SESLHD PROCEDURE COVER SHEET

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SUMMARY	This document aims to provide a pathway for collaborative care planning and provision of care for consumers/clients with moderate to severe mental health and alcohol and other drug conditions.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Collaborative care planning for consumers/clients experiencing both mental health and alcohol and other drug use conditions

SESLHDPR/752

1. POLICY STATEMENT

This procedure supports the provision of high quality evidence based care for consumers/clients experiencing moderate to severe[1] comorbid mental health (MH) and alcohol and other drug (AOD) conditions. Staff who work with consumers/clients with MH and AOD conditions should have a high level of confidence in assessment, engaging consumers/clients into care, and working collaboratively with other specialist teams to ensure provision of evidence based treatments for both MH and AOD conditions.

2. BACKGROUND

Many consumers/clients have significant co-occurring conditions in addition to the main presentation that is the focus of the specialist service they are engaged with. The 2022 Australian Bureau of Statistics National Study of Mental Health and Wellbeing found that in 2020-2021, approximately one in five (21%) Australian adults (18% of men and 25% of women) had a substance use, anxiety or mood disorder in the past year. Approximately 21% of people with MH conditions had two or more classes of MH diagnosis. In people seeking treatment for their MH condition the rates of co-occurring substance use disorder are likely to be higher than in general population surveys.

The Guidelines on the Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (Third Edition) provide guiding principles for the provision of integrated care, rather than sequential or stepped care approaches for the management of co-occurring MH and AOD conditions. They also highlight that neither condition is primary or takes priority over the other. Both conditions must be addressed equally.

Clinicians are skilled in assessing signs and symptoms of conditions within their specialty, identifying situations of high risk and the presence of co-occurring conditions. Treatment plans and pathways often include referral to specialist services, but collaboration with those services may not occur at the point of assessment or in ongoing treatment planning. Consumers/clients with more severe conditions may experience poorer outcomes from episodes of illness due to the interaction of multiple conditions. Rates of relapse, the risk of critical incidents, and repeated presentations to acute services, may be increased by the failure to ensure treatment for multiple conditions is implemented during an episode of care.

Consumers/clients with co-occurring severe MH and AOD conditions may have difficulties in accessing separate services, highlighting the need for services to collaborate effectively at the point of initial consumer/client contact. High rates of cognitive impairment[2,3,4] in this consumer/client population can make negotiating separate services more difficult. Additionally, consumers/clients report a traumatising and unhelpful process of having to repeat their story to different services.

[1] NSW Health NSW Clinical Guidelines For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (see 5.1 Level of Care Quadrant p17)

3. PRINCIPLES OF COLLABORATIVE CARE

MH and Drug and Alcohol (D&A) clinical staff are responsible for implementing this procedure based on established principles of care, including delivering care in a person-centred, respectful way, and involving the consumer/client in developing their own care plan. Collaboration with carers and the consumer/client's social support system is an expected part of planning and delivering care.

MH and D&A staff will support a "no wrong door" principle in planning and delivering care for people with both MH and AOD conditions. A person with moderate to severe MH or AOD conditions presenting to one of the services can expect a structured care plan for both conditions to be developed with them, and that handover and engagement with other specialist services will be supported by the staff throughout an episode of care, up until transfer of care is completed. Care provided by D&A Services is guided by the NSW Health NSW Clinical Care Standards: Alcohol and Other Drug Treatment (May 2020).
MH and AOD staff will take active steps to communicate with each other using Identify, Situation, Background, Assessment and Recommendation (ISBAR) principles.

It is important to differentiate a service *providing information* about relevant local services, including D&A and MH services (e.g. by providing contact details), from *a referral for ongoing specialist care*, where the referring service needs to ensure that the receiving service has accepted the transfer of care, and ideally have begun to see the consumer/client before discharging the consumer/client from the referring service.

If the receiving service declines to accept the referral (e.g. the client/consumer's MH acuity is too high for the D&A service to be engaged at that time), the reason for the referral being declined should be clearly documented within the client/consumer's electronic medical record with an identifiable point for re-referral to the service noted.

Combined MH and AOD care will be delivered according to each practitioner's scope of practice, in a safe, effective and timely manner, adhering to principles of personal autonomy and least restrictive care.

Care will be delivered in a trauma-informed way, ensuring that consumers/clients are not re-traumatised through contact with services (e.g. awareness and education[2] with consumers/clients regarding the link between traumatic experiences and their MH and use of AOD / having to re-tell their story to multiple clinicians).

Utilising the patient electronic medical record (eMR) to clearly document all aspects of care from intake to transfer of care, will assist in providing coordinated, comprehensive care, while reducing the need for patients to re-tell their story.

