Public Health England

Protecting and improving the nation's health

Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Executive summary

Introduction

Public Health England (PHE) has produced this guidance as one of the actions in the Crisis Care Concordat national action plan. It is for commissioners, providers and users of alcohol, drug and mental health services. It aims to support commissioners and service providers to work together to improve access to services which can improve health and recovery outcomes and life chances for all individuals who experience alcohol and/or drug misuse with co-existing mental health issues. It also aims to support local areas to commission timely and effective responses to individuals experiencing mental health crises. The key elements which will help local areas to deliver these improved service responses and individual outcomes are:

- Strategies and commissioning jointly owned by local authority, clinical commissioning group (CCG) and NHS England (NHSE) commissioners
- Involvement of service users, their families and carers, providers and clinicians in developing local strategy and commissioning services
- Involvement of all stakeholders, particularly the police and local safeguarding boards, in developing effective responses to mental health crisis care where alcohol/other drugs are involved
- Developing a local workforce who are competent to identify, assess and deliver evidence-based interventions, and to work flexibly across organisational boundaries to deliver care centred on individual needs

Scope

The guidance covers:

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

Service responses should reflect the transient and changeable nature of alcohol and drug use and mental health. It will be particularly important to develop appropriate responses to intoxicated individuals in crisis.

Background

Alcohol and drug misuse is common among people with mental health problems. High prevalence of these co-existing issues has been found among the following populations; prisoners, children, young people and adults in alcohol and drug treatment, mentally ill people who commit suicide or homicide, individuals presenting to hospital emergency departments in mental health crisis, and people experiencing severe and multiple disadvantage[1].

Both alcohol and drug misuse and mental health problems can lead to considerable physical morbidity and premature mortality. Smoking is also highly prevalent among both mentally ill and alcohol and drug misusing populations, and is a significant contributor to illness and death.

Evidence from service user and provider surveys suggests that people with co-existing alcohol, drug and mental health issues are often unable to access the care they needs, with mental health problems being insufficiently severe to meet access criteria for mental health services, or because of co-existing alcohol and/or drug misuse issues. And individuals experiencing mental health crisis can fail to access appropriate care due to intoxication (in spite of the heightened risk of harm that this brings).

Policy and delivery context

While the national guidelines developed in 2002 (dual diagnosis policy and implementation guide, Department of Health) contains guidance which is still relevant today, provider feedback suggests that the recommendations in this guidance have not been widely implemented, with individuals unable to access much-needed care for complex problems. Changes to the commissioning and delivery landscape in recent years present new challenges – with commissioning for co-existing alcohol and drug misuse and mental health uniquely positioned across local authority, CCG and NHSE commissioners. Without shared ownership and strong leadership of this agenda, this risks a fragmented approach which is reflected in the experience of the service user.

Successful outcomes require early intervention and effective collaboration across alcohol, drug and mental health services. New policy developments and associated funding in mental health have the potential to help deliver these.

This guidance outlines the following principles for commissioning and delivery of care to help local areas successfully meet the needs of individuals with co-existing alcohol, drug and mental health issues:

[1] Substance misuse, homelessness and criminal justice involvement.

1. Commissioners and providers of alcohol and drug misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing alcohol and drug misuse and mental health issues.

2. Commissioning enables services to respond effectively and flexibly to presenting needs and prevent exclusion

3. Providers in alcohol and drug, mental health and other services should have an open door policy for individuals with co-existing alcohol and drug misuse and mental health issues, and should make every contact count.

4. Vulnerable children and young people are able to access the support they need, when and where they need it.

5. People can and do recover from alcohol and drug misuse and mental ill health

Accompanying these principles are suggested priorities to guide commissioning, and implementation prompts for both commissioners and providers. Other sources of help and information are included at the end of the document.

Introduction

NHS England (NHSE) and Public Health England (PHE) have produced this guidance as one of the actions in the National Crisis Care Concordat Action Plan. This guide is for commissioners, providers and users of substance misuse and mental health services including

Clinical commissioning groups
Local authorities
Directors of Public Health
Health and wellbeing boards
NHS England local area teams
Users of mental health and substance misuse services, their families and carers
Mental health and substance misuse service providers in community and secure settings.

The guide is split into two parts as follows:

Part one details the scope of the guidance, gives an overview of the current situation and outlines responsibilities of local partners

Part two considers how partners can ensure they are responding to the needs of the local population by setting out both principles for commissioning and delivery of care, and implementation questions and case studies to help put principles into practice. Suggested outcomes are:

- identifying and providing relevant care for individuals with co-existing substance misuse and mental health issues is seen as an integral part of both sets of services
- effective collaboration between commissioners and providers of mental health and substance misuse services which improve the treatment experience and recovery outcomes of individuals with co-existing alcohol, drug and mental health issues.
- people can access the care they need, with assessment information used to inform care planning, not to exclude from services
- people with co-existing alcohol, drug and mental health needs are able to better manage their lives through access to person centred and co-ordinated services
- services are more tailored and better connected and empower users to take full part in effective service design and delivery
- timely, compassionate and effective responses to individuals in crisis, including individuals intoxicated or in acute withdrawals

These outcomes should be underpinned by:

- shared local strategies and co-commissioning with outcomes jointly owned by substance misuse and mental health commissioners and supported at senior level

- involvement of service users, providers and clinicians in developing local strategy

- involvement of all stakeholders, including the police and local safeguarding children and adults boards, in developing effective responses to mental health crisis care where alcohol or other substances are involved

- a workforce in mental health and substance misuse services who are competent to identify, assess and deliver evidence-based interventions, and who can work collaboratively across agencies to deliver care centred on the needs of individuals

Scope

The scope of the current guidance includes any alcohol and/or drug misuse with coexisting mental health issues. It reflects the high prevalence of alcohol and drug use amongst people with a broad spectrum of mental health problems, and is intended to improve service responses to people with these co-existing issues.

These problems are evident in populations within community, residential, inpatient and prison settings, across the lifespan and in specific high risk populations; veterans, homeless people, and those involved in the criminal justice system. The scope includes:

- children, young people and adults, including older adults
- community settings and prescribed places of detention
- all psychoactive drugs used for subjective effects (illicit as well as currently legal / prescribed) including
    - alcohol
    - tobacco
    - legal highs/NPS
    - prescribed medication subject to misuse
- all mental health problems including
    - common mental illnesses
    - severe mental illness
    - personality disorder
    - dementia
    - alcohol-related brain damage, including Korsakoff's syndrome
- transient episodic use as well as dependent use. This includes intoxication effects in those that are not dependent

It is important to recognise that both alcohol and drug use and mental health issues are changeable and that degrees of symptoms and levels of dependence may fluctuate. This should be reflected in the local service response, including responding appropriately to intoxicated individuals in crisis, as well as intoxicated individuals trying to engage with services.

Part 1

Background

Prevalence and harm

Alcohol and drug misuse is common among people with mental health problems and the relationship between the two is complex. Research indicates that up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems[1]. 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, with very low referral rates from mental health treatment into alcohol and drug treatment[2].

- The National confidential enquiry into suicide and homicide by people with mental illness found that suicides among patients with a history of alcohol or drug misuse (or both) accounted for 54% of the total sample, an average of 671 deaths per year[3]. Other evidence shows that alcohol use disorder is an important predictor of suicide/premature death[4]

- Co-existing alcohol use 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)[5]

- A high prevalence among prison populations with the 2009 Bradley report[6] recognising that co-existing alcohol and drug misuse and mental health issues are the norm rather than the exception among most offenders. Prisoners are also at increased risk of self-harm and suicide[7]

- Data collected from trial sites commissioned by NHSE under the Liaison and Diversion Programme showed that over 55% of service users identified in with mental health needs also had problem with either substance abuse, alcohol misuse or both. Similarly, amongst those with alcohol misuse issues, over

three-quarters also suffered a mental health problem. In the case of people with other substance misuse, the percentage who also demonstrated mental health needs was even higher at 79%.

- Hard Edges, a report looking at severe and multiple disadvantage in England, found that of an estimated 58, 000 people nationally experiencing severe and multiple disadvantage (substance misuse, homelessness and criminal justice involvement), over half (55%) had a diagnosed mental health condition

- Both alcohol and drug misuse and mental health problems can lead to 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 misuse disorders compared to national norms[8]

- People with mental health problems are more likely to smoke and it is the single largest contributor to their ten to 20-year reduced life expectancy. A recent UK study highlighted that men and women living with schizophrenia in the community have a 20.5 and 16.4-year reduced life expectancy respectively[9].

- 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 by these mental health populations[10].

- 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[11].

Service response

"People with a dual diagnosis are, in effect, a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can fall just below the threshold of all "helping" services."

Psychiatrist, quoted in Turning Point/Rethink toolkit[12]

In addition to the evidence describing the range of risk factors and poorer health outcomes experience by those with co-existing mental health and alcohol and/or drug problems, service user and practitioner data describes how people with these co-existing issues are often unable

to access the care they need. This may be particularly true of those who are not mentally unwell enough to access community mental health services (where typically only those with severe and enduring mental health issues are able to access care), yet also struggle to access IAPT services with co-existing alcohol or drug misuse issues. At the most severe end of the mental health spectrum, it is common to hear of people being excluded from adult mental health services because they have co-existing alcohol and/or drug issues.

"Voices from the Frontline: listening to people with multiple needs and those who support them"[13] presents qualitative data drawn from interviews with individuals and support services which 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."

Other evidence suggests that there are still significant gaps at both strategic planning and service delivery level – and the situation may be worsening. Drugscope's 'State of the Sector' report for 2014/2015 surveyed 189 drug treatment services in England and found that 22% of respondents indicating that access to mental health services had deteriorated over the 12 months to September 2014.

The Care Quality Commission's thematic review of mental health crisis care 'Right here, right now' raised concerns that public services, such as local authorities, NHS trusts and clinical commissioning groups, were failing to work together to make sure that people in their local areas have access to crisis care. While many good examples of crisis care exist, the report 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.[14]" Data from Improving Access to Psychological Therapies (IAPT) services suggest that people with mental health problems associated with alcohol use are underrepresented in referral rates, and, when they do access services, are least likely to have a successful outcome[15].

