Practice Guideline: Operational Interfaces between Mental Health and Addictions Services

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Author/s:	CAS, CMHT, ACAST / Ending the Exclusion Steering Group		
Document Owner/s::	Mike Reid, General Manager		
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1.0 Introduction

This guideline describes how West Lothian HSCP's mental health and addictions services will work together to assess, treat or support people who have co-morbid mental health and substance use problems. It is designed to support clinical judgment, not direct it and to help clear away arbitrary or artificial barriers to care or treatment.

People with co-morbid mental illness or harmful use of substances are often doubly disadvantaged due both to their illnesses and to the attitudes of others such as the presence of stigma. This guideline adopts an underpinning human rights approach which supports patient access and choice, whilst being clear that any treatment must be assessed as safe and effective and within the competence of the person or team providing it.

It is recognised that this guideline is developmental and that the interface will change over time, as services develop, and as the evidence base for treatment in co-morbid mental illness and substance use disorder emerges.

2.0 Background

2.1 Policy Background

It is well known that drug misuse deaths in Scotland have increased substantially over the past few decades and Scotland continues to have the highest drug death rate recorded by any country in Europe.

In response to this, the Scottish Government set out new treatment standards for services and organisations that support people with a drug problem in Scotland: the "Medication Assisted Treatment (MAT) Standards for Scotland; Access, Choice, Support".

The evidence-based standards aim to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland and recommend that alcohol, drugs, mental health and social services work jointly and in a holistic way and improve service arrangements for "dual diagnosis".

In their 2022 report "Ending the Exclusion", the Mental Welfare Commission found that people with lived experience and families/carers experience a system in which they feel discriminated and are often 'bounced' between mental health services and addictions services. It is estimated that alcohol or drug misuse was a factor in something between 48% and 56% of all suicides between 2008 and 2018 in Scotland. A "No Wrong Door" approach provides people with, or links them to, appropriate services regardless of where they enter.

This guideline delivers on the recommendation for an agreed protocol regarding operational interface between mental health and substance use services, outlined in The Way Ahead and Ending the Exclusion and responds to the more detailed standards in Standard 9 of the MAT Standards.

The clinical guidelines, standards and policy documents that inform the approach include:

Department of Health and Social Care (2017) Drug misuse and dependence: UK guidelines on clinical management

Mental Welfare Commission (2022) Ending the Exclusion: Care, Treatment and Support for People with Mental Ill Health and Problem Substance Use in Scotland

Scottish Government (2021) Medication Assisted Treatment (MAT) standards: access, choice, support

Scottish Government (2022a) The Way Ahead: Recommendations to the Scottish Government from the Rapid Review of Co-Occurring Substance Use and Mental Health Conditions in Scotland

Scottish Government (2022b) Co-Occurring Substance Use and Mental Health Concerns in Scotland: A Review of the Literature and Evidence

Scottish Government (2023a) Drug Deaths Taskforce response: cross government approach

Scottish Government (2023b) Core Mental Health Quality Standards

Scottish Government (2024) Substance use amongst inpatients on mental health wards: practical guide for mental health services

2.2 Trauma and Stigma

People who use substances have a very high rate of experience of psychological trauma both in their past but often continuously into adulthood, often as a result of their experiences of drug and alcohol use, loss of friends or family, or involvement with the justice system. Use of substances may result from this experience of trauma or at times contribute to it.

Trauma informed approaches 'acknowledge… previous histories of adverse childhood experiences and trauma, and the impact they have on people accessing mental health and substance use services. These approaches aim to recognise that people who use mental health and substance use services may have experienced trauma and that this may have an impact on them. Trauma-informed services aim to offer people the kind of relationships that promote recovery and do not cause further trauma or harm.' (Scottish Government, 2022b, 21-22).

Staff will be trained in and be competent in Trauma Informed Approaches across both mental health and drug and alcohol services.

Stigma refers to situations when a person, or group of people, are seen in a negative way or myths are believed about them. This may be because of a particular characteristic such as a disability, mental health condition or drug and alcohol use.