[2] NSW Health Integrated Trauma-Informed Care Framework: *My story, my health, my future* (22 February 2023)

4. PROCEDURE

4.1 Intake and Assessment

Clinical staff will conduct a comprehensive triage and initial assessment. For MH staff this will be according to the MH outcomes and assessment tool (MHOAT) documentation modules in the eMR (including the MH Substance Use assessment form), and for D&A Services this will be a comprehensive assessment according to the NSW Clinical Care Standards for Alcohol and Other Drugs. Assessments should include screening questions about AOD and MH conditions and, if identified as a significant issue, clinicians will use appropriate tools to further assess and document the nature and extent of the conditions.

If at the point of admission it appears that a patient has a moderate to severe AOD condition, the MH clinician may use a more specific evidence based AOD assessment tool, known as the ATOP (Australian Treatment Outcomes Profile*)* . The clinician should discuss options with the consumer/client for further assessment and treatment of their AOD or MH conditions, and their willingness to be referred to other specialist services.

Following assessment, a comprehensive care plan should be developed with the consumer/client and their carer, if appropriate, that may lead to several outcomes. Outcomes may include; ongoing specialist care with the service they have been assessed by, either inpatient or community, transfer of care to primary care providers/other follow up services, or referral to other specialist services. It is important that the consumer/client and carer can contribute to the care plan, understand the plan, and be given opportunities to ask questions about the plan. The structured plan should be documented, as well as the consumers/clients consent to the plan. If the consumer/client makes it clear to the clinician that they do not wish to address their AOD or MH condition, this should be clearly documented, as well as any information provided at this point to the consumer/client and their carer about how to access services or supports for their identified condition. For less severe conditions, consumers/clients should be given information about support services, and online AOD/MH/comorbidity resources which the clinician can obtain from the SESLHD intranet (http://seslhdweb.seslhd.health.nsw.gov.au/DA-Resources.asp).

For moderate to severe conditions, clinicians may work within their own scope of practice, refer to the other specialist service, or discuss the consumer/client with the other specialist service to determine the appropriate action plan, in consultation with the consumer/client and carer, where indicated. For more acute presentations there may need to be a joint multidisciplinary team review following assessment of the consumer/client by the other specialist service. These will be arranged by the staff within the MH and D&A services involved in the care of the consumer/client, as soon as is practical following completion of the assessments.

In order to address issues with referral and assessment in a timely manner, local services should establish escalation processes and direct lines of communication between team

leaders so that questions and logistics about referral and assessment for comorbid treatment can be rapidly resolved. Non-urgent matters can be discussed at the local Drug & Alcohol and Mental Health Services (DAMHS) meeting for resolution.

Escalation for urgent MH related clinical advice should be through the Duty MH Consultant Psychiatrist, who can be contacted via the local hospital switchboard during and after business hours. For escalated urgent D&A clinical advice during business hours contact should initially be with the D&A CNC, via the local Hospital switchboard. **After hours,** the D&A Registrar on-call can be contacted via the switchboard 02 9382 7111 at Sydney/Sydney Eye Hospital.

Throughout the assessment and treatment process, Pharmacists play an important role in assisting clinicians and consumers/clients through; medication supply options, medication reconciliation, advising on drug interactions, and best possible medication history, in addition to the provision of other information and specialist advice.

4.2 Ongoing care planning and care review

For consumers/clients who are engaged in ongoing care, either as an inpatient or in community care, there are regular opportunities to review and refine the care plan developed with the consumer/client in a multidisciplinary team (MDT) setting. For consumers/clients admitted to inpatient facilities this takes place at least once a week in an MDT meeting. Clinicians from other specialist services involved in the assessment or ongoing care of the consumer/client should be invited to these meetings or case reviews as indicated. Where possible, the consumer/client should also attend the meeting. For consumers/clients treated in community settings, MDT meetings may be less frequent, but should still include clinicians from the other specialist service, to ensure collaborative care planning.

Clinical Care conferences to plan continuing care can be arranged on an ad hoc basis, in addition to the regular MDT reviews, for consumers/clients experiencing significant ongoing MH and AOD conditions. This form of care planning is particularly useful for consumers/clients with a long length of stay, recurring difficult to treat conditions, or other situations of clinical complexity. It is the responsibility of the consumer/client's primary clinician, or a nominee of the treating team for admitted consumers/clients (inpatients), to arrange and invite participants for clinical care conferences to consider ongoing care plans. Ideally the consumer/client and their carer should also be present for clinical care conferences, or the consumer/client may request that a Consumer/Peer Worker attends the care conference with them.

