Adult Mental Health & Addictions Service Shared Guidance & Specification for Interface Working

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The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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Responsible Director	**Lead Associate Medical Director MH**
Approved by	**Mental Health Service Governance Exec Group**
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Replaces previous version: [if applicable]	**Mental Health and Addictions Services Guidance On Interface Working (2014)** **MHS 03 Adult Mental Health & Addictions Service shared Guidance and specifications for interface working (2016).**

Following discussion by the Short Life Working Group and consequent agreement from the Mental Health Exec Governance Group it was approved that MHS 03 Adult Mental Health & Addictions Service Shared Guidance & Specification for Interface Working would have its review schedule extended to April 2022.

MHS 03 – Adult Mental Health & Addictions Service Shared Guidance & Specification for Interface Working

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.03	Feb 2011	Original Draft	F McMahon. Dr J Mitchell
2.0	Dec 2016	Review completed Updated the contact person within the guidance Amendment to section 13 Dispute, changed the responsibility from CD's to Service Managers	Dr S Priyadarshi Dr M Smith
3.0	Dec 2020	Review completed, Additional wider review currently active taking into account changes in Mental Health Services, Unscheduled Care, Crisis and the development of Mental Health Assessment Units. MHAU mentioned in section 8 Psychiatric Emergencies.	Dr S Priyadarshi Dr U Graham S McCulloch

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NHS Greater Glasgow & Clyde

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1. Introduction and Background

Delivering for Mental Health (2006) set out a challenge for NHS Boards in relation to implementing the recommendations made in the reports “Mind the Gap” (2003) and “A Fuller Life” (2004). These made several recommendations to improve services for people with dual diagnosis or Alcohol Related Brain Disorder (ARBD). The focus of the recommendations was for services to be joined up and collaborative in their approach to care and that staff working with this client group from both Alcohol and Drug recovery services (ADRS) or General Adult Mental Health Services would have the knowledge and skills to deliver a quality service. The National Enquiry into suicides and homicides has subsequently made recommendations emphasing good joint working An Adult Mental Health and ADS Clinical Interface Forum identified issues and developed guidance for Glasgow. A resultant 2011 document was consulted on and accepted for use. This is now reissued following further consultation and work through the comorbidity subgroup of the ADRS clinical services review.

This guidance has been developed to support clinical staff who work at the interface of ADRS and mental health services. It is a dynamic document subject to review. Consultation comments are incorporated.

General mental health services are described in the psychiatric emergency plan and it is intended that this document sits beside these. This is a living document and comments should be made to Saket.Priyadarshi@ggc.scot.nhs.uk.

2. Routine Referrals

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

3. Routine Referrals New to CMHT and CADT

The following applies when a routine referral is received into a CMHT or CADT:

- 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 a comorbid Mental health and alcohol/ drug problems, ADRS and general adult mental health need to agree if there is scope for joint working and which service should take lead responsibility and care management. Episodic case conferences may be helpful to coordinate a mutually agreed patient care plan.
- 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.

4. Routine Referrals on Existing Caseload of CMHT/ESTEEM and/ or on Existing Caseload of CADT

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

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

5. CADT Patient with Routine Mental Health Problems

- Any CADT Care Manager 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 the CADT Mental Health Professionals.
- Routine referrals to a CMHT from CADT should have had a mental health assessment prior to referral to the CMHT. The CADT referrals should communicate the up to date A&Ds issues for the patient and how they are being managed in the patients care plan. The CADT referral should explain the mental health concern and what the CADT is hoping for.
- If the patient's mental health issues can be managed within ADS, this should be the preferred option and appropriate supports put in place.
- If CADT 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.

6. CMHT Patients with Alcohol/ Drug Problems

- CMHT staff involved with patients who have or develop an addiction problem should consider referral to their local CADT of the patient for advice, assessment or transfer of care.
- Referrals from a CMHT to a CADT should have had an alcohol and drugs assessment prior to referral to the CADT.
- Referrals to a CADT from a CMHT should communicate the up to date mental health assessment, the alcohol and drugs assessment and what the CMHT is hoping for.

7. In-patient Services – Acute Mental Health and IPCU

Mental health staff are encouraged to involve the ADRS as early as possible in an individual's admission if they wish addictions opinion and involvement.

- If the patient is already known to a CADT, inpatient staff should inform them of the admission and subsequent discharge. Staff should agree what ADRS input is clinically appropriate at what stage e.g. review whilst an inpatient or as an outpatient.
- If the patient is **not** already known to the local CADT then inpatient staff should refer the patient to the appropriate CADT during the admission who would then identify the appropriate intervention from ADRS through the allocation process. This may involve general inpatient assessment of post discharge assessment or signposting / information on other services.

- Information should be provided to patients who have agreed to ADRS referral but who have discharged themselves against medical advice before ADRS have had a chance to see them or offer an appointment. Inpatient staff must inform the local CADT of the discharge. The patient should be informed of the referral to ADRS and provided with the contact details of the CADT they have been referred to.
- If addiction issues have been identified at point of assessment but the patient does not want referred to addiction services staff should provide the patient with literature regarding their local addiction resources.
- Because of the special vulnerability of people with drug and alcohol problems consideration must be 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.

8. Psychiatric Emergencies

A psychiatric emergency is defined as "a situation of immediate risk to the patient or others as a consequence of possible or known mental illness". Whether they are known to CADT or not this should result in a same day assessment by mental health services.

- If an emergency mental health assessment is needed this is provided via the Mental Health Assessment Unit (MHAU) OR local CMHT. Referral by CADT should be direct to the MHAU/CMHT not via the GP or an emergency department/ A&E. The only reason for referring a patient to emergency department/ A&Es is for a physical health emergency. As an example a patient threatening self-harm would go to a MHAU/CMHT whereas a patient who has actually swallowed an overdose of medication would go to an emergency department / A&E.
- CADT staff should always communicate the emergency referral to the MHAU/CMHT with as much relevant clinical information as is possible in the circumstances. The minimum expected would be a SBAR conversation (situation – background – assessment – recommendation). If possible written assessment material should be communicated. If this is not possible however in the time scales the MHAU/CMHT should still accept the psychiatric emergency referral.
- MHAU/CMHTs should not decline any psychiatric emergency assessment on the basis that a patient has a substance misuse issue and/ or is open to a CADT.
- ADRS staff may have to use the police in emergencies to transport a patient to a place of safety to allow general psychiatry assessment – the police may use an A&E department.
- Crisis / out of hours / intensive home treatment team mental health services are open to addiction patients and should accept direct referrals from ADRS RMNs, medical officers or psychiatrists.
- Known CADT patients that are referred as psychiatric emergencies by GPs to CMHT / crisis / out of hours should be directly assessed by MHAU/CMHT/ crisis/ out of hour's staff. Prior ADRS emergency assessment is not required.
- If known to CADT, the MHAU/CMHT should liaise with the local CADT service to discuss the individual and agree a management plan once the assessment has concluded.
- 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.

9. Complex Comorbidity

Patients with both significant alcohol / drug problems and significant mental health problems will always 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.
    - 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.
    - Consideration of application of the care programme approach.
    - 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 monthly.
- All parties described in it need informed of any change.
- In Renfrewshire dedicated comorbidity staff should be aware of all comorbidity patients and clinically involved with those relevant.

10. GP Shared Care Scheme / GP Enhanced Service.

The Shared Care Scheme / enhanced service is a major contributor to opiate replacement therapy (ORT). Care and Treatment is provided via the clients General Practitioner (GP) and it is the GP who is the Responsible Medical Officer.

In the Glasgow shared care scheme the patient should be considered to be open to the appropriate local CADT and care managed through it. They are on the CADT caseload.

In Renfrew and Inverclyde a patient attending the GP enhanced service are not active clients on the specialist Alcohol and drugs service caseload.

Clients are supported by Social Care Workers or RMNs depending on geography. Community Pharmacists support community dispensing and any necessary supervision. The addiction Worker should maintain the recovery action plan, update addiction assessment and discuss any change in the client's presentation/needs with the GP.

Patients with chaotic drug use and / or complexity should be transferred to a CADT doctor who would take over the substitute prescribing responsibilities. This may be a medical officer or psychiatrist. When possible, patients should be transferred back to GPs. It is important that information management systems clearly identify which doctor is responsible for a patient's medical care and treatment and there is good communication between CADT medical staff and GPs to agree who is the best person to be involved in opiate substitute prescribing at any time.

Advice is available about who is best to be prescribing for any individual from the local senior medical officer or consultant psychiatrist.

11. Mental Health Problems

- The 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 CADT patient. CADT mental health assessments are done by CADT RMNs, medical officers and psychiatrists depending on the nature and severity of the problem.
- CADT mental health review by RMN/ medical officer is appropriate for mild to moderate mental health problems when comorbid drug use is unstable and/ or thought to be impacting on mental health.
- CADT mental health review by RMN/ medical officer and subsequent internal referral to addiction psychiatrist is appropriate for more complex or severe mental health problems typically involving psychosis and higher concerns of risk.

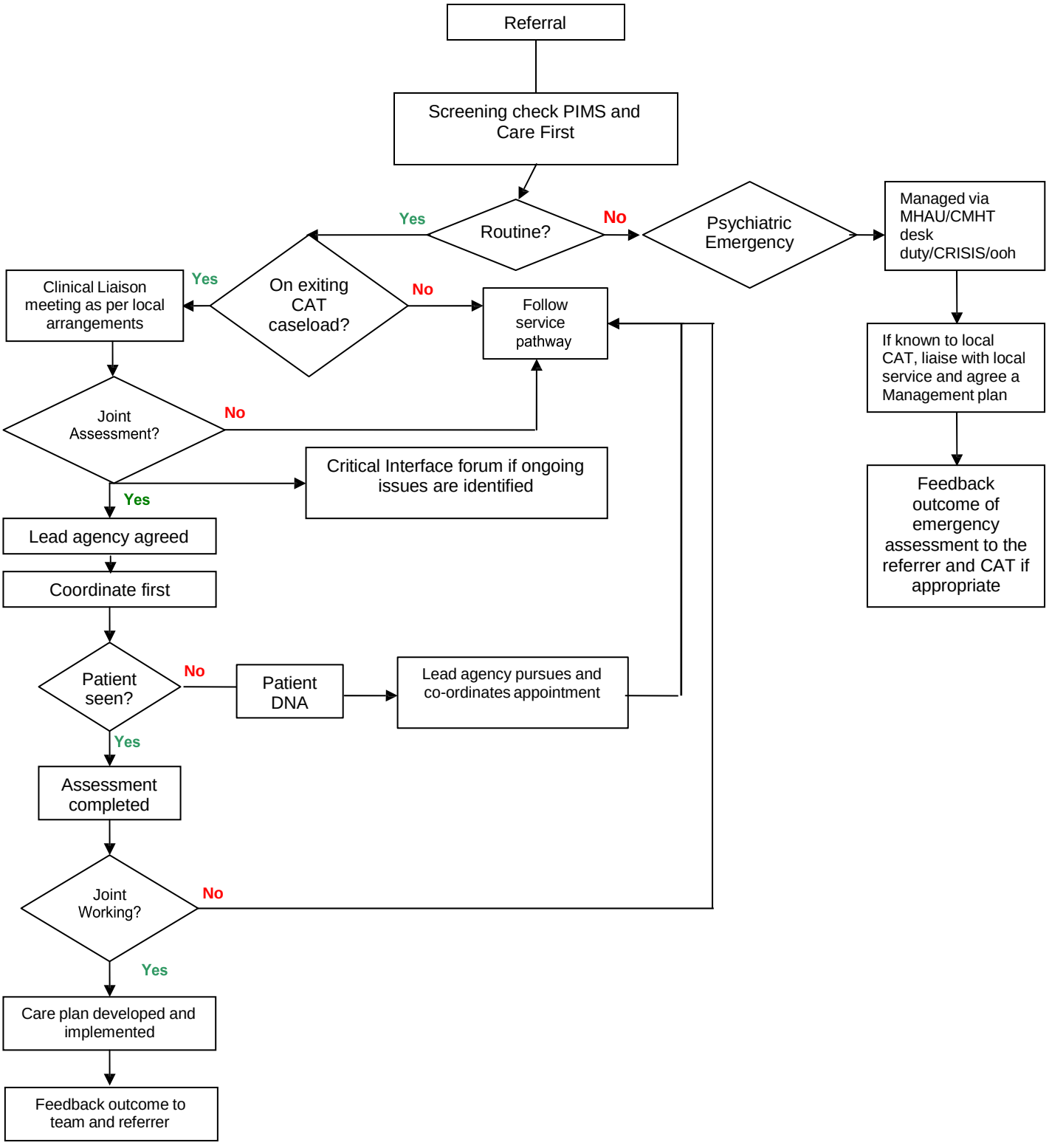
12. Psychiatric Emergencies

- These 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 or possible detention under the mental health act.
- These should be directly referred to general mental health services (CMHTs).
- CMHTs should never decline the referral on the basis the patient has a drug or alcohol problem. The CMHT should follow the referral pathway for new referrals and arrange to see the client based on the information provided by the GP. The CMHT will assess and update any assessments and feedback the outcome to the GP and A&D care manager.

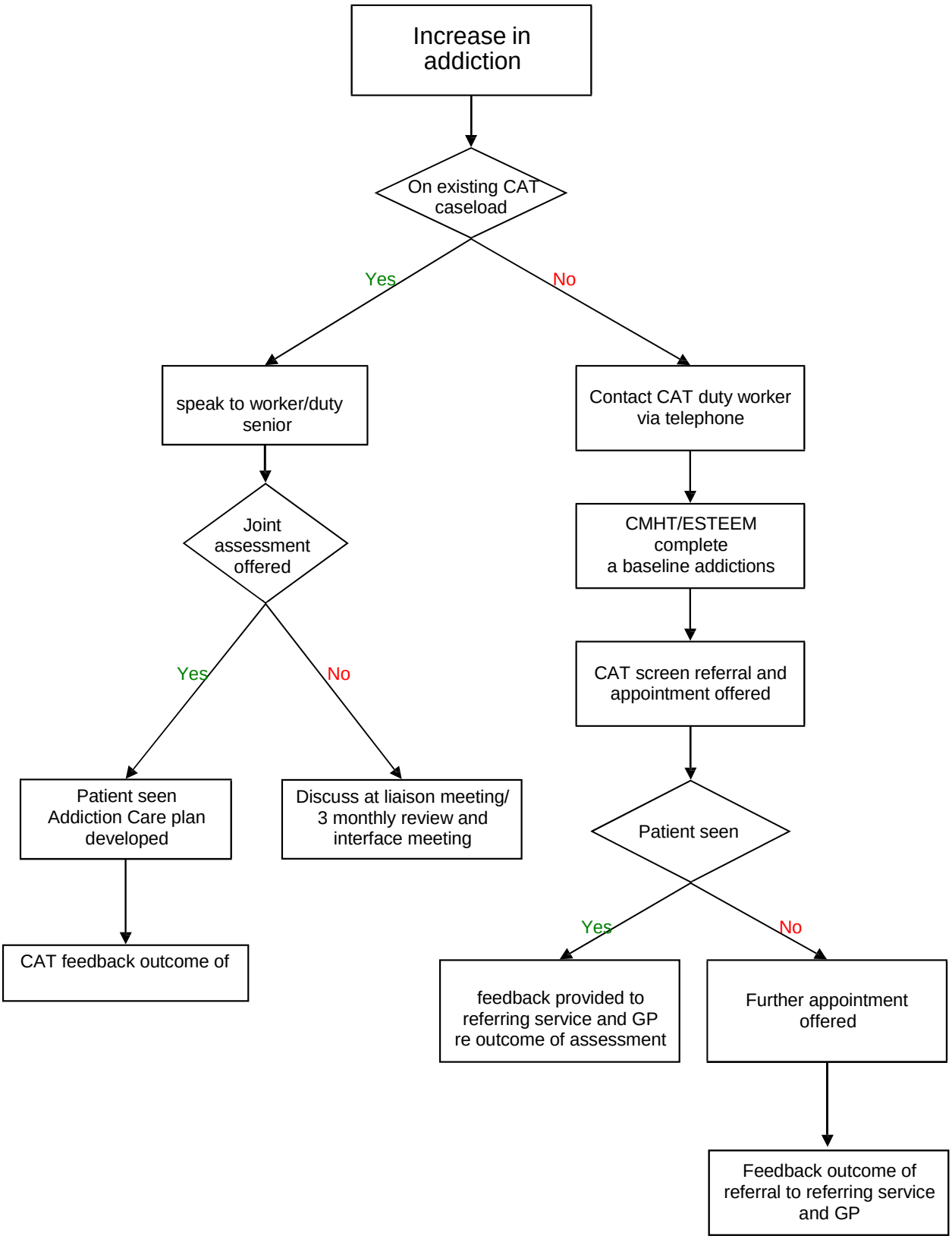
13. Dispute

- 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 service manager will make the final adjudication based on advice from clinical staff.

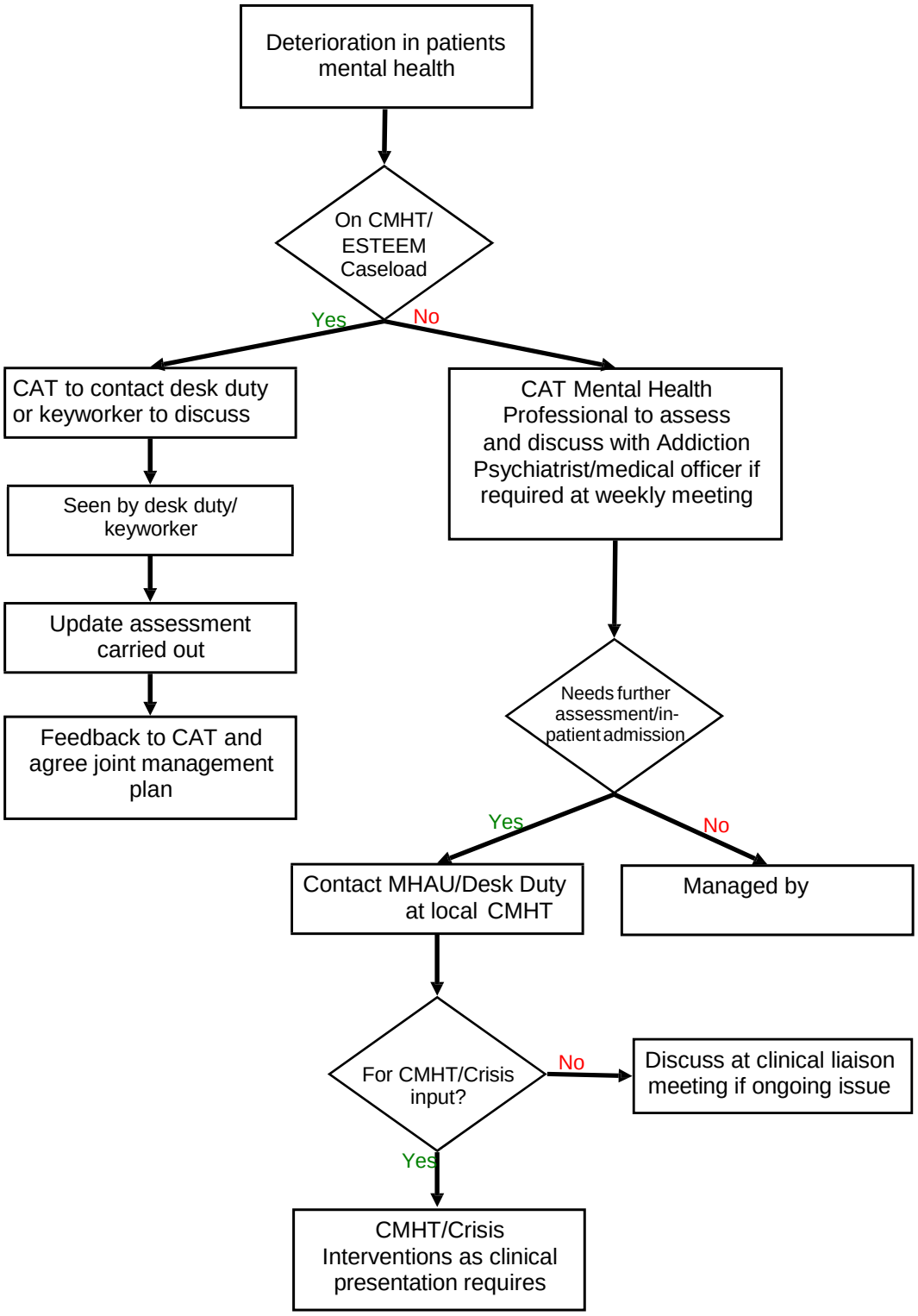
Adult Mental Health and Addictions Interface Flowchart for Routine & Emergency Referral



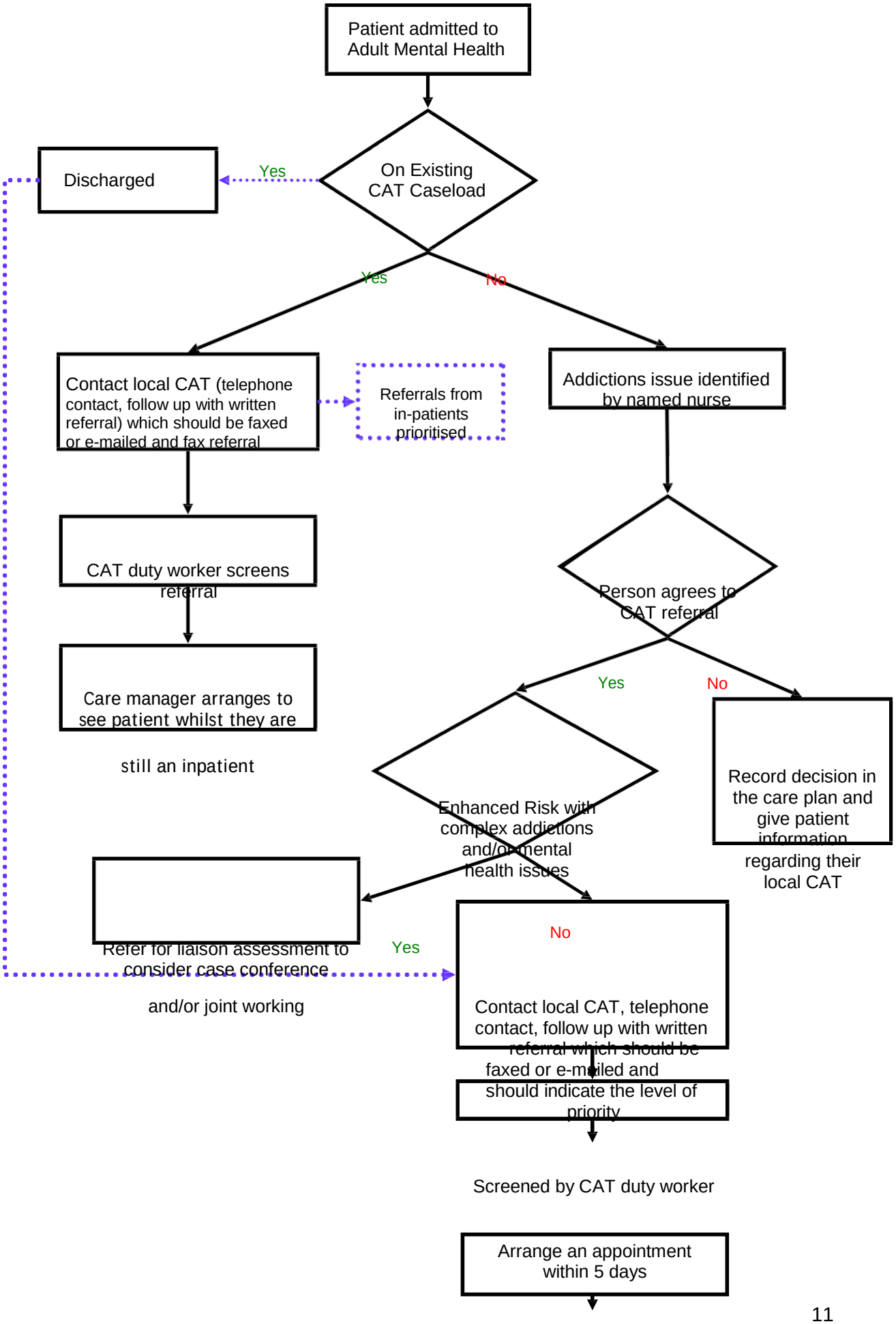
Adult Mental Health & Addictions Interface
Flowchart for Patients on Existing Caseload (CMHT/ESTEEM)



Adult Mental Health & Addictions
Interface Flowchart for Patients On Existing Caseload (CAT)



Adult Mental Health & Addictions
Interface Flowchart for Adult MH In-Patients



Service Pathway