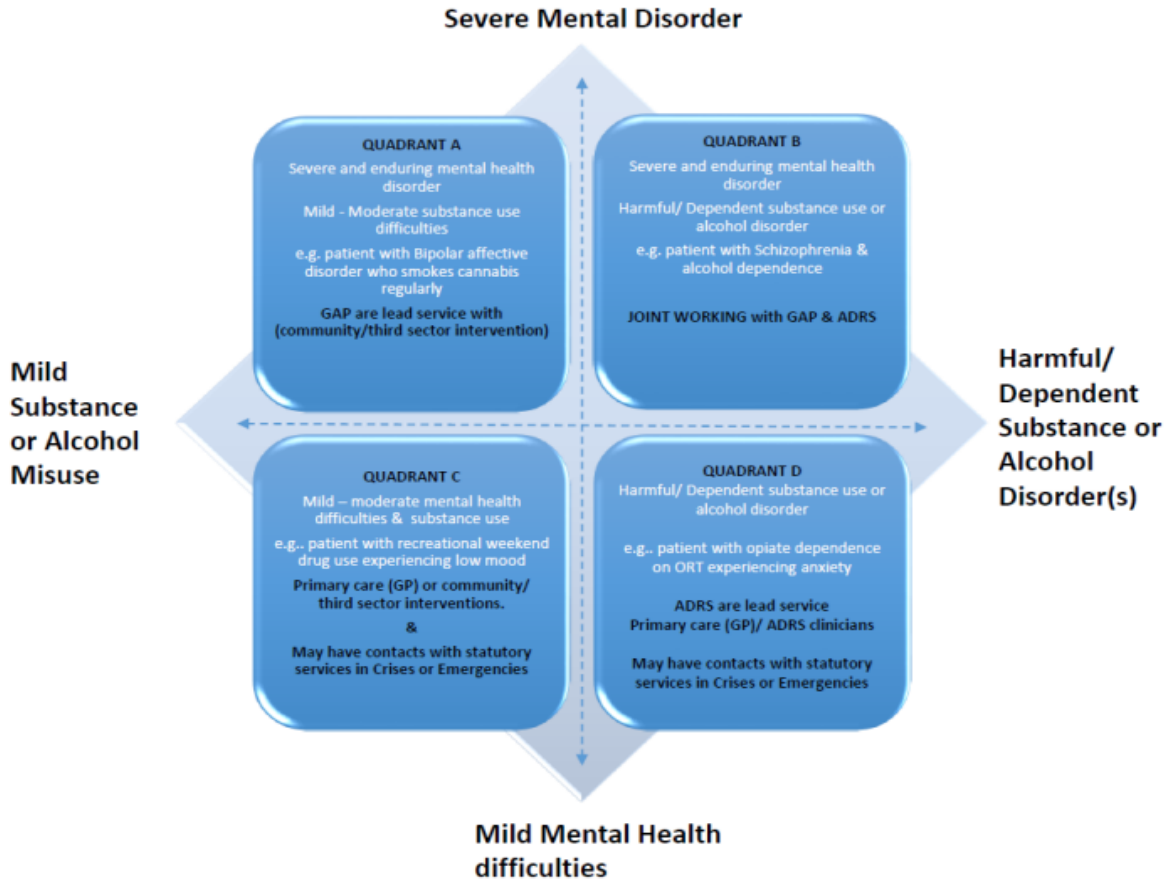
Drug and alcohol stigma:

- stops people who need treatment and support from getting help as they feel judged
- affects the friends and family of people struggling with an alcohol or drug problem
- affects organisations and people who provide support

2.3 Four Quadrant Model

The four-quadrant model proposes a model of how mental health and addictions teams can work together or alongside each other depending on the relative severity of people conditions. Both mental health and addiction services extend beyond NHS or council provided services and sometimes the advice or treatment noted in the quadrant may come from third sector services. For example, someone with schizophrenia who has a dependent drinking problem may receive psychological input from the third sector for their addiction, whilst someone who has an opiate addiction and needs support for low mood may find that from a third sector wellbeing provider.

It is better to have smallest number of services that can competently look after someone's needs involved in their care to reduce confusion and ensure good communication. People with complex and high-risk conditions are likely to require more agencies and these should be carefully coordinated.



3.0 Services

Both mental health and addiction services extend beyond the statutory services provided by WL HSCP. They include specialist addictions services commissioned by WLC on behalf of West Lothian ADP as well as a range of independent third sector mental health provision.

Addictions services come together in the West Lothian Addiction Care Partnership which works together to provide the best care for people. NHS and Council services for mental health and addictions are managed together.

