DRUG & ALCOHOL FINDINGS Analysis

Coexisting severe mental illness and substance misuse: community health and social care services.

National Institute for Health and Care Excellence (NICE).
[UK] National Institute for Health and Care Excellence, 2016.

NICE guidance on health and social care for substance users with severe mental illness says that rather than creating specialist 'dual diagnosis' services, health and social care (including substance misuse) services should adapt to this caseload, and their care should be led by the mental health service.

SUMMARY From the UK's official health and care intervention assessors, this guideline covers how to improve services for people aged 14 and above diagnosed as having coexisting severe mental illness and substance use problems. Severe mental illness includes a clinical diagnosis of schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, or severe depressive episodes with or without psychotic episodes. The aim is to provide a range of coordinated services that address wider health and social care needs, as well as other issues such as employment and housing. The recommendations are for both commissioners and providers of services which may be the first point of contact for these patients, including primary care, and for the mental health services to which the patients may be referred.

This account selects from and abridges the featured report's recommendations. Another NICE guideline has dealt specifically with psychosis and coexisting substance use problems.

First contacts

At first contact with services, aim to meet these service user's immediate needs, wherever they present. This includes looking out for multiple needs (including physical health problems, homelessness or unstable housing) and remembering that stigma may make it difficult for them to access services. Be aware that unmet needs such as social isolation, homelessness, poor or lack of stable housing, or problems obtaining benefits, may lead them to relapse or affect their physical health. Provide direct help, or get help from other services, for any urgent physical health, social care, housing or other needs, and ensure their safeguarding needs and those of their carers and wider family are met. Ensure that the focal patient is referred to and followed up within secondary care. Mental health services should take the lead in assessment and care planning.

Ensure secondary care mental health services do not exclude people with severe mental illness because of their substance misuse, and do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance use. Mental health services should adopt a person-centred approach to reduce stigma, address any inequity in access to services, and undertake a comprehensive assessment of the person's mental health and substance misuse needs.

At the secondary care mental health service

On the patient's acceptance at a secondary care mental health service, provide a care coordinator working in mental health services in the community to act as a contact for the patient, identify and contact their family or carers, and help develop a care plan with the patient and coordinate it. Ensure the care coordinator works with other services to address the patient's social care, housing, physical and mental health needs, as well as their substance use problems, and provide any other support they may need.

Involve the patient (and their family or carers if the patient wants them involved) in developing and reviewing the care plan to ensure it is tailored to their needs. This includes offering the patient information about the services available so they can decide which ones would best meet their jointly identified needs and goals. Also involve practitioners from mental health and substance misuse services and other health and social care disciplines. Ensure the care plan is based on a discussion with the patient about how their abilities (such as the extent to which they can take part in the activities of daily living) can help them to engage with services and recover, that it takes into account the patient's experiences (such as their coping strategies to deal with crises), and lists how they will be supported to meet their identified needs and goals, including any carers they have identified to help them, and the type of support the carer can provide. Care plans should also take into account the concerns of the patient's family or carers, recognise and, if possible, reconcile any goals the patient may have decided for themselves if they differ from those identified by their service provider, be optimistic about the prospects of recovery, and be reviewed at every contact. If they agree, share a copy of the care plan with the patient's family or carers and (in line with local information-sharing agreements) with other services as needed.

Mental health services should ensure carers are offered an assessment of their own needs. Based on this assessment, advise the carer that they may be entitled to their own support, for example, using a personal budget to buy care or to have a break from their caring responsibilities. Give information and advice on how to access services in the community, for example, respite or recreational activities or other support to improve their wellbeing.

Consider approaches to keep the patient involved in their care plan including practical one-to-one support, for example in relation to housing, education, training or employment, support to develop self-care skills, arranging travel or travelling with them to appointments or support groups, and arranging for an independent advocate to accompany them at their appointments. Ensure agencies and staff communicate with each other so the patient is not automatically discharged from the care plan because they missed an appointment.

