DUAL DIAGNOSIS PARTNERSHIP FRAMEWORK

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Acknowledgements
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Why is this important?
It is our 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. This document describes arrangements for consistent service user assessment, care co-ordination and joint working.

How it works
Everyone contributing to this framework should follow the three steps described below to offer care based on individual needs.

STEP 1: Screening/review of overall needs
A screening/review 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, both past & present in relation to all of the above. Consider risk of self-harm, suicide, violence, aggression, neglect, exploitation by or of the service user.

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

If the answer is NO, move to step 2 ensuring that all information gathered in the assessment relating to risk & support needs are shared with the service being referred to.

STEP 2: Using the Partnership Framework
Discuss out come of screening/review and all identified risks with your team’s liaison worker/supervisor. During this discussion you may wish to consider the following options

- 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 Framework

### Drugs & Alcohol Services - Preston

<table>
<thead>
<tr>
<th>Harm reduction, motivational work, pathway into structured treatment</th>
<th>Structured drugs treatment, *Substitute prescribing</th>
<th>Residential Detox &amp; Rehab</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugline</strong>&lt;br&gt; Triage for all drug issues, harm reduction advice, needle exchange Tel: 01772 253840 – 01772 825492</td>
<td></td>
<td><strong>Residential Detox And Rehabilitation:</strong>&lt;br&gt;Preston use a number of different detox units and residential rehab units around the country.</td>
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<tr>
<td><strong>ADS</strong>&lt;br&gt; Triage for pre dependant &amp; dependant alcohol use.&lt;br&gt; Tel: 01772 561300</td>
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<tr>
<td><strong>Inward House</strong>&lt;br&gt; Floating housing support. 01772 251634</td>
<td></td>
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<tr>
<td><strong>Preston Drugs Team</strong>&lt;br&gt; Needle exchange <strong>Treatment for Drug Dependency</strong>&lt;br&gt; Tel: 01772 676000</td>
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</tr>
<tr>
<td><strong>Preston Alcohol Team</strong>&lt;br&gt; Treatment for Alcohol Dependency, home detoxification, relapse avoidance&lt;br&gt; Tel: 01772 561300</td>
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</tbody>
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**Spectrum of readiness / motivation to change and to engage with structured treatment**
Dual Diagnosis Framework

Mental Health Services - Preston

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe &amp; Enduring</th>
<th>Crisis/Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>LCFT- Primary Mental Health Team (single point of access for all referrals into secondary mental health care) Tel: 01772 773437</td>
<td>Preston Community Mental Health Team Tel: 01772 401255</td>
<td>Early Intervention Services First Episode Psychosis aged 14-34 yrs Tel: 01772 645761</td>
<td>Crisis Resolution Home Treatment Team – all requests for inpatient care to this team. Tel: 01772 773433</td>
</tr>
<tr>
<td>Central Lancs PCT-Primary Mental Health Workers Team- offer interventions for mild to moderate mental health needs Tel -01772 777696</td>
<td>Assertive Outreach Team Severe and Enduring Mental Illness and Difficulties re Engagement. Tel: 01772 401258</td>
<td>Preston Inpatient Unit Oak 01772 773464 Willow 01772 773469 Sycamore 01772 773468</td>
<td>Mental Health Liaison Tel: 01772 773499</td>
</tr>
</tbody>
</table>
STEP 3: Treatment Models & Care Co-ordination

Treatment Models

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

The LCFT dual diagnosis partnership framework promotes and supports the liaison model and considers it to be the model most likely to succeed in delivering a service for service users with mental health & substance misuse issues.

Main principles of this model:

- **Dual diagnosis is common** – increasing overlap between the two services as evidenced in literature. The message is therefore to expect substance misuse in psychiatry. Similarly, substance misuse services should be vigilant in detecting mental health related issues.

- **Don't create a super specialism** – every worker that a dual diagnosis client makes contact with is a dual diagnosis worker

- **It's good to talk** – communication and information sharing is the backbone of this model. Its importance is highlighted in the Report of the National Confidential Inquiry (Appleby, 2000)

- **Do not argue what is a primary problem** – Dual diagnosis clients present with multiple needs. They require expert and high quality response from both services. In a significant number of cases the chronology of the disorder is not clear. This model encourages joint assessment and joint working between the two services.

- **Developing competencies** – a commitment to provide intensive and comprehensive training.

- **Collaboration not conflict** – best care for dual diagnosis clients can only be provided by collaboration and joint working between mental health, substance misuse services, families, carers & all other agencies involved. Services provided concurrently can result in higher chances of engagement as opposed to the serial or parallel model of service delivery.

Roles and responsibilities of the liaison worker

All services will identify liaison workers to support the implementation of the liaison model. It is anticipated that roles and responsibilities will be an addition to existing duties. Resource and Capacity issues will need to be determined by each service.

- The liaison worker will be responsible for developing and maintaining the interface between mental health and substance misuse services. The post holder will act as a specialist resource within their service area. The main tasks of the liaison worker are as follows:

  - Create maintain and foster effective communication and working relationships between each service
• Contribute to the initiation and implementation of change and improvement to service and care delivery

• To actively engage in and foster multi disciplinary/multi agency co-operation and collaboration in respect of patient care and service development

• Contribute to the formulation and review of care pathways, policies and protocols

• Facilitate plan and contribute towards the teaching and training of other staff. This will be introduced later in the strategy.

**Co-ordination/ Care Management 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. If 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/management role. This may be negotiated between services involved, in agreement with service user. However, it may be more appropriate for specific services to coordinate care in certain scenarios:
  
  **If severe & enduring MH ➔** Secondary Care MH service via CPA / Enhanced. Consider accessing the Managed Clinical Network for Personality Disorders
  
  **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.

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 with all care providers both formal & informal is sought from the service user; although this may differ in exceptional circumstances such as crisis / high risk scenarios (refer to LCFT’s Security & Confidentiality policy- IMT&T 004).
- Consent to share information will be re-considered / up-dated at regular review meetings & documented within care record.

Summary Flowchart: Dual Diagnosis Care Co-ordination