Public Health England

Protecting and improving the nation's health

# Better care for people with co-occurring mental health and alcohol/drug use conditions

## A guide for commissioners and service providers

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Emma Christie
This information can be made available in alternative formats. For queries relating to this document, please contact: publications@phe.gov.uk

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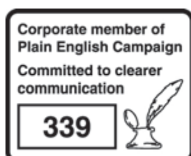


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# Glossary

| | |
|---|---|
| Co-occurring conditions | Co-occurring mental health and alcohol and/or drug use conditions, including smoking. |
| Mental Health Crisis Care Concordat | A national agreement between services and agencies involved in the care and support of people in crisis which sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. |
| Five Year Forward View for Mental Health | The independent report of the NHS-commissioned Mental Health Taskforce, which sets out a series of recommendations for the NHS and its arms length bodies aimed at transforming mental health care in England. |
| Making every contact count (MECC) | An approach to behaviour change which uses every day contacts that staff working in the NHS, local authorities and the voluntary sector have with people to promote health and healthy lifestyles. |
| Recovery | The concept of recovery features prominently in both alcohol and drug misuse and mental health service sectors. At the core is the idea that people can live well despite their illness and that recovery is an ongoing process or journey. |
| Prescribed places of detention (PPsD) | The scope of PPsD includes prisons, Young Offender Institutions, Secure Training Centres, Secure Children's Homes and Immigration Removal Centres. |
| Liaison and Diversion Programme | A service which seeks to identify offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice |

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| | system |
| Improving Access to Psychological Therapies (IAPT) | A NHS (England) project aimed at increasing the provision of evidence-based treatments for common mental health conditions such as anxiety and depression aimed at the level of primary care |
| Collaborative Care | Where a range of services work in close collaboration to deliver care centred on the needs of the person. There should be a lead co-ordinator of care and a shared care plan and desired outcomes agreed with the person. |
| Integrated Care | Care 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. Integrated care is delivered in and by mainstream services and not in specialist dual diagnosis teams. |
| Care Programming Approach (CPA) | A system for co-ordinating the care of people who have been diagnosed as having 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 health and social services. |
| Care co-ordinator | The mental health practitioner responsible for co-ordinating care under the CPA |
| Case manager | The practitioner responsible for co-ordinating care for people with co-occurring conditions. This person is likely to be from mental health or alcohol/drug services, but could be from any relevant health or social care service. |
| Specialist dual diagnosis teams | A team of practitioners commissioned to meet the mental health and alcohol/drug use treatment needs of |

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| | people with these co-occurring conditions. These teams are typically based within mental health services. |
| Police and Crime Commissioner (PCC) | PCCs are elected by the public to hold Chief Constables and the force to account, effectively making the police answerable to the communities they serve. All 40 force areas in England are represented by a PCC, except Greater Manchester and London, where PCC responsibilities lie with the Mayor. |
| Public Health England (PHE) | PHE is an executive agency of the Department of Health which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. PHE is a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS. |
| NHS England | NHS England leads the National Health Service (NHS) in England. This includes setting the priorities and direction of the NHS and commissioning health care services in England |
| Clinical Commissioning Groups (CCGs) | CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. |
| Mutual Aid | Typically provided outside formal treatment agencies and is one of the most commonly travelled pathways to recovery. Mutual aid groups come in different types, with the most widely provided being based on 12-Step principles, for example Narcotics Anonymous and Cocaine Anonymous. Other forms include SMART Recovery and locally derived groups. |
| 12 Step Recovery | A mutual aid based pathway based on a set of 12 guiding principles which outline a course of action for recovery from addiction. |
| SMART Recovery | SMART Recovery (SMART) is a |

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| | programme to help people manage their recovery from any type of addictive behaviour. SMART stands for ‘Self Management And Recovery Training’. |
| Community engagement | A planned process with the specific purpose of working with identified groups of people, whether they are connected by geographic location, special interest, or affiliation or identity, to address issues affecting their well-being. |
| Harm Reduction | Refers to policies, programmes and practices that aim to reduce the harms associated with the use of alcohol or drugs in people unable or unwilling to stop. |
| Asset-based community development | Asset-based approaches are an integral part of community development. They are concerned with facilitating people and communities to come together to achieve positive change, using their own knowledge, skills and lived experience of the issues they encounter in their own lives. |

# 1. Executive summary

## Introduction

It is very common for people to experience problems with their mental health and alcohol/drug use (co-occurring conditions) at the same time. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) of alcohol users in community substance misuse treatment.[1 2] Death by suicide is also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems.[3] Other evidence tells us that people with co-occurring conditions have a heightened risk of other health problems and early death.[4] We also know that in spite of the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with co-occurring conditions are often excluded from services[5 6].

This Public Health England (PHE) guide, developed with the support of NHS England, seeks to address this disparity. It should be used by the commissioners and providers of mental health and alcohol and drug treatment services, to inform the commissioning and provision of effective care for people with co-occurring mental health and alcohol/drug use conditions. It also has relevance for all other services that have contact with people with co-occurring conditions, including people experiencing mental health crisis. It is an action for PHE from the Crisis Care Concordat[i] national action plan. It has been co-produced with members of the expert reference group for co-existing substance misuse with mental health issues, and in consultation with experts through experience, service providers, practitioners, commissioners and policy leads.

It supports implementation of the Five Year Forward View for Mental Health[7], including current and forthcoming development of a comprehensive set of evidence-based treatment pathways (EBTPs)[8].

It 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:

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[i] The mental health crisis care concordat is a national agreement between services and agencies involved in the support of people in crisis. It sets out how organisations will work together better to make sure people get the help they need when they are having a mental health crisis.

1 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.

2 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 for any of the co-occurring conditions is available through every contact point.

## Scope

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)[ii]
- is intended to be used alongside and in support of implementation of NICE and other clinical guidance

## Background

Alcohol and drug dependence is common among people with mental health problems. High prevalence of these co-occurring conditions has been found among many of the following populations; people in prison and those in the criminal justice system;[9] children, young people and adults in alcohol and drug treatment;[10] [11] [12] individuals presenting to hospital emergency departments in mental health crisis;[13] and people experiencing severe and multiple disadvantage.[iii] [14]

Both alcohol and drug use and mental ill-health are associated with physical health problems and early death.[15] Smoking is highly prevalent among both people with mental health conditions and those who use alcohol/drugs, and is a significant contributor to illness and death among this group.[16]

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[ii]This term refers to prisons, including youth offender institutions, immigration removal centres, children and young people's secure settings, Liaison and Diversion teams in police custody suites and sexual assault referral centres.

[iii] Substance use, homelessness and criminal justice involvement.

Evidence from service user and provider surveys suggests that people with co-occurring conditions are often unable to access the care they need from both mental health and addiction services.[17] Individuals experiencing mental health crisis may experience difficulty in accessing care due to intoxication (in spite of the heightened risk of harm that this brings).[18]

## Policy and service delivery context

Evidence suggests that the recommendations contained in the Department of Health 2002 national guidance 'Dual diagnosis policy and implementation guide'[19] and the 2009 Department of Health and Ministry of Justice publication 'A guide for management of dual diagnosis in prisons'[20] have not been widely implemented. Challenges are presented by the commissioning of care for people with co-occurring conditions being shared by local authorities, CCGs and NHS England (see fig 1, page 15 below). New mental health and alcohol drug and tobacco policy frameworks and guidelines offer opportunities to deliver better care for people with co-occurring conditions. Delivering the principles described in this guide will require shared ownership and leadership by mental health and alcohol and drugs commissioners, and close involvement of commissioners of physical healthcare. These requirements are essential to effective implementation of key recommendations in the Five Year Forward View for Mental Health[21] [22], delivery of Crisis Care Concordat commitments and to implement NICE guidelines for alcohol, drugs, tobacco and mental illness and UK clinical guidelines for drug misuse and dependence (see Appendix 2). They are underpinned by the NHS Constitution, the local authority public health duties, and the shared duty of NHS England and CCGs to reduce inequalities between patients in access to health services and the outcomes achieved[23].

## Guidance for commissioning and delivery of care

To support the principles of 'everyone's job' and 'no wrong door' we have suggested the following priorities 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

## A framework for delivery of care

The guide also recommends a framework for delivery of care based on the following factors:

- strong therapeutic alliance
- collaborative delivery of care
- care that reflects the views, motivations and needs of the person
- care that supports and involves carers (including young carers) and family members
- therapeutic optimism
- episodes of intoxication are safely managed
- stop smoking advice/support is a routine part of care

The guide points to a number of resources available to support development of a competent workforce with the requisite values, knowledge and skills, include those with sufficient expertise to provide clinical leadership and supervision.

There are links to implementation prompts for commissioners and providers, and further sources of help and information are included at the end of the document.

# 2. Introduction

PHE have produced this guidance with the support of NHS England in line with commitments set out in the national Mental Health Crisis Care Concordat action plan. This guide is for commissioners, providers and users of services including:

- clinical commissioning groups
- local authorities – particularly directors of public health, children's services and adult social services and alcohol and drug commissioners
- health and wellbeing boards
- NHS England specialised commissioning teams
- NHS England regional teams
- NHS health and justice commissioners
- users of mental health and substance use services, their families and carers (including young carers)
- mental health, substance use and other service providers in community and secure settings
- prison governors and other agencies working in the criminal justice system
- police and crime commissioners (PCCs)

Sections 3 and 4 describe the scope of the guidance, give an overview of the current situation and outline responsibilities of local partners.

Sections 5 and 6 set out principles for commissioning and delivery of care, drawing on evidence-informed standards. Implementation checklists and links to further resources to help put principles into practice are included at the end of the guide and in the appendices.

