NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Coexisting severe mental illness and substance misuse
Output: Prioritised quality improvement areas for development.
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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for coexisting severe mental illness and substance misuse. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

- Coexisting severe mental illness and substance misuse: community health and social care services (2016) NICE guideline NG58
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011) NICE guideline CG120

The evidence supporting this guideline was reviewed in November 2016. No new evidence affecting the recommendations in this guideline was found.

2 Overview

2.1 Focus of quality standard

This quality standard will cover the assessment, management and care provided to people aged 14 and above who have coexisting severe mental illness and substance misuse.

2.2 Definition

NICE guideline CG120 Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings states that the term psychosis, the form of severe mental illness within the scope of that guideline, is used to describe a group of severe mental health disorders characterised by the presence of delusions and hallucinations that disrupt a person's perception, thoughts, emotions and behaviour. The main forms of psychosis are schizophrenia (including schizoaffective disorder, schizophreniform disorder and delusional disorder), bipolar disorder or other affective psychosis.

NICE guideline NG58 Coexisting severe mental illness and substance misuse: community health and social care services also includes severe depressive episodes with or without psychotic episodes.

Substance misuse refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage.

2.3 Incidence and prevalence

Adults and young people with coexisting severe mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. It is not clear how many people in the UK have a coexisting severe mental illness and misuse substances, partly because some people in this group do not use services or get relevant care or treatment.

People with coexisting severe mental illness and substance misuse have significantly poorer outcomes than people who either have a severe mental illness or substance misuse. These outcomes include worsening psychiatric symptoms, poorer physical health, increased use of institutional services, poor medication adherence, homelessness, increased risk of HIV infection, greater dropout from services and higher overall treatment costs. Social outcomes are also significantly worse, including increased homelessness, a higher impact on families and carers, and increased contact with the criminal justice system.

In 2017, Public Health England reported[1] that it is very common for people to experience problems with their mental health and use alcohol or drugs at the same time. Mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment. Death by suicide is also common, with a history of alcohol or drug misuse being recorded in 54% of all suicides in people experiencing mental health problems.

2.4 Management

The Department of Health's Refocusing the Care Programme Approach identifies people with coexisting severe mental illness and substance misuse as one of the groups in need of an enhanced Care Programme Approach (CPA). That is because they are not identified consistently and services sometimes fail to provide the support they need. The policy highlights the need for a whole systems approach to their care, involving a range of services and organisations working together. The CPA is a system for co-ordinating the care of people who have been diagnosed as having a serious mental illness and are receiving care from secondary mental health services. Its aim is to ensure that people with serious mental illness have a full assessment of need and a named care coordinator to ensure that needs are being met via the delivery of appropriate, regularly reviewed care based on collaboration between health and social services. For people to be eligible for the CPA, they must have a

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

‘severe mental disorder (including personality disorder) with a high degree of clinical complexity’, other non-physical co-morbidities including substance misuse, and/or a range of other complexities.

The Five Year Forward View for Mental Health sets out a series of recommendations to the NHS and government to achieve parity of esteem between mental and physical health, placing a particular focus on tackling inequalities. As part of the response to this, Public Health England has produced Better care for people with co-occurring mental health and alcohol / drug use conditions. This notes that despite the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with co-occurring conditions are often excluded from services. It therefore highlights two key principles:

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 misuse services have a joint responsibility to work collaboratively to meet the needs of people with co-occurring conditions.

2) No wrong door. Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions. Commissioning enables services to respond collaboratively, effectively and flexibly to presenting needs and prevent exclusion, offering compassionate and non-judgemental care centred around the persons needs which is accessible from every access point

This document also notes other key points for good care, including:

- people with coexisting severe mental illness and substance misuse should have a named care coordinator to help coordinate the multi-agency care plan under the CPA

- people should be able to access the care they need when they need it and in the setting most suitable to their needs

- there should be a 24/7 response to people experiencing mental health and alcohol and drug misuse crisis, including intoxicated individuals, with episodes of intoxication being managed safely, and an agreed plan to help people access ongoing care and manage future crisis episodes

- services should be commissioned to help people to access a range of recovery support, and all stakeholders should recognise that recovery is a highly individual process which can often occur in fits and starts and may take many years.