MH or D&A consultation and liaison services should be requested at other times, such as for consumers/clients admitted to MH Units with comorbid conditions, or consumers/clients admitted by D&A Services for withdrawal from alcohol or other drugs who also have MH conditions. These consultation requests should be made early in the hospital admission, and thereafter as indicated. It is desirable to invite further consultation prior to discharge if an initial consultation has been unsuccessful in developing a structured treatment plan with the

consumer/client. The aim is to provide as much opportunity as possible to address significant co-morbid conditions and ensure that consumers/clients are engaged in follow up care for both conditions prior to discharge.

Throughout the course of continuing care for a consumer/client experiencing both MH and AOD conditions, clinicians will communicate relevant clinical information about consumers/clients to the other specialist services (SESLHDBR/049 Mental Health Service (MHS) Communication of Clinical Information to NSW Health Drug and Alcohol (D&A) Services). It is also important to consider transitions of care, and risks associated with changes in care level, for consumers/clients experiencing MH and AOD conditions. For example, if a MH consumer/client receiving inpatient care will have an opportunity for un-escorted, or overnight leave, and has engaged with the D&A service during the admission, the MHS will invite the D&A service to contribute to the development of the care plan as a part of the consumer's MDT to manage identified risks during the period of leave.

4.3 Discharge and transfer of care

For consumers/clients experiencing both AOD and MH conditions who are approaching discharge, care is needed to ensure that structured treatment/care plans are in place, are understood by the consumer/client and carer, and are able to be implemented. This involves careful coordination and discussion between the MH Service and D&A services, particularly if ongoing follow up is planned by only one of the services.

In circumstances where there may be high risks of relapse into harmful substance use, or other highly changeable risks including self-harm, special care is needed before discharging a consumer/client from MH care. This may be more important in acute settings e.g. in MH Acute Care Team (ACT) follow up, where discharge should not occur until the ACT has taken steps to sight the consumer/client and confirm the discharge plan, or at least contact carers and other involved services before discharge, and a handover of care takes place.

Transfer of care should be planned, ensuring that the service taking on care, including primary care services, have accepted the referral and are ideally already engaged with the consumer/client. This should be clearly documented in the medical record for all service providers to have access to this information.

5. DOCUMENTATION

All clinical plans/care must be documented in the consumer/client's eMR, to ensure all services involved in the care of the consumer/client are aware of support already being provided.

6. AUDIT

D&A and MH teams will regularly audit inpatient and community/outpatient medical records to ensure this procedure is complied with.

7. REFERENCES

NSW Ministry of Health

- NSW Clinical Care Standards: Alcohol and Other Drug Treatment (May 2020)
- NSW Clinical Guidelines For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings
- Integrated Trauma-Informed Care Framework: My story, my health.my future (February 2023)

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- SESLHDBR/049 Mental Health Service (MHS) Communication of Clinical Information to NSW Health Drug and Alcohol (D&A) Services
- SESLHDBR/012 Community Mental Health Acute Care Teams - Key Practices
- SESLHDGL/074 Clinical Documentation in Mental Health

Other

- 2022 Australian Bureau of Statistics National Study of Mental Health and Wellbeing
- Marel C, Siedlecka E, Fisher A, Gournay K, Deady M, Baker A, Kay-Lambkin F, Teesson M, Baillie A, Mills KL (2023) Guidelines on the Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (Third Edition) Australian Government Department of Health and Aged Care, The University of Sydney Matilda Centre
- [2] Katherine Y. Ko , Nicole Ridley, Shayden D. Bryce, Kelly Allott, Angela Smith and Jody Kamminga, Screening tools for cognitive impairment in adults with substance use disorders; A systematic Review. Journal of International Neuropsychological Society (2021), 1-24.
- [3] Gooden JR, Cox CA, Petersen V, Curtis A, Manning V, Lubman DI. Characterisation of presentations to a community-based specialist addiction neuropsychology service: Cognitive profiles, diagnoses and comorbidities. Drug Alcohol Review 2020.
- [4] Manning, V., Gooden, J. R., Cox, C., Petersen, V., Whelan, D., & Mroz, K. (2021). Managing Cognitive Impairment In AOD Treatment: Practice Guidelines for Healthcare Professionals. Richmond, Victoria: Turning Point.

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
February 2023	DRAFT	Dr Nicholas Babidge and Dr Sandra Sunjic. Consultation between both D&A and the MHS. Draft endorsed for listing on Draft for Comment by Executive Sponsor.

March 2023	0.1	Feedback from Draft for Comment period incorporated. Returned to authors for review.
April 2023	0.2	Feedback endorsed by authors and incorporated into document. Endorsed by both the MHS and the D&A for progression to Executive Sponsor.
May 2023	1	Approved at SESLHD Clinical and Quality Council meeting.