This document does not address in detail services for children and young people as they are not delegated to the HSCP and does not include the specialist mental health services delivered on a Lothian wide or regional basis by the Royal Edinburgh and Associated Services.

There are a number of pathways into services. Emergency mental health presentations access the Acute Care and Support Team (ACAST) following either an ED presentation, a call to NHS 24 or a same day GP referral. Routine mental health referrals are usually made by a GP via SCI Gateway. The pathways into addiction services are most commonly by self-referral to a Drop In, GP referral or referral from an ADP partner agency.

Addictions Services

Community Addictions Service

ADP Comissioned Services
WLDAS Psychological Interventions
CGL: Assertive Outreach and Recovery Services
Circle (CAPSU)

LEAP (Quasi-residential Rehabilitation Unit)
Ritson Clinic (Inpatient Detox)
Residential Rehabilitation

4.0 Interfaces

There are many possible interfaces between these complex services and this guideline offers both some general principles and specific detail for some key interfaces.

4.1 General Principles

Assessment and treatment for mental health problems and substance use should follow general agreed principles such as 'Everyone's Job' and 'No Wrong Door' or those of Right Care, Right Place.

Where referrals are made to, or access is sought into, a team which is not the right fit for the person's condition then the receiving team will help the person get to the right team.

Assessment and treatment should always take place at the lowest possible tier of a service. This may entail, for example, a statutory service in mental health working alongside a third sector addiction service and help may be needed to navigate referrals to those services as described in the Quadrant.

4.2 Specific Interfaces

4.2.1 Mental Health Crises where substance use is a factor

Mental Health Crises are situations of immediate risk to the patient or others due to mental illness or probable mental illness, where the patient needs a same day assessment and includes possible detention under the Mental Health (Care and Treatment) Act.

Whether known to CAS/CMHT or not, this should result in a same day assessment by mental health services. These should be directly referred to ACAST unless the patient is under the care of the CMHT and occurs during CMHT operating hours, when the CMHT will take the lead.

If an emergency mental health assessment is needed this is provided by ACAST. Referral by CAS/CMHT should be direct to ACAST and not via the GP or the Emergency Department. The only reason for referring a patient to ED is for a physical health emergency. For example, a patient expressing active suicidal intent would be seen by ACAST whereas a patient who has swallowed an overdose of medication would go to ED.

CAS/CMHT staff should always communicate the emergency referral to ACAST with as much relevant clinical information as possible. The preference would be for a phone call to ACAST to discuss the situation, concerns and what CAS/CMHT are expecting. The minimum expected written referral would be an SBAR conversation (situation – background – assessment – recommendation). If possible written assessment material should be communicated. Referral information should be documented in TRAK and / or emailed to ACAST. If this is not possible however in the time scales ACAST should still accept the psychiatric emergency referral.

ACAST should not decline any psychiatric emergency assessment on the basis that a patient has a substance misuse issue and/or is open to a CAS. CAS should be involved to offer support and provide background information. A joint assessment with the CAS worker, if available, is the best assessment strategy, but absence of this should not preclude assessment.

If there is immediate risk to self / others CAS/CMHT staff may have to seek police support to transport a patient to a place of safety to allow general psychiatry assessment – the police may convey to ED where there is an immediate risk to self / others, but is not expected to be a transport service in other situations. Many individuals feel flight or flight responses when police are involved in transports therefore every effort must be made by staff to attempt to transport individuals to hospital in a trauma responsive way. Following completion of a risk assessment, staff should support individuals in the transport to hospital and include families in the process, if safe and appropriate.

The Psychiatric Emergency Plan outlines processes where the person is, or needs to be, assessed for detention under the Mental Health (Care and Treatment) Act.

Known CAS patients that are referred as psychiatric emergencies by GPs to ACAST should be directly assessed by ACAST staff. Prior CAS emergency assessment is not required, but a joint assessment is recommended, and CAS should provide information on baseline presentation, risks and strategies to engage.

Once an assessment by ACAST of someone known to CAS has concluded, if known to CAS, ACAST should liaise with CAS to discuss the individual and agree a management plan.

Because of the special vulnerabilities of people with drug and alcohol problems, consideration must always be given to child protection and adult support and protection in relation to the patient and their dependents and this assessed, actioned and communicated in emergency situations.

