Dual Diagnosis Pledge and Pathway

Our aim is to improve the support and treatment for individuals who have co-existing mental health and alcohol and drug difficulties, which is known as a dual diagnosis.

Individuals with a dual diagnosis often have a range of problems, which can require a range of solutions. Help and support needs to be accessible and flexible, which will meet the needs of the individual. Treatment should be shaped by those accessing services whenever possible, based on their own personal recovery goal.

Our collective aim is to work with individuals who have a dual diagnosis, their families and supporters, to provide the treatment and support required to make recovery possible.

Overview

- Assessment- Entry points
- Planning- Who what and how?
- Review – How often and how?
- Discharge – focus on relapse prevention

Assessment

- Entry points into the system can be from a range of points
- Wherever the client enters the pathway there should be consideration given to undertaking a joint assessment
- Where it is not possible to arrange one on the same day the maximum amount of time that a client should wait is 5 days
- Where there is significant risk urgent cases should referred directly to the A2i service and this will also be the pathway into the CRHT where its deemed that an admission to hospital is needed.
- The focus at this stage should not be on diagnosis but rather a needs led assessment and determination of what service / services are best placed to meet the individuals needs.
- This should include an assessment of social needs

Planning

- The following are standard care planning areas for people with DD regardless of where in the system they are
- Accommodation and housing needs need to be taken into account
- Full physical health care planning to include physical health screen and checks and linking with primary care to determine the level of physical health care interventions
- The planning of community support for the client . Frequency of visits, intensity of the visits and mobility issues.
- Planning around how financial needs are going to be met
- Meeting the safeguarding needs of any children that may be in the household
- Coordination of community detox, rehab and recovery plan

Review

- 3 monthly multi agency meetings as a minimum requirement but more frequent if required

Discharge

- Discharge planning should include all agencies
- Discharge should be jointly managed
- Relapse prevention plans

Benefits So Far

- Joint assessments at first appointment. DD Nurse available on Recovery Hub assessment days.
- Joint assessments arranged through RW within five days.
- Joint home visits when RW has concerns about SU mental health.
- Early intervention - DD Nurse and GPs agreed rapid prescribing of anti depressant and low dose anti psychotic prescriptions. Changes of medication when adverse side affects identified.

Benefits

- Facilitation of hospital admission, professional care planning meetings and Care Coordination.
- Clear understanding of process within community teams
- Improving relationship with MH in patient teams and processes developed for joint planning at discharge

Issues To Consider

- DD Nurse funding not confirmed beyond end of March 2014, if lost how can we sustain benefits?
- Improvements from Recovery Hub to AMH services. How do we see improvements in opposite direction and engage AMH Patients with Recovery Hub?
- Can we replicate the peer led Recovery Broker model in mental health/DD settings?
- What is your agency's response to dual diagnosis, are there opportunities to promote recovery in your own settings, if so how?