The SUMH Resource Pack

Working with people with coexisting Substance Use & Mental Health (SUMH) issues

A good practice guide for practitioners

TURNING POINT
inspired by possibility

Contents

Foreword

The challenges facing people with coexisting substance misuse and mental health issues in accessing treatment and support are not new. In 2004, Turning Point and Rethink published a Dual Diagnosis Toolkit. Over 15 years on, the risk of people falling between the gaps between services is even worse than it was then. A decade of austerity has hit the sector hard and drug and alcohol treatment and mental health services are more stretched than ever. The transfer of public health functions to local government has resulted in an accountability gap across substance misuse and mental health services. Despite changing attitudes among the public towards mental health and government commitments to increased investment, mental health services continue to struggle to meet demand. COVID-19 has brought with it a whole new set of challenges.

Alongside all these challenges, practitioners continue to work tirelessly to support people with the most complex needs. This Substance Use Mental Health (SUMH) Resource Pack aims to pull together information and resources and a set of operating principles which frontline staff, managers and commissioners working in community drug and alcohol and mental health services can use to guide practice in a fragmented, complex environment. We draw on some of the learning Turning Point has gained from delivering substance misuse and mental health services across the country, sharing good practice examples from our own internal guidance on developing strong inter agency working with people with substance use and mental health issues. We hope you find it useful.

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Executive Summary

Coexisting substance use and mental health issues are common. 70% of people in drug services and 86% of alcohol service users experience mental health problems[1]. **And yet it is not uncommon for mental health services to exclude people because of substance use and people with serious mental illness may be excluded from alcohol and drug services due to the severity of their mental illness**. Coexisting substance use and mental health issues are particularly common among people with the most severe and multiple disadvantage which means people with the most complex needs are the most likely to be excluded. This group experience significantly poorer outcomes than people who have either severe mental illness or substance misuse alone.

The guidance is very clear that providers in alcohol and drug, mental health and other services should have an open-door policy for individuals with co-occurring conditions and ensure that every contact counts. No one should be excluded from IAPT services because they are being prescribed substitute medication and community drug and alcohol services should deliver psycho-social interventions experiencing common mental health problems such as anxiety or depression, where they are not able to access IAPT services.

Early and shared assessment is vital to engage individuals in treatment and reduce the risk of poor outcomes. If someone accessing secondary mental health services has a severe mental disorder and they are using substances they should get a dedicated care coordinator and a holistic care plan including a crisis plan in place. Advocates from all organisations should be included in the care planning / care programming process with clear roles and accountabilities, information sharing agreements and a named person who can coordinate care packages. **Assessment may need to be conducted over several meetings with the individual and early identification of initial goals that reflect the individual's short and long-term aspirations will enable a more motivational approach and help enable the individual to define their own recovery journey**. Joint assessment which takes into account the complex and individual relationships between substance misuse, cognitive and emotional symptoms, behaviour and the person's social context is important because people with coexisting severe mental illness and substance misuse often face a number of barriers when accessing wider support services.

Considering the prevalence of coexisting mental health and substance use it is really important that practitioners across mental health and drug and alcohol services have a knowledge base that spans both areas. **Practitioners must have the resilience and tolerance to help people with coexisting severe mental illness and substance misuse through a relapse or crisis, so they are not discharged before they are fully equipped to cope or excluded from services**. There should be opportunities for advice, consultation and/or training from specialists, shadowing, observing and participating in client case discussions or regular clinical supervision from appropriately qualified professionals if necessary.

Individuals (and their family or carers if the person wants them involved) should be fully involved in the development of their plans

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1 Weaver, T., Madden, P., Charles, V., et al (2003a) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. British Journal of Psychiatry, 183, 304–313

for treatment, care and recovery, in setting appropriate goals and reviewing progress. Families play an important role in ensuring that appointments are not missed and also in ensuring follow up to avoid future non-attendance. Practitioners should also identify carers and family members who may have unmet needs, making appropriate referrals for carers assessments and/or to family support services.

Peer mentors are a good example of how people with lived experience can play an important role in service delivery and people with lived experience of coexisting substance use and mental health issues have a valuable contribution to make. Peer mentors act as role models, demonstrating that recovery is possible as well as helping deliver interventions e.g. co-facilitating structured groups and running mutual aid groups.

There is a growing body of research which describes the use of substances by women to cope with the psychological and physical harm resulting from their experiences of violence. For this reason it is integral that a 'trauma informed' approach is embedded within service provision. Staff employed in drug and alcohol treatment services should be aware of protocols for identifying, assessing and working with domestic abuse and with survivors and perpetrators of intimate partner violence (IPV), and of local care pathways for domestic abuse survivors, including IPV survivors and perpetrators. Women with coexisting mental health and substance use who are pregnant or have recently given birth are particularly vulnerable to difficulties in accessing care and require services to be coordinated.

Where there are known drug use issues in specific communities, providers should establish a culturally relevant service offer. Providers should work with local faith, cultural and community organisations and groups to help support and engage people with mental health problems and coexisting substance use. For too many people, particularly black men, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. Substance use is often a factor. Multiple points of entry into specialist mental health assessment/care are needed. This requires better direct access through non-clinical routes such as community agencies, places of worship, the education and social welfare system, housing providers, criminal justice and the voluntary sector.

Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions. The lack of join-up between funding and performance management of mental health services, which are commissioned by the NHS, and substance misuse services, commissioned by local authority public health teams is at the root of much parallel decision making and silo-working. Resource constraints dictate that commissioners should focus on improving existing services using the expertise that is available instead of creating a stand-alone 'dual diagnosis' services. Integrated care need not be delivered in the same location, or by the same person – although people with co-occurring conditions report positively on their experiences of co-located services. Changes required might include widening the range of ways people can engage with the service e.g. opening during evenings, offering a drop-in, co-locating with other services, and upping the volume of contacts with clients. Much of the guidance calls for more co-production with clinicians and experts-by-experience within the commissioning and service design process, including partnerships with voluntary and community sector organisations. Commissioners have a responsibility to drive effective multi-agency working in the face of structural fragmentation, which requires services to develop a shared vision, joint ownership of the issue and regular communication between partners.

Introduction

This resource pack has been written to support the development of services for people with coexisting mental health and substance use problems. At the heart of the resource pack is a series of case studies showing how particular services have implemented good practice.

The key aims of the resource pack are to:

- Build on current guidance and demonstrate its application in a range of settings and services
- Promote dialogue between practitioners so that experiences, knowledge, skills and resources are shared
- Provide case studies, demonstrating how good practice can be replicated elsewhere
- Share learning to enable services to improve care pathways and provide quality support

Who is this resource pack for?

The SUMH Resource Pack is a practical guide primarily for staff involved in the development and delivery of services which work with people who have coexisting mental health and substance use problems.

It will be useful for those working in specialist substance misuse or mental health services and other community based services. There are also some key messages for commissioners and those in other strategic roles.

What the resource pack offers

The resource pack contains practical information designed to help you to learn from, and apply, good practice in your services. It is divided into three sections:

1. Prevalence and impact
2. Good practice – focussing on engagement, behaviour change, diversity and inclusion and planning and commissioning - including case studies
3. Key guidance and policy documents

After this introduction, there is a section outlining the research evidence about the prevalence and impact of coexisting mental health problems and substance use.

We then include a discussion of good practice. This focuses on engagement, behaviour change, diversity and inclusion, planning and commissioning. Questions for self-reflection are included throughout, along with case studies from services working with people with coexisting mental health and substance misuse issues in a range of settings.

The final part of the resource pack contains an overview of key guidance and policy documents including links to the source material.

Prevalence and Impact

Public Health England - *Better care for people with co-occurring mental health and alcohol/drug use conditions*[2] outlines a range of research on the prevalence of coexisting substance use and mental health issues:

"Alcohol and drug dependence are common among people with mental health problems and the relationship between them is complex. Research done by Weaver et al (2003) indicated that up to 70% of people in drug services and 86% of alcohol service users experienced mental health problems. More recently, Delgadillo et al found 70% of a sample from community substance use treatment also met criteria for common mental health problems."

Key issues:

- Of mental health crisis related admissions to acute hospital via A&E in 2012/13, 20% were due to alcohol use
- Cannabis use has emerged as issue amongst young people, being used by 18.7% of 16- to 24-year-olds and increasing risks of later developing psychotic illness, including schizophrenia[3]
- Similarly there are many psychological symptoms to be associated with NPS use including aggression, anger, paranoia, anxiety, and hallucinations
- Death by suicide is also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people with mental illness[4]
- Of the 58,000 people nationally experiencing the most severe and multiple disadvantage (substance use, homelessness, and criminal justice involvement), over half (55%) had a diagnosed mental health condition and nearly all (92%) had a self-reported mental health problem[5]

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2 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

3 Cannabis use and the risk of developing a psychotic disorder (nih.gov)

4 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2017

5 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

The Public Health England report also tells us that:

"People with co-occurring conditions are often unable to access the care they need. It is not uncommon for mental health services to exclude people because of co-occurring alcohol/drug use, a particular problem for those diagnosed with serious mental illness, who may also be excluded from alcohol and drug services due to the severity of their mental illness.

Accessing help may also be difficult for those who do not meet the criteria for specialist/ secondary mental health care, but whose symptoms are considered outside the scope of services aimed at managing common mental health problems.

Primary care, where the majority of people with common mental health conditions are treated, often has no capacity to support those who present with co-occurring conditions."