Hold multi-agency and multidisciplinary case review meetings annually or more frequently, based on the patient's

Hold multi-agency and multidisciplinary case review meetings annually or more frequently, based on the patient's circumstances, and involve practitioners from a range of disciplines. Ensure the care plan is updated in response to changing needs or circumstances.

Before discharging the patient from their care plan or before they move between services, settings or agencies, ensure all practitioners who have been (or who will be) involved are invited to multiagency and multidisciplinary meetings and the discharge or transfer meeting, that there is support to meet housing needs, and that the discharge plan includes strategies for ongoing safety or risk management and details of how the patient can re-contact services. There should also be crisis and contingency plans if mental or physical health deteriorate, including for risk of suicide or unintentional overdose.

Coordinating and improving services

Specialist services, health, social care and other support services and commissioners should work together to encourage people with coexisting severe mental illness and substance use problems to use services. Joint strategic working arrangements should ensure continuity of care and service provision (for example, when commissioning contracts are due to expire), that services are based on a local needs or a joint strategic needs assessment, and that service quality is monitored and data-sharing protocols are in place. Agreed joint care pathways should meet the health, social care or other support needs and preferences of people with coexisting severe mental illness and substance misuse, wherever they may present, give people access to a range of primary healthcare and social care providers, and ensure prompt access to these services. These arrangements should also ensure that staff follow people up to make sure their needs are being met and ensure continuity of care through transition points in their lives.

The following steps could be taken to improve service delivery. Ensure existing health and social care services (including substance misuse services) are adapted to engage with and meet the needs of people with coexisting severe mental illness and substance use problems, and involve these people and their family or carers in improving the design and delivery of existing services. Provide local services in places that are easily accessible, safe and discreet, bearing in mind any perceived stigma involved in being seen to use the service. Consider flexible opening times, drop-in sessions, or meeting people in their preferred locations. Adapt existing secondary care mental health services to meet a person's mental illness and substance use needs and their wider health and social care needs. Do not create a specialist 'dual diagnosis' service. Offer interventions that aim to improve engagement with all services, support harm reduction, change behaviour and prevent relapse. Take advice from substance misuse services (if applicable) about these interventions. Challenge negative attitudes or preconceptions about working with this patient group and develop the leadership to conduct such challenges. Ensure practitioners have the resilience and tolerance to help people with coexisting severe mental illness and substance use problems through a relapse or crisis, so they are not excluded from services or discharged before they are fully equipped to cope.

Steps could also be taken to maintain contact between services and people with coexisting severe mental illness and substance misuse. Recognise that even though building a relationship with the patient and even small improvements may take a long time, it is worth persevering. Show empathy and adopt a non-judgemental approach to listen, identify and be responsive to the patient's needs and goals. Provide consistent services, for example, by trying to keep the same staff member as their point of contact and the same lead for organising care. Stay in contact by using the patient's chosen method of communication.

Explore with the patient why they may stop using services that can help them. Reasons may include: fragmented care or services; inflexible services (for example, not taking into account that medication side-effects may affect attendance at appointments); inability to attend due for example to transport difficulties or because services do not provide childcare; not being allowed to attend, for example because they have started misusing substances again; fear of stigma, prejudice or being labelled as having both mental health and substance misuse problems; feeling coerced into using treatments or services that do not reflect their preferences or their readiness to change; and previous poor relationships with practitioners. Ensure any loss of contact or non-attendance is viewed by all practitioners involved as a matter of concern. Follow-up actions could include: contacting the person to rearrange an appointment; visiting them at home; contacting any other practitioners involved in their care or family or carers identified in the care plan; contacting their care coordinator immediately if there is a risk of self-harm or suicide, or at least within 24 hours if there are existing concerns.

FINDINGS **COMMENTARY** For more on the care of mentally ill problem substance users see this Effectiveness Bank hot topic.

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