'The Bradley Report five years on[16]' noted that substance misuse 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. It considered that NHSE having responsibility for commissioning healthcare services including substance misuse in prisons and other prescribed places of detention provided opportunities for driving more integrated working.

It is clear that effectively meeting the needs of this very vulnerable population will require a new focus and significant degree of priority. This guidance aims to support commissioners and service providers across alcohol, drugs and mental health to work together to ensure that these vulnerable and high-risk individuals are able to access they care they need, when they need it. Individuals with these co-existing problems need high quality and collaborative care which is

organised around their needs and the needs of their families and carers. **This should be delivered in the setting which is most suitable for their needs.**

The policy context

In 2002 the Department of Health developed a policy and implementation guide[17] which sought to summarise good practice in relation to assessment and treatment of severe mental health problems with co-morbid alcohol and drug misuse and set out a programme for local implementation. The stated aspiration 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 misuse services today as they were then, **this aspiration has not translated into practice.**

Individuals with both mental health and alcohol and drug misuse issues are the subject of a wide range of NICE clinical guidelines covering serious mental illness[18 19 20], alcohol misuse[21], drug misuse[22 23 24], and tobacco use[25 26 27 28]. While these are all important reference points for clinicians and those planning and delivering services, significant gaps remain.

Both the 2010 drug strategy[29] and 2011 mental health strategies[30] acknowledge the link between mental health problems and alcohol and drug problems, going on to note that individuals with co-existing alcohol and/or drug and mental health issues are likely to experience both issues simultaneously and may be at risk of a range of other excluding factors, such as homelessness, offending behaviour, social isolation, unemployment and financial exclusion. 'Future in mind[31]' highlights the fragmentation in delivery of care to vulnerable young people who are experiencing mental health issues.
Successful outcomes for these problems need early intervention and effective joint working between drug and alcohol treatment and mental health services in integrated, recovery-orientated local systems. New policy developments and funding have the potential to deliver these.

The Crisis Care Concordat has established a national action plan to improve crisis care for people with mental health issues, and this new national guidance is one of the key actions in that plan. New access and waiting time standards have been introduced nationally from 1st April 2016 for mental health. The first of these focuses on early intervention in psychosis (EIP), Improving access to psychological therapies (IAPT) and eating disorders, with equivalent standards for mental health crisis care currently being developed. Access and waiting time standards in mental health services must be implemented so as to ensure reduced inequity in access and improve outcomes for all who require care. Funding of £1.25 billion funding has been allocated in response to 'Future in Mind'[32], and a further £1 billion has recently been announced[33] (including nearly £250 million for mental health services in hospital emergency departments, and over

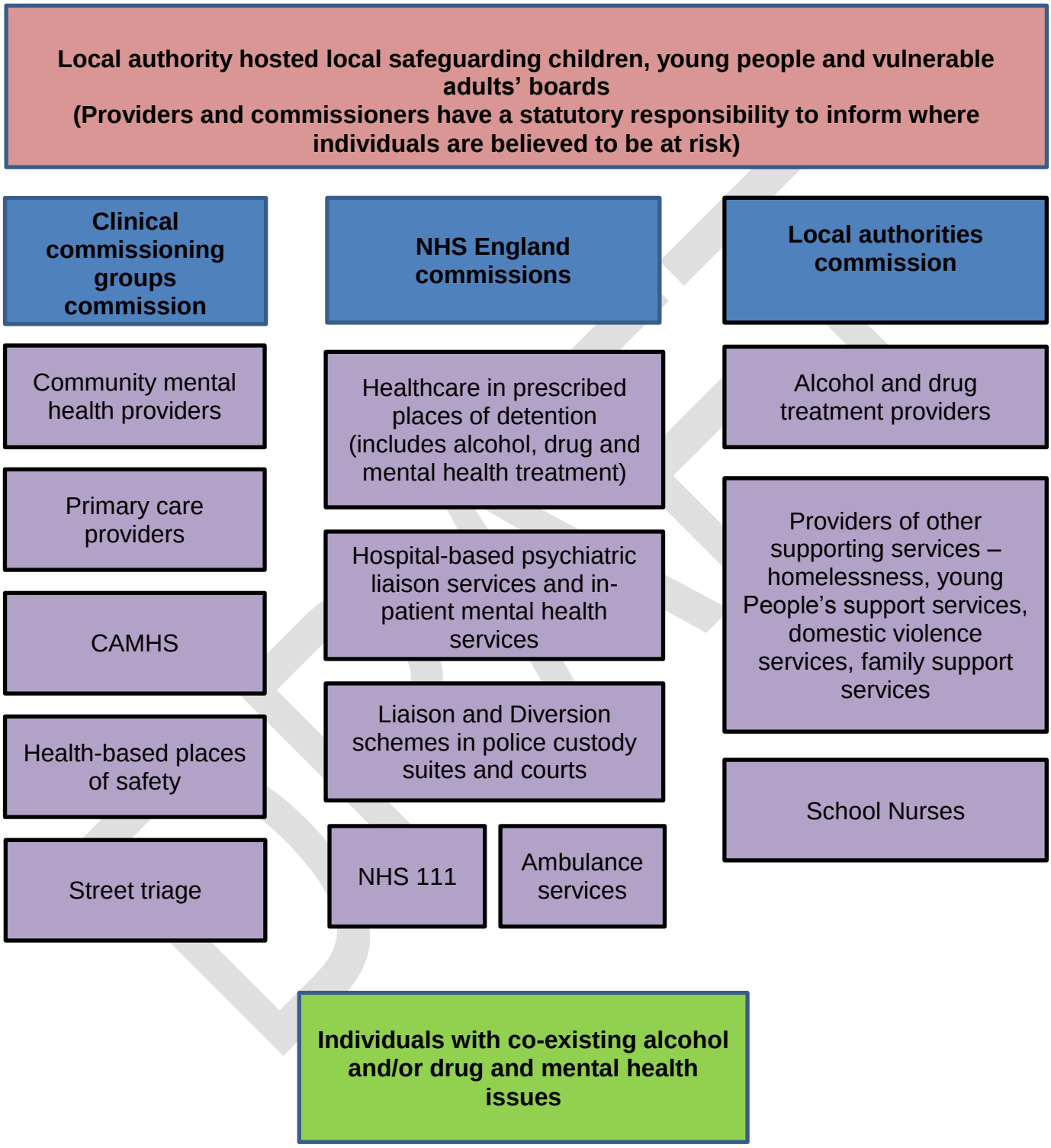
£400 million to enable 24/7 treatment in communities as safe and effective alternative to hospital).