Key impacts

- Making Every Adult Matter (MEAM) have noted failures of services to work collaboratively to support people with multiple and complex needs, and the inadequacy of a support system which "treats people based on what it considers to be their primary need, be that mental ill-health, dependence on drugs and alcohol, homelessness or offending"[6]
- Delayed diagnosis is common. This can lead to conditions worsening because of an interaction between the misused drugs and the medications they may be receiving for a mental or physical illness[7]
- The Recovery Partnership's 'State of the Sector' report for 2015/2016 found that 20% of respondents stated that access to mental health services had worsened in the previous 12 months[8]
- People who use alcohol and/or drugs often find themselves excluded from improving access to psychological therapies (IAPT) services[9]

6 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

7 NICE Guideline scope - Severe mental illness and substance misuse (dual diagnosis): community health and social care services (2016)

8 The Recovery Partnership - State of the Sector (2016)

9 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

Good Practice

This section highlights good practice in working with people co-occurring substance muse and mental health problems drawing on national guidance and local practice examples. There are 4 sections focussing on: engagement; behaviour change; working with diversity and inclusion; and planning and commissioning of services.

Engagement

This section looks at the ingredients for ensuring effective engagement of people with co-occurring substance use and mental health problems including:

- Effective referral process
- Early and shared assessment
- High quality assessment

Effective referral processes

A key principle set out by Public Health England for services working with people co-occurring substance use and mental health problems is No wrong door. Providers in alcohol and drug, mental health and other services should have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point. [10] This principle has been reiterated by subsequent NICE guidance[11] which stresses the importance of policies and training for staff which ensures people are not excluded because of severe mental illness or substance use.

IAPT Positive Practice Guide for Working with People who use Drugs and Alcohol says that IAPT should be considered suitable if the client is able to attend sessions, has motivation to limit their drug or alcohol use and the client is stable. No one should be excluded from IAPT services because they are being prescribed substitute medication.[12]

In order to ensure access for all who need it, specialist mental health and substance misuse services should be very clear about the inclusion and exclusion criteria for accepting referrals, for example:

- Age of client
- Type of substance used
- Severity/complexity of mental health problem
- Whether referral is dependent on formal diagnosis
- Use of screening tools – for example GAD-7, PHQ-9
- Mode of referral – professional, self
- Type of contact offered – emergency, routine, timescales given from contact to assessment

[10] Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

[11] NICE – Quality standard – Coexisting severe mental illness and substance misuse (2019)

[12] IAPT positive practice guide for working with people who use drugs and alcohol (2012)

Reflecting on your own practice: Referrals

- How are needs for referral identified and with whom?
- Where is need for referral discussed and with whom? Does referral need to be 'signed off' by a senior, manager or clinician?
- How is client consent for referral sought and what information is to be shared?
- Who makes the referral and how is it made? (phone, online) What is recorded and where?
- Is there a Single Point of Contact for referrals at each service and opportunities for informal conversation about appropriateness of referral without sharing client information?
- Use of screening tools in SM for referral to MH services? (e.g. GAD-7, PHQ-9)
- Use of screening tools in MH for referral to SM services? (e.g. AUDIT-C, AUDIT, SADQ)
- What documentation is shared at point of referral and how is this stored? (client goals, recovery plan, risk assessment, type of support needed)
- Does the client have any support from a family member/friend and do they consent to their presence at the assessment?
- Can time scales be agreed between referral and assessment? Are there criteria for prioritisation of assessment and different time scales for routine or high priority?

Early and shared assessment

NICE Guideline CG120 recommends that advocates from all organisations are included in the care planning and care programming process wherever this is possible and agreed by the person with psychosis and coexisting substance misuse. [13] By doing this, practitioners are able to account for complex and individual relationships between substance misuse, psychotic symptoms, emotional state, behaviour and the person's social context.

Public Health England's 2017 review[14] outlines how care may be provided by the same person or, by relevant practitioners/services working in close collaboration. This requires accountability and clarity of role, information sharing agreements, and shared care planning with the individual at the centre of the process. There should be a named person who can coordinate care packages and act as a central point of contact for the person and their carers (including young carers) and the other service providers. For people with severe mental illness this would be led by and managed within the care programme approach (now superseded by the **Community Mental Health Framework**) by a mental health team.

NICE Quality statement 1: Initial identification of coexisting substance misuse[15] outlines the importance of early and shared assessment:

"People who have severe mental illness and substance misuse have significantly poorer outcomes than people who have either severe mental illness or substance misuse alone. Identifying substance misuse as soon as possible, by asking people about it when they attend services, such as child and adolescent mental health services (CAMHS), mental health services, emergency departments, general practice and services within the criminal justice system, gives a better chance of tailored care and treatment plans being effective. Initial identification and subsequent comprehensive assessment also help to reduce the risk of worsening psychiatric symptoms and homelessness, to reduce contact with the criminal justice system and to improve physical health."

The importance of early assessment is also laid out in the NICE guideline CG120 which recommends that all NHS-funded services should be competent to identify harmful drinking. Routine assessment of current use of drugs and alcohol is therefore recommended for all IAPT clients.[16]

High quality assessment

The 2017 update of the Orange Book sets out the latest evidence on the most effective ways to engage people with coexisting substance misuse and mental health issues. Assessment for psychosocial interventions may need to be conducted over several meetings with the service user. The assessor should balance obtaining comprehensive information with engaging the individual. One way of achieving this is to quickly identify treatment goals that reflect the individual's short and long-term aspirations. It says that clinicians should work collaboratively with patients to identify preferred options from a positive and flexible menu, with opportunities to review decisions as part of the ongoing process. This can help the patient define their own recovery journey carefully in an informed way.[17]

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13 NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

14 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

15 NICE – Quality standard – Coexisting severe mental illness and substance misuse (2019)

16 NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

17 Drug misuse and dependence UK guidelines on clinical management (2017)

NICE Guidance CG120 recommends a care plan for an adult or young person with psychosis and coexisting substance use, take account of the complex and individual relationships between substance misuse, psychotic symptoms, emotional state, behaviour and the person's social context. Assessment should take into account:[18]

- Personal history
- Physical health
- Sexual health
- Social, family and economic situation
- Accommodation, including history of homelessness and stability of current living arrangements
- Current and past substance use and its impact, and response to treatment
- Criminal justice history and current status
- Personal strengths and weaknesses and readiness to change

The importance of wider factors during assessment is especially important given that people with coexisting severe mental illness and substance misuse face a number of barriers when accessing social care services. For example for many housing agencies and supported housing trusts will not accept drug users and this can exacerbate substance use and mental health issues.

There are a variety of different tools available to assess substance use (e.g. AUDIT) and mental health (e.g. GAD-7). A review of SUFARI – an integrated tool to assess substance use in mental health service users illustrated some important learning on what to consider when using any tool:[19]

- The screening of alcohol and drugs use can be facilitated by standard forms and is easily collected when incorporated in electronic systems
- Tools should be flexible to update as trends for new substances arise and should include service user and staff input, where possible
- The way in which information is structured should enhance the knowledge and understanding of staff who are not specialists in substance use
- Where possible, these forms and risk assessment forms should have linked fields to avoid repetition or inconsistency and to ensure that any risks highlighted form part of a clear care plan
- The current physical health risk CQUIN requires screening for alcohol use and tobacco use, plus delivery of brief interventions and/or onward referral. Any forms used should allow recording of risk as perceived by mental health workers and service users. Ideally any interventions or referral should be recorded on the same form

NICE suggest that assessment should take a flexible and motivational approach, and consider that:[20]

- Stigma and discrimination are associated with both psychosis and substance misuse
- Some people will try to conceal either one or both of their conditions
- Many people with psychosis and coexisting substance misuse fear being detained or imprisoned, being given psychiatric medication forcibly or having their children taken into care, and some fear that they may be 'mad'

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18 NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

19 NICE Shared Learning - SUFARI – a substance use tool for mental health services (2018)

20 NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

Reflecting on your own practice: Joint assessment

- Is joint assessment between services necessary or helpful? How is it decided whether clients are invited to an assessment by a single service or with practitioners from both services at the same time? (for example, CMHT and SM practitioner)
- Where and how often can these joint assessments take place? How are they arranged?
- Can there be any flexibility in time of day/location/mode of assessment to increase engagement? (for example, online assessment if that will help engagement)
- Is there a possibility of support from family or a peer mentor during assessment?
- Can client be prepared for the purpose and outline of what will be asked at assessment? (e.g. sharing of assessment templates between services so that client is informed about what will be asked)
- How much information is shared after assessment with client/GP/other agencies?
- Is process for risk assessment and management clearly outlined?
- How are treatment plans shared with the client?
- Identification for support needs of family members affected and signposting for support?
- Escalation process if a client is assessed and found not to be appropriate?

Good Practice Examples

Turning Point - Slough Treatment, Advice & Recovery Team (START)

A Community Mental Health Team assessor attends the substance misuse service twice a week to complete assessments with all clients identified as needing mental health support (continuing by phone during Covid). A copy of the assessment is then shared with Turning Point for client notes. The assessor also refers clients with substance misuse issues into the service when assessed externally in mental health services. If not offered support through the Community Mental Health Team, the assessor signposts to appropriate local services. The substance misuse manager is discussing with commissioners and senior mental health staff the need to include onward referrals for clients who may not yet be abstinent.

Turning Point - Leicester, Leicestershire & Rutland

There is currently a strong established link with the local crisis house and the inpatient unit. The Turning Point Clinical Lead and Dual Diagnosis/Adult Safeguarding Lead attend the ward weekly and review inpatient and outpatient clients and also undertake joint assessments. Services share information via information sharing agreements and safeguarding. Having designated employed link workers within in-patient settings has also significantly improved liaison between substance misuse and mental health services.

North Staffordshire Combined Healthcare Early Intervention Team

North Staffordshire Combined Healthcare's Early Intervention team with the Consultant Nurse for Co-occurring need undertook a project with the support of the Foundation of Nursing studies and the Burdett Trust, to develop the response to substance use in those with first episode of psychosis. Through engagement with those using the service, carers, and colleagues, the team started to map out interventions that were found to be both useful and engaging for those with both mental health and substance misuse needs. However it became quickly apparent that the timing of interventions was a critical factor, not only in the success of the intervention but also the acceptance of that intervention to the person in need of support.