4.2.2 Co-morbid serious mental illness and opiate use / alcohol dependence

People in this category where both their drug / alcohol use and mental illness is uncontrolled are likely to receive input from both CMHT and CAS. Care will be coordinated between those services with joint reviews and a joint care plan.

Where one condition is more stable, care may be stepped down for that condition – so, for example, Outpatient Psychiatry may support someone alongside CAS involvement or CMHT alongside GP OST prescribing.

Section 5 contains detailed procedures describing the interface between CAS and CMHT.

4.2.3 Inpatient mental health care and harmful use of substances

If someone is admitted to a mental health ward, drug and alcohol input will be delivered through support and advice of the Addictions Liaison Service. Mental health staff are encouraged to involve CAS liaison as early as possible in an individual's admission if they wish addictions opinion and involvement.

If the patient is already known to CAS, inpatient staff should inform them of the admission and subsequent discharge. Staff should agree what addictions input is clinically appropriate and at what stage e.g., review whilst an inpatient or as an outpatient. The addictions liaison team can help with this.

Information should be provided to patients who have agreed to a CAS or alternate addictions service referral (e.g., Change Grow Live (CGL) or West Lothian Drugs & Alcohol Service (WLDAS)) but who have discharged themselves against medical advice before addictions liaison have had a chance to see them or offer an appointment. Inpatient staff must inform the addictions service of the discharge. The patient should be informed of the referral to the addictions service and provided with the contact details of the substance

misuse service they have been referred to.

If addiction issues have been identified at point of assessment but the patient does not want referral to addiction services, staff should provide the patient with literature regarding their local addiction resources. This can be provided by contacting the addictions service and asking for duty/liaison to provide this.

Because of the special vulnerability of people with drug and alcohol problems consideration must always be given to child protection and adult support and protection in relation to the patient and their dependents and this assessed, actioned and communicated at the point of admission and discharge.

People who use substances and are inpatients in mental health wards should have a care plan which addresses their needs in relation to substance use. The assessment should include description of use: which substances; the route and quantity; any withdrawal symptoms. The care plan should address access to substances; withdrawal symptoms and their management; motivation to change; harm reduction and onward referrals. The Addictions Liaison team will work with the ward staff to support that care plan.

People who use alcohol or drugs whilst an inpatient will not automatically be discharged from the ward but assessed and a plan developed. The plan may include discharge if that is the most appropriate course of action or increased support to address substance use up to and including detention if the criteria for detention under the Mental Health (Care and Treatment) Act are met.

The Scottish Government has produced guidance Substance use amongst inpatients on mental health wards: practical guide for mental health services. Care should be exercised in following this guidance and this does not override NHS policy nor legal safeguards.

4.2.4 Psychology and Psychological Therapy

CAS, alongside inpatient mental health wards, CMHTs and Older People's Mental Health team have their own dedicated psychology services. Adults of working age not on the caseloads of those teams receive psychological assessment or therapy from the Psychological Therapy Service. People with unstable or dependent drug or alcohol use will usually receive psychological input from the Addictions Psychology team. People with less harmful use of drugs or who are stable on OST should not be excluded from PTS or other psychology services. Patients should be assessed and if their drug or alcohol use does not prevent active engagement with psychological approaches then they can receive a service from PTS or the other psychology teams. If their use of substances prevents them from benefiting from treatment then they should be seen by addictions services to address their substance use.

4.2.5 Homeless People

A high proportion of people with problematic substance use are homeless or roofless. Homeless people are entitled to and should be supported to access mainstream mental health and addictions services. There is currently a worker employed to support access for homeless people with an addiction to access to services, including mental health services. Where someone who is homeless has co-morbid substance use and mental health problems teams should work together alongside homeless services to agree how to support the person to access appropriate services.

They should be supported by CMHT/CAS staff to engage with the homeless presentation procedures with West Lothian Council. Individuals are required to attend the drop in at the Civic Centre, Livingston. Due to

limitations in available emergency accommodations some people may be accommodated out with the Lothian area or have multiple moves around emergency accommodation locations within short periods of time. Sometimes with limited notice. Every effort should be made to help individuals engage with the housing process and be able to access pharmacies for medications. This will need to be risk assessed on a person-by-person basis and CAS staff should be flexible to the individual's needs. It may be that short time frame prescriptions will be required to support the moves. Many accommodations do not have safes for storage of medication, and it should be assessed as to whether medication may need to be on daily dispensed or daily supervised during this period. Bus passes can be applied for to allow individuals to access treatment if having to travel. CAS staff should liaise with housing staff to provide holistic care and support during this process. Advocacy should be offered to clients to help with housing.