The new commissioning and delivery landscape

The commissioning and delivery landscape for co-existing alcohol/drug and mental health issues has changed substantially since national guidance for co-existing alcohol and drug misuse with mental health issues was last issued in 2002. Changes brought in by the 2013 Health and Social Care Act mean that services for co-existing alcohol and drug misuse with mental health issues are uniquely positioned, with commissioning responsibility/budgets split across local authority public health commissioners, CCGs, and NHSE Local Area Teams (LATs).

These changes have afforded both opportunities and challenges. While location of alcohol and drug misuse commissioning within local-authority based public health was intended to strengthen links between treatment services and services vital to recovery such as housing and employment, separate commissioning arrangements for mental health, now CCG and NHS England-led, create a risk that commissioning and provision will become increasingly fragmented. Commissioning of services for individuals in contact with the criminal justice system in prescribed places of detention (led by NHS England's local area teams) is an additional complicating factor, although the recent emphasis on the need for 'through the gates' services that better connect community and prison services again offers new opportunities. The following diagram depicts the commissioning responsibilities and service delivery landscape for the co-existing alcohol/drug misuse with mental health issues population:

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



The challenge for today's commissioners is to work collaboratively across organisational boundaries. What this means in practice is that lead commissioners for mental health, alcohol and drug misuse and other relevant sectors such as criminal justice, employment and housing will need to work in partnership with service users, their families and carers, and service providers to **develop a shared local understanding, vision and agree a set of priority outcomes** for the local co-existing alcohol and drug misuse with mental health issues population which can **inform commissioning of a continuous care pathway**. This may be achieved by using existing strategic boards such as the Health and Wellbeing Board or Clinical Commissioning Group, or it may be desirable to establish a separate board to oversee a specific, targeted system-change intervention. It may involve the development of co-commissioning or joint commissioning between the Local authority and CCG. The essential element here is a shared ownership and leadership of the co-existing alcohol and drug misuse with mental health issues agenda, at a senior local level to influence commissioning and delivery, to join up the service response and to deliver outcomes for individuals.

Part two

Guidance for service commissioning

Commissioners have a shared responsibility to meet the needs of their local population, and the needs of individuals with co-existing alcohol and/or drug misuse with mental health issues should be reflected in the local Joint Strategic Needs Assessment (JSNA), Clinical Commissioning Group needs assessments, and NHS England needs assessments. Commissioning partnerships need to establish their own local prevalence estimates which can form the starting point for service development and better joint-working across mental health and alcohol and drug misuse services. Commissioning should be in line with the evidence base (NICE and national clinical guidelines – see Appendix 1)), and the views of people who use services and their carers should be considered alongside the scientific and research evidence.

Commissioners are key influencers of provider behaviour, and shared leadership from mental health and alcohol and drug misuse commissioners together with adequate investment in providers to deliver will be crucial to success. However the local partners choose to approach commissioning services for coexisting alcohol and drug misuse with mental health issues, there are two key principles which should inform commissioning activity:

Principle 1 – Commissioners of alcohol and drug misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing alcohol and drug misuse and mental health issues.

Senior level local leadership by those who oversee both mental health and alcohol and drug misuse commissioning is critical to success. Collaboration between local authority commissioners, clinical commissioning groups, National Offender Management Service (NOMs) and NHS England (LAT) commissioners will be key to ensuring appropriate commissioning and delivery of care for all those with co-existing alcohol and drug misuse and mental health issues, irrespective of severity, duration or care setting (community or prison).

Principle 2 – Commissioning enables services to respond effectively and flexibly to presenting needs and prevent exclusion

All commissioning should be based on a process of collaboration, co-production and shared decision making between commissioners, service users and service providers. Services should be built around the needs of users and 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.