# 3. Scope

The scope of this guidance includes any alcohol and/or drug use with co-occurring mental health conditions. It covers:

- children, young people and adults, including older adults
- community settings and prescribed places of detention[iv]
- all psychoactive drugs used for subjective effects (illicit as well as currently legal/prescribed) including
    - alcohol
    - tobacco
    - new psychoactive substances (NPS)
    - prescribed and over the counter (OTC) medication
- all mental health problems including
    - common mental health problems
    - severe mental illness and personality disorder
    - dementia
    - alcohol-related brain damage, including Korsakoff's syndrome
- dependent users of alcohol/drugs, and people who are not dependent.

Alcohol/drug use and mental ill-health symptoms and levels of dependence fluctuate. Local services need to respond in a way that reflects this variability, particularly when developing effective responses to intoxication in people experiencing crisis and/or trying to engage with services.

## Terminology

We have chosen to use the term 'co-occurring mental health and alcohol/drug use conditions' as stakeholder feedback suggests this term can encompass the breadth of mental health and substance use – particularly intoxication, mental health crisis and more common mental health problems, all of which have previously been outside the scope of national guidance. While we acknowledge that the term 'dual diagnosis' is still widely used, we feel it is often interpreted to include only those people who have received a mental health diagnosis from a health professional. We talk specifically of 'use' rather than 'misuse' of alcohol/drugs to cover the full range of how and why people use alcohol, drugs and tobacco. We have shortened this to 'co-occurring conditions' for ease of reading.

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[iv] This term refers to prisons, including youth offender institutions, immigration removal centres, children and young people's secure settings, Liaison and Diversion teams in police custody suites and sexual assault referral centres.

# 4. Background

## In brief

- there is a high prevalence of co-occurring conditions in mental health and alcohol/drug treatment populations in community and prison settings
- mental ill health and alcohol/drug use are both associated with physical health problems and early death, with smoking a significant contributor to morbidity and mortality
- evidence suggests that people are frequently unable to access care from services, including when intoxicated/experiencing mental health crisis
- the Five Year Forward View for Mental Health (and its implementation plan) and the Crisis Care Concordat have established national action plans to respond to this unmet need, and this guide forms part of that response
- use of the Sustainability and Transformation Planning (STP), children and young people's mental health Local Transformation Planning (LTP) and joint strategic needs assessment (JSNA) processes, and of commissioning for quality and innovation (CQUIN), quality premiums, enhanced primary care contracts, alliance commissioning and other payment incentives can help commissioners to develop local solutions
- there is an authoritative evidence base and clinical guidance to inform commissioning and delivery of care
- services may be commissioned by CCGs, local authorities, PCCs and prison governors, and there is a need to collaborate across sector boundaries

## Prevalence and harm

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.[24] More recently, Delgadillo et al found 70% of a sample from community substance use treatment also met criteria for common mental health problems.[25] Other evidence from research, national data and population surveys paints a picture of very high levels of need and associated health harms including:

- Evidence from children and young people's alcohol and drug treatment data which shows high levels of self-harm, domestic violence and sexual exploitation among

children and young people in alcohol and drug treatment, with very low referral rates from mental health treatment into alcohol and drug treatment.[26]

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, which found that suicides among people with a history of alcohol or drug use (or both) accounted for 54% of the total sample, an average of 672 deaths per year.[27] Only 11% of these people were in touch with alcohol or drug services at the time of death. Other evidence shows that alcohol use disorder is an important predictor of suicide/premature death.[28]

- Co-occurring alcohol use conditions with mental health issues featured prominently in hospital admissions data - of mental health crisis related admissions to acute hospital via A&E in 2012/13, 20% were due to alcohol use (the second highest proportion after self-harm and undetermined injury).[29]

- Rises in drug-related deaths which, although having multiple and complex causes, have been ascribed in large part to an ageing cohort of increasingly ill and vulnerable heroin users, and to people whose complex needs are not being adequately met[30]

- A high prevalence among people in prison as indicated in the 2009 Bradley report[31] recognising that co-occurring conditions are the norm rather than the exception among most offenders. Prisoners with addiction issues are also at increased risk of self-harm and suicide.[27]

- Data collected from trial sites commissioned by NHS England under the Liaison and Diversion Programme[v] showed that over 55% of service users, in contact with the criminal justice system and identified with mental health needs also had problem with drug use, alcohol use or both. Among those with alcohol use issues, over three-quarters also experienced a mental health issue. In the case of people with other substance use, the percentage who also demonstrated mental health needs was even higher at 79%.

- The Lankelly Chase Foundation commissioned a report looking at severe and multiple disadvantage in England.[32] It found that of an estimated 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.

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[v] Liaison and Diversion (L&D) services operate by referring offenders who are identified with having mental health, learning disabilities, substance misuse or other vulnerabilities to an appropriate treatment or support service.

- 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.[33, 34]

- Both alcohol and drug use and mental health problems are associated with considerable physical morbidity and premature mortality (15-20 years in people with mental health problems and 9-17 years in those with alcohol and drug use disorders) compared to national norms.[35]

- People with mental health problems are more likely to smoke and smoking is the single largest contributor to their 10-20 year reduced life expectancy. A recent UK study highlighted that men and women living with schizophrenia in the community have 20.5 and 16.4 year reduced life expectancies respectively.[36]

- A third (33%) of people with mental health problems and more than two thirds (70%) of people in psychiatric units smoke tobacco. Reductions in smoking rates in the general population over the last 20 years have not been matched in these mental health populations.[37]

- Tobacco smoking is highly prevalent in drug and alcohol users and a significant contributor to illness and death. Many people may recover from their drug or alcohol dependence only to later die of their continued and untreated tobacco dependence.[38]

## Unmet need

Evidence, presented below, 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 have no capacity to support those who present with co-occurring conditions. Emergency department and acute services often do not undertake an alcohol/drug or mental health assessment (which may be the cause of the presentation):

- The Home Affairs Committee report on mental health and policing found that people in crisis, even those being taken to a place of safety, are withheld vital support because of alcohol and drug use being applied as exclusion criteria[39]

- A report by the Making Every Adult Matter (MEAM) coalition describes a persistent failure 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." [40]

- The Recovery Partnership's 'State of the Sector' report for 2015/2016 surveyed 176 drug and alcohol treatment services in England and 20% of respondents stated that access to mental health services had worsened in the previous 12 months.[41]

- The Care Quality Commission (CQC) review of mental health crisis care, "Right here, right now", found that far too many people in crisis have poor experiences due to service responses that "fail to meet their needs and lack basic respect, warmth and compassion." [42]

- People who use alcohol and/or drugs often find themselves excluded from improving access to psychological therapies (IAPT) services, in spite of NICE recommendations that they should be able to access psychological interventions such as cognitive behavioural therapy (CBT) for depression and anxiety.[43]

- The Bradley Report five years on noted that substance use services and mental health services in adult prisons continued to work separately and that a model of integrated working needed to be developed in prisons which recognised the multiplicity of need typical in this population. [44]

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness calls for availability of specialist alcohol and drug services with the ability to manage clinical risk, working closely with mental health services, with agreed arrangements for "dual diagnosis" patients. [45]

In 2002 the Department of Health published guidance[46] which summarised good practice and set out a programme for local implementation, for the assessment and treatment of people with severe mental health problems who have co-occurring alcohol and drug use. The aim was high quality, patient focused and integrated care, delivered within mental health services. While the key principles outlined in the 2002 policy implementation guide are as relevant for mental health and alcohol and drug use services today as they were then, they have not always translated into practice, and significant gaps remain; especially with regard to accessibility to services.

## The new policy context

Local authorities now have a duty to take necessary steps to reduce inequalities and improve the health of their local populations.[47] NHS England and CCGs have a duty to reduce inequalities between patients in access to health services and the outcomes achieved[48]. The NHS Constitution[49] likewise commits the NHS to work across organisational boundaries and in partnership to deliver improvements to health and wellbeing. Recent years have seen a number of policy developments which seek to improve access to care for people with co-occurring conditions.

In 2014, and in response to evidence of significant gaps and variations in quality and availability of care, signatories to the Crisis Care Concordat partners agreed a national action plan[50] which included a specific focus on improving crisis care for people with mental health issues and co-occurring alcohol/drug use. It is through this plan that PHE committed to developing this guidance with the support of NHS England.

The Five Year Forward View for Mental Health[51] sets out a series of recommendations to the NHS and government to achieve parity of esteem between mental and physical health, placing a particular focus on tackling inequalities. It makes a set of recommendations for the six NHS arm's length bodies and commissioners and providers of care to achieve this ambition. Key elements of this include a 24/7 mental health crisis response, meeting the physical healthcare needs of 280,000 people with serious mental illness by 2020/21, the expansion of crisis resolution and home treatment teams (CRHTTs, also by 2020/21) and support for local areas to develop JSNAs which include co-occurring mental health with alcohol/drug use conditions. The The Five Year Forward View for Mental Healthcalls for care centred on the person, addressing physical and social needs as well as mental healthcare needs. STPs and JSNAs are the mechanisms through which all parts of the system can work together and come to shared solutions, and both should explicitly address co-occurring conditions.

In addition to STPs, in 2015 123 children and young people's mental health Local Transformation Plans (LTPs) were developed covering all local health and care systems in England. LTPs will be refreshed on an annual basis and aligned with STPs. The LTP development and update process is led by Clinical Commissioning Groups, but should include all relevant local partners across public health, the NHS, education, children's social care and youth justice, with plans signed off by Health and Wellbeing Boards.

## How this document supports delivery of the Five Year Forward View for Mental Health

As recommended in The Five Year Forward View for Mental Health, NHS England is working with NICE, the National Collaborating Centre for Mental Health (NCCMH) and

other arm's-length body (ALB) partners to develop and publish a clear and comprehensive set of evidence-based treatment pathways (EBTPs), with accompanying access and quality standards and implementation support tools.

All of the EBTPs will address co-occurring mental health and alcohol/drug use conditions in line with relevant NICE guidance. This document aligns with and supports the EBTP development and implementation approach, providing a clear set of underpinning principles which will be drawn upon as the more detailed pathways and their supporting 'infrastructure' (datasets, workforce, lever and incentive systems etc.) are developed.