4.2.6 Older People

Older people can access 'adult' addiction services in the Addiction Care Partnership (e.g. Community Addictions Service, CGL, WLDAS). Clients of older people's mental health (OPMH) services can be referred in the normal way to ACP services and can be supported by OPMH teams to attend.

CAS council offer a service to people up to the age of 65. If social work services are required, then referrals would be sent to the older people social work department for input. CAS NHS, WLDAS and CGL will work with people across the full lifespan.

When service users are living in residential care, staff would liaise with carers around treatment plans and risks. It may be appropriate to offer harm reduction advice to residential staff for out of hours deterioration. Risk assessments should be completed to take into account the needs of an older person accessing the service such as mobility and cognition. Older people may require a different approach to addictions care due to frailty or co-morbidities, for example, may require inpatient detoxes instead of community ones. Every effort should be made to offer an inclusive and holistic service to the people over 65 who require input from substance misuse services.

4.2.7 Children and Young People (CYP)

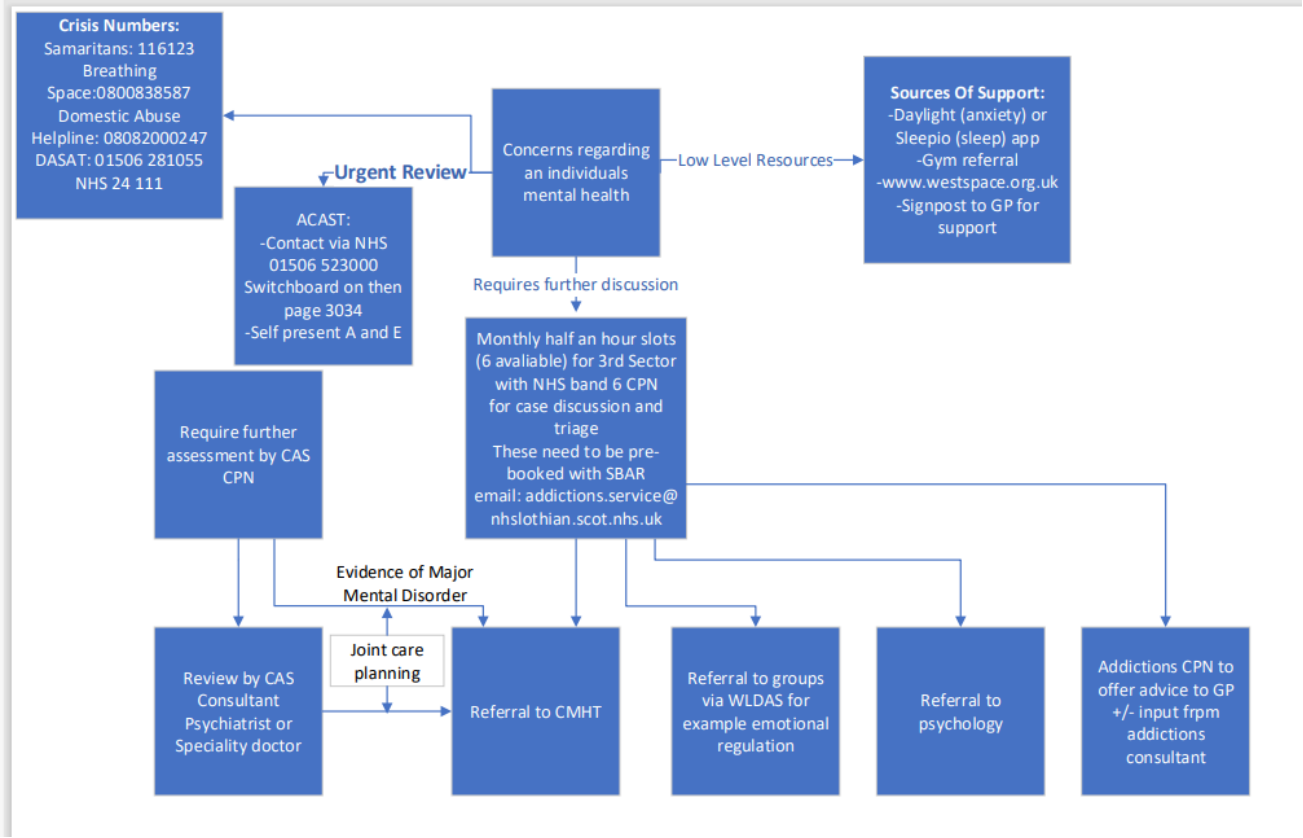
Clinical services for children and young people experiencing mental ill-health or harmful use of substances are not delegated to the HSCP In West Lothian and responsibility for them sits with Child and Adolescent Mental Health Services (CAMHS). West Lothian Council and West Lothian ADP commission a range of services for children or young people not requiring clinical intervention but who have mental health problems or who use substances. CYP mental health services work alongside CYP addictions services through a number of interfaces.