Commissioners will want to assure themselves that staff in both alcohol and drug misuse and mental health services need to be competent to identify and respond to presenting needs. Given the prevalence of comorbid mental illness with alcohol and drug misuse (and in the absence of robust evidence for the effectiveness of specialist dual diagnosis teams) it is vital that staff in alcohol and drug services are competent to recognise assess and respond appropriately to presenting mental health needs, and that staff in mental health services can do the same for presenting alcohol and drug needs.

What should commissioners look for in a good service for their co-existing alcohol and drug misuse with mental health issues population?

- an appropriate level of clinical expertise to oversee and ensure quality of service provision for this group in both sets of services
- comprehensive assessment and evidence-based interventions available within both alcohol and drug, and mental health services
- staff teams in both services are competent, adequately trained and supervised to respond to a range of presenting needs, including alcohol/drug use and mental health issues
- service access criteria are not used to exclude individuals presenting based on levels of alcohol and/or drug dependency, or on diagnoses (or lack of diagnoses) of mental illness, but to actively support individuals presenting to get the help they need
- emergency and mental health services offer appropriate interventions and support to individuals in states of intoxication/experiencing mental health crisis. This includes suicidal or psychotic patients where intoxication or withdrawal is considered the cause.
- services provide support to help individuals access other services required, recognising that increased levels of need/risk/vulnerability will require increased support.
- where people are assessed as having co-existing alcohol and drug misuse and mental health issues, do providers address both initially and refer on when needed, working collaboratively, rather than only addressing one area of need?
- services are provided in line with NICE and other relevant national guidance
- there is a continuous care pathway that all providers sign up to and take responsibility for. Coordination and communication of care planning between alcohol and drug misuse and mental health is consistent, well-articulated, and reflected in case files
- There is a joined-up response across children's services using care and referral pathways for vulnerable children and young people

- alcohol and drug recovery and community engagement, in all forms (harm reduction, 12 Step, SMART, peer support workers, service user and mutual aid groups, family and carer groups), are assertively promoted across all mental health services for those with co-existing alcohol and drug misuse issues

To achieve this, the following are suggested as commissioning priorities:

1. Leadership and culture change

Tackling gaps in provision across sectors requires strong, high visibility leadership from commissioners and clinical leaders in both adult mental health and alcohol and drug misuse. Commissioners should foster a culture where providers have a mandate to work flexibly and collaboratively across organizational boundaries to deliver outcomes for the client group. There is a real risk that without this, work will continue to take place in isolation and opportunities for the client group to achieve their goals will be lost.

Implementation questions:

- are relevant local stakeholders, with the power to effect change participating and leading the work?
- is there 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 service users, their carers/family members and clinicians in both sets of services? Is this understood and owned by service users and providers across all sectors?
- have shared outcomes been agreed? 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 misuse engaging service users, local provider managers and lead clinicians in a collaborative way to address gaps in provision?
- promoting 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 lead commissioners considering joint commissioning and development of an integrated health and wellbeing offer to young people in your area? Are both child and adult services involved in development of this offer?
- are local providers sufficiently resourced to deliver?

- are local leaders visible and accessible?
- is effective use made of local evidence to influence local strategy and ensure that local strategic partners are engaged and supportive of the agenda?
- is there a flexible and responsive approach to commissioning relationships/interactions with providers?
- are 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 used as mechanisms to ensure that this happens? Facilitating a local operations group and investing in coordination capacity can help to achieve this.
- are there clear mechanisms to understand the lessons learned from serious incidents where issues of co-existing diagnosis played a role?
- have local partners 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. Invest in the user and carer voice

It is essential to listen and respond to the service user voice – which should be viewed as the first source of information as to how services can better meet their needs. The importance of service users and those outside of services having a strong voice in this process cannot be overstated. A strong service user voice will help to ensure that user-defined recovery goals across alcohol and drug use and mental health are reflected in service level outcomes and that the partnership is held to account for delivery of these. Capacity building may be beneficial in ensuring that engagement is effective and meaningful. Supporting and investing in service user involvement can also support individuals to recover and to begin to play an active, participative role. The following will help to achieve effective service user involvement:

Implementation questions:

- have service users, families and carers been consulted about what they want?
- have service users, their families and carers been involved at every stage of the commissioning process? This is likely to require investment in training and capacity building for service users and carers to ensure their involvement is positive and meaningful.
- have the views of service users been acted on? Are they able to shape the future direction of the services to best meet their needs?
- have service users and providers worked together to find out which services work in the best way for clients, and which might need to work differently
- Have strong links been developed with local recovery communities and peer networks? Have service users 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 individuals 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 user and clinical expertise?

3. Develop a shared understanding across mental health and alcohol and drug misuse commissioning

Local needs assessments should be based on the best available information, which is likely to include feedback of service users, clinicians and service providers as well as national datasets such as the National Drug Treatment Monitoring System (NDTMS) for alcohol and drug treatment, and the Mental Health Minimum Data Set (MHMDS) for mental health treatment.

The Fingertips Co-existing substance misuse with mental health issues data platform collates and analyses a wide range of publically 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 stakeholder 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:

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 Episodes Statistics (HES data)
- Service user 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

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 co-existing alcohol and drug misuse and mental health issues, and vison, aspiration and desired outcomes.