3 Summary of suggestions

3.1 Responses

In total 19 stakeholders and 3 specialist committee members responded to the engagement exercise 11/10/2018 – 13/11/2018.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 1 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 1 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Access to services • Access to substance misuse and mental health services • Homelessness	FPH, HCC, IMPFT, ON, PHE, RCGP, SCM, SLAM
Identification and assessment • Recognition and assessment • Consistency of assessment • Physical health	ASH, FPHASIG, IMPFT, LP, NCD, NHSE, NWBH, ON, RCGP, RCPsych, SCMs, SLAM, TP
Interventions • Range of interventions • Prescribing and harm reduction	Add, ADASS, FPH, LP, NCD, NHSE, NWBH, RCGP, SCM, SLAM
Care planning • Care coordinators • Care programme approach • Long term support following alcohol detoxification • Long term support to maintain contact with services • Families and carers	FPHASIG, IMPFT, NCD, NHSE, ON, PHE, RCGP, SCMs, TP
Improving service delivery • Communication and information sharing • Commissioning of services • Older people	ADASS, FPHASIG, NHSE, NWBH, RCGP, RCPsych, SCM, SLAM, TP
Partnership working • Multi-agency approach • Joint working	Add, ADASS, FPH, HCC, IMPFT, LP, NCD, NHSE, ON, PHE, RCGP, SCMs, SLAM
Additional areas • Suicide prevention • Additional and updated guidance • Training • Electronic patient record systems • Prevention • Experience of people using services	Add, ADASS, FPH, HCC, IM, LP, NHSE, NWBH, PHE, RCGP, SCMs, SLAM, TP

ASH, Action on Smoking and Health
Add, Addaction
ADASS, Association of Directors of Adult Social Services
FPH, Faculty of Public Health
FPHASIG, Faculty of Public Health Alcohol Special Interest Group
HCC, Hampshire County Council – Public Health Team
IMPFT, Inclusion Midlands Partnership Foundation Trust
LP, Leicestershire Partnership NHS Trust
NCD, National Clinical Director
NHSE, NHS England
NWBH, North West Boroughs Healthcare NHS Foundation Trust
ON, Opportunity Nottingham
PHE, Public Health England
RCGP, Royal College of General Practitioners
RCN, Royal College of Nursing
RCPCH, Royal College of Paediatrics and Child Health
RCPsych, Royal College of Psychiatrists
SCM, Specialist Committee Member
SLAM, South London and Maudsley Mental Health Foundation Trust
TP, Turning Point

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 517 papers were identified for coexisting severe mental illness and substance misuse. In addition, 90 papers were suggested by stakeholders at topic engagement and 14 papers internally at project scoping.

Of these papers, 13 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Access to services

4.1.1 Summary of suggestions

Access to substance misuse and mental health services

Stakeholders commented that people in mental distress are denied access to mental health support because of current intoxication, substance misuse or dependence or historical dependence. All people who come into contact with mental health services should be screened and assessed for substance misuse but the outcome of screening is often to exclude people rather than providing support. Stakeholders commented that no wrong door is an important principle but the options need to be accessible.

Levels of staff competence and confidence and a lack of joined-up pathways for people with co-existing conditions can lead to exclusion from treatment and services and impact on people's chance of recovery.

A stakeholder noted that it is important to have quick access to low threshold services where possible for co-occurring severe mental illness and substance misuse as problems can escalate if support at a low level is delayed or not available.

Homelessness

A stakeholder commented that mental health and substance misuse services for people who are street homeless is important and action is needed to help them to access and navigate the range of services they need to sustain stable accommodation.

4.1.2 Selected recommendations from development source

Table 2 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 2 to help inform the committee's discussion.

Table 2 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Access to substance misuse and mental health services	**First contact with services** NICE NG58 Recommendations 1.1.1, 1.1.3 and 1.1.4 **Referral to secondary care mental health services** NICE NG58 Recommendation 1.2.1

	Making health, social care and other support services more inclusive NICE NG58 Recommendation 1.5.4 **Secondary care mental health services** NICE CG120 Recommendations 1.4.3 and 1.4.4
Homelessness	**First contact with services** NICE NG58 Recommendations 1.1.1 and 1.1.4

First contact with services

NICE NG58 – Recommendations 1.1.1, 1.1.3 and 1.1.4

1.1.1 Identify and provide support to people with coexisting severe mental illness and substance misuse. Aim to meet their immediate needs, wherever they present. This includes:

- looking out for multiple needs (including physical health problems, homelessness or unstable housing)
- remembering they may find it difficult to access services because they face stigma.

