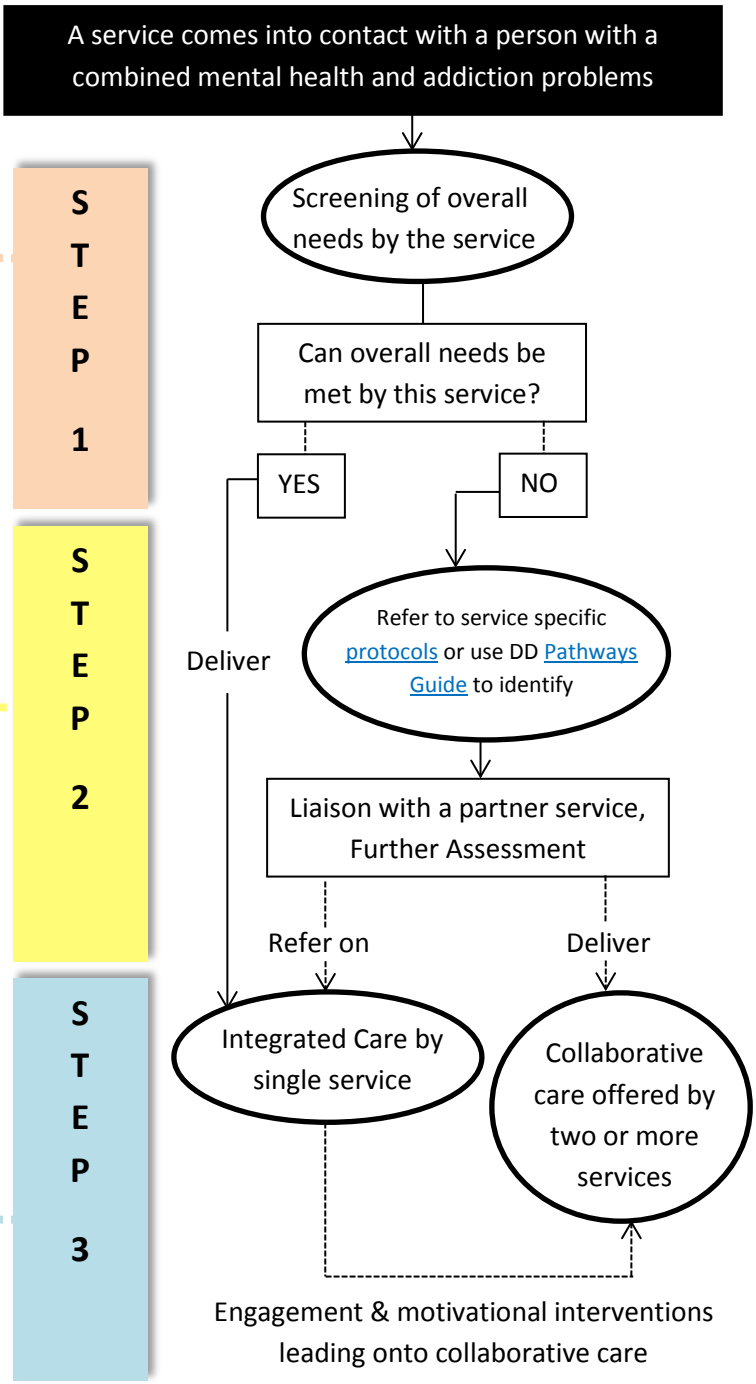
STEP 2: Using the Pathways Guide

- The pathways guise 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 this person in a 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.
  N.B. – 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 person's care.



LEAD AGENCY

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	LEAD AGENCY
Severe and Enduring Mental health Problem (and combined addiction)	Secondary care mental health service (including voluntary sector).
Common Mental Health problems (and combined addiction)	Substance misuse service.
Involvement in criminal justice sector (and dual diagnosis)	Criminal Justice service (e.g. DIP, forensic services)
Homelessness (and dual diagnosis)	Housing/homeless service.