Where there is a need for specialist clinical addiction input, such as OST prescription, this can be negotiated on a co-working arrangement between CAS and CYP services.

4.2.8 People receiving addictions care from third sector services seeking mental health review

Third sector agencies work in close partnership with CAS. Many individuals attending these agencies present with multiple mental health concerns and so CAS has developed a pathway to allow staff the opportunity to explore and learn new skills to help people manage their own symptoms. The consultations are prebookable

(via CAS administration staff) on a rolling fortnightly basis. The nurse leading these reviews can, if appropriate, refer individuals directly to mental health services without the need for people to present to their GP. It provides staff an opportunity to seek supervision for complex cases and, if appropriate, a mental health review with CAS doctors can be arranged following the nurse consultation. The following diagram indicates pathways to support.



4.2.9 Access to Hubs

Where an individual presents to one of the Community Wellbeing Hubs and discloses a problem with drug or alcohol use during assessment or intervention, a Link Worker or a member of the Hub clinical team can:

a. Offer to support the individual to engage with Addictions Services and make the referral on their behalf or,
b. Signpost the individual for self-referral to Addictions Services

Addiction or problematic use of drugs and/or alcohol does not exclude an individual from receiving support from the Community Wellbeing Hubs if they are able to continue engaging with the service, though it may reduce the benefit of some interventions offered by the Hubs.

Where someone has received treatment or support from an addictions team and is stable (which may include continuing to use drugs / alcohol but in a generally stable way) and requires mental wellbeing interventions the person can be signposted to the Wellbeing Hubs via their GP practice. The Hubs are exploring how to widen access without a GP referral.

5.0 Processes for Referrals Between CAS and CMHT

5.1 Routine Referrals

All referrals should be screened using Trak to identify if the patient is on the caseload of either the Community Mental Health Team (CMHT) or the Community Alcohol and Drug Team (CAS).

5.1.1 New Referrals

The following applies when a routine referral (new to both services) is received into a CMHT or CAS:

- If a referral is received by a service describing both mental health and addiction issues the receiving service should complete an initial assessment of the patient.
- Following initial assessment If the patient has comorbid mental health and alcohol/drug problems, CAS and CMHT will agree if there is scope for joint working and which service should take lead responsibility and care management.
- The team who receive the original referral is responsible for informing the referrer of the outcome of the discussion i.e., which team will be seeing the patient for assessment, if there will be a joint working and who the care manager/key worker is.
- The care manager/key worker has the responsibility for letting the referrer know the outcome of any assessments and they will provide ongoing updates to the referrer.
- If agreed as appropriate for joint working, an appointment with CPNs from both CAS and CMHT will be arranged to complete a joint assessment and initiate the joint care plan.

5.1.2 Referrals already on caseload of alternate team

The following applies when a routine referral is received into a CMHT or CAS and the patient is already on the caseload of CAS or CMHT, respectively:

- The allocation meeting on noting the patient is open to another service should discuss the referral with the other service Team Leader/CPN and agree whether a new assessment is needed by them or whether the nature of the assessment would be better carried out by the service who already has the patient on their caseload.

5.1.3 Referrals within team

CAS Patient with Routine Mental Health Problems

- Any non-mental health trained CAS member of the MDT who has a patient for whom they are concerned about the development or deterioration of a mental health problem which is not a psychiatric emergency should seek mental health assessment through CAS mental health professionals.
- Routine referrals to CMHT from CAS should have had a mental health assessment prior to referral to the CMHT. The CAS referrals should communicate the up-to-date substances used for the patient and how they are being managed in the patients care plan. The CAS referral should explain the mental health concern, what steps have been taken so far to alleviate the issues, and an indication of what CAS believe would be beneficial for the client.
- If the patient's mental health issues can be managed within CAS, this should be the preferred option and appropriate supports put in place.
- If CAS staff think that referral to a CMHT is necessary then they will do this directly – the patient's GP should not be asked to make the referral.

CMHT Patients with Alcohol/ Drug Problems

- CMHT staff involved with patients who have or develop an addiction problem should consider a referral to CAS for advice, assessment or transfer of care.
- Referrals from CMHT to CAS should have a brief description of the client's alcohol and drug use and their expectations/goals prior to referral to CAS.
- Referrals to CAS from CMHT should follow the agreed proforma, the minimum expected written referral would be an SBAR (situation – background – assessment – recommendation) written assessment. This should include a brief mental health assessment, the alcohol and drugs assessment, what steps have been taken so far to alleviate the issues, and an indication of what the CMHT believe is required and what the client is agreeing too eg detox or counselling.
- An eight weekly report is currently in place from TRAK to identify individuals who are on the caseload of both CMHT and CAS. For those using drugs, an alert will be placed on TRAK and a joint care plan will be expected. Please see below for joint care planning between CMHT and CAS.
- Individuals who decline CAS input should be offered services on a regular basis and made aware of the self-referral process. Training will be offered to CMHT staff to enhance knowledge and skills to encourage individuals to engage with substance misuse services and provide harm reduction advice.

6.0 GP and Community Interfaces

Primary Care has a key role in the assessment and treatment of mental ill health and people receiving care for substance use disorders would expect that mild or moderate mental health problems would be addressed through consultation with GPs or Practice Mental Health Nurses, with step up to CAS / mental health services when that exceeds the competence of primary care to manage. Primary care interfaces with people with co-morbid mental health problems and substance use fall into 2 categories:

Where CAS is already involved and there is shared care:

- The CAS Addiction Worker should discuss care regularly with the GP. If they have any concerns the GP should directly assess the patient.
- Patients in GP shared care that need a mental health assessment, beyond the care worker and GP, would be managed just like any other CAS patient. CAS mental health assessments are done by CAS RMNs or psychiatrists depending on the nature and severity of the problem.
- CAS mental health review by RMN is appropriate for mild to moderate mental health problems when comorbid drug use is unstable and/or thought to be impacting on mental health.
- CAS mental health review by RMN and subsequent internal referral to Adult MH Psychiatrist is appropriate for more complex or severe mental health problems typically involving psychosis and higher concerns of risk.

Where CAS is not involved, e.g., where there is enhanced GP prescribing of OST, or when substance use is non-opiate, then referrals shood be made in the usual way to mental health services – including wellbeing hubs if appropriate or secondary care mental health services.

7.0 Complex Comorbidity

7.1 People who have both mental illness and significant substance use disorder

Patients with both significant alcohol/drug problems and significant mental health problems will sometimes be present in both services. Services and staff therefore need to be able to respond effectively to this complex comorbidity by effectively communicating and managing care between services, agreeing who takes the lead in certain situations and maintaining basic clinical skills that are mutually necessary. For such comorbid patients:

- Any involved member of staff should consider arranging a clinical case conference with attendance by all those staff involved in a patients care.
- The case conference should agree a joint care plan which should contain:-
    - The details of individuals involved in providing care and treatment, agreeing and defining their responsibilities.
    - A list of the patient's needs with agreed actions and interventions to address these.
    - Where possible, and agreed by the client, family members' views should be taken into consideration and they should be actively involved in the care planning process.
    - A risk assessment and action plan. This must include issues to do with dependent children or frail elderly.
    - Consideration of application of adult support and protection legislation and other mental health legislation.
    - If 2 psychiatrists are involved in treatment, agreement about which one is the lead responsible medical officer. For instance, it may be agreed that the Addiction Psychiatrist will see the patient in outpatients and manage the situation day to day, but that the corresponding General Adult Psychiatrist would provide access to in- patient care if there is a relapse of the mental illness requiring this.
    - The views, aims and goals of the patient and relevant carers/ relatives.
- The joint care plan should be reviewed 3-6 monthly or when significant changes are made/required.
- All parties described in it should be informed of any change. Patients should be offered a copy of their care plan.
- Care plans are discussed weekly at CAS MDT to highlight risks, clinical or staffing issues that prevent the care plan from being completed. This will identify gaps within current procedures.
- CMHT staff will have care plans reviewed as part of their monthly managerial supervision agenda.
- The responsibility of completing the Care Plan falls jointly with CPNs from CAS (if applicable) and the CMHT. For clients with no involvement with CAS the responsibility of completing the Care Plan will fall with the CMHT CPN (however should still involve colleagues from Social Work and/or 3rd sector services e.g. CGL, WLDAS in its production).
- Care Plans should be uploaded to SCI store with a message created in the significant information box (on TRAK) including the text: A "Complex Co-morbidity" Care Plan exists for this client dated dd/mm/yy, and can be found on SCI Store.

  Clients do not have to have a confirmed Mental Health or Substance Misuse diagnosis for the use of the Complex Co-morbidity Care Plan to be indicated.

  For individuals who decline CAS input the option for staff to discuss cases within the fortnightly support teams sessions should be considered. Staff can utilize supervision sessions to explore concerns and risks within monthly management supervision and during MDT meetings.

7.2 Where there is a proposed change of diagnosis

Where the patient is under the care of both general adult psychiatry and the community addictions services and a change of diagnosis is being considered, this should be discussed with both consultants. Any change in

diagnosis should occur as part of a MDT discussion and formulation, informed by a timeline from the patient's notes and discussed with both teams. This allows more robust follow-up and informs the assessment of future presentations to either team. While a psychologist-led formulation offers a depth that is valuable in thinking about a complex case, a team biopsychosocial formulation considering predisposing, precipitating and perpetuating factors would be sufficient. It is the MDT thinking and discussion that is of value and communication between teams.

7.3 Complex Case Consultations

Fortnightly MS Teams sessions are available to give staff the opportunity to access mental health and addiction support (Clients are not to attend). This is available for third sector agencies (WLDAS and CGL) and to CMHT staff. For clients who decline CAS input the option for staff to discuss cases within the fortnightly support teams sessions should be considered. If the nurse led sessions identify referral needs these will be followed up by the staff running the consultations. Face to face assessments can be arranged, if appropriate following this initial discussion and if consented

8.0 Advocacy

People with mental health or substance misuse difficulties are able to access advocacy through the Mental Health Advocacy Project. To challenge the power imbalance and stigma as well as supporting people to have their views and opinions be heard, independent advocacy should be offered to each person accessing addiction services. Where people identify as being unable to access a mental health or addiction service due to co-morbidities or substance use they should be offered advocacy. Leaflets, advice and referrals should be completed as agreed by service users.

9.0 Dispute and Second Opinion

- Teams in dispute about who should take the primary responsibility for a patient at any point in time should try to promptly resolve this between themselves clearly documenting the agreement.
- If dispute continues the issue should be referred up through line management and resolved at as a low a level as possible. If dispute continues the General Manager and Clinical Director will make the final adjudication based on advice from clinical staff

10.0 Implementation and Development

This Guideline should be regarded as a working document and will develop over time as culture and working practices change. The development of the guideline is overseen by the Ending the Exclusion Board and is also reported at the MAT Standards Group. Where issues relate to children and young people, they can be taken to the Whole Family Approach Public Social Partnership and Children and Families Strategic Planning Group.

10.1 Training

A Training Needs Analysis will be carried out and reviewed annually regarding training to support mental health and addictions services to provide care informed by the Quadrant Model – ie, drug and alcohol services learning and mental health and vice versa.

CAS and CMHT staff can access a quarterly programme of training and development sessions will take place over the year, giving staff an opportunity to develop skills and knowledge out with their "usual" field of practice. Staff will be able to identify and define their roles and learn from each other to improve practice for supporting individuals who use substances or present with mental illness. The programme should identify gaps in staff knowledge to inform future training content.

The aim of these 'away days' is hoped to bring staff from CMHT and CAS together to develop and build essential therapeutic working relationships. The value of knowing each other and becoming more informed of roles will benefit service users in terms of providing concomitant mental health and addiction care.