NHS FORTH VALLEY

Interface and Shared Care between Substance Use Services and other Mental Health and Learning Disability Services

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Author / Contact	Ross Cheape	
Escalation Manager	Dr Jennifer Borthwick	
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Consultation and Change Record – for ALL documents

Contributing Authors:	Ann Milne, Julia Ferrari, Heather Tainsh, Jacqueline Maher , Ross Cheape, Sharon Drummond, Dr Iain Smith, Dr Seonaid McCallum, Dr Matthew Turner, Dr Nabila Muzaffar, Mary Straub, Ruth Murray
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1. Introduction

Co-occurring substance use and mental ill health are seen commonly in mental health and learning disability services. In some cases patients with severe and enduring mental illness and substance use issues will require the input of two specialist services, namely Substance Use Services (SUS) and Community Mental Health Teams (CMHTs), or Community Learning Disability Teams (CLDTs) i.e. joint working / shared care. The purpose of this document is to provide practical guidance for staff working in these services in navigating systems and processes. It is intended that the following sections will support good communication and ensure patients are seen by the right people at the right time.

This guideline has been written with reference to the Mental Welfare Commission Themed Visit Report "Ending the Exclusion: Care, Treatment and support for people with mental ill health and problem substance use in Scotland" (Mental Welfare Commission 2022). Reference has also been made to the Medical Assisted Treatment (MAT) Standards for Scotland (Scottish Government 2021), specifically Standard 9 which states "All people with co-occurring drug use and mental health difficulties can receive mental health care at the joint of MAT delivery". This guideline will help ensure that practice in NHS Forth Valley delivers the intention of both of these documents.

2. Definitions

Substance Use Services (SUS) - includes Community Alcohol and Drugs Service (CADS) Core teams, Alcohol Related Brain Injury (ARBI) Team, Hospital Addiction Team (HAT), and the Young Persons Liaison Service. Services provided by Change, Grow, Live (CGL) are also part of the wider SUS service and where necessary, specific reference is made to these services in this document.

Patients Seeing CGL – CGL are a third sector provider who support patients with drug and alcohol use. Patients who are seeing CGL are not open to the Consultant Psychiatrist in CADS for routine reviews and are not seen by Mental Health Nurses. Patients seen by CGL may be receiving a prescription from doctors or non-medical prescribers from the SUS, but these patients are not open to this service for ongoing input. In the case of a mental health emergency the GP may have to be involved if transfer between CGL and SUS will cause undue delay. Referral to MHAATS by the GP may be the initial route into services in a mental health emergency.

Community Team - For the purposes of this document this term is used to refer to the community based mental health and learning disability services for adults and older adults across Falkirk, Stirling and Clackmannanshire.

Severe and Enduring Mental Illness – Patients who have their illness characterised in this way will present with symptoms of mental illness resulting is debility, or significant risk and complexity.

Moderate to Severe Drug or Alcohol Use – is characterised by patients who have a minimum of four symptoms of substance use disorder for moderate to six or more symptoms for those with severe disorder, out of a list of 11 symptoms (American

Psychiatric Association, 1994). It should be noted that the work of the SUS is primarily focussed on opiate dependence and its treatment -the MAT system- and the treatment of alcohol dependence. There are no specific treatments offered for Substance Use Disorders where the primary drug is cannabis or one of the stimulants (amphetamines, cocaine etc).

3. Principles

It is not possible to provide detailed guidance for every eventuality, however the following principles should be applied when making decisions in the context of joint working between the specialist Community Mental Health or Learning Disability Services and SUS:

- Shared Care will be the norm - In all cases where a patient needs the input of SUS and the specialist community teams, this will be provided.
- Care will be patient-centred and needs-led. There will be no wrong door for patients accessing help – services will work together to provide a response to the patient.
- The patient should know who to contact
- The patient should be aware of referrals and joint working plans
- Transitions of care should be planned and communicated between the services involved.
- Mental health and learning disability services should be able to treat substance use disorders up to a point and similarly the SUS should be able to treat mental health conditions up to a point. This is in keeping with current Scottish Government policy around “No Wrong Door”.

4. Scope

Change, Grow, Live (CGL) provide a large portion of Substance Use Services in NHS Forth Valley. Their remit is to work with people whose substance use and psychiatric presentation is stable and less complex, therefore making it unlikely that patients with a severe and enduring mental illness will receive input from CGL. However, there may be people who are stable in treatment who are managed by CGL and one of the specialist community mental health or learning disability teams. Although these patients will be seen by the medical team within SUS for the prescribing of Opiate Replacement Therapy (ORT), they will not have a key worker from within the NHS provided component of SUS.

This guideline applies to staff working in SUS, the CMHTs in Adult and Older Adult, the Community Learning Disability Teams (CLDTs) and those working across the mental health and learning disability services who support patients, make referrals and manage interfaces.

This guideline does not cover patients with Alcohol Related Brain Injury (ARBI) and the interface with assessment and diagnosis of dementia. The ARBI pathway for this patient group should be followed.

5. Emergencies

In a psychiatric emergency it is essential that efficient processes are put in place to ensure safety. The Psychiatric Emergency Plan (PEP) should be followed in these cases as this will guide clinicians through the process of admitting the patient to hospital.

All clinicians working in mental health and learning disability services can make referrals to the Mental Health Acute Assessment and Treatment Service (MHAATS) when a patient is thought to need admission to hospital because of their mental illness.

6. Care Programme Approach (CPA)

Many of the patients who require input from both the specialist community mental health or learning disability services and SUS will require a CPA to managing their care. Where this approach is being used to manage a patient's care, this guidance will supplement the CPA process.

7. Referrals

All referrals made to mental health, learning disability or SUS must be made using SCI Gateway (except emergency referrals to MHAATS).

When a referral is received, the receiving service will check the electronic record to identify if the patient is already on the caseload of a Mental Health Service, Learning Disability Services or SUS.

The following applies when a routine referral is received into a community team or to SUS:

7.1 Referrals received by the community team with co-morbid substance-use:

Where the community team receive a referral for a patient with co-morbid substance use in the presentation the referral co-ordinator/team leader will determine if SUS input is required. The level of input should be established by discussing the case with the referrer (if necessary) and with the SUS, who may respond as follows:

- Provide advice – which may include the suggestion that seeing the patient will be required in order to determine the appropriate service.
- Participate in a Joint Assessment
- Takeover the assessment as there is clear moderate to severe drug and alcohol use

Undue delay in the patient being assessed needs to be avoided.

The referral co-ordinator should contact SUS and ask for the Charge Nurse dealing with referral allocations on the following telephone numbers:

SUS Contact Details

Falkirk: 01324-673670
Stirling and Clackmannanshire: 01786-486282
Email (both teams): fv.cadsprescribing@nhs.scot

It would not be appropriate for referrals made to the community teams to be passed directly to CGL, although following assessment within SUS, it may be determined that CGL are best placed to meet the needs of the patient.

7.2 Referrals received by SUS for patients with co-morbid mental illness

Where SUS receive a referral for a patient with moderate to severe mental illness in the presentation the Charge Nurse dealing with referral allocations will determine if community team input needs to be sought. The level of input should be established by discussing the case with the referrer (if necessary) and with the community team's Referral Co-ordinator, who may respond as follows:

- Provide advice – which may include the suggestion that seeing the patient will be needed to determine the appropriate service.
- Participate in a Joint Assessment
- Takeover the assessment as there is clear moderate to severe mental illness

The Charge Nurse dealing with referral allocations should contact the Referral Co-ordinator, or Team Leader on the following telephone numbers:

Community Team Contact Details

Adult
Woodlands: 01324-624111
Livilands: 01786-446913
CCHC: 01259-290343
Older Adult
Older Adults Falkirk: 01324-673808
Older Adults Stirling: 01786-454665
Older Adults Clackmannanshire: 01259-290392
Dementia Outreach Team: 01324-832610, or 01786-454665
Learning Disability
Additional Support Team: 01324-574305
Clackmannanshire Team: 01259-216118
Stirling Team: 01786-434404
Falkirk Team: 01324-590510

If the original referral was made to CGL and co-morbid mental illness identified, CGL would discuss this referral at the SUS Multi-Disciplinary Team (MDT) Meeting.

8. Existing Patients and Shared Care

This section guides staff on how to access support and input for a patient who develops a substance use need when being treated within the community team, or a serious mental health concern when being treated within SUS.

For patients who require the ongoing input of both the community team and SUS consideration should be given to the need for Care Programme Approach (CPA). It may also be appropriate to offer the patient joint appointments where they can see staff from the community team and SUS together.

Where input from another service is thought to be necessary this must always be discussed within the team before consulting the other service.

8.1 The process for accessing input from SUS for an existing community team patient

- The key worker identifies the need for input from SUS.
- The key worker discusses this at the MDT/within the team.
- The key worker will contacts SUS and ask for the Charge Nurse dealing with referral allocations

Falkirk: 01324-673670
Stirling and Clackmannanshire: 01786-486282
Email (both teams): fv.cadsprescribing@nhs.scot

Discussion between the two services may result in one of the following outcomes:

- Provide advice
- Redirect the team to a more appropriate service (for example, Change Grow Live (CGL))
- Referral to SUS via SCI Gateway

8.2 The process for accessing input from the community team for an existing SUS patient

- The key worker identifies the need for input from the community team.
- The key worker discusses this at the MDT/within the team.
- The key worker will contact the community team and ask for the Referral Co-ordinator, or Team Leader

Community Team Contact Details
Adult
Woodlands: 01324-624111
Livilands: 01786-446913
CCHC: 01259-290343
Older Adult
Older Adults Falkirk: 01324-673808
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Learning Disability
Additional Support Team: 01324-574305
Clackmannanshire Team: 01259-216118
Stirling Team: 01786-434404
Falkirk Team: 01324-590510

Discussion between the two services may result in one of the following outcomes:

- Provide advice
- Redirect the team to a more appropriate service (for example, FDAMH)
- Referral to the community team via SCI Gateway

8.3 Referrals between the community team and CADS for existing patients

In cases where the discussions in section 6.1 and 6.2 identify that a referral should be made via SCI Gateway, this will be processed through the usual MDT/allocations meeting. Not all referrals will require a full assessment and some will be appropriate to allocate to groups, teams or key workers directly. However, as a minimum clinical staff from both services will discuss and agree the treatment plan. This may involve a joint appointment where a clinician from both services is present. Where a full assessment is required, the clinician currently working with the patient (or deputy) should be involved in the assessment with the receiving service.

Consideration must always be given to risk and complexity in determining whether a professionals meeting is required to agree the care plan. However, in many cases where the referral makes a specific request, for example for Safety and Stabilisation, the services can be provided without the need to convene a professionals meeting.

In cases where the plan is unclear, there is diagnostic ambiguity or differences in opinion, a professionals meeting should be convened to determine the plan of care. A professionals meeting will also be necessary where it is not clear who the lead clinician should be. This meeting should also consider the need for CPA. The team making the referral are responsible for arranging this meeting.

9. Who Should the Patient Contact?

Patients should be made aware of who to contact should they need additional support. In most cases this should be the community team for any problems with their mental health and the SUS for any problems relating to substance use. In practice these problems will not be easily separated and it will therefore be necessary for staff to help the patient access the right part of the service. The clinical staff responding to this should engage the other service where needed, instead of redirecting the patient.

10. Transfer of Care and Discharge

If a patient is identified for discharge from either the community team or SUS when both services are engaged with the patient, it is crucial that the discharge is

discussed with the other service before it takes place. If discharge is being considered at the time when the patient is transitioning to the other service, the care plan to support this transition must be agreed by both services and shared with the patient. The patient should not be discharged from either service until the transition plan is agreed and communicated to the patient.

11. Discharge from Inpatients and Follow Up

Where a patient is being discharged from the inpatient service it is important to be clear about what follow-up will be provided and by whom. The inpatient team should assess the need for shared care between community teams and SUS, noting that patients being seen by CGL will not have consultant psychiatry or registered nursing input and in cases where these patients need mental health follow-up it is likely that a referral to the community mental health team will be needed.

It is important also to be clear that if psychotropic medications have been commenced as to who will be responsible for reviewing these medicines as part of the discharge planning process.

12. Maintaining Communication

The development of fortnightly half hour meetings between CIMHS and SUS provides a good model for encouraging communication around this interface and should be adopted as a model with teams where there are large enough numbers of patients shared between the services.

13. Specific Conditions

There are a number of conditions where the locus of care within the overall mental health, learning disability and substance use services needs to be considered and agreed if the substance use problem is stable enough to allow for engagement. These would include in particular ADHD, Personality Disorders, PTSD, Eating Disorders and Drug-Induced Psychosis.

14. Conflict Resolution

Differences in clinical opinion do arise and it is important that open communication is maintained to ensure that care and treatment remain safe and the patient receives the appropriate service. Teams in dispute 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 early a stage as possible, for example if key-workers are in dispute, this should be escalated to the team leaders.

If dispute continues the Clinical Directors (CD) or Associate Medical Director (AMD) should discuss the case and agree a way forward.

15. References

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorder: DSM-IV. Washington DC.

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

Scottish Government (2021) Medication Assisted Treatment (MAT) Standards for Scotland. Access, Choice, Support. Edinburgh, Scotland.

Publications in Alternative Formats

NHS Forth Valley is happy to consider requests for publications in other language or formats such as large print.

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