A revisit of change theory and literature, led to the selection of Prochaska and Diclemente's change model in order to help structure and present the interventions in a structured meaningful way and in a manner that matched the need to understand the issues of timing.

The team and those using the service, then started to map out the interventions against the model's change phases: Pre-Contemplation; Contemplation; Action and Maintenance. With one of the service user's design and print knowledge, the lists were then further developed into a set of pocket change cards. The 'Change Cards' have been utilised to aid reflection, guide intervention, develop a pathway and to maintain a therapeutic optimism. The aim of the cards is to provide a focus for a collaborative partnership that prompts phase specific interventions that reflect a person's position in the cycle of change.

Turning Point - Wakefield Inspiring Recovery

This service has a Dual Diagnosis Nurse Consultant (DDNC) role in partnership between the Turning Point substance misuse service and the local NHS Trust. This has led to a model of either 'stepping up' mental health interventions into specialist settings or 'stepping down' into community settings following assessment.

Figure A – Visual representation of Dual Diagnosis pyramid of need

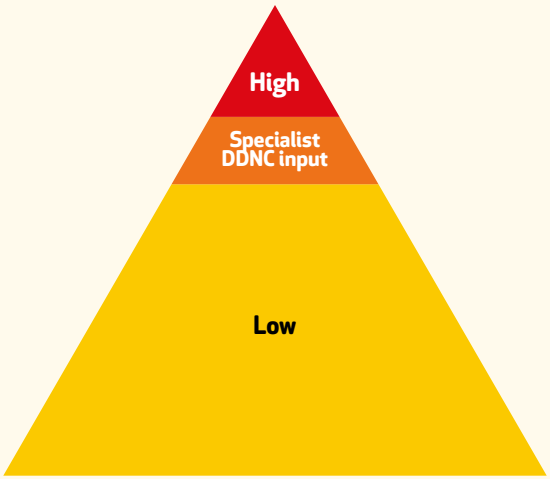

Figure B – Visual representation of High and Low stepped care interventions

Low level mental health needs	**High** level mental health needsAaavd
Interventions agreed may include: ● Key worker led brief interventions ● Self help guides ● Referal to Talking Therapies ● Recovery College ● Creative Minds ● Richmond Fellowship @ Socialcious ● Andy's Man Club ● Other specialist provision	Those identified with a high level of Mental Health needs by the DDNC will be then supported with distinct referral pathways from the DDNC into: ● SPA ● CMHT ● Fieldhead or other specialist provison as required

Ongoing overview of all **high** level need cases to be maintained by the DDNC

Turning Point - Oxfordshire Roads to Recovery

This service has monthly joint assessment clinics at the Turning Point hub with the Turning Point Clinical Psychologist and the NHS Trust Consultant Psychiatrist. The substance misuse services have developed a form to record consent for share information with mental health services.

Information Sharing and Consent Form for Communication with Mental Health Services

(To be completed for clients being referred to or who are or have been under the care of Mental Health Services.)

Turning Point believes that good communication of relevant clinical information between all the services involved in your care is vitally important, in order to provide you with the best possible care. We therefore ask for your permission to communicate with the services involved in your care – if you are happy for us to do so.

I .....(first and last name)

of .....(home address)

give my consent for:

a) Turning Point to communicate with all Mental Health Services who are or have been involved in my care – unless I have specifically excluded them below.

This could include but is not limited to all mental health teams, the liaison service, counsellors, psychology services, primary care psychology services (IAPT), and prison health services

I do not wish for Turning Point to communicate with the following Mental Health Services:

.....

(If left blank, I am giving permission for Turning Point to communicate with all relevant Mental Health Services)

b) All Mental Health Services who are or have been involved in my care to communicate with Turning Point – unless I have specifically excluded them below.

The Mental Health Services can include all the types of services listed above.

I do not wish for the following Mental Health Services to communicate with Turning Point:

.....

(If left blank, I am giving permission for all relevant Mental Health Services to communicate with Turning Point).

c) Exchange of suitably encrypted electronic e-mails about my clinical care between Mental Health Services and Turning Point

I do not wish for the Mental Health Services and Turning Point to communicate by e-mail:

.....

(If left blank, I am giving permission communication between Mental Health Services and Turning Point via e-mail).

I understand that I may withdraw my consent at any time, without needing to give a reason, simply by informing my keyworker or the service.

Signature of client: ..... Date: .....

Signature of witness: ..... Date: . . ..

Witness confirms that the client has capacity to make this decision (tick):

Yes ☐ No ☐

(is able to understand, retain, use or weigh the information and communicate their decision.)

Print name and job title of witness: .....

This consent form is to be sent to the relevant Mental Health Services by post or fax, and also scanned and uploaded to the consents section of the electronic patient record.

Behaviour Change

This section looks at the ingredients for successfully supporting behaviour change with people with co-occurring substance use and mental health problems including:

- Supervision, training and expert advice
- Care co-ordination
- Delivering psycho-social interventions within drug and alcohol treatment services
- Continuity of care
- Safeguarding

Supervision, training and expert advice

Different attitudes towards, or knowledge of, mental health and drug or alcohol-related problems may exist between agencies and may present a barrier to delivering services. In order to manage these challenges it's important to tackle negative attitudes or preconceptions about working with people with coexisting severe mental illness and substance misuse and develop leadership skills so staff can challenge attitudes and preconceptions. Practitioners must have the resilience and tolerance to help people with coexisting severe mental illness and substance misuse through a relapse or crisis, so they are not discharged before they are fully equipped to cope or excluded from services. The Leeds Capability Framework[21] is a useful resource which describes the organisational and individual capabilities for working with combined mental health and substance use problems and defines the roles and responsibilities of the various agencies in providing care for people with coexisting substance use and mental health needs; training and service developments required to implement this in practice.

Drugscope's *Positive Practice Guide for Working with People who use Drugs and Alcohol* suggests the IAPT workforce would benefit from basic drug and alcohol awareness training to enable them to understand the effects of substances and related health issues including impact on mental health and psychological well-being. Many of the cognitive and behavioural techniques used by IAPT therapists are transferable to working with people with drug or alcohol issues. Similarly, training and supervised practice in the assessment of drug and alcohol use and use of brief interventions are useful for people who are unfamiliar with or lack confidence in this area. The Drugscope guide advocate that IAPT practitioners should familiarise themselves with the local specialist addictions treatment services as well as local mutual aid groups (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, DDA).[22]

There remains no standardised treatment for coexisting substance misuse and mental health issues. Studies of therapist's attitudes or beliefs suggest more flexible orientations and ability to draw on different approaches contributes to better outcomes. The most effective way for services to assure the building of such positive therapeutic relationships is through provision of regular clinical supervision from appropriately qualified professionals.[23] NICE Guidelines CG120 suggests that healthcare professionals working within secondary care mental health services with adults and young people with psychosis and coexisting substance misuse should consider having supervision, advice, consultation and/or training from specialists in substance misuse services.[24]

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21 http://www.revolving-doors.org.uk/file/2384/download?token=irhf7kp6

22 Drugscope - IAPT positive practice guide for working with people who use drugs and alcohol (2012)

23 Drug misuse and dependence UK guidelines on clinical management (2017)

24 NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

Reflecting on your own practice: Training

- Are there arrangements for training opportunities between mental health and substance misuse services?
- Can opportunities be offered for new staff from each service to shadow staff in the other service?
- Can substance misuse staff be invited to observe and participate in client case discussions at mental health services and vice versa?
- How can outreach opportunities be maximised in terms of training and liaising with staff in non-health settings such as universities and veteran support services?

Care coordination

The Orange Book advocates a more explicit focus on individually defined recovery journeys with an enhanced focus on key working and care planning that integrates pharmacological and psychosocial interventions, peer engagement and mutual aid with management of long term conditions in mainstream healthcare services and wider support services.

"Implementing the treatment process within such a framework involves comprehensive assessment, active engagement, collaborative teamwork across local health, social care, family services, education and employment services, utilisation of the broad range of evidence-based interventions for substance use/misuse and for comorbid conditions, and active follow up. Coordinated, well-led interventions should mobilise resources of local communities, including safeguarding, education, training, mental health and resilience building".[25]

The Care Programme Approach (now superseded by the **Community Mental Health Framework** the aim of which is to apply the principles of CPA to a wider group of mental health patients) should be used for anyone diagnosed with a serious mental illness and co-occurring substance use. Public Health England's 2017 report outlines the benefits of CPA:[26]

"CPA is an approach to co-ordinating the care of people who have been diagnosed with a serious mental illness. Its aim is to ensure that people with serious mental illness have a full assessment of need and a named care coordinator to ensure that needs are being met via the delivery of appropriate, regularly reviewed care based on collaboration between hospital and community based mental health services. For people to be eligible for the CPA, they must have a 'severe mental disorder (including personality disorder) with a high degree of clinical complexity', other non-physical co-morbidities including substance use, and/or a range of other complexities."

[25] Drug misuse and dependence UK guidelines on clinical management (2017)

[26] Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

Reflecting on your own practice: Care coordination

- Is there a process for agreeing which service has care coordination responsibilities according to client need and complexity?
- How are Recovery Workers invited to Care Programme Approach meetings?
- What is the process for Recovery Workers being invited to in-patient key work sessions prior to client discharge?
- How can Recovery Workers request a Care Programme Approach meeting for clients in Mental Health Services? Should this be discussed at team meetings or Complex Case Reviews?
- Are there regular SUMH link worker meetings to discuss joint working at a client level?
- Is there a process for Recovery Workers presenting clients at these meetings or link workers presenting clients with specific questions about the way forward?
- How are decisions at these link worker meetings recorded?
- What is the process for checking that actions agreed at link worker meetings have taken place?