1.1.3 Be aware that people's unmet needs may lead them to have a relapse or may affect their physical health. This could include: social isolation, homelessness, poor or lack of stable housing, or problems obtaining benefits.

1.1.4 Provide direct help, or get help from other services, for any urgent physical health, social care, housing or other needs.

Referral to secondary care mental health services

NICE NG58 – Recommendation 1.2.1 (relevant sections)

Ensure secondary care mental health services:

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

Making health, social care and other support services more inclusive

NICE NG58 Recommendation 1.5.4

Ensure people with coexisting severe mental illness and substance misuse, their family or carers are given accurate information about relevant local services (including, for example, community or family support groups). Also ensure they are given help to make initial contact with services. This could include information on how to access services, ways to contact the service, opening hours and how long the waiting list may be.

Secondary care mental health services

NICE CG120 – Recommendations 1.4.3 and 1.4.4

1.4.3 Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental healthcare because of their substance misuse.

1.4.4 Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis.

4.1.3 Current UK practice

Access to substance use and mental health services

In 2014 the Care Quality Commission (CQC) published a report[2] on health-based places of safety for people being detained under section 136 of the Mental Health Act. To inform this report the CQC surveyed mental health trusts and social enterprise providers of health-based places of safety. 48% of providers stated that people would be excluded from a place of safety if they were intoxicated and 36% said people would be excluded if they had disturbed behaviour.

Public Health England data on co-occurring substance misuse and mental health issues[3] for 2016/17 showed that, in England, 22.7% of people who were in contact with substance misuse services due to alcohol misuse had concurrent contact with mental health services and 24.3% of people in contact with substance misuse services due to drug misuse had concurrent contact with mental health services.

The Centre for Mental Health and the Institute of Alcohol Studies published a report on alcohol and mental health[4] in 2018. As part of this report, a survey of people working in both alcohol and mental health services was carried out. 134 responses were received: 33% from people working in alcohol services, 28% from people working in mental health services and the rest from other roles in public health, other health services and academic bodies. 84% of respondents felt that having an alcohol misuse disorder was a barrier to getting any kind of mental health support.

7% of alcohol workers thought alcohol was adequately considered in mental health services compared with 45% of mental health staff. 32% of mental health workers thought alcohol services adequately considered mental health compared with 66% of alcohol staff. No similar studies for people who misuse substances were identified.

No additional studies on access to services for people with coexisting severe mental illness and substance misuse when intoxicated were identified.

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[2] Care Quality Commission (2014) A safer place to be
[3] Public Health England (2016/17) Co-occurring substance misuse and mental health issues
[4] Centre for Mental Health and Institute of Alcohol Studies (2018) Alcohol and mental health

Homelessness

Public Health England reported[5] that, in England at the end of the first quarter of 2018/19, 57.5% of people with a serious mental illness who were on a care programme approach had stable and appropriate accommodation.

St. Mungo's, a homelessness charity and housing association working across London and the south of England, published a report[6] on mental health and rough sleeping. This report found mental health services in England actively targeting people sleeping rough are commissioned in 32% of the areas where 10 or more people are sleeping rough on any one night. In this report it was noted that, of 225 homelessness professionals from across England who responded to a survey in 2015, 26% thought that people sleeping rough in their area were able to access appropriate mental health services if they needed them.

A separate 2016 report[7] by St. Mungo's included a survey completed by 90 of their staff working with people in hostels and supported housing services across 24 local authority areas. 44% of the staff members surveyed felt that the people they work with could access NHS mental health services.

No additional studies on the availability of services for coexisting severe mental illness and substance misuse for people who are homeless were identified.

4.1.4 Resource impact

This area is not expected to have significant resource implications. However, resource impact assessment for NG58 highlighted that there may be additional assessment costs involved if there is an increase in the number of people accessing primary care with subsequent referrals to secondary care.

[5] Public Health England (2018) Severe mental illness profiling tool
[6] St. Mungo's (2016) Stop the Scandal: the case for action on mental health and rough sleeping
[7] St. Mungo's (2016) Stop the scandal: can people living in homelessness accommodation access mental health services?

4.2 Identification and assessment

4.2.1 Summary of suggestions

Recognition and assessment

Stakeholders commented that improved identification and recording of alcohol and substance misuse in people with a possible severe mental illness is needed. If alcohol misuse is not identified, interventions to improve their physical and mental health cannot be offered. This will impair the response to psychotropic medication and prevent interventions to reduce their risk of suicide.

Stakeholders felt a mental health needs and risk assessment should be undertaken that shows how and when the person should be referred to secondary care mental health services. This is important for timely referrals to mental health services.

A stakeholder commented that assessment should be face to face and ideally would be joint with mental health and substance misuse services. It was noted that people with coexisting severe mental illness and substance misuse often have complex assessment and treatment needs however comprehensive assessments that consider mental health, substance misuse, physical health and social care needs are often not completed meaning substance misuse in people with serious mental illness is not diagnosed.

A stakeholder felt that identifying potential impacts of substance misuse on mental health, physical health and social circumstances is important. Another stakeholder noted that assessment and treatment should be carried out by experienced practitioners.

It was noted that some young people self-medicate undiagnosed mental illness and that earlier interventions, diagnosis and professional support, significantly improve their long term outcomes.

Consistency of assessment

A stakeholder noted that there are few assessment tools that can be used and those that are used are currently different across organisations.

A stakeholder noted that assessing the needs of substance misuse and mental health issues in a consistent way at the initial needs assessment is crucial but this is not done.

Physical health

Stakeholders commented that screening for physical health problems by mental health services is important as this population are likely to have physical co-morbidity.

Stakeholders felt that all people with coexisting severe mental illness and substance misuse should have their physical health monitored routinely in primary care, or in secondary care if they are an inpatient.

A stakeholder felt that embedding smoking cessation support in treatment pathways for people with coexisting severe mental illness and substance misuse is important.

A stakeholder noted that improvements in recognition, diagnosis and support for alcohol related brain damage are needed, with a dedicated support worker between dementia services and substance misuse.

4.2.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 3 to help inform the committee's discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Recognition and assessment	**First contact with services** NICE NG58 Recommendation 1.1.1 **Referral to secondary care mental health services** NICE NG58 Recommendation 1.2.1 **Recognition of psychosis with coexisting substance misuse** NICE CG120 Recommendations 1.2.1 and 1.2.2 **Assessment** NICE CG120 Recommendation 1.4.10
Consistency of assessment	Not directly covered in NICE CG120 or NG58 and no recommendations are presented
Physical health	**First contact with services** NICE NG58 Recommendations 1.1.1 and 1.1.2 **The care plan: multi-agency approach to address physical health, social care, housing and other support needs** NICE NG58 Recommendation 1.3.2 **Physical healthcare** NICE CG120 Recommendation 1.3.3 **Assessment** NICE CG120 Recommendation 1.4.10

First contact with services

NICE NG58 – Recommendations 1.1.1 and 1.1.2

1.1.1 Identify and provide support to people with coexisting severe mental illness and substance misuse. Aim to meet their immediate needs, wherever they present. This includes:

- looking out for multiple needs (including physical health problems, homelessness or unstable housing)
- remembering they may find it difficult to access services because they face stigma.

1.1.2 Be aware that the person may have a range of chronic physical health conditions including:

- cardiovascular, respiratory, hepatic or related complications
- communicable diseases
- cancer
- oral health problems
- diabetes.

Referral to secondary care mental health services

NICE NG58 – Recommendation 1.2.1 (relevant sections)

Ensure secondary care mental health services:

- Undertake a comprehensive assessment of the person's mental health and substance misuse needs.

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

NICE NG58 – Recommendation 1.3.2

Ensure the care plan includes an assessment of the person's physical health, social care and other support needs, and make provision to meet those needs. This could include:

- personal care and hygiene
- family and personal relationships
- housing
- learning new skills for future employment or while in employment (including those administering social security benefits)
- education
- pregnancy and childcare responsibilities.

Recognition of psychosis with coexisting substance misuse

NICE CG120 – Recommendations 1.2.1 and 1.2.2

1.2.1 Healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. If the person has used substances ask them about all of the following:

- particular substance(s) used
- quantity, frequency and pattern of use
- route of administration
- duration of current level of use.

In addition, conduct an assessment of dependency (see Drug misuse: opioid detoxification [NICE clinical guideline 52] and Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence [NICE clinical guideline 115]) and also seek corroborative evidence from families, carers or significant others[8], where this is possible and permission is given.

1.2.2 Healthcare professionals in all settings, including primary care, secondary care mental health services, CAMHS and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely assess adults and young people with known or suspected substance misuse for possible psychosis. Seek corroborative evidence from families, carers or significant others, where this is possible and permission is given.

Physical healthcare

NICE CG120 Recommendation 1.3.3

Monitor the physical health of adults and young people with psychosis and coexisting substance misuse, as described in the guideline on schizophrenia (NICE clinical guideline 82). Pay particular attention to the impact of alcohol and drugs (prescribed and non-prescribed) on physical health. Monitoring should be conducted at least once a year or more frequently if the person has a significant physical illness or there is a risk of physical illness because of substance misuse.

Assessment

NICE CG120 – Recommendation 1.4.10

Adults and young people with psychosis and coexisting substance misuse attending secondary care mental health services should be offered a comprehensive, multidisciplinary assessment, including assessment of all of the following:

- personal history

[8] 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

- mental, physical and sexual health
- social, family and economic situation
- accommodation, including history of homelessness and stability of current living arrangements
- current and past substance misuse and its impact upon their life, health and response to treatment
- criminal justice history and current status
- personal strengths and weaknesses and readiness to change their substance use and other aspects of their lives.

The assessment may need to take place over several meetings to gain a full understanding of the person and the range of problems they experience, and to promote engagement.

4.2.3 Current UK practice

Recognition and assessment

The national clinical audit of psychosis[9] (NCAP) carried out in 2017 found that 93% of inpatients and 87% of people in the community with psychosis had their alcohol consumption monitored at least once in the previous 12 months. 95% of inpatients and 86% of people in the community with psychosis were monitored for substance misuse at least once in the previous 12 months.

The quality and outcomes framework[10] (QOF) 2017/18, covering general practice in England, found that 81% of people with schizophrenia, bipolar affective disorder and other psychoses had a record of alcohol consumption in the preceding 12 months.

Consistency of assessment

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder knowledge and experience.

Physical health

The quality and outcomes framework (QOF) 2017/18 found that 81% of people with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months.

NCAP found that 42% of people with psychosis had an annual assessment of the five major risk factors for cardio-vascular disease (smoking, BMI, glucose, lipids, blood pressure). This was an increase from 27% in 2012. The variation in

[9] HQIP and Royal College of Psychiatrists (2018) National clinical audit of psychosis
[10] NHS Digital (2018) Quality and outcomes framework

assessment across NHS trusts ranged from 4% of people to 78%. Only 16 NHS trusts comprehensively screened more than half of people with psychosis.

NCAP also noted that an overall average of 79% of current smokers with psychosis who required an intervention were offered help to stop smoking. The variation across NHS trusts was 31% of people to 100%. In five NHS trusts less than half of people with psychosis who smoke were offered an intervention.

4.2.4 Resource impact

This area is not expected to have significant resource implications. However, resource impact assessment for NG58 highlighted that there may be additional assessment costs involved if there is an increase in the number of people accessing primary care with subsequent referrals to secondary care.

4.3 Interventions

4.3.1 Summary of suggestions

Range of interventions

Stakeholders commented that all people with coexisting severe mental illness and substance misuse should have access to the full range of interventions for substance misuse and treatment of their mental health condition. This should be delivered through close joint working between mental health services and substance misuse services. This can include group support and access to specialist psychiatric and psychology services.

It was noted that some of this population have experienced trauma and abuse and a history of adverse childhood events is common. Many people exceed the threshold for improving access to psychological services (IAPT) based on their mental health need, even when they are not being excluded due to using substances, and do not meet thresholds for secondary care.

A stakeholder commented that there is limited availability of rehabilitation services for coexisting severe mental illness and substance misuse. Services available are often expensive and do not meet the needs of people with complex issues. There is also a need for rehabilitation for homeless populations.

Stakeholders commented that mental health services should provide advice, guidance and support on reducing harm or achieving abstinence from substance misuse appropriate to the person's needs and level of motivation. People with severe mental illness may not attend specialist addictions services because they do not consider their substance misuse to be problematic.

A stakeholder noted that treatment should be individualised. Some people with severe mental illness and substance misuse can achieve life changing stability whilst receiving prescription medication for an extended period however the system focusses solely on abstinence.

Prescribing and harm reduction

A stakeholder commented that poly-pharmacy is common in people with severe mental illness and this can have serious consequences when combined with substance misuse. Reducing mortality from drug-related deaths is a key priority but there is high morbidity that includes addiction to prescribed drugs.

A stakeholder commented that people should have access to harm reduction strategies, including take home naloxone which has been shown to significantly reduce fatal overdoses and to be safe and cost-effective. However, mental health services generally do not have systems for providing this to people using opiates upon discharge from hospital or in the community, and restrict it to emergency incidents where opiate overdose is diagnosed or suspected.

4.3.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Range of interventions	**The care plan: multi-agency approach to address physical health, social care, housing and other support needs** NICE NG58 Recommendation 1.3.7 **Adapting existing secondary care mental health services** NICE NG58 Recommendation 1.5.7 **Treatment** NICE CG120 Recommendations 1.4.19 and 1.4.20
Prescribing and harm reduction	**Assessment** NICE CG120 Recommendation 1.4.14 **Treatment** NICE CG120 Recommendation 1.4.25 Provision of take home naloxone is not directly covered in NICE CG120 or NG58 and no recommendations are presented

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

NICE NG58 Recommendation 1.3.7

Consider the suitability of the type of housing (for example, high to low support or independent tenancies), employment, detox, rehabilitation services or other support identified for the person, in collaboration with relevant providers. Take the person's preferences into account.

Adapting existing secondary care mental health services

NICE NG58 Recommendation 1.5.7

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. (See NICE's pathways on: coexisting severe mental illness and substance misuse: assessment and management in healthcare settings; psychosis and schizophrenia in young people and adults; bipolar disorder; self-harm; alcohol use disorders and drug misuse.)

Assessment

NICE CG120 Recommendation 1.4.14

Regularly assess and monitor risk of harm to self and/or others and develop and implement a risk management plan to be reviewed when the service users' circumstances or levels of risk change. Specifically consider additional risks associated with substance misuse, including:

- physical health risks (for example, withdrawal seizures, delirium tremens, blood-borne viruses, accidental overdose, and interactions with prescribed medication) and
- the impact that substance use may have on other risks such as self-harm, suicide, self neglect, violence, abuse of or by others, exploitation, accidental injury and offending behaviour.

Treatment

NICE CG120 Recommendations 1.4.19, 1.4.20 and 1.4.25

1.4.19 For the treatment of psychosis, see Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care (NICE clinical guideline 38) or the guideline on schizophrenia (NICE clinical guideline 82).

1.4.20 For the treatment of substance misuse, see: Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications and the guideline on alcohol dependence and harmful alcohol use (NICE clinical guidelines 100 and CG115) and/or Drug misuse: psychosocial interventions and the guideline on opioid detoxification (NICE clinical guidelines 51 and 52).

1.4.25 When prescribing medication for adults and young people with psychosis and coexisting substance misuse:

- take into account the level and type of substance misuse, especially of alcohol, as this may alter the metabolism of prescribed medication, decrease its effectiveness and/or increase the risk of side effects
- warn the person about potential interactions between substances of misuse and prescribed medication
- discuss the problems and potential dangers of using non-prescribed substances and alcohol to counteract the effects or side effects of prescribed medication.

4.3.3 Current UK practice

Range of interventions

The national clinical audit of psychosis[11] (NCAP) found that 89% of people with psychosis whose use of alcohol was judged to be harmful or hazardous were offered an intervention. There was a wide range across NHS trusts, from 0% to 100%. Within the group whose alcohol consumption was judged to be harmful or hazardous 68% were offered an intervention and accepted it; 21% were offered an intervention and refused it; and 11% were not offered any intervention.

NCAP found that 83% of people with psychosis and substance misuse were offered an intervention. There was a wide range across NHS trusts, from 40% to 100%. Within the group with substance misuse 61% were offered an intervention and accepted it; 22% were offered an intervention and refused it; and 17% were not offered any intervention.

NCAP noted that 36% of people with psychosis had been offered some form of CBT and only 26% had been offered CBTp (CBT for psychosis). 12% of people with psychosis who were in contact with their families had been offered family intervention, a reduction from 18% four years earlier.

In 2015 Alcohol Policy UK noted in a report[12] based on 3 national surveys, individual interviews and workshops, that 58% of respondents said family therapy wasn't available in their area, 28% didn't know if it was available and 14% said it was available.

Prescribing and harm reduction

NCAP looked at anti-psychotic polypharmacy. It noted that 4% of people with psychosis were receiving two oral anti-psychotic drugs (excluding clozapine) and 6% were receiving one long-acting injectable anti-psychotic and one oral. 8% