DRUG & ALCOHOL FINDINGS *Analysis*

This entry is our analysis of a document considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original document was not published by Findings; click Title to order a copy. The summary conveys the findings and views expressed in the document. Below is a commentary from Drug and Alcohol Findings.

▶ Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers.

Public Health England.
Public Health England, 2017

People with co-occurring mental health and substance use problems are often unable to access the care they need. This 2017 guide from Public Health England describes what better care would look like, underpinned by the principles that there is 'no wrong door' for accessing support, and it is 'everyone's job' the other side of the door to help.

SUMMARY With the support of NHS England, which leads the National Health Service in England, Public Health England developed a guide to improve care for people with co-occurring mental health and drug/alcohol problems. It was intended to be used by commissioners and providers of mental health and alcohol and drug treatment services, as well as people who use these services, and aimed to: support local areas to commission timely and effective responses for people with co-occurring conditions; encourage commissioners and service providers to work together to improve access to services that reduce harm, improve health, and enhance recovery; and enable services to respond effectively and flexibly to people's needs and prevent exclusion.

There are two principles informing the goal of "better care":

1. **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. The UK's National Institute for Health and Care Excellence (NICE) does not recommend the use of specialist dual diagnosis teams. 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.
2. **No wrong door.** Providers should have an open door policy for people with co-occurring conditions, supported by commissioners that enable services to respond collaboratively, effectively and flexibly to presenting needs, offering compassionate and non-judgemental care centred around the person's needs, accessible from every access point.

Delivering effective care

Available evidence and feedback from experts by experience indicate that the following principles should form the basis of the delivery of care for people with co-occurring conditions:

Therapeutic alliance. When a stronger supportive 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. This will include:
• showing empathy and using a non-judgemental approach to listening;
• identifying and being responsive to the person's 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 patients are not discharged before they are fully equipped to cope, or excluded from services.

Collaborative delivery of care. 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

> *'How do you see your alcohol/drug/tobacco use helping or hindering your mental health?'*

central point of contact for the client, their carers, and other service providers. When assessing co-occurring conditions, practitioners should think about the interrelationship and mutual influence of both conditions, rather than assessing each part 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 imposing rigid treatment goals;
• recognising the person's level of motivation to address mental health and alcohol/drug use problems and adapting the 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 problems, practitioners should identify carers and family members who may have unmet needs, making appropriate referrals for carers' assessments and/or to family support services. This may include: considering 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; and the need to create support networks.

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 achieve recovery. 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, which means having staff able to identify the signs of intoxication, and responding appropriately to the associated risks such as 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 to people with co-occurring conditions who smoke. Opportunities for harm reduction for people 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 part of a care review, rather than continued acceptance of the status quo of being unwilling or unable to stop smoking.

Workforce development. People working in mental health and substance use services will require different levels of skills and knowledge depending on their roles 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.

Actions for commissioners and providers

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.

2. Agree a lead or joint lead commissioner with authority to commission across NHS mental health services and local authority public health services.

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 and NHS England

NO WRONG DOOR

'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, 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

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 problems 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, signed up to by all relevant providers (not just mental health and alcohol/drug treatment providers), able to respond to the full range of mental health and alcohol/drug needs, and able to maximise opportunities for engagement and eventual recovery.

6. Commission an effective and compassionate 24/7 urgent and emergency mental health care response for all ages, which includes the provision of adequate health-based places of safety for people who police believe to have a mental health problem or to be intoxicated, *and* at risk of causing harm to themselves or another. The service should offer screening and further interventions as necessary to keep people safe and connect them with other services for longer term care.

multiple providers effectively, underpinned by clear communication reflected in case notes;
• explore with clients 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, and improve their mental health and wellbeing.

7. Monitor providers 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.

8. Make sure that commissioning involves experts by experience and carers in decisions about services and care. Capacity building and investment in client/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 and that the local suicide multi-agency partnership group is given sight of commissioning decisions and service developments.

11. Collaborate across services and with input from experts by experience and 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. For people with severe mental illness this would be led by and managed within the care programme approach process by a mental health team. [Unfold supplementary text to read definitions of *collaborative care*, *integrated care*, and the *care programme approach*.]

Close supplementary text

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.

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.

The **care programme approach** 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 care programme approach, they must have a severe mental illness (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.
>
> Close supplementary text

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 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 re-engage) people – particularly supporting people with chaotic lifestyles and complex needs to manage their 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, and using text reminders and/or daily 'check ins'.

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

16. Ensure mental health practitioners have the skills and knowledge to respond to people presenting with drug and alcohol problems, and drug and alcohol practitioners are able to respond to people presenting with mental health problems.

17. Ensure that drug and alcohol services and stop smoking services are assertively promoted across all mental health services for those with co-occurring drug and alcohol problems.

FINDINGS **COMMENTARY** The featured guidance published in 2017 sought to resolve perennial questions about whose responsibility it is to support people with co-existing mental health and substance use problems:

> *Should substance use services take the lead in coordinating their clients' care, or should this be taken on by mental health services?*
>
> *Is either willing and able to take on both issues, or would a better option be to create new integrated services?*

The principles underpinning the guidance were clear and unambiguous: it is **everyone's job** to support people with co-occurring mental health and substance use problems; and, there is **no wrong door** for accessing effective, flexible, compassionate and non-judgemental services.

Complementing this is a set of NICE quality statements published in August 2019 for improving the quality of care that people with co-existing severe mental illness and substance use problems receive:

> *Statement one: "People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs."*
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> *Statement two: "People aged 14 and over are not excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness."*
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> *Statement three: "People aged 14 and over with coexisting severe mental illness and substance misuse have a care coordinator working in mental health services when they are identified as needing treatment from secondary care mental health services."*
>
> *Statement four: "People aged 14 and over with coexisting severe mental illness and substance misuse are followed up if they miss any appointment."*

Australian guidelines updated in 2016 recommend universal mental health screening for people accessing substance use services, and say that mental health issues do not pose an "insurmountable barrier" to effective substance use treatment. In the past the tendency has been to establish the order of onset of the mental health and substance use issues, in an effort to identify which is the 'primary disorder'. Although establishing the order of onset can be useful for understanding the relationship between conditions, the guidelines emphasise that once the comorbid conditions are present it is most likely that the relationship between them is one of "mutual influence" rather than there being a "clear causal pathway".

An Effectiveness Bank hot topic discusses the barriers that have traditionally stifled access to appropriate support for people with co-existing mental health and substance use problems, and identifies opportunities and occasions to improve the lives of those affected.

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