Delivering psycho-social intervention within drug and alcohol treatment services

There is a consistent cohort of service users that do not have a severe and enduring mental health problems who use substances who find their mental health difficulties too severe to be addressed in primary care mental health services and not severe enough to access secondary mental health services.

The Orange Book describes how more highly structured interventions should be provided by those with specialist training, using approved manuals and techniques. However, even if a fully manualised, structured psychosocial intervention cannot be delivered, such interventions have important elements that services can consider integrating into standard care. However, many substance misuse treatment providers do not have these skills within their organisation.[27]

They do though mention that progress in meeting this need may be addressed by a lower-intensity psychosocial intervention using relevant techniques. Adapting such evidence-based interventions to the platform of key working requires suitable clinical leadership and a robust clinical supervision structure.

[27] Drug misuse and dependence UK guidelines on clinical management (2017)

Continuity of care

NICE Guidelines NG58 emphasises the importance of continuity of care at the point of transition between services and at key points in a person's life.

This work should involve practitioners from adult or child and adolescent mental health teams and substance misuse services as well as from other health and social care disciplines such as medicine, nursing, social work, occupational therapy, housing and pharmacy. This is especially important as people go from childhood to adulthood and there is a need to ensure they receive the care they require.

NICE found that often pathways were not properly planned and supported and that movement across a care pathway was often restricted because none of the specialist services took responsibility for this group. They also noted that continuity of care can be interrupted because of changes of provider at which point new care pathways should be developed.

Safeguarding

NICE Guidelines CG120 outlines the main recommendations in ensuring that safeguarding is a top priority:[28]

- If people with psychosis and coexisting substance misuse are parents or carers of children or young people, ensure that the child's or young person's needs are assessed according to local safeguarding procedures
- Where appropriate, children or young people cared for by people with psychosis and coexisting substance use should be referred to CAMHS under local safeguarding procedures:
  - Use a multi-agency approach, including social care and education, to ensure that various perspectives on the child's life are considered
  - Consider using the Common Assessment Framework[29]
- When working with people with psychosis and coexisting substance misuse who are responsible for vulnerable adults, ensure that the home situation is risk assessed. Advice on safeguarding vulnerable adults can be sought from the local authority named lead for safeguarding
- Consider adults with psychosis and coexisting substance misuse for assessment according to local safeguarding procedures for vulnerable adults if there are concerns regarding exploitation or self-care, or if they have been in contact with the criminal justice system

[28] NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

[29] The Common Assessment Framework for children and young people

Good Practice Examples

Leicestershire Partnership NHS Trust

The Leicestershire Partnership NHS Trust has a dedicated team to support people with coexisting mental health and substance misuse issues comprising: 1 Nurse Consultant – Dual Diagnosis, 1 Senior Recovery Worker – 1 day a week, a substance misuse worker for inpatient mental health services, 1 Peer Mentor and Link workers in all areas. The service offers assessment and treatment for co-occurring mental health and substance misuse in conjunction with the local substance misuse service provider Turning Point. The joint working protocol includes:

- Access to emergency detox as part of mental health admissions
- A weekly clinic for dual diagnosis jointly run with a NHS nurse consultant and a senior recovery worker from Turning Point
- Training provided to all mental health staff on substance misuse

The service has improved access to substance misuse services for mental health patients, improved engagement and reduced risk levels e.g. link workers support mental health patients to engage with the substance misuse service prior to discharge from hospital and there is now less risk on discharge with OST (opiate substitute prescribing) switching directly to substance misuse services. Patients no longer take out OST which reduces risk.

North West Boroughs Healthcare NHS Foundation Trust

The Trust service model has dual diagnosis practitioners based within all community mental health recovery teams. There is one dual diagnosis nurse consultant and five specific dual diagnosis practitioners (one for each geographic area covered by the North West Boroughs mental health services) who can provide assessments, treatment interventions, bespoke training and consultation. These seek to work within services and provide case consultation to add insight and ensure joint working where appropriate.

Regular liaison takes place and a Joint Working Agreement is in place across the substance misuse services and secondary mental health services and includes a mixture of local liaison about individual cases and regular liaison about training and addressing any pathway issues around accessing help and support where there is no wrong door.

The Nurse Consultant is an active member of Progress (the National Consortium of Consultant Nurses in dual diagnosis and substance use) providing a regular news service and national e-learning modules and resources via the national website www.dualdiagnosis.co.uk

Manchester Dual Diagnosis Liaison Service (MDDLS)

MDDLS provide specialist dual diagnosis training to all mental health and substance misuse services in the city. Specialist advice and consultancy is available to all practitioners within mental health and substance misuse service to support their work with services users who are Manchester residents and have a dual diagnosis. This can be delivered on trust premises or in community venues. MDDLS provides:

- Training for all staff
    - Inpatient 1-day mandatory course for all inpatient staff
    - Community 1-day course for all Community and Psychological and Wellbeing Services staff
- Policy and practice development across substance misuse and mental health services
- Support to front line staff, through case advice and consultation – advise around care planning and liaison support with substance misuse services
- Development of Dual Diagnosis Champion network
    - 1 - Dual Diagnosis Lead for inpatient and community
    - 1 - Consultant Nurse Dual Diagnosis
    - 1 - Dual Diagnosis Trainer

MDDLS is funded by Manchester City Council but work out of Greater Manchester Mental Health NHS Foundation Trust.

MDDLS role is to upskill the substance misuse and mental health workforces to understand each other. This helps change cultures and allows providers to interact better thus ensuring that people can receive the treatment they require and don't fall through the gaps.

The case advice offer includes:

- Specialist case supervision to staff working with service users of substance misuse or mental health services
- Advice & consultations with service user and their practitioner / worker
- Referral information & liaison support with mental health and substance misuse services within the City
- Provision of dual diagnosis materials and information for service users, carers and staff

Fulfilling Lives South East Partnership

A 2021 report from Fulfilling Lives South East Partnership summarises the findings from research into what good psychological support can look like for people who have coexisting mental ill-health and substance use, prior to them accessing formal substance misuse treatment. The research also addresses how complex trauma impacts on peoples' engagement with support and explores how services respond to trauma presentations.

The report includes reflections on specific psychological models that can be used at this stage with this group. Many contributors to the report felt psychodynamic approaches are not appropriate for this group at a pre-treatment stage. Trauma focused CBT is favoured by the NICE guidelines and by clinical psychologists who contributed but some felt it requires engagement and a level of stability. Some contributors shared a view that emotional regulation models support 'fast to slow' thinking and can be helpful for this client group. Most supported models of therapy that contributors shared as being helpful for this group, pre-treatment, target emotional regulation – addressing how trauma is presenting itself and not directly opening up to the trauma itself.[30]

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30 The Perspectives Project: Discussions on psychological support and complex trauma pre-substance misuse treatment February 2021

Person-Centred Services

This section looks at three ingredients to ensuring services are person-centred when working with people with co-occurring mental health problems and substance use:

- Service user involvement in decision making
- Involving families and carers
- Peer support

Service user involvement in decision making

The Orange Book outlines how involving patients as active partners in their drug treatment and recovery is essential and is associated with good outcomes. Patients should be fully involved in the development of their plans for treatment, care and recovery, in setting appropriate goals and reviewing their progress.[31]

Nice Guidelines CG120[32] supports this suggesting that treatment and care should take into account people's needs and preferences. People with psychosis and coexisting substance misuse should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

They also stress the importance of good communication between healthcare professionals and service users. It should be supported by evidence-based written information tailored to the person's needs.

Involving families and carers

In line with the Care Act 2014, practitioners should identify carers and family members who may have unmet needs, making appropriate referrals for carers assessments and/or to family support services.

NICE Guideline NG58 found that it was integral to involve the person (and their family or carers if the person wants them involved) to ensure care and support is tailored to meet the person's needs. This includes offering the person information about the services available so they can decide which ones would best meet their jointly identified needs and goals.[33]

Practitioners should ensure the care plan:

- Lists how the person will be supported to meet their identified needs and goals. This includes listing any carers they have identified to help them, and the type of support the carer can provide
- Takes into account the concerns of the person's family or carers
- Recognises and, if possible, reconciles any goals the person may have decided for themselves if they differ from those identified by their service provider
- Share a copy of the care plan with the person's family or carers (if the person agrees)

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31 Drug misuse and dependence UK guidelines on clinical management (2017)

32 NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

33 NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

When undertaking an assessment they should also consider:

- Carers have needs in their own right
- The effect that caring has on their mental health
- Carers may be unware of, or excluded from, any plans or decisions being taken by the person
- Any assumptions the person with coexisting severe mental illness and substance misuse has made about the support and check that they agree with the level of support their carer will provide

Families and carers can play an important role in following a quality standard outlined by NICE[34] that people aged 14 and over with coexisting severe mental illness and substance misuse are followed up if they miss any appointment. This can be done through engaging families in ensuring that appointments are not missed and also in ensuring follow up so that non-attendance doesn't occur. They can also be involved wherever possible and agreed by the individual e.g. by attending appointments with them. However, they are often in need of information and support for themselves, and their needs should not be overlooked.

Peer support

Peer mentors are a good example of how people with lived experience can play an important role in service delivery and this should include people with lived experience of coexisting substance use and mental health issues. Peer mentors act as role models, demonstrating that recovery is possible as well as helping deliver interventions e.g. co-facilitating structured groups and running mutual aid groups.

Dual Diagnosis Anonymous (DDA) is a self-help organisation run by people with lived experience. DDA make the point that people with coexisting substance use and mental health issues may feel alienated at traditional 12-step meetings yet need the peer support provided by such groups.

DDA have established a peer support program specifically for people with co-occurring mental health and substance use issues. To the traditional 12 steps of AA and NA, Dual Diagnosis Anonymous has added five steps acknowledging both illnesses, accepting help for both conditions, understanding the importance of a variety of interventions, combining illness self-management with peer support and spirituality, and working the program by helping others."[35]

[34] NICE – Quality standard – Coexisting severe mental illness and substance misuse (2019)

[35] www.ddauk.org

Good Practice Examples

Adfam

Adfam have published a **toolkit** for practitioners working with those affected by someone else's co-occurring mental ill-health and substance misuse conditions.

The toolkit has been produced by Adfam and family members with lived experience. It is designed for practitioners who support those caring for a loved one who is having difficulties with their mental health and substance use. This will include substance use and mental health practitioners, family support workers, housing officers and advocacy practitioners, among others.

The toolkit is intended to offer practitioners some simple but effective tools to help to overcome those barriers and help families to cope more effectively with the challenges they face.

North West Boroughs Healthcare NHS Foundation Trust

Service users are involved in developing local pathways, training and individual care planning. Carers are always encouraged to be involved, as appropriate, when planning individual care plans.

The Trust model aims to ensure that people with co-occurring mental health and drug/alcohol use conditions are considered in all services. Access to services, should be made as seamless as possible and carefully supported to limit dropout between services.

Dual diagnosis course, York University, Department of Health Sciences

York University's Dual Diagnosis Course looks at the complex relationship between substance use and mental health, examining the implications for service users, carers, workers and services. It is funded by Health Education England and open to anyone working with people who have a mental health problem, regardless of the severity. Each course attracts a variety of practitioners including: drugs workers, probation officers, accident and emergency staff, general practitioners, walk in centre staff, practice nurses, health visitors, midwives, prison health care staff and those working in mental health. The training provides a blend of skills training and theoretical evidence.

The course is facilitated by a team that include clinical and research staff, also someone with lived experience of cannabis psychosis shares their experience in one of the session which students really value. Service user and carer involvement is part of the module team involved in planning content and quality assurance.

Diversity and Inclusion

Working with survivors of intimate partner violence (IPV)

There is a growing body of research which describes the use of substances by (mainly but not exclusively) women to cope with the psychological and physical harm resulting from their experiences of violence.

The Orange Book gives a detailed account of high rates of intimate partner violence (IPV) (both perpetration and victimisation) reported among individuals misusing or dependent on drugs and/or alcohol. IPV includes psychological, physical, sexual, financial and emotional abuse, and controlling behaviours with differing degrees of violence and control by a current or former intimate partner.[36]

It suggests that survivors of IPV who use substances have been reported to be more likely to experience mental health disorders (depression and post-traumatic stress disorder (PTSD) particularly) and physical health problems. For this reason it is integral that a 'trauma informed' approach is used for this group.

NICE guidance[37] also highlights the need for multi-agency working to ensure that there are integrated care pathways for identifying, referring and providing interventions to support those who are survivors or perpetrators of IPV. Staff employed in substance use treatment services should be aware of protocols for identifying, assessing and working with domestic abuse and with IPV survivors and perpetrators, and of local care pathways for domestic abuse survivors, including IPV survivors and perpetrators.

Pregnancy

In NICE NG58 guidance[38] it is recognised that everyone with coexisting severe mental illness and substance misuse faces difficulties in receiving care, but it wanted to highlight that some groups are particularly vulnerable. Notably those who are pregnant or have recently given birth.

The Orange Book[39] builds on this and suggests that midwifery and obstetric services should develop policies and good links with local drug specialists, GPs and social services. Moreover, there should be a "balance between reducing the amount of prescribed drugs in order to reduce foetal withdrawal symptoms, and the risk of the patient returning to, or increasing, their misuse of illicit drugs".

NICE's CG120[40] guideline recommends that agencies jointly develop care plans that contain information about opiate replacement therapy, that services are co-located and that women are offered information about the services provided by other agencies. This type of joint approach to management has been found to improve outcomes of pregnancy.

Sex work

The 2017 Drug Strategy describes the links between sex work, substance misuse and mental health issues. It mentions that those selling sex are at greater risk of drug/alcohol misuse, which can be a coping mechanism, the result of coercion (into both prostitution and/or drug use), or because they became involved in prostitution to fund an existing drug dependence.

In addition, long-term depression or a mental health diagnosis, made holding down 'mainstream' jobs difficult and meant an increased likelihood of turning to sex work.

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36 Drug misuse and dependence UK guidelines on clinical management (2017)

37 NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

38 NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

39 Drug misuse and dependence UK guidelines on clinical management (2017)

40 NICE Guideline CG120 - Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011)

Good Practice Examples

Turning Point's Drug and Alcohol Wellbeing Service (DAWS)

The Drug and Alcohol Wellbeing Service (DAWS) in central London provides advice, support and treatment for young people and adults with drug and alcohol problems within the London Boroughs of Kensington and Chelsea, Hammersmith and Fulham and the City of Westminster. DAWS women's service provides a women only service which is a safe space for women to seek guidance and support for domestic abuse and relationships, parenting, sexual health, health and wellbeing, substance misuse and personal development – regardless of current situation or experiences. It is open to anyone who identifies as female. The women's only service provides:

- Women only groups and 1:1 support
- Counselling
- Outreach service - meet you where it suits you
- Personal development
- Employment, Education & Training
- Signposting and referring to community services
- Yoga and seated yoga
- Drama
- Park fit

Working with faith-based and cultural communities

Providers should work with local faith, cultural and community organisations and groups to help support and engage adults and young people with psychosis and coexisting substance misuse. This is a common theme throughout all the guidance.

Where there are known drug use issues in specific communities, providers should establish a culturally relevant service offer. This should include maintaining cultural resilience against drugs among successive generations in a way that does not stigmatise users and families and inhibit help-seeking.[41]

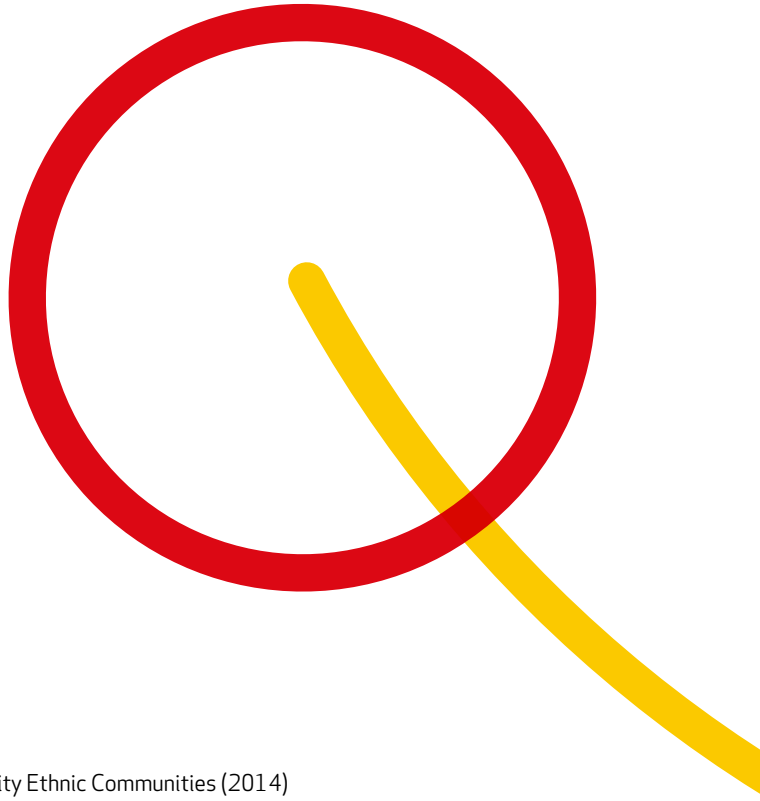
For too many people, especially black men, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. Substance use is often a factor. The guidance recommends providing training for faith, cultural and community organisations and groups, delivered jointly by mental health and substance misuse services, about how to recognise psychosis with coexisting substance misuse and how to access treatment. The different pathways to care, and thresholds for admission and inpatient provision should be reviewed, to determine any ethnic or racial bias and address this.[42]

Flexible and accessible provision

Consideration should be given to sensitively and flexibly engaging with people who may be from certain groups. This can be done by improving recognition of symptoms and how these are expressed in different ethnic groups and increasing understanding of how loss (particularly for refugee/migrant children) and trauma are contributing factors of mental illness.[43]

Multiple points of entry into specialist mental health assessment/care are needed. This will require direct access through non-clinical routes such as community agencies, places of worship, the education and social welfare system, housing providers, criminal justice and the voluntary sector.[44]

Similarly, lack of information about drugs and the services available inhibits people from accessing treatment in some faith/cultural minority groups. Specialist drug services for specific communities will be unsustainable in many areas. Local partnerships and commissioners need to assess local needs and stimulate innovative solutions to meet the needs of the local population.[45]



41 UKDPC - Drugs and Diversity: Ethnic minority groups (2010)

42 Dual Diagnosis – Good practice Handbook (2007)

43 UKDPC - Drugs and Diversity: Ethnic minority groups (2010)

44 JCMPH - Mental Health Services for People from Black And Minority Ethnic Communities (2014)

45 Drugs and Diversity: Ethnic minority groups Learning from the evidence - UKDPC

Establishing trust

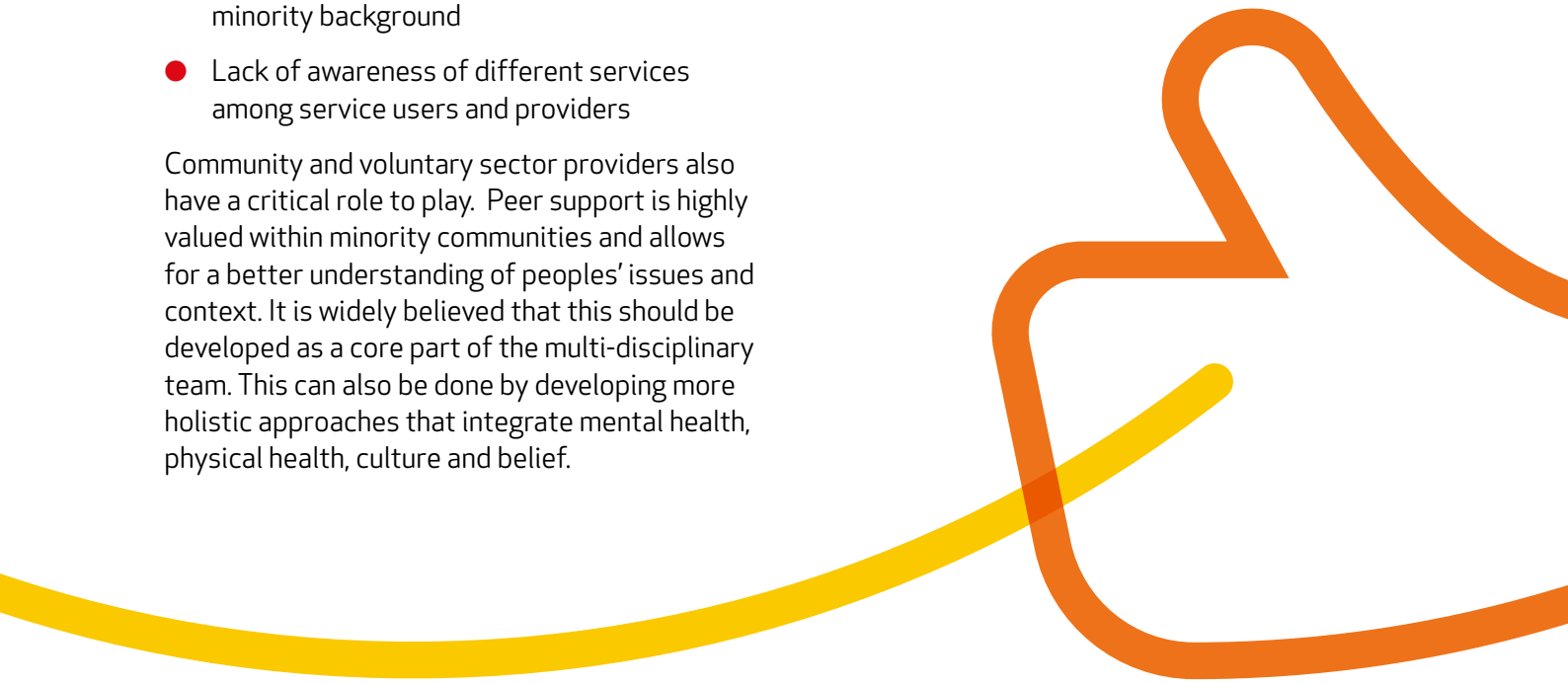
People from ethnic and cultural minority communities have often said that they had lost trust in services and wanted more support within the community. A qualitative study in south east England found that there were a range of factors which caused this trust to break down. These included:[46]

- Impact of long waiting times for initial assessment
- Language barriers
- Poor communication between service users and providers
- Inadequate recognition or response to mental health needs, imbalance of power and authority between service users and providers
- Cultural naivety
- Insensitivity and discrimination towards the needs of service users from ethnic or cultural minority background
- Lack of awareness of different services among service users and providers

Community and voluntary sector providers also have a critical role to play. Peer support is highly valued within minority communities and allows for a better understanding of peoples' issues and context. It is widely believed that this should be developed as a core part of the multi-disciplinary team. This can also be done by developing more holistic approaches that integrate mental health, physical health, culture and belief.

Memon et al further outline how to establish this trust:[47]

- People from some ethnic and cultural minority backgrounds require considerable support to develop mental health literacy, raise awareness of mental health conditions and combat stigma
- There is a need for improving information about services and access pathways. Healthcare providers need relevant training and support in developing effective communication strategies to deliver individually tailored and culturally sensitive care
- Improved engagement with people from ethnic and cultural minority backgrounds in the development and delivery of culturally appropriate mental health services could facilitate better understanding of mental health conditions in the community and improve access



46 Memon et al - Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities (2016)

47 Memon et al - Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities (2016)

Good Practice Examples

Hestia BAME Substance Misuse Floating Support Service

The service offers intensive support over a period of 12 weeks to service users open to Westminster and Kensington & Chelsea CNWL Mental Health Teams with mental health and substance/alcohol misuse. The aim is to prevent hospital admissions and facilitate earlier discharge, promoting recovery, social inclusion and helping service users to maximise their independence and wellbeing, and enabling access to employment, training, and other mainstream activities. Support is arranged and delivered flexibly by a named and competent support worker in collaboration with CNWT and the CMHT, to meet the specific and changing requirements of each individual referral. The support worker provides a wide range of support including practical support with finances, housing and appointments, emotional support and advocacy.

Planning and Commissioning of Services

The lack of join-up between funding and performance management of mental health services, which are commissioned by the NHS, and substance misuse services, commissioned by local authority public health teams, often results in parallel decision making and silo-working. This division has exacerbated a longstanding disconnect between the mental health and substance misuse sectors with commissioners working to two different sets of organising principles. There is also considerable variation across the country.

NICE Guideline NG58 emphasises the importance of developing integrated models of care, comprising a range of different agencies working together to support people with coexisting mental health issues and substance use; they found that adopting this approach increased engagement and resulted in positive improvements in health, functioning and wellbeing.[48]

A key principle set out by Public Health England for commissioners of services working with people co-occurring substance use and mental health problems is:

- **Everyone's job** - Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions[49]

Focus on improving integration rather than creating standalone services

The NG58 committee agreed that commissioners should focus on improving existing services using the expertise that is available instead of creating a stand-alone 'dual diagnosis' services. It felt that the standard care delivered in the UK could be improved by increasing the level of engagement of people with severe mental illness and substance misuse with existing services and that existing capacity and resources could be used to deliver this.[50]

Public Health England's 2017 report described integrated care as where mental health and alcohol/drug needs are addressed at the same time as part of an integrated package of care. This care need not be delivered in the same location, or by the same person – although people with co-occurring conditions report positively on their experiences of co-located services. The report describes the sort of changes that might be required to enable practitioners to work assertively and flexibly. Changes required might include: extended opening hours, offering a drop-in service, co-locating with or operating satellite services alongside other key services such as homelessness or domestic violence services, using text reminders and/or daily 'check ins'.[51]

Engaging a range of stakeholders in commissioning

The NHS Five Year Forward View for Mental Health FYFVMH calls for co-production with clinicians and experts-by-experience to be at the heart of commissioning and service design, including partnerships with voluntary and community sector organisations. It advocates using the 4PI framework of Principles, Purpose, Presence, Process and Impact to help ensure services or interventions are accessible and appropriate for people of all backgrounds, ages and experience.[52]

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48 NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

49 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

50 NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

51 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

52 The Five Year Forward View for Mental Health (2016) - NHS

Enabling effective multi-agency working

NICE Guideline NG58 details how providers need to work together to encourage people with coexisting severe mental illness and substance misuse to use services. Important factors in providing a coordinated approach included a shared vision, joint responsibilities and regular communication.[53]

This should include:

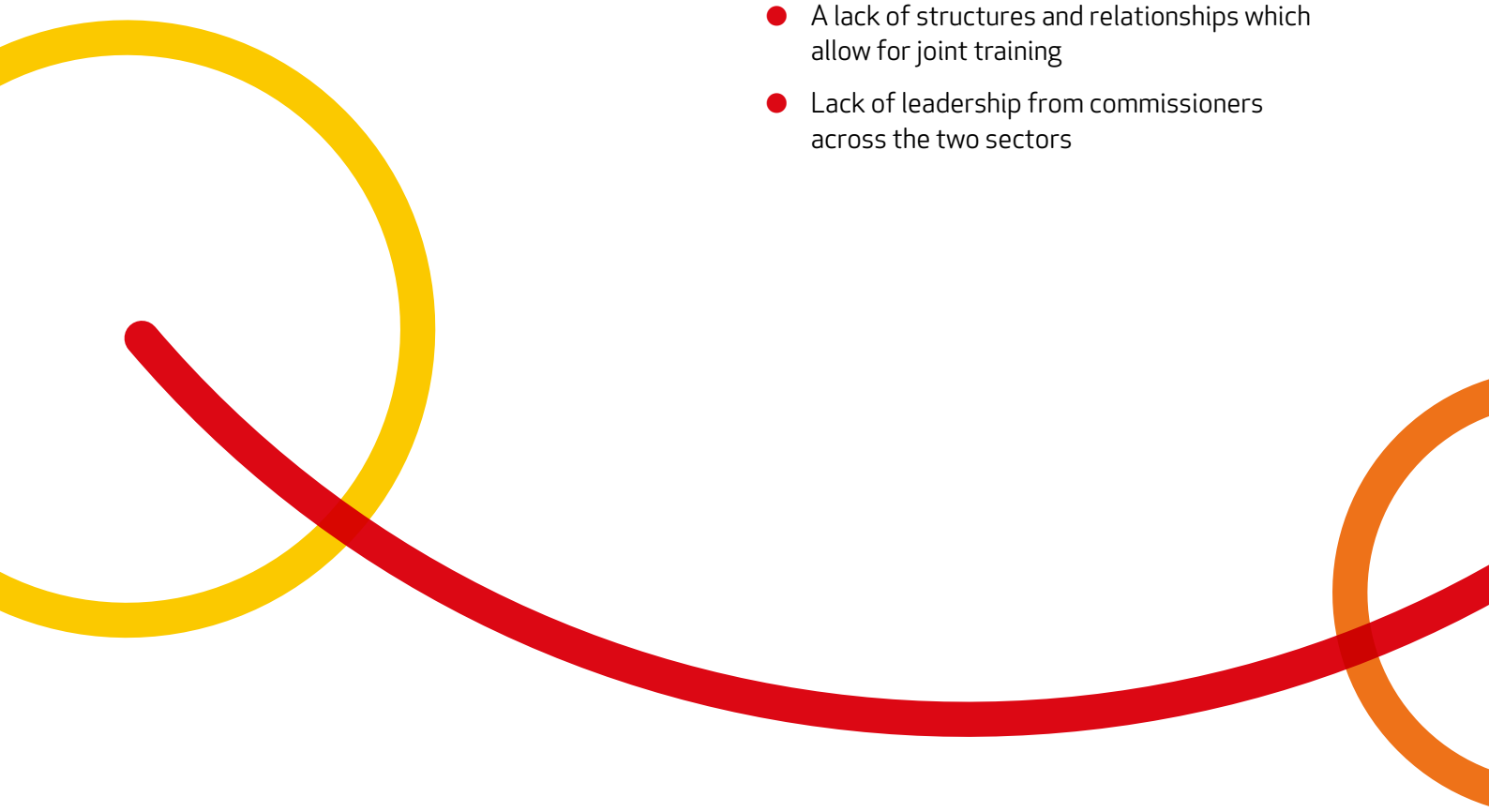
- Using an agreed set of local policies and procedures that is regularly reviewed by key strategic partners
- Working across traditional institutional boundaries
- Being responsive to requests for advice and joint-working arrangements
- A shared approach to risk management

There should be a consistent approach to getting people with coexisting severe mental illness and substance misuse help from the most relevant service by sharing information on support services between agencies and ensuring all providers know about and can provide information on the services.

Public Health England advises that local areas should undertake a training needs assessment to gather data on where the gaps lie in terms of the substance misuse workforce's knowledge of mental health and the mental health workforce's knowledge of substance misuse.[54]

There are a number of barriers to training initiatives to enables services to better support people with coexisting mental health and substance issues, including:

- High caseloads which allows little time for this type of work
- A lack of structures and relationships which allow for joint training
- Lack of leadership from commissioners across the two sectors



[53] NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

[54] Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

Reflecting on your own practice: Joint working protocol

Does your strategic joint working protocol describe:

- The context of local services
- Key staffing roles in these services
- Inclusion and exclusion criteria for services
- Referral processes between services and use of national guidance to inform this
- Information sharing protocols
- Escalation processes in case of dispute on whether or not a referral is appropriate
- Assessment process
- Recovery planning and review
- Care coordination and multi-agency working
- Strategic planning
- Training and induction of substance misuse and mental health staff

Understanding need

From a data perspective, commissioning partnerships need to make use of all available data to establish their own local prevalence estimate, understand the extent to which needs are met by services, and project likely future demand on services. This work forms the starting point for pathway development and better joint working across mental health and alcohol and drug use services.[55]

The Fingertips coexisting substance misuse with mental health issues data platform [56] collates a wide range of publicly available data around tobacco smoking, alcohol use and drug use, including data on prevalence, risk factors, treatment demand and treatment response. It provides commissioners, treatment providers and other stakeholders with the means to benchmark their area against other areas.

Service user involvement in commissioning

The Drug Strategy 2017 outlines how service user involvement in the design and delivery of services and recovery systems can contribute significantly to the evolution of effective drug and alcohol treatment systems. In addition to involving people with lived experience in contracting mechanisms and outcome monitoring, commissioners should refer to feedback from service users and local provider/clinicians, in addition to the Care Quality Commission's reports, to identify and address any concerns about service quality.[57]

Public Health England's 2017 report calls for involving experts by experience and carers (including young carers) in commissioning decisions about services and care. Capacity building and investment in user/carer involvement may be needed to ensure that involvement is effective and meaningful.[58]

55 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

56 PHE - Fingertips coexisting substance misuse with mental health issues data platform (2021)

57 Drug Strategy (2017)

58 Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

Good Practice Examples

North Staffordshire Combined Healthcare Trust

North Staffordshire Combined Healthcare Trust Board and local commissioners set a high level objective that a joint care review structure, between mental health and substance misuse services needed to be implemented if robust clinical and risk management practices were to be established for this particularly vulnerable group.

These ambitions were subsequently written into the work plan of the Trust's Consultant Nurse for co-occurring substance use and mental health need, alongside a stated expectation of the involvement of the Service Lead for substance use and the clinical lead for each Community Mental Health Team (CMHT).

They decided the minimum staff required to provide a credible and useful joint review was:

- One credible senior mental health clinician
- One senior credible substance misuse clinician
- One care co-ordinator (clinician)

Following the identification of this simple plan a regular monthly slot of ninety minutes was identified, and the attendance of the Consultant Nurse and Service/ Clinical lead representing substance misuse and the CMHT was agreed.

The opportunity for case review along with the intended outputs was advertised and organised by the service /clinical lead within a CMHT and the first joint review commenced. The intended outputs were delivered as advertised, and very quickly thereafter the usefulness of the joint review was accepted and taken up by a number of clinicians within the CMHT.

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Three months later a neighbouring CMHT requested a similar review opportunity, followed 4 months later by a third and eventually the final CMHT within the area. Both early intervention in psychosis services and acute inpatient facilities are now currently considering how they can become utilise the opportunity afforded from joint reviews.

The outcomes of the project to date are multifaceted:

- The CMHTs report that the reviews have resulted in improved access and engagement with services, with greater confidence in services among patients and practitioners in the system.
- Relationships and joint working between services have improved resulting in better information sharing, a wider understanding of therapeutic risk management strategies and a greater willingness to hold risk across the system, and less repetitive assessment and multiple appointments for individuals.

Birmingham and Solihull Mental Health Foundation Trust COMPASS Programme

The COMPASS service in Birmingham is a specialist team within the mental health trust which provide interventions for mental health patients with coexisting substance use as well as providing support; training and clinical input to mental health and substance use services to promote a high quality of care include. Key achievements include:

- An integrated treatment approach within assertive outreach, Early Intervention Services, Homeless Mental Health Teams and Community Mental Health Teams
- Ongoing improvement in confidence and skills of staff to work with service users with combined problems
- Enhanced assessment skills have resulted in clinicians being more able to develop formulations and individualised treatment plans with service users

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- Successful engagement and retention of service users in treatment
- Ongoing development of evidence based interventions including; trauma focussed therapy through continuous evaluation of interventions by service user involvement
- Comprehensive training package in place for staff based on a researched and evaluated model of intervention (C-BIT)
- Ongoing development of evidence based interventions through the COMPASS Programme research committee

Learning from the initial establishment of the team include:

- Maintain a clear focus on the development of the service and appreciate that initially you may not be able to meet the demands of all those involved but that your service can develop over time
- It is important to discuss with service users the possible positives about using drugs or alcohol and once rapport has been established to discuss the negative impact of drugs and alcohol
- Partnership working is vital to developing a clear common understanding of issues and opportunities and getting services to work closely with each other
- Undertaking direct clinical work enhances credibility when providing training as trainers can refer to case examples and demonstrate the links between theory and practice
- Enhance team skills and build confidence not just through training but with individual support and development of individuals
- If possible, train whole teams and also provide training for new staff joining the team so that there is consistency in approach
- Ensure that there is a process in place to follow up and assess whether training is leading to integrated treatment

Key Guidance and Policy Documents

This section highlights the main policies and guidance for people with coexisting substance use and mental health issues. Some of the policy documents from the mental health or substance misuse field that are relevant to co-occurring conditions are listed below:

NICE Guideline CG120: Assessment and Management in Healthcare Settings

This guideline[59] covers the assessment and management of adults and young people (aged 14 years and older) who have a clinical diagnosis of psychosis with coexisting substance misuse.

It recommends that when working with adults and young people with known or suspected psychosis and coexisting substance misuse, that practitioners should take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism.

Recognition of psychosis with coexisting substance misuse in adults and young people

It also outlines that healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs.

If the person has used substances, staff should ask them about all of the following: particular substance(s) used quantity, frequency and pattern of use route of administration duration of current level of use.

Secondary Mental Health Services

It details how healthcare professionals working within secondary care mental health services should ensure they are competent in the recognition, treatment and care of adults and young people with psychosis and coexisting substance misuse.

They should consider having supervision, advice, consultation and/or training from specialists in substance misuse services. This is to aid in the development and implementation of treatment plans for substance misuse within CAMHS or adult community mental health services.

[59] NICE Guideline CG120 (2011)- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings

Substance misuse services

The guidance suggests that those in substance misuse services should be competent to:

- Recognise the signs and symptoms of psychosis
- Undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services

Following this and young people with psychosis and coexisting substance misuse attending substance misuse services should be offered a comprehensive, multidisciplinary mental health assessment in addition to an assessment of their substance misuse.

NICE Guideline NG58: Community Health and Social Care Services

This guideline[60] covers how to improve community services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing. It has 6 key areas of focus.

First contact with services

- Identify and provide support to people with coexisting severe mental illness and substance misuse. Aim to meet their immediate needs, wherever they present
- Provide direct help, or get help from other services, for any urgent physical health, social care, housing or other needs
- Ensure the person is referred to and followed up within secondary care, and that mental health services take the lead for assessment and care planning

Referral to secondary care mental health services

- Do not exclude people with severe mental illness because of their substance misuse
- Do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse

The care plan: multi-agency approach to address physical health, social care, housing and other support need

- Involve the person (and their family or carers if the person wants them involved) in developing and reviewing the care plan (as needed) to ensure it is tailored to meet their needs
- The care coordinator should work with other services to support the person to address their social care, housing, physical and mental health needs, as well as their substance misuse problems
- Carers (including young carers) who are providing support should be aware they are entitled to, and are offered, an assessment of their own needs
- It should also be ensured that agencies and staff communicate with each other, so the person is not automatically discharged from services because they missed an appointment

[60] NICE Guideline NG58 (2016) - Coexisting severe mental illness and substance misuse: community health and social care services

Partnership working between specialist services, health, social care and other support services and commissioners

- Ensure joint strategic working arrangements are in place
- Agree a protocol for information sharing and work across traditional institutional boundaries

Improving service delivery

- Ensure existing health and social care services (including substance misuse services) involve people and their family or carers in improving the design and delivery of existing services
- Provide local services in places that are easily accessible, safe and discreet, bearing in mind any perceived stigma involved in being seen to use the service
- Adapt existing secondary care mental health services to meet a person's mental illness and substance use needs and their wider health and social care needs. Do not create a specialist 'dual diagnosis' service

Maintaining contact between services and people with coexisting severe mental illness and substance misuse who use them

- Provide consistent services, for example, by trying to keep the same staff member as their point of contact and the same lead for organising care. Stay in contact by using the patient's chosen method of communication
- Ensure any loss of contact or non-attendance is viewed by all practitioners involved as a matter of concern

Public Health England Guidance

Better care for people with co-occurring mental health and alcohol/drug use conditions, published by PHE in 2017[61], aims to support local areas to commission timely and effective responses for people with co-occurring conditions. It encourages commissioners and service providers to work together to improve access to services which can reduce harm, improve health and enhance recovery, enabling services to respond effectively and flexibly to presenting needs and prevent exclusion.

Two key principles support these aims:

- Everyone's job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions
- No wrong door. Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment and/or sign-posting for any of the co-occurring conditions is available through every contact point

The guidance:

- Covers all substances of use, levels of dependency, harmful use (including tobacco use) and states of intoxication
- Covers all mental health problems – both common and severe mental illness and personality disorder
- Covers all ages (children to adults, including older adults) and settings (including community and prescribed places of detention)

To support the principles of 'everyone's job' and 'no wrong door', the following priorities are outlined to guide commissioning and delivery of care:

- Agree a pathway of care which will enable collaborative delivery of care by multiple agencies in response to individual need
- Appoint a named care coordinator for every person with co-occurring conditions to coordinate the multi-agency care plan
- Undertake joint commissioning across mental health and alcohol/drugs (including primary care, criminal justice settings and specialist/acute care, supported by strong, senior and visible leadership
- Enable people to access the care they need when they need it and in the setting most suitable to their needs
- Commission a 24/7 response to people experiencing mental health crisis, including intoxicated people
- Commission local pathways which enable people to access other services such as homelessness, domestic abuse or physical healthcare
- Make sure people are helped to access a range of recovery supports, while recognising that recovery may take place over a number of years and require long term support

[61] Public Health England - Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)

The NICE Quality Standard

The NICE Coexisting Severe Mental Illness and Substance Misuse Quality Standard[62] covers the assessment, management and care provided for people aged 14 and over who have coexisting severe mental illness and substance misuse. It describes high-quality care in priority areas for improvement.

The 4 key statements all practitioners should follow are:

1. People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs
2. People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness
3. People aged 14 and over with coexisting severe mental illness and substance misuse have a care coordinator working in mental health services when they are identified as needing treatment from secondary care mental health services
4. People aged 14 and over with coexisting severe mental illness and substance misuse are followed up if they miss any appointment

Drugscope Guidance for IAPT Services

Drugscope's *Positive Practice Guide for Working with People who use Drugs and Alcohol*[63] was published in 2012 to support IAPT workers to work confidently and inclusively with those who have common mental health problems and non-severe drug or alcohol problems. It explains how simple assessment can identify IAPT clients whom will be suitable for brief interventions for their drug or alcohol misuse.

The key message of the guide is that a substance misuse issue is not a sufficient reason to deny IAPT treatment and that it is essential this cohort can receive the support they require. In addition it specifically mentions that no one should be excluded from IAPT services because they are being prescribed substitute medication.

Routine assessment or 'identification' of current use of drugs and alcohol is recommended for all IAPT clients. Many of the general cognitive and behavioural techniques used by Psychological Wellbeing Practitioners are transferable to working with drug or alcohol use, where a non-judgemental approach is fundamental.

The guide highlights that substance misuse clients with mental health problems should have access to NICE-recommended psychological interventions, including CBT for depression and anxiety. It states there is no evidence that substance misuse per se makes key psychological therapies ineffective.

Between 70 and 80 per cent of clients in drug and alcohol services have common mental health problems, largely anxiety, depression and trauma-related difficulties.

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62 NICE – Quality standard – Coexisting severe mental illness and substance misuse (2019)

63 IAPT positive practice guide for working with people who use drugs and alcohol (2012)

The National Drug Strategy

The drug strategy[64] published in 2017 sets out how the government and its partners, at local, national and international levels, will take new action to tackle drug misuse and the harms it causes.

The strategy builds on the core principles of the drugs strategy 2010 and, highlights that "the solutions to these challenges are grounded in a smarter, more coordinated approach which complements wider cross-department action." Although the strategy focuses on drug use, it recognises the importance of joined-up responses to alcohol and drug use and highlights the need for the commissioning of drug and alcohol treatment services to take place in an integrated way. This includes a commitment to improving the co-ordination of mental health services with other local services, including police forces and drug and alcohol rehabilitation services.

The strategy highlights that reduction in demand will take place through universal action (focused on building confidence and resilience of young people and developing dedicated resources to support evidence-based prevention of drug and alcohol misuse). This will be combined with more targeted action for high priority groups (including those who are in contact with the criminal justice system, people who are homeless and people experiencing intimate partner violence or abuse).

Finally, it focuses on the Government's ambition for "full recovery" of people experiencing drug misuse problems, which it will achieve through "improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs; and facilitating the delivery of an enhanced joined-up approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs."

The Orange Book

Last revised in 2017, the Orange Book - *Drug misuse and dependence: UK guidelines on clinical management*[65] provides guidance for clinicians on the management and treatment of people who misuse or are dependent on drugs. This 2017 iteration updates the guidance and includes a greater focus on mental health co-morbidity and the importance of psycho-social interventions.

The guidelines suggest that the quality of the experience of care for those with coexisting problems with mental health and with substance use is significantly affected by management and organisation of services and the local system and pathways of care, which is the responsibility of the commissioners of care as well as providers.

It also says that those with severe mental health problems should have high-quality, patient-focused care integrated with support from mental health services and that comorbid mental health and other problems need to be assessed and may need to be addressed alongside or ahead of the drug misuse problem.

The guidelines stress important to recognise that those affected by coexisting mental health and substance use problems (who are in need of effective and collaborative planning, delivery and accountability of their services), are not limited only to those with psychosis but include many others, not least those with mild-to-moderate mental ill health, those with early traumatic experiences or recent trauma, and those with personality disorders.

64 HM Government - The Drug Strategy (2017)

65 Drug misuse and dependence UK guidelines on clinical management (2017)

Mental Health Five Year Forward View

The NHS Five Year Forward View for Mental Health (FYFVMH)[66] was published in February 2016 and sets out the start of a ten year journey for the transformation of mental health services.

It outlines how mental and physical health support will be integrated. People with severe mental illness at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care.

Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include support on substance misuse issues.

This work will in future be built on by the Community Mental Health Transformation Programme. This is a massive programme of change to how community mental health services are delivered and some argue change on this scale will not have been seen since deinstitutionalisation.

The NHS Long Term Plan describes a:

"new community-based offer [that] will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use… and proactive work to address racial disparities."

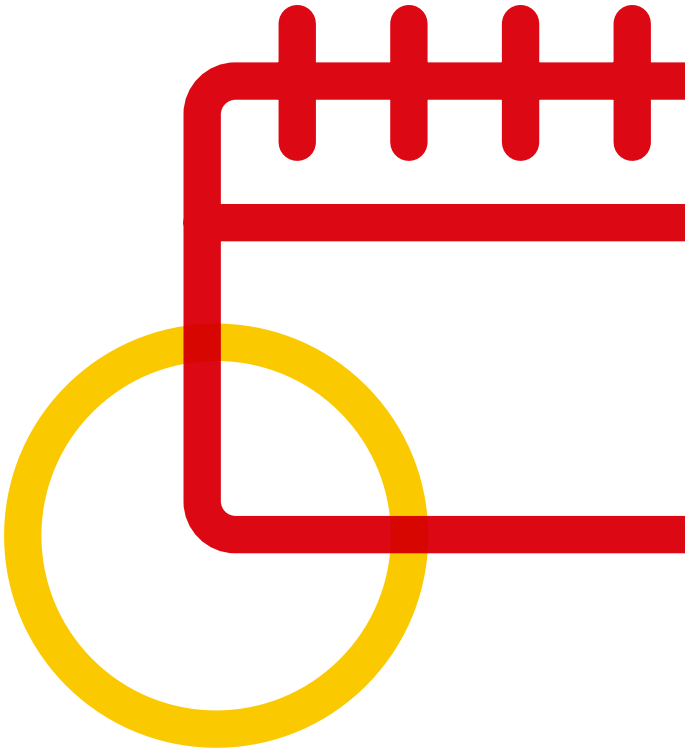
Local areas will be: "supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks." [67]

The NHS Long Term Plan

In January 2019, the NHS Long Term Plan[68] was published, which sets out how NHS England intends to use this investment across its services over the next 10 years.

The plan commits to spend at least £2.3bn a year on mental health care as part of a renewed commitment to grow investment in mental health services faster than the overall NHS budget for each of the next five years. The plan commits to the continued expansion of the Improving Access to Psychological Therapies programme to reach an additional 380,000 adults by 2023/24, as well as new and integrated models of primary and community mental health care for adults with severe mental illness.

The plan also pledges that Alcohol Care Teams will be provided in up to 50 hospitals with the highest number of alcohol-related admissions to support patients and their families who have issues with alcohol misuse. Teams will deliver alcohol checks to people and provide access to health services within 24 hours if problems are found.



66 The Five Year Forward View for Mental Health (2016) - NHS

67 NHS Long Term Plan (2019)

68 NHS Long Term Plan (2019)

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