There are currently a number of EBTPs at different stages of development. More details are available in the resources sections of this document.

The Five Year Forward View for Mental Health recommendations most relevant to people with co-occurring alcohol/drug use conditions are as follows:

**Recommendation 2:** PHE to develop a national Prevention Concordat programme to support health and wellbeing boards (along with CCGs) to put in place updated JSNAs and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing by no later than 2017.

**Recommendation 3:** The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug use. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided to the Department of Health.

**Recommendation 4:** The Cabinet Office should ensure that the new Life Chances Fund of up to £30 million for outcome-based interventions to tackle alcoholism and drug addiction through proven approaches requires local areas to demonstrate how they will integrate assessment, care and support for people with co-occurring substance use and mental health problems. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.

**Recommendation 13**: By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should

incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by:

- Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement)
- Alignment of approaches to mental health provider regulation (NHS Improvement and CQC)
- Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE)
- Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE)

The Five Year Forward View for Mental Health also sets out the ambition for a revised payment system to be in place by 2017/18 for adult mental health services, to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action. It recommends that outcome measures should be used as part of the payment system. These should be co-produced with all stakeholders with a leading role taken by people with lived experience of mental ill health and their carers (including young carers) and family members.

**Other relevant recommendations include:**

- availability of a 24/7 community-based mental health crisis response in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission
- priority access to prevention and screening programmes for people with mental health problems at greater risk of poor physical health and supporting all mental health inpatient units and facilities to be smoke-free by 2018
- by 20/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention
- development of a complete health and justice pathway to deliver integrated interventions in the least restrictive setting, appropriate to the crime which has been committed
- development of a costed, multi-disciplinary workforce strategy to deliver the Five Year Forward View for Mental Health programme (reporting no later than 2016)

**For suggested local action to support implementation of the Five Year Forward View for Mental Health see appendix 1.**

A number of new initiatives can help local commissioners to respond to the challenge of effectively meeting the needs of people with co-occurring conditions and deliver the vision of the five year forward view. From 2016/17 every health and care system in England has produced a multi-year STP. These plans are based on the needs of local populations and delivered by health and care organisations within 44 STP ‘footprints’. STP leaders (senior local partners) convene the process and oversee the development of local plans. Both NHS and local authorities have crucial roles to play in development and delivery of STPs, which require the engagement of all partners across a local health and care system.

The Five Year Forward View for Mental Health also outlined the need for services to be able to demonstrate how they deliver evidence-based, integrated mental healthcare with services assessed on the quality and outcomes that are valued by the people who use them. It recommends national and local outcomes measures should be used as part of the payment system.

Working with stakeholders, NHS England and NHS Improvement have produced guidance[52] [53] [54] to help local footprints develop quality and outcome measures and implement routine measurement to help build the foundations for outcomes-based payment for mental health services in local areas. Further technical guidance on two new payment approaches, capitated payment approach, or an episode of treatment (year-of-care) payment approach has also been recently developed: available here.

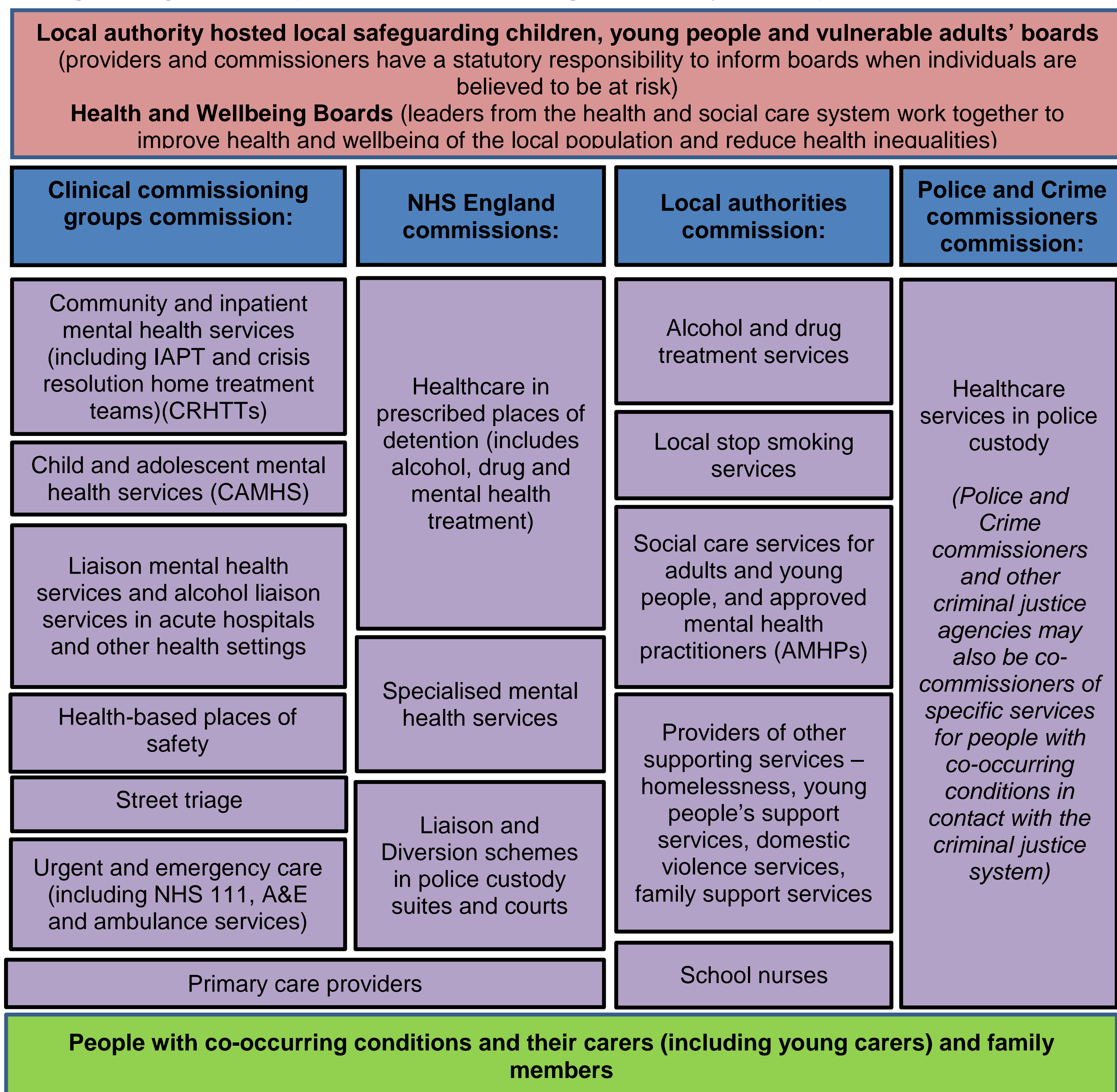
The CQUIN payment incentive programme provides another opportunity for commissioners to incentivise improved care pathways for people with co-occurring conditions. The national CQUINs on emergency department attendance for people with mental ill-health, physical health for people with severe mental illness, and those targeting smoking and higher risk alcohol consumption are likely to be particularly important in improving health outcomes for this group.[55]

People with both mental health and alcohol and drug use conditions are the subject of a wide range of NICE and other clinical guidelines covering serious mental illness,[56] [57] [58] alcohol use,[59] drug use,[60] [61] [62] and tobacco use.[63] [64] [65] [66] A new NICE public health guideline on serious mental illness and co-existing substance misuse[67] was published in November 2016 and echoes the principles described in this guidance. These are authoritative and evidence-based reference points for practitioners and those planning and delivering services.

## The new commissioning and delivery landscape

Changes brought in by the 2012 Health and Social Care Act mean that commissioning responsibility/budgets for services for co-occurring conditions are split across local authority public health commissioners, CCGs, and NHS England regional teams (see Fig 1.).

**Fig. 1. Diagram of the post 2013 commissioning and delivery landscape**



# 5. Guidance for commissioning and delivery of care

## In brief

- this is everyone's job - meeting co-occurring alcohol/drug and mental health needs should be core business for both alcohol, drug and mental health services, supported by wider health and social care services
- commissioners and providers should agree a pathway of care and routinely measured outcomes which will enable collaborative delivery of care by multiple agencies in response to individual need
- every person with co-occurring conditions should have a named care coordinator to help coordinate the multi-agency care plan (for people with severe mental illness this should come under the care programme approach (CPA) – see note on terminology below)
- joint working across sectors needs strong, senior and visible leadership underpinned by shared child and adult safeguarding and quality governance arrangements
- people should be able to access the care they need when they need it and in the setting most suitable to their needs
- there should be a 24/7 response to people experiencing mental health and alcohol and drug use crisis, including intoxicated individuals, with episodes of intoxication being managed safely, and an agreed plan to help people access ongoing care and manage future crisis episodes
- commissioners should ensure that local pathways exist which enable people to access appropriate services e.g. for homelessness, domestic abuse or physical healthcare
- services should be commissioned to help people to access a range of recovery support, and all stakeholders should recognise that recovery is a highly individual process which can often occur in fits and starts and may take many years
- care pathways should meet the specific needs of people in prison, children and young people, older adults and other vulnerable groups
- all contact should be conducted with compassion and convey optimism and belief in the possibility of recovery
- factors in the delivery of effective care include a strong therapeutic alliance, therapeutic optimism, and care that reflects the views, needs and priorities on the person
- advice and interventions to help people stop smoking should be a routine part of care
- carers (including young carers) should be able to access support and care in their own right

- delivery of better care requires a workforce with the requisite skills, knowledge and values

### A note on terminology: collaborative care, the care programming approach, integrated care and specialist dual diagnosis teams

**Collaborative care** means a range of services working in close collaboration to deliver care centred on the needs of the person. There should be a lead co-ordinator of care and a shared care plan and desired outcomes agreed with the person. As well as addressing immediate needs in relation to mental and physical health and alcohol/drug use, the plan should address urgent social care needs, with a focus on specific areas of vulnerability/risk. Collaborative care should be supported by commissioned care pathways which span mental health, alcohol/drugs and wider health/social care needs, and agreed outcomes which all providers are contracted to deliver.