Implementation questions:

- Have mental health and alcohol and drug misuse 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 a local vision for the health of young people aged 10-24, including the specific needs of vulnerable groups? Is this should be supported by the health and wellbeing board and included in the joint strategic needs assessment (JSNA) and the joint health and wellbeing strategy?
- Is there explicit agreement on a shared local understanding of co-existing alcohol and drug misuse and mental health issues?
- Is there a coherent, shared vision and aspiration for the client group?
- Have the above been co-produced with service users, their families and carers, and local clinicians?
- 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?
- is crisis care provision adequately resourced? If not, can you work with other local partners (police, CCG) to address this?

3. Engage local clinical expertise

Local clinical leaders are key to identifying and responding to gaps in provision. In addition to having access to detailed information about the health and social profile of the potential client group, they have the expertise and detailed knowledge of the evidence base required to design safe, effective and evidenced care pathways for individuals with coexisting alcohol and drug misuse and mental health issues.

Implementation questions:

- 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 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?
- Do clinical 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[34 35 36 37])?
- Has local clinical expertise informed service design? Have clinicians been consulted on changes necessary to better meet the needs of the co-existing alcohol and/or drug misuse with mental health issues population?

Guidance for delivery of care

Providers have a responsibility to respond appropriately to individuals in need who present to their service. This responsibility is not abrogated by the level of intoxication or dependency, or the seriousness of any mental health issues. An initial assessment of mental health and substance misuse needs should be completed, and individuals should be supported to access other services as appropriate. The following principles should inform service delivery and development of working protocols between providers in mental health and substance misuse services:

Principle 1 – Providers in alcohol and drug, mental health and other services should have an open door policy for individuals with co-existing alcohol and drug misuse and mental health issues, and should make every contact count.

What this means:

Service users can access screening, advice and comprehensive assessment which address alcohol and drug and mental health issues, and other presenting needs in both alcohol and drug and mental health services. All local services need to be ready to respond to the needs of individuals with co-existing substance misuse and mental health issues, not just the presenting issue. Use of diagnoses as exclusion criteria compounds issues of stigma and is likely to result in unmet need and increased risk of harm. Services should work to identify risks and mitigations to support engagement of all presenting individuals (including intoxicated individuals). Additionally, every opportunity should be taken to reduce health harms and earl death among individuals with these co-existing issues by offering advice and support to:

• stop smoking
• eat healthily
• maintain a healthy weight
• drink alcohol within the recommended daily limits
• undertake the recommended amount of physical activity
• improve their mental health and wellbeing.

How to know if this principle is translating to delivery:

Service users:

- 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

Clinicians and frontline staff:

- Are competent to recognise and respond to presenting alcohol, drug and mental health needs
- 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-existing issues that the provider addresses both initially and refers on when needed, rather than only addressing one area of need
- Work flexibly across organisational boundaries to enable service users to access the care that they need for alcohol, drug and mental health issues,

Service managers:

- Agree jointly owned care pathways and protocols for delivery of care to individuals across the full spectrum of alcohol and drug misuse, and mental health need
- Ensure that staff are supported to develop the competencies they need to respond effectively to individuals with co-existing alcohol, drug and mental health issues.
- Foster a service culture where clinicians and frontline staff can respond flexibly and offer care that is timely, compassionate and responsive to the needs of the individual

Principle 2 - Providers of substance misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing substance misuse and mental health issues

What this means:

The assessment and treatment of people who need care for co-existing alcohol and drug misuse and mental health issues are the responsibility of both mental health and alcohol & drug

services, and all partners need to work together effectively across and outside organisational boundaries to meet their needs.

Mental health and alcohol and drug services should work together in line with relevant NICE and other national guidance, to deliver evidenced based interventions as part of jointly agreed care pathways. These should be jointly planned, designed to minimise any gaps in provision and opportunities for disengagement and relapse. Services should also work in partnership with other services as necessary, particularly housing, employment and criminal justice services. If services are unable to engage certain individuals this should be seen as a system failure not a client failure. The partnership should work with the individual and services involved to establish better or more appropriate ways of engaging these individuals.

Individuals with co-existing alcohol, drug and mental health issues are often at significant risk of suicide and self-harm, particularly during periods of intoxication or untreated withdrawal. Services (particularly crisis care services) need to be able to respond appropriately and safely to mental health needs such as suicide risk which arise during periods of intoxication where the individual is not dependent on alcohol or drugs.

Services also need to be able to respond effectively to individuals who present a risk to others e.g. violent/sex offenders or MAPPA clients who may not engage well with treatment services, but may present in crisis. This is likely to require short-term safety measures with provision of longer-term support with mental health and/or substance use issues.

How to know if this principle is translating to delivery:

Clinicians and front line staff:

- know where to escalate issues with local pathways – including whistleblowing/making use of local safeguarding procedures if the system is failing to provide an adequate response to vulnerable people
- Use assessment information to develop comprehensive care plans rather than to exclude people from service
- Are competent, adequately trained and supervised to recognize and respond to presenting alcohol, drug and mental health need
- are able to work persistently and flexibly across organizational boundaries to ensure the full range of service user needs are met
- Always work within the limits of their competence and know when to involve other agencies
- Have participated in the development of/ have a clear understanding of locally agreed pathways and are able to support individuals to navigate these

- 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

Service Managers:

- Have agreed a continuous care pathway with alcohol and drug, mental health and other providers, with appropriate links to other supporting services (e.g. primary care, homelessness)
- Have agreed assessment protocols to ensure mental health needs and substance misuse issues can be identified, and information shared with other professionals as necessary
- have established supervision structures for staff around treating this patient group.
- work constructively and flexibly across organizational boundaries, and negotiate solutions to issues which arise without adversely affecting continuity of care
- understand and make use of local quality governance structures, including safeguarding and SUI reporting
- 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 misuse and mental health is consistent and well-articulated.
- have established agency level structures which support service user involvement, and regularly involve service users in service design activity as well as decisions about their care

Service users:

- know where to escalate issues if they are not happy with the offer of care they have received.
- are consulted and involved in decisions about their care, including involvement of other agencies
- are involved the design of services and care pathways by service providers and commissioners

Principle 3 – Vulnerable children and young people are able to access the support they need, when and where they need it.

What this means:

Alcohol, drug and mental health services for children and young people work effectively together, providing co-ordinated care and support that meets individual needs, and is focussed on early identification and coherent pathways so that young people, particularly those most at risk, do not have to navigate complex referral systems.

Clinicians and frontline staff:

- provide young people friendly services in accessible locations and target provision where necessary
- comply with legal requirements, which require services to be child-centred and appropriate to the young person's age and maturity of development of the young person, to take account of individual vulnerabilities
- offer a range of evidence-based interventions that are appropriate to the age and development of young people, and that vary in intensity and duration according to changing needs, and which reflects changes in their risk and resilience factors
- offer young people with multiple vulnerabilities or a high risk of harm extra support (This includes young people affected by child sexual exploitation and abuse, parental substance misuse, experiencing domestic violence, early problematic misuse, class A users, looked-after children, those not in education, employment or training, and involved in crime.)
- offer services tailored to the needs of vulnerable girls (e.g., girls are offered the option of a female keyworker)
- offer very brief advice to young people who smoke in school and youth settings
- offer interventions with young people who use tobacco and nicotine vapourisers which focus on discouraging tobacco smoking

Service managers:

- involve local clinical and safeguarding leads in the review, design and delivery of services for children and young people with co-existing alcohol, drug and mental health issues
- regularly review the range and type of interventions available, who receives them, and which service is best placed to deliver them depending on risk and harm levels
- ensure that vulnerable young people with complex needs receive multi-agency care packages by involving all other services in care planning as necessary
- develop joint working protocols between child and adolescent mental health services (CAMHS) and young people's alcohol and drug treatment services which include meeting the needs of young people with complex needs
- provide workforce training on confidentiality and communicating with young people (including a focus on the more vulnerable, knowing the lines between safeguarding and confidentiality)

- ensure staff are supported and competent to identify and respond appropriately to victims of child sexual exploitation[38]
- put mechanisms in place for young people's involvement in all aspects of the service including commissioning and evaluation

Commissioners:

- Consider multi-component programmes, involving a combination of schools and parenting interventions, with support for individuals and families. These may require joined up commissioning and planning locally and may be universal or targeted.
- align prevention approaches for young people with complex needs with other services (such as sexual health) that also focus on building resilience in the same 'at risk' groups
- commission services to target young people at increased risk of harm, with the aim of strengthening their resilience
- promote a joined-up response across children's services using care and referral pathways for children who have been sexually exploited
- include a section on the needs of vulnerable young people that reflects the links between substance misuse and a range of other risk factors, such as mental health, offending and sexual health and the need for integrated commissioning in the JSNA
- are working across CCGs, local authority public health and the NHS England local area team to agree a joint approach for co-existing alcohol, drug and mental health issues in the young people's secure estate
- are working with police and crime commissioners and other crisis care concordat local partners to move away from use of police custody as places of safety for children and young people experiencing mental health crisis
- have taken into account the needs of young people who suffer from domestic abuse, sexual assault and sexual exploitation, who are more likely to be vulnerable to co-existing alcohol, drug and mental health issues[39]
- have established hospital care pathways for young people presenting to A&E with alcohol-related problems, including mental health crises

Principle 4 – People can and do recover from alcohol and drug misuse and mental ill health

What this means:

The concept of recovery features prominently in both alcohol and drug misuse and mental health service sectors. While there is no single definition of recovery in either sector, there are some elements which are very relevant to both:

The recovery process:

- provides a holistic view of mental illness and alcohol and drug misuse that focuses on the person, and their strengths or ‘recovery capital’ not just their symptoms
- believes that recovery from mental illness and alcohol and drug misuse is possible
- is a journey rather than a destination
- does not necessarily mean getting back to where you were before
- happens in 'fits and starts' and, like life, has many ups and downs
- calls for optimism and commitment from all concerned
- is profoundly influenced by people’s expectations and attitudes
- requires a well organised system of support from family, friends or professionals

What this means:

Above all, it is vital that people working with individuals with co-existing alcohol and drug misuse with mental health issues demonstrate a genuine belief in the possibility of recovery, defined by the patient, for all service users, and that all interaction and engagement with service users is undertaken in a spirit of optimism and commitment to supporting the individual to achieve this. In practical terms, services should adopt a ‘whole person’ approach, supporting individual service users to enjoy the rights and responsibilities of active participation in their community. This may involve ensuring that their housing needs, 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 the recovery journey of an individual.

Service users:

- Have an agreed recovery plan which includes an assessment of strengths and recovery supports
- Report that staff convey a spirit of hope and belief that they can make positive change, and also that staff offer a range of support to enable them to make this change.

Clinicians and frontline staff:

- Approach every contact with people with co-existing alcohol, drug and mental health issues 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-existing issues.

Service managers:

- foster a culture which promotes hope, commitment and belief in recovery
- ensure that access to mutual aid, recovery communities and recovery support feature prominently in the agreed care pathway
- support effective engagement with carers and family members in support of the individual's recovery

Where to get help/information

Commissioning/delivery guidance

PHE centre-based teams can offer advice and support on implementation

See also:
The MEAM approach

http://meam.org.uk/the-meam-approach/

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

http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf

Guidance on values-based commissioning in mental health

http://www.jcpmh.info/resource/guidance-values-based-commissioning-mental-health/

Turning Point/Rethink dual diagnosis good practice handbook

http://www.turning-point.co.uk/media/170796/dualdiagnosisgoodpracticehandbook.pdf

Clinical guidelines

Department of Health (England) & devolved administrations. Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive; 2007. (update due 2016)
www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

National Institute for Health and Clinical Excellence. Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London: NICE; 2007.
www.nice.org.uk/guidance/cg115

National Institute for Health and Clinical Excellence. Psychosis with coexisting substance misuse: Assessment and management in adults and young people (CG120) March 2011

National Institute for Health and Clinical Excellence. Psychosis and schizophrenia in adults: treatment and management (CG178) February 2014

National Institute for Health and Clinical Excellence. Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185) Sept 2014

National Institute for Health and Clinical Excellence. Drug misuse – psychosocial interventions (CG51) July 2007

National Institute for Health and Clinical Excellence. Methadone and buprenorphine for the management of opioid dependence (TA 114) January 2007

National Institute for Health and Clinical Excellence. Naltrexone for the management of opioid dependence (TA115) January 2007

Staff competency

Public Health England. The role of addiction specialist doctors in recovery orientated treatment systems: a resource for commissioners, providers and clinicians. London: PHE; 2014.
www.nta.nhs.uk/uploads/the-role-of-addiction-specialist-doctors.pdf

British Psychological Society. The contribution of clinical psychologists to recovery orientated drug and alcohol treatment systems London: BPS; 2012.
www.nta.nhs.uk/uploads/contributionofcpsychologiststorecoveryorientateddrugandalcoholtreatment2012-022013.pdf

Galvani S. Alcohol and other drug use: the roles and capabilities of social workers. Manchester: Manchester Metropolitan University; 2015.
www.mmu.ac.uk/media/mmuacuk/content/documents/hpsc/research/Alcohol%20and%20other%20drug%20use%20report.pdf

DANOS competencies
www.skillsforhealth.org.uk/standards

Quality governance/system oversight

National Treatment Agency. Clinical governance in drug treatment: a good practice guide for providers and commissioners. London: NTA; 2009.
www.nta.nhs.uk/uploads/clinicalgovernance0709.pdf

CQC essential standards for substance misuse services

www.cqc.org.uk/sites/default/files/20140919_cqc_a_fresh_start_substance_misuse_final_low_res.pdf

Quality surveillance group guidance
www.england.nhs.uk/wp-content/uploads/2014/03/quality-surv-grp-effective.pdf

Appendix 1.

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 • Psychosis and schizophrenia in adults: treatment and management (CG178) February 2014 • 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) • Drug misuse – psychosocial interventions (CG51) July 2007 • Methadone and buprenorphine for the management of opioid dependence (TA 114) January 2007 • Naltrexone for the management of opioid dependence (TA115) January 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) Nov 2013

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[5] Care Quality Commission (2015) Right here, right now - http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf
[6] The Bradley Commission (2009) the Bradley Report http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf
[7] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester.
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[12] Turning Point/Rethink (2004) dual diagnosis good practice handbook
[13] Voices from the Frontline: Listening to people with multiple needs and those who support them (MEAM Coalition, 2015)
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[21] NICE (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115)
[22] NICE (2007) Drug misuse – psychosocial interventions (CG51) July 2007
[23] NICE (2007) Methadone and buprenorphine for the management of opioid dependence (TA 114)
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[25] NICE (2006) Brief interventions and referral for smoking cessation (PH1)
[26] NICE (2008) Smoking cessation services (PH10)
[27] NICE (2013) Tobacco: harm-reduction approaches to smoking (PH45)
[28] NICE (2013) Smoking cessation in secondary care: acute, maternity and mental health services (PH48)
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www.mmu.ac.uk/media/mmuacuk/content/documents/hpsc/research/Alcohol%20and%20other%20drug%20use%20report.pdf

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