The **Care Programme Approach (CPA)** is a system for co-ordinating the care of people who have been diagnosed as having 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 health and social 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.[68]

**Integrated care** describes care 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.

NICE does not recommend the use of **specialist dual diagnosis teams**. They are not currently supported by the evidence base, and while dual diagnosis practitioners can be an important part of a multi-disciplinary team, particularly in clinical lead roles, the prevalence of co-occurring conditions in mental health and alcohol/drug settings is sufficiently high to make it vital for all services to be competent to respond to these needs (everyone's job).

## Commissioning and delivering pathways of care for people with co-occurring conditions

Commissioners and providers have a shared responsibility to meet the needs of people with co-occurring conditions. Commissioners are key influencers of provider behaviour, and shared leadership from mental health and alcohol and drug commissioners together with adequate investment is crucial to success.

Commissioning should be in line with the evidence base (see Appendix 2). Commissioning plans and outcomes should also be co-produced with experts by experience, carers (including young carers) and family members and service providers, and described in JSNAs, STPs, children and young people's mental health Local Transformation Plans (LTPs)[vi], CCG needs assessments, and NHS England needs assessments.

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.

However the local partners choose to approach commissioning and delivering services for co-occurring conditions, the following principles should drive all local activity:

### Everyone's job

Co-occurring conditions are the norm rather than the exception, and commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to work collaboratively to meet the needs of people with co-occurring conditions.

### No wrong door

Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions. Commissioning enables services to respond collaboratively, effectively and flexibly to presenting needs and prevent exclusion, offering compassionate and non-judgemental care centred around the persons needs which is accessible from every access point.

## Actions for commissioners

[vi] https://www.england.nhs.uk/mentalhealth/cyp/transformation/

1 Develop a shared local understanding of co-occurring conditions, including prevalence and likely demand as well as a shared vision, aspiration and desired outcomes - see below:

**Developing a shared understanding of local need across mental health and alcohol and drug commissioning**

Local needs assessments should be based on the best available information, which includes feedback of experts by experience, carers (including young carers), practitioners and service providers as well as national datasets such as the National Drug Treatment Monitoring System (NDTMS) for alcohol and drug treatment, Health and Justice Indicators of Performance (HJIPs) for criminal justice based interventions, and the Mental Health Services Data Set (MHSDS) for mental health treatment. Reference to primary care data will be important to establish unmet need. The Fingertips Co-existing substance misuse with mental health issues data platform collates and analyses 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. Other Fingertips platforms which may be useful can be found at the Mental health, dementia and neurology intelligence network page, including:

- crisis care
- children and young people's mental health and wellbeing
- community mental health profiles
- common mental health disorders
- severe mental illness
- suicide prevention profile
- dementia profile
- neurology profile

Other useful sources include:

- child health profile data (National child and maternal health intelligence network)
- Hospital Episode Statistics (HES data)
- expert by experience/carer surveys and satisfaction
- data on use of section 136 of the Mental Health Act
- audits of suicides and local alcohol and drug related deaths in line with recommendations – for guidance please refer to PHE/NTA publications 'Local suicide prevention planning – a practice resource', and 'Drug related deaths: setting up a local review process'

To allow for differences in recording, time lags and the need to track people between multiple elements of provision, providers should be brought together to discuss shared cases. Walk-throughs of the current or proposed care pathways involving experts by experience can also help to identify gaps or blockages. When gaps are identified in local information these can be addressed in the resulting action plan which should seek to articulate the shared local understanding of levels on need as well as the local vision, aspiration and desired outcomes.

2 Agree a lead or joint lead commissioner with authority to commission across NHS (mental health services) and local authority public health (alcohol, drugs and tobacco services) sectors (If this is a shared role, commissioners will need to work in close collaboration)

3 Agree an appropriate senior strategic board to oversee commissioning activity and monitor outcomes, supported by shared or aligned quality governance structures.

4 Undertake joint commissioning across mental health and alcohol/drugs/tobacco with a named lead. The lead commissioner(s) should work closely with National Offender Management Service (NOMS) and NHS England commissioners to ensure continuity of care between community and prison settings for all those with co-occurring conditions moving between community and criminal justice care settings

5 Ensure that co-occurring substance use and mental health conditions are addressed as an integral part of all relevant care pathways locally, which should be adequately resourced, co-produced with experts by experience and carers, and signed up to by all relevant providers (not just mental health and alcohol/drug treatment providers) and able to respond to the full range of mental health and alcohol/drug needs and which maximises opportunities for engagement and eventual recovery.

6 Commission an effective and compassionate 24/7 Urgent and Emergency Mental Health Care (UEMHC) response, for all ages which includes adequate health based places of safety (HBPoS) provision – including for those in states of intoxication - and offers screening and further interventions as necessary to keep people safe and connect them with other services for longer term care.[vii]

7 Monitor providers particularly closely on the effectiveness of their response to intoxicated people in mental health crisis, people who are frequently excluded from services because their condition is not judged severe enough, and people with particular risk and vulnerability such as children and young people, people living with children, people homeless or at risk of becoming homeless, and people experiencing domestic abuse. Consider incentivising contracts to support engagement and positive outcomes for people with additional risk/vulnerability factors.

[vii] To support commissioners to do this locally, NHS England is currently working with NICE and NCCMH to develop four EBTPs for 24/7 Urgent and Emergency Mental Health Care with accompanying guidance and resources to aid implementation. These pathways are listed in the resources section and each has been developed with the relevant expertise to ensure they align with the principles set out in this guidance.

8 Make sure that commissioning involves experts by experience and carers (including young carers) in decisions about services and care. Capacity building and investment in user/carer involvement may be needed to ensure that involvement is effective and meaningful.

9 Make sure commissioned providers have staff that are supported and competent to effectively meet all presenting needs with respect, compassion and belief in the possibility of recovery, and following the evidence base/NICE guidelines. There should be an appropriate level of clinical expertise to oversee and ensure quality of service provision for this group in both sets of services.

10 Ensure that the increased risk of suicide for people with co-occurring conditions is well understood locally, that local suicide prevention plans include a strong focus on alcohol and drug use[69] and that the local suicide multi-agency partnership group is sighted on commissioning decisions and service developments.

## Actions for commissioners and providers

11 Collaborate across services and with input from experts by experience and carers (including young carers) to develop an integrated 'offer' of care which addresses physical health, social care, housing and other needs as well as mental health and alcohol/drug/tobacco use. This offer should recognise that increased levels of need, risk and vulnerability will require increased support, and should take account of specific needs.

12 Review service access criteria with experts by experience. Make sure they are not used to exclude people based on levels of alcohol and/or drug dependency, or on diagnoses (or lack of diagnoses) of mental illness, but are used to actively support people to get the help they need.

13 Make sure local arrangements enable reporting and investigation of serious untoward incidents and management of risks. Quality governance and local safeguarding for the co-occurring group should be shared across mental health and alcohol/drugs services.

14 Consider what changes might be needed to enable practitioners to work assertively and flexibly to engage (and assertively re-engage) people– particularly supporting people with chaotic lifestyles and complex needs to manage appointments. This may require 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'.

15 Ensure comprehensive assessment and NICE-compliant interventions are available, delivered by competent, adequately trained and supervised practitioners.

16 Ensure mental health practitioners are competent to respond to presenting alcohol and drug use conditions, and alcohol and drug practitioners to respond to presenting mental health needs.

17 Ensure that alcohol and drug recovery and community engagement, in all forms (harm reduction, 12 Step, SMART, peer support workers, expert by experience and mutual aid groups, family and carer groups), and stop smoking services, are assertively promoted across all mental health services for those with co-occurring alcohol and drug use conditions.

**More detailed implementation questions for commissioners can be found at Appendix 3, and for providers at Appendix 4.**

**Guidance on developing a local collaborative care protocol can be found at Appendix 5.**

## Groups with specific or additional needs

### Those detained in prisons and other prescribed places of detention

People detained in prisons and other prescribed places of detention may have particularly complex co-occurring needs. Care for these people will also need to take account of risk and the impacts of the prison or other place of detention regime in which they are held but should be equivalent to the provision which exists in the community. Commissioning pathways of care that enable people to maintain continuity of treatment when moving between prison and community services is particularly important.

Times and events during the custody journey may increase risk of harm or exacerbate symptoms of mental distress – such as on reception into custody, the first two weeks in custody, changes of cellmate, incidents of violence, transitions to other establishments or back to the community and so on; at such times, providers will need to be increasingly vigilant of managing risk and promoting / ensuring safety.

As well as mental health and alcohol/drug/tobacco use conditions, high numbers of people in the health and justice systems have complex physical health needs and vulnerabilities that are not routinely identified. Those with learning disabilities, autistic spectrum disorders or ADHD and other vulnerabilities need to be identified and provided with supported access to appropriate services. There may also be small numbers of people detained with very specific needs, such as women who are pregnant or have recently given birth. Given the high levels of co-morbidity in those with alcohol drug problems, assessment and treatment of these co-occurring conditions can be crucial to effective care.

People in contact with the criminal justice system may be diverted into programmes designed to support stopping smoking, and tackle drug and alcohol use conditions and mental health problems alongside their offending. These can include requirements to attend treatment services as part of a community rehabilitation order or post release sentence plan. In planning treatment systems commissioners should consider, in consultation with stakeholders, the likely demand from their criminal justice system for treatment services and any additional mechanisms which may be necessary to retain and support individuals in contact with the police, courts and offender rehabilitation services.

### Children and young people

Children and young people need to be protected from harm and be able to access the support they need, when and where they need it. Young people who suffer from domestic abuse, sexual assault and sexual exploitation are more likely to be vulnerable

to co-occurring conditions. Extra support will be needed where young people have multiple vulnerabilities or a high risk of harm (this includes young people affected by child sexual exploitation and abuse, those who parents use substances, those experiencing domestic violence, those engaged in early problematic use, those using Class A drugs, looked-after children, those not in education, employment or training, those at risk of homelessness, and those involved in crime).

Services for children and young people should (in line with legal requirements) be child-centred and appropriate to the young person's age and maturity of development to take account of individual vulnerabilities. Local clinical and safeguarding leads should be involved in the review, design and delivery of services for children and young people with co-occurring conditions.

CAMHS should work in collaboration with alcohol, drug and other services for young people, providing co-ordinated care and support that meets individual needs, and is focused on early identification and coherent pathways so that children and young people do not have to navigate complex referral systems. The annually refreshed Local Transformation Plans (LTPs) for Children and Young People's mental health offer an opportunity for partners across the local health system to identify and agree priorities and joint action. The co-ordination of care should be lead by the most appropriate body, depending on the individual child or young person's need. In many cases this will be CAMHS.

Local commissioning leads should be working with police and crime commissioners and other crisis care concordat local partners to end use of police custody as places of safety for children and young people experiencing mental health crisis. There should be established hospital care pathways for young people presenting to A&E with alcohol-related problems, including mental health crises.

All services have a responsibility to protect children living with people with co-occurring conditions from potential harm via effective and well-understood local safeguarding protocols. This will require joint assessment and management in conjunction with child protection services. There should also be a recognition that encounters with health and social services by people with co-occurring conditions are often negative and lead to fears that children will be removed – this may be an important reason for poor treatment engagement and requires sensitive handling.

Other important factors to consider when commissioning/delivering care for parents with co-occurring conditions are the need for:

- joint work with children's social care area teams with regular meetings and exchanges of staff

- close cooperation with child protection services and the courts with a clear understanding of duties to highlight issues likely to adversely affect parenting capacity
- robust medicines management protocols which highlight the risk of accidental ingestion of prescribed medication by children living with people in treatment
- lead commissioner(s) to attend the local safeguarding children board to address issues relating to child safeguarding

## Older adults

Older people with co-occurring conditions have distinct needs. They are more likely to:

- have other co-occurring conditions
- be on multiple medications
- need 'age sensitive' treatment such as support with sensory, cognitive and physical problems
- need interventions at a slower pace, involving repetition and provision of written information

Mental health services for older adults should provide integrated care with support from alcohol and drug, stop smoking and other services. The provision of skilled assessment, treatment and recovery focused care should take account the need for multiple assessments which are delivered at a slower pace using modes of information that can overcome sensory and cognitive impairment; should involve carers (including young carers), and should offer choice. This is particularly important for people who are frail or cognitively impaired and cannot easily travel to hospital or other settings. Access to crisis services and inpatient units that can meet the specific needs of older adults is also important.

Other important areas include:

- offering harm reduction interventions for the prevention of alcohol related brain injury
- understanding the causes of drug and alcohol-related deaths and taking action to prevent premature and avoidable deaths
- offering support to stop smoking, including harm reduction advice and appropriate pharmacotherapy
- working with other medical specialities to assess and treat multiple physical co-morbidity and polypharmacy
- offering interventions for carer support and family therapy
- offering interventions that improve social needs such as appropriate living conditions, activities of daily living and social activities
- having safeguarding protocols in place, agreed by the local safeguarding leads, to protect older people at risk of abuse

- being able to meet the needs in all settings of older adults for maintenance opioid substitution treatments
- having established robust risk assessment and medicines management protocols which highlight the risk of drug interactions with substances and adverse drug reactions

### Other vulnerable groups

Some groups of people with co-occurring conditions may be particularly at risk of losing contact with services, while also being at greater risk of harm, including:

- people who are homeless
- people who have experienced or witnessed abuse or violence, including women with experience of domestic abuse
- women who are pregnant or have recently given birth
- children and young people
- people who are parents or carers who may fear the consequences of contact with statutory services - for example young carers may fear speaking out in case they are taken into care
- people involved in selling sex
- lesbian, gay, bisexual and transgender (LGBT) people and black, Asian and minority ethnic groups (BAME)
- refugees and asylum seekers
- people without recourse to public funds

Reaching these populations may require local and innovative strategies and service models. Services should be built around the specific needs, and work to overcome potential issues of stigma, mistrust based on poor past experiences or other barriers preventing access. They need to be able to respond to a range of presenting needs, including: alcohol and drug use, mental and physical health issues, and other vulnerabilities such as homelessness and domestic violence. This will require collaboration with a wide range of other services, and close working with local safeguarding for children and vulnerable adults.

## Operating principles for delivery of care

People need to be able to access screening, advice and assessment which address alcohol, drug and tobacco use, mental health issues and other presenting needs in alcohol and drug, stop smoking and mental health services, as well as other health and social care services.

“No wrong door” doesn’t mean that people have to receive care at the first service they attend, but all services should:

- be proactive, flexible, compassionate and anti-discriminatory in their response
- offer rapid assessment and referral if appropriate
- offer a rapid response to urgent physical and mental health and social care needs, while also making plans for longer term care and support
- have a named lead who can coordinate care and wrap around support from multiple providers effectively, underpinned by clear communication reflected in case notes
- explore with people why they may have stopped using services in the past and agree a plan to help them stay engaged

A key part of the “no wrong door” principle is that providers should make every contact count – taking every opportunity to reduce health harms by offering advice and support to:

- stop smoking
- eat healthily
- maintain a healthy weight
- drink alcohol within the lower risk guidelines
- undertake the recommended amount of physical activity
- improve their mental health and wellbeing

It is also vital to recognise that:

- unmet social care needs such as social isolation or poor housing may lead people to have a relapse, increase the risk of mental health crisis, or affect their physical health
- reducing alcohol, drug and tobacco related harm is a valid goal of treatment and abstinence may not always be possible
- mental ill health and alcohol, drug and tobacco use can be chronic and re-occurring conditions, and recovery often occurs in fits and starts, and may take many years
- hope, flexibility and persistence of practitioners are a vital part of supporting people’s recovery, as is visibility of people with lived experience of recovery
- organisations that provide groups and opportunities for people with co-occurring conditions to reduce social isolation can play a crucial role in enabling and sustaining recovery

## Factors in the delivery of effective care

Feedback from experts by experience, and available evidence, tells us that the following should form the basis of delivery of care for people with co-occurring conditions.

## Therapeutic alliance

When a stronger supporting relationship is established, people are more likely to complete treatment, actively explore problems, experience less distress and more pleasant mood, abstain from alcohol and drugs during treatment, and achieve better long-term substance use outcomes[70]. This will include:

- showing empathy and using a non-judgemental approach to listen
- identifying and being responsive to the persons needs and goals
- working flexibly and persistently across sector boundaries to respond to a range of needs, not just one presenting need
- ensuring staff have the resilience and tolerance to help people through relapse or crisis so that they are not discharged before they are fully equipped to cope, or consequently excluded from services

## Collaborative delivery of care

People who have complex needs must have access to care that can comprehensively meet those needs. In addition, people value consistency and stability in their treatment and support. There is evidence that mainstream mental health teams that integrate the mental health and substance use interventions have better outcomes.[71] [72] This aligns with the forthcoming NICE guideline on severe mental illness and substance use,[73] which provides more detailed guidance.

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 (CPA) process by a mental health team.

When assessing co-occurring conditions, practitioners should think about the interrelationship and mutual influence of both conditions, rather than assessing both parts separately. The key question should be ‘how do you see your alcohol/drug/tobacco use helping or hindering your mental health and vice versa?’

## Care that clearly reflects the views, motivations and needs of the person

This should include:

- engagement in a meaningful therapeutic relationship
- creation of a safe and positive environment where people can feel able to engage in an honest dialogue about their situation and goals for treatment
- providing help with practical aspects of care of importance to the person as a way of facilitating engagement
- being prepared to be flexible about the focus of care rather than impose rigid treatment goals
- recognising the persons level of motivation to address mental health and alcohol/drug use conditions and adapt approach accordingly
- recognising that change can be slow especially when there are multiple needs at play, and taking a long term view of progress
- use of behavioural change strategies to facilitate dialogue about goals and aspirations

## Care that supports and involves carers and family members

Carers (including young carers) have needs in their own right. As part of delivering timely, compassionate and effective care to people with co-occurring conditions, and 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. When assessing carers, it will be particularly important to consider:

- the impact of caring on their mental and physical health
- that carers may not be aware of or included in any plans or decisions made by the person
- the extent to which the carer can/will meet the person's support needs – the level of support should be agreed with the carer
- The need to create support networks - for example for young carers.

## Therapeutic optimism

Practitioners should demonstrate a genuine belief in the possibility of recovery, and all interaction and engagement with people using services should be undertaken in a spirit of optimism, with a clear commitment to helping them to achieve this. In practical terms, services should adopt a 'whole person' approach, supporting people to enjoy the rights and responsibilities of active participation in their community. This may involve ensuring that their housing, education, training and employment needs are understood and met; it may require family or parenting support. Local mutual aid organisations and recovery communities can often play a key role in supporting a person's recovery journey.

## Episodes of intoxication are safely managed

People can be at risk of harm to self and/or others when experiencing a mental health crisis and the risks are heightened if they are intoxicated. Services need to ensure that they are equipped to respond. This means having staff able to identify the signs of intoxication and responding appropriately to the associated risks, in particular not being able to maintain one's own safety, physical risks (toxicity, overdose) and disinhibition (possibly enhancing feelings of distress or anger). Once the crisis has been managed and urgent mental and physical health needs have been met it is important to use the opportunity to engage the person in subsequent treatment.

## Advice and support about stopping smoking is a routine part of care

All practitioners should be delivering very brief advice (VBA) to people with co-occurring conditions who smoke. Opportunities for harm reduction to those people who for are unwilling or unable to stop smoking should be available, including access to nicotine replacement therapies and behavioural support. Opportunities to revisit the delivery of very brief advice should be taken as a part of care review, rather than continued acceptance of the status quo of being unwilling or unable to stop smoking.

# Workforce development

Delivering effective care to people with co-occurring conditions requires a workforce with the requisite values, knowledge and skills. People working in mental health and substance use services will require different levels of skills and knowledge depending on their role and seniority.

There will also need to be sufficient people with expertise in co-occurring conditions to be able to provide supervision and clinical leadership.

Local areas should undertake a training needs assessment to gather data on where the gaps lie. Useful tools include the Leeds Capability Framework (an updated version of the Closing the Gap Capability Framework[74] commissioned by the Department of Health to support the implementation of the 2002 Dual Diagnosis Guidance), the 2017 Core Mental Health knowledge and skills framework (commissioned by the Department of Health from Health Education England (HEE), Skills for Health and Skills for Care and PHE's Public mental health leadership and workforce development framework.[75]

This information could then inform training and workforce development initiatives. Research has demonstrated that training alone doesn't impact on outcomes for people who use services. [76] Supervision and good leadership are fundamental to maintaining good standards of care. Other strategies for skills development should be considered such as work-based learning, shadowing in other services, and local multi-agency network meetings with guest speakers, local updates, and opportunities for discussion on specific issues. A suite of learning resources is available on HEE's e-learning for healthcare platform.

# 6. Resources

## Implementation advice and support

PHE centre teams can offer advice and support on implementation.

## Practice examples

We will be adding practice examples to the recovery resources section of the NTA legacy site and the mental health data and analysis section on the gov.uk website.

If you have practice examples to share, please send these to PHE.Enquiries@PHE.gov.uk

Practice examples are also included in the MEAM approach

## Practitioner networks

National consortium of consultant nurses in dual diagnosis and substance use (Progress)

## Commissioning guidance

Local suicide prevention planning – a practice resource

Alcohol and drugs prevention, treatment and recovery – why invest?

Smoking cessation in secure mental health settings: guidance for commissioners

JSNA support packs for alcohol, drugs, tobacco and young people's alcohol and drug use 2017/18

Understanding and preventing drug-related deaths - the report of a national expert working group to investigate drug-related deaths in England

Drug-related deaths: setting up a local review process

Turning evidence into practice – preventing drug-related deaths

Drug alerts and local information systems

Guidance on values-based commissioning in mental health

## Guidance for delivery of care

IAPT positive practice guide for working with people who use drugs and alcohol

Alcohol Concern's Blue Light project: working with change-resistant drinkers – the project manual

Mutual aid framework

Evidence into practice: helping service users to engage with treatment and stay the course

Turning Point. Dual Diagnosis- Good Practice Handbook

Novel psychoactive substance treatment UK network (NEPTUNE). Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances

New psychoactive substances (NPS) in prisons: A toolkit for prison staff

Smoke free mental health services in England: implementation document for providers of mental health services

Practice standards for young people with substance misuse problems

You're welcome – quality criteria for young people friendly health services

Healthcare standards for children and young people in secure settings (2013)

Young people's hospital alcohol pathways

Substance misuse interventions within the young people's secure estate (2012)

**Mental Health Evidence-Based Treatment Pathways and Implementation Guidance**

NHS England is working with NICE and the National Collaborating Centre for Mental Health to develop a series of  evidence-based treatment pathways including recommended response time, intervention and outcome measures,  which will be

published with accompanying implementation guidance and helpful resources to support commissioning and delivery. All will address co-occurring conditions as appropriate to the specific pathway.

Published pathways and implementation guidance:

- Early intervention in psychosis (EIP)
- Eating disorders among children and young people
- Urgent and emergency liaison mental health services for adults and older adults

To be published during 2017/18:

- Perinatal mental health
- Pathways for urgent and emergency mental health care
    - ‘Blue Light’ emergency services crisis response
    - Community crisis response and liaison mental health in acute hospitals for children and young people;
    - 24/7 community crisis response (adults).
- Acute mental health care (adults)
- Dementia
- Children and young people’s mental health

From 2017/18, further pathways will be developed and published for adult community mental health services.

## NICE and clinical guidelines

NICE and national clinical guidelines provide a comprehensive overview of evidence-based practice. Those guidelines most relevant to co-occurring conditions are summarised here:

Coexisting severe mental illness and substance misuse – community health and social care services (NG58). London: NICE; 2016

Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London: NICE; 2007.

Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG120) March 2011

Psychosis and schizophrenia in adults: treatment and management (CG178) 2014

Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185) 2014

Drug misuse – psychosocial interventions (CG51) 2007

Methadone and buprenorphine for the management of opioid dependence (TA 114) January 2007

Naltrexone for the management of opioid dependence (TA115) 2007

Brief interventions and referral for smoking cessation (PH1) 2006

Smoking cessation services (PH10) 2008

Tobacco: harm-reduction approaches to smoking (PH45) June 2013

Smoking cessation in secondary care: acute, maternity and mental health services (PH48) 2013

Older people with social care needs and multiple long term conditions (NG22) 2015

Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

## Staff competency and resources

Closing the gap: a capability framework for working effectively with people with combined mental health and substance use problems (dual diagnosis)

Dual diagnosis e-learning resource

Public mental health leadership and workforce development framework.
Skills for Health and Skills for Care. Core mental health knowledge and skills framework

E-learning for healthcare.

The role of addiction specialist doctors in recovery orientated treatment systems: a resource for commissioners, providers and clinicians

The contribution of clinical psychologists to recovery orientated drug and alcohol treatment systems

Alcohol and other drug use: the roles and capabilities of social workers.

The role of nurses in alcohol and drug treatment services: a resource for commissioners and services (Due February 2017)

Drug and alcohol national occupational standards

## Quality governance/system oversight

Quality governance guidance for local authority commissioners of alcohol and drug services (2015)

Essential standards for substance misuse services

Guidance on CQC regulation of mental health services.

How to make your quality surveillance group effective

# 7. List of contributors

This guidance was co-produced with members of the co-existing substance misuse with mental health issues expert reference group and guidance sub-group

| Name | Job Title | Organisation |
|---|---|---|
| Professor David Kingdon (co-chair, guidance sub-group) | Clinical Service Director (Southampton)/ Professor of Mental Health Care Delivery University of Southampton | University of Southamptom |
| Stephanie Royston-Mitchell | Drug and Alcohol Strategy Manager | Kingston upon Thames |
| Adrian Brown | Alcohol Nurse Specialist | Central and North West London Mental Health Trust |
| Sam Thomas | Policy Manager | Making Every Adult Matter Coalition |
| Richard Edwards | Nurse Consultant for Dual Diagnosis (Co-existing mental health and alcohol and drug problems) | Avon and Wiltshire Mental Health Partnership NHS Trust and representing PROGRESS (national consortium of consultant nurses in dual diagnosis) |
| Professor Ilana B. Crome (representing the Royal College of Psychiatrists) | Emeritus Professor | Keele University |
| Dr Mike Kelleher (Chair, Co-existing substance misuse with mental health issues expert reference group) | Clinical Advisor, Alcohol Drugs and Tobacco | Public Health England |
| Dr Luke Mitcheson (co-chair, guidance sub-group) | Clinical Advisor, Alcohol Drugs and Tobacco | Public Health England |
| **Name** | **Job Title** | **Organisation** |

| | | |
|---|---|---|
| Dr Geraldine Strathdee | National Clinical Lead | Mental Health Intelligence Network |
| Professor Mark Gabbay | Professor of General Practice and HoD Health Services Research | University of Liverpool |
| Dr Linda Harris | Medical Director, RCGP Substance Misuse and Associated Health | Royal College of General Practitioners |
| Professor Sarah Galvani | Chair of Special Interest Group in Alcohol and other Drugs | British Association of Social work |
| Viral Kantaria | Project Manager, Adult Crisis & Acute Care | Mental Health Clinical Policy & Strategy Team<br>Medical Directorate, NHS England |
| Dr Sarah Welch | Clinical Lead | Turning Point |
| Pauline Fisher | Programme Manager | Public Health England |
| Dave Jones | Programme Manager | Public Health England |
| Dr Tony Rao | Consultant Old Age Psychiatrist | South London and Maudsley NHS Foundation Trust |
| Dr Savitha Eranti | Consultant Psychiatrist | Newham Early Intervention Service |
| Lily Makurah | Deputy National Lead, Mental Health and Wellbeing | Public Health England |
| Dr Mark Prunty | Senior Medical Advisor | Department of Health |
| Professor Elizabeth Hughes | Professor of Applied Mental Health Research | University of Huddersfield |
| Gail Gilchrist | Senior Lecturer in Addictions | National Addiction Centre, Institute of Psychology, Psychiatry and Neuroscience, Kings College London |
| Dr Ed Day | Senior Clinical Lecturer in Addiction Psychiatry | National Addiction Centre |

| | | |
|---|---|---|
| Andrew Brown | Alcohol Programme Implementation Manager | Public Health England |

| Name | Job title | Organisation |
|---|---|---|
| Michael Streather | Head of Intelligence (Mental Health), National Mental Health, Dementia and Neurology Intelligence Network | Public Health England |
| Simran Sandhu | Mental Health Intelligence Network Programme Manager | Public Health England |

## We would also like to acknowledge the contribution of the following stakeholders who provided comments on consultation drafts of the guidance

**Name of group/body/organisation**

Service users from Revolving Doors Agency

Alcohol and Drugs Team, London Public Health England

Homeless Link Expert Panel

Making Every Adult Matter coalition (Clinks, Homeless Link and Mind)

AVA (Against Violence and Abuse)

The Royal College of Psychiatrists

Turning Point

Nottingham City Dual Diagnosis Service User Forum

Hertfordshire Drugs and Alcohol Management Group

Shropshire Drug and Alcohol Action Team

Hertfordshire Substance Misuse and Mental Health Governance Group

| Name | Job Title | Organisation |
|---|---|---|
| Angela Harris | Lead Nurse | Yorkshire Ambulance Service |
| Matthew Lees | Mental Health Policy Team | Department of Health |
| Stephen Chandler | Director of Adult Social Services | Somerset County Council |
| Professor Jim McManus | Director of Public Health | Hertfordshire County Council |
| Abigail Gallop | Senior Adviser – Community Wellbeing | Local Government Association |
| Dr A.L. Verner | Consultant Psychiatrist | Reset, East London Foundation NHS Trust |
| Dr John Heckmatt | Consultant Paediatrician and Designated Doctor Child Safeguarding | Hertfordshire Peace Children’s Centre, Peace Prospect |
| Helen Conroy | Public Health Theme lead (Vulnerable People and Improving Lives) | Doncaster Metropolitan Borough Council |
| Ian Hamilton | Lecturer | University of York |
| Professor Eilish Gilvarry | Consultant in Addictions | Northumberland Tyne and Wear NHSFT |
| Dr Ken Checinski | Regional Lead Consultant (South East) | Change, Grow, Live |
| Dr Pardeep Grewal | Consultant Psychiatrist in Addictions | Dual Diagnosis Network, Barnet Enfield and Haringey Mental Health NHS Trust |
| Mary Bailey | Alcohol Project Manager | Public Health Department Sandwell Council |

| Name | Job Title | Organisation |
|---|---|---|
| Eustace de Sousa | Interim Deputy Director - Healthy People (job share) National Lead - Children, Young People and Families (job share) | Public Health England |
| Helen Phillips-Jackson | Strategic Commissioning Manager – Drugs and Alcohol | Sheffield City Council |
| Colleen Simon | Lead Practitioner  Substance Misuse Social Worker/AMHP | Ealing Council |
| Helen Wraith | Project Manager | Calderdale CCG |
| Dr A J Moulson | Clinical specialist lead adult mental health | Airedale, Wharfedale and Craven, Bradford District and Bradford City CCGs |
| Michael O’Kane | Programme Manager | Public Health England |
| Catherine Glew | Senior Policy and Public Affairs Officer | St Mungo’s |
| Oliver Standing | Director of policy and communications | Adfam |
| Susan O'Looney | Commissioning Manager Public Health | Liverpool City Council |
| Dr Derrett Watts | Clinical Director Substance Misuse | North Staffordshire Combined Healthcare Trust (working with the Edward Myers Inpatient Unit and One Recovery Staffordshire) |

| Name | Job Title | Organisation |
|---|---|---|
| Adrian Brown | Alcohol Nurse Specialist Psychiatric Liaison | (CNWL MHT) Northwick Park & Central Middlesex Hospitals Royal College of Nursing, Mental Health Forum |
| Dr Cheryl Kipping | Consultant Nurse (Dual Diagnosis) | South London and Maudsley NHS Foundation Trust |
| Sandra McDermott | Chief Executive | Family Support Link, Northamptonshire |
| Dr Helen Bellfield | Consultant Clinical Psychologist – Dual Diagnosis | Somerset Partnership NHS Foundation Trust |
| Becki Hemming | Programme Lead, Perinatal Mental Health | NHS England |
| Mark Gillyon-Powell | National Programme Lead - Smoke Free Prisons, Substance Misuse and Public Health (Secure & Detained) | NHS England |
| Helen Garnham | Public Health Manager – Mental Health | Public Health England |
| Dr Mark Holland | Consultant Nurse | Dual Diagnosis Liaison Service Manchester Mental Health & Social Care Trust |
| Dr Jennifer Ness | Research Project Manager | Centre for Self-harm and Suicide Prevention Research Derbyshire Healthcare NHS Foundation Trust |

| Name | Job Title | Organisation |
| --- | --- | --- |
| Dr Aideen O'Kane | Consultant Psychiatrist | Newcastle Addictions Service (Prisons/community) NTW NHS Foundation Trust |
| Róisín Reynolds | Acting General Manager | Central and East Locality Cheshire and Wirral Partnership NHS Foundation Trust |
| Dr Graham Sanderson | Clinical Speciality Lead Drugs & Alcohol Misuse | Airedale, Wharfedale and Craven, Bradford District and Bradford City CCGs and Bradford Metropolitan District Council |
| Juliet Grainger | Public Health Commissioning Manager | Wolverhampton City Council |
| Simon Smith | Health and Justice Commissioning Manager | NHS England Lancashire and Greater Manchester |
| David Smith | Victims Services Commissioning and Third Sector Advisor | West Yorkshire Police and Crime Commissioning |
| Dr Lise Hertel | Clinical Lead<br>Clinical Associate New Care Models Team<br>GP | North Central London (NCL) Integrated Urgent Care (IUC) |

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# Appendix 1. Local action to support implementation of the Five Year Forward View For Mental Health

**Recommendation 2:** PHE to develop a national Prevention Concordat programme to support health and wellbeing boards (along with CCGs) to put in place updated joint strategic needs assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing by no later than 2017.

| Action | Desired outcome | Lead | Supporting |
|---|---|---|---|
| Update JSNA and develop joint prevention plans to include mental health and co-morbid alcohol/drug use | Partners describe the local mental health with co-morbid alcohol/drug use population and the extent to which needs are being met, and detail priority actions and desired outcomes in the JHWS<br><br>The actions reflected in contracts with providers and monitored by the HWB | Local authority | CCG<br>Providers<br>Experts by Experience<br>Carers (including young carers)<br>PCC<br>Prison governors |
| Supporting resources: PHE JSNA support packs for mental health, alcohol, drugs, tobacco and young people's substance use, Fingertips data profiles | | | |

**Recommendation 3:** The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug use. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided to the Department of Health.

| Action | Desired outcome | Lead | Supporting |
|---|---|---|---|
| Multi-agency suicide prevention plan to be in place which demonstrate how area will implement evidence-based interventions targeting high-risk locations and supporting high-risk groups | Identified interventions targeting people with co-occurring conditions commissioned jointly by NHS and local authorities<br><br>Established systems to gather and share localised real time data in place | HWB chair/CCG chair | Other commissioners and providers across health and social care, in particular:<br><br>Local authority commissioners<br><br>CCGs<br><br>Primary Care Providers<br><br>Secondary Mental Health care providers<br><br>Emergency Services<br><br>Criminal Justice Services |
| Supporting resources: Local suicide prevention planning portal: https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance | | | |

**Recommendation 4:** The Cabinet Office should ensure that the new Life Chances Fund of up to £30 million for outcome-based interventions to tackle alcoholism and drug addiction through proven approaches requires local areas to demonstrate how they will integrate assessment, care and support for people with co-morbid substance use and mental health problems. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.

| Action | Desired outcome | Lead | Supporting |
| --- | --- | --- | --- |
| Local areas to integrate assessment, care and support for people with co-morbid mental health and alcohol/drug use conditions | People with co-occurring conditions receive packages of care addressing the totality of their health, social care and recovery support needs<br><br>Commissioners and providers have a shared vision, joined up pathway with shared communication and referral arrangements, and an agreed set of outcomes for people with co-occurring conditions | Lead commissioner for co-occurring mental health/alcohol drug use (CCG, Local authority or joint role) | Other commissioners and providers across health and social care, in particular:<br><br>Local authority commissioners and directors of children and adult services<br><br>CCG<br><br>NHS England regional teams<br><br>Prison governors<br><br>PCC |

**Recommendation 13**: By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by:

- Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement)

- Alignment of approaches to mental health provider regulation (NHS Improvement and CQC)
- Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE)
- Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE)

| Action | Desired outcome | Lead | Supporting |
|---|---|---|---|
| Local health and care systems implement evidence-based mental health treatment pathways (EBTPs) which recognise and respond to the needs of people with co-occurring conditions<br><br>Local provider leads undertake workforce competency audit and identify and respond to any gaps | People with co-occurring conditions receive evidence based interventions and care which meets their particular mental health needs and addresses the totality of their health, social care and recovery support needs<br><br>Local workforce are competent to deliver evidence based interventions for co-occurring conditions, and to respond to the totality of health, social care and recovery support needs that people present with | CCG chair<br>STP Lead<br>Provider leads | Lead commissioner for co-occurring mental health/alcohol drug use (CCG, Local authority or joint role) |

# Appendix 2. Evidence-based interventions

NICE and national clinical guidelines provide a comprehensive overview of evidence-based practice. Those guidelines most relevant to co-existing alcohol and drug misuse with mental health issues are summarised here:

| **Adult mental health** | **Alcohol** | **Drugs** | **Tobacco** |
|---|---|---|---|
| Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG120) March 2011<br><br>Psychosis and schizophrenia in adults: treatment and management (CG178) February 2014<br><br>Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185) Sept 2014 | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115) February 2011 | Drug Misuse and Dependence: UK guidelines on clinical management (2007) – update due November 2016<br><br>Drug misuse – psychosocial interventions (CG51) July 2007<br><br>Methadone and buprenorphine for the management of opioid dependence (TA 114) January 2007<br><br>Naltrexone for the management of opioid dependence (TA115) January 2007 | Brief interventions and referral for smoking cessation (PH1) 2006<br><br>Smoking cessation services (PH10) 2008<br><br>Tobacco: harm-reduction approaches to smoking (PH45) June 2013<br><br>Smoking cessation in secondary care: acute, maternity and mental health services (PH48) Nov 2013 |
| Coexisting severe mental illness and substance misuse: community health and social care services (NG58) November 2016<br><br>Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110) September 2010 | | | |

# Appendix 3. Implementation questions for commissioners

## 1. Leadership and culture change

- Are relevant local stakeholders, with the power to effect change participating in and leading on the work?
- Do you have a named lead commissioner with authority to work across sector boundaries?
- Is there a shared vision and aspiration for the target group? Has this been co-produced with experts by experience, their carers/family members (including young carers) and practitioners in both sets of services? Is this understood and owned by experts by experience and providers across all sectors?
- Have you agreed shared outcomes? Are these monitored via operational and strategic boards? Does the partnership have a means of communicating progress against outcomes including improved wellbeing and value for money to senior strategic partners?
- Are lead commissioners for adult mental health and alcohol and drug use engaging experts by experience, local provider managers and lead practitioners in a collaborative way to address gaps in provision?
- Do you promote cross-sector approaches by working on integrated models for service delivery, helped by bringing staff from different disciplines together with agreed information sharing protocols?
- Are your providers encouraged to collaborate with one another, and make use of evidence and local expertise to reach innovative solutions to delivery problems?
- Are commissioning and contracting (including payment incentives) used as mechanisms to ensure that this happens?
- Are you facilitating a local operations group and investing in coordination capacity to help to achieve this?
- Have you identified and prioritised vulnerable groups and are services able to invest time and resources to make every contact count and work to engage people into the care they need?

## 2. Developing a shared understanding of need

- Have mental health and alcohol and drug use commissioners agreed a shared understanding of the challenge and scale of the issue locally? Is this informed by the best available evidence, including local data as well as national?

- Is there explicit agreement on a shared local understanding of co-occurring conditions?
- Is there a coherent, shared vision and aspiration for the client group?
- Is there a local vision for the health and specific needs of vulnerable groups? Is this supported by the health and wellbeing board and included in the joint strategic needs assessment (JSNA), the joint health and wellbeing strategy (JHWS) and the sustainability and transformation plan (STP)?
- Have the above been co-produced with experts by experience, their families and carers (including young carers) and family members, and local practitioners?
- Have you identified which gaps in provision cannot be met by working more flexibly with existing resources? Can you develop a case to invest in these?
- Have you considered a walk-through of the current crisis/acute pathways with experts with experience of co-occurring conditions and other stakeholders to identify the main blocks and offer solutions to overcome these?
- Is crisis care provision adequately resourced to deliver parity in quality of service out of hours? If not, can you work with other local partners to address this?

## 3. Quality governance

- Are there currently any risks in relation to service safety/governance which need to be addressed urgently to save lives and deliver improvements to health and wellbeing?
- Are appropriate, linked quality governance structures in place across both local authority and health commissioning for the co-existing group, and are these well-understood and utilised by providers?
- Are you confident that provider clinical/practitioner leads from all relevant disciplines have the required clinical skills and supervision structures (in line with NICE, national clinical guidelines and guidance on roles and competencies of professionals)?[77] [78] [79] [80]
- Do practitioners understand and make use of safeguarding protocols in relation to vulnerable adults, children and young people, including children living with people with co-occurring conditions?
- Are there established agency level structures which support service user involvement, and regularly involve experts by experience in service design activity as well as decisions about their care?
- Do you have a multi-agency forum or other mechanism to understand the lessons learned from serious incidents where issues relating to co-occurring conditions played a role?
- Are all providers who provide a regulated activity registered with the CQC, and do lead commissioners contribute to post inspection quality meetings to ensure services are meeting the needs of people with co-occurring conditions?

## 4. Investing in and listening to the expert by experience and carer voice

- Have decisions about care and services been co-produced with experts by experience and carers (including young carers)?
- Have experts by experience, and their carers and family members been involved at every stage of the commissioning process?
- Has there been investment in training and capacity building for experts by experience and carers (including young carers) and family members to ensure their involvement is positive and meaningful?
- Have strong links been developed with local recovery communities and peer networks? Have experts by experience been supported to engage with these networks as part of developing positive social networks and engaging in meaningful activities?
- Have local partners identified and engaged people not currently accessing services via emergency departments' homelessness services, liaison and diversion and street triage schemes, schools, employment agencies and local police and criminal justice agencies?
- Does the contract award/review process encourage providers to invest in developing expert by experience, carer and clinical expertise?
- Have strong links been developed with local recovery communities and peer networks? Have experts by experience been supported to engage with these networks as part of developing positive social networks and engaging in meaningful activities?
- Have local partners identified and engaged people not currently accessing services via emergency departments, homelessness services, liaison and diversion and street triage schemes, schools, employment agencies and local police and criminal justice agencies?

[77] Public Health England. The role of addiction specialist doctors in recovery orientated treatment systems: a resource for commissioners, providers and clinicians. London: PHE; 2014.
[78] British Psychological Society. The contribution of clinical psychologists to recovery orientated drug and alcohol treatment systems. London: BPS; 2012.
[79] Galvani S. Alcohol and other drug use: the roles and capabilities of social workers. Manchester: Manchester Metropolitan University; 2015.
[80] Skills for Health. https://tools.skillsforhealth.org.uk/competence_search/

# Appendix 4. Implementation questions for service providers

Are you confident that people with co-occurring conditions:

- Are never turned away from services based on levels of alcohol and drug use or degree of mental ill health, and are supported to access the care they need in the service(s) most appropriate to their needs?
- Have their alcohol and drug needs recognised, prioritised and responded to by mental health practitioners, and their mental health needs recognised, prioritised and responded to by alcohol and drug practitioners?
- Regardless of their entry point to the care pathway, report that the care they receive is timely, compassionate and responsive to their needs?
- Are encouraged and supported to make healthier choices to achieve positive long-term behaviour change?
- Are supported to reflect on their experience of crisis and to develop a plan for managing it in the future?

Are you confident that people delivering care in your services:

- Are competent to recognise and respond to presenting alcohol, drug and mental health needs?
- Are competent to respond to individuals presenting in mental health crisis and/or in states of intoxication, including assessing risk and involving other agencies as appropriate?
- Recognise people may have difficulty communicating their needs while using drugs and alcohol and adopt methods and language that support them to do this?
- Use effective screening, assessment, and (where appropriate) diagnosis information to inform development of comprehensive care planning, never to exclude people from services?
- Ensure where people are assessed as having co-occurring conditions that both are addressed initially, referring on when needed, rather than only addressing one area of need?
- Understand that unmet social care needs such as social isolation or poor housing may lead people with co-occurring conditions to have a relapse or affect their physical health?
- Work with relevant staff in local authorities, social care, community or voluntary sector organisations to meet people’s social care, housing or other support needs?
- Work with individual practitioners or services across primary and secondary health care to ensure that the physical healthcare needs of people with co-occurring conditions are met?

- Are able to identify carers (including young carers) and family members who may have unmet needs, and make appropriate referrals for carers assessments and/or to family support services?
- Ensure ongoing support is available for people who reduce or stop their alcohol or drug use?
- Are able to escalate issues with the agreed care pathway to local commissioners as appropriate?
- Have established recording systems so that the coordination and communication of care planning between substance use and mental health is consistent and well-articulated?
- Approach every contact with people with co-occurring conditions in a spirit of hope and belief in the possibility of positive change?
- Ensure that screening and assessment protocols focus on strengths and recovery capital as well as presenting issues and challenges?
- Assertively promote alcohol and drug recovery and community engagement, in all forms (12 Step, SMART, peer support workers, service user and mutual aid groups, family and carer groups), across all alcohol, drug and mental health services for those with co-occurring conditions?
- Recognise that recovery takes time and that each person will have different goals
- Support effective engagement with carers (including young carers) and family members in support of the individual’s recovery?
- Are competent to offer advice, interventions and support to help people to stop smoking and lead healthy lifestyles, and revisit these goals at each care plan review?
- Incorporate activities that can help to improve wellbeing and create a sense of belonging or purpose into a person’s care plan?

# Appendix 5. Developing a collaborative care protocol

The following are elements to consider when developing your own local protocol to enable collaborative care across different services. They have been adapted from NICE (Coexisting severe mental illness and substance misuse – community health and social care services (NG58))

The protocol should outline how organisations will collaborate, share responsibilities and ensure regular communication when developing or reviewing the person's care plan. The protocol may include mental health and substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.

## 1. Before developing your local protocol, do you have:

- Support from commissioner (s) for co-occurring conditions/delegated authority from commissioners to develop a protocol?
- An identified local forum to oversee development, monitor implementation and review/adapt the protocol in response to changing need?
- Support from other providers of care?
- Support of and input by experts through experience and carers (including young carers)?
- Support of and input by competent clinical leads (mental health and substance use)?

## 2. Deciding where case management should sit:

In line with NICE, this should be a community mental health services practitioner for people with severe mental illness/personality disorder (normally referred to as the care coordinator).

For people with common mental illness (depression, anxiety) a number of different agencies may be able to case manage, including

- Alcohol/drug treatment services
- Primary care
- Social services
- Homelessness services

### 3. Developing the care plan:

The care plan should:

- be developed around the person's needs, involving other organisations as necessary
- include an assessment of the person's physical health, social care and other support needs, and make provision to meet those needs
- address barriers to self-care to enable the person to take care of their physical health
- include agreed review dates
- include a plan to manage mental health crisis agreed with the person
- include a plan to manage discharge and transition points (e.g. young people who move from child and adolescent services to adult services)
- include an assessment of recovery capital/strengths and plan to assertively link the person to recovery supports
- cover behaviours that may affect the person's physical or mental health, in addition to their substance use
- include activities to improve wellbeing

### 5. Communication between care plan review meetings

- Regular communication between the care coordinator or case manager and other practitioners involved in the persons care should be recorded in case notes

### 6. Discharge/transfer arrangements

Before discharging the person from their care plan (the Care Programme Approach) or before they move between services, settings or agencies (for example, from inpatient care to the community, or from child and adolescent mental health services to adult mental health services) ensure:

- There is support to meet the person's housing needs.
- The discharge plan includes strategies for ongoing safety or risk management and details of how they can get back in contact with services.
- There are crisis and contingency plans in place if the person's mental or physical health deteriorates (including for risk of suicide or unintentional overdose).
- Providers share information on how to manage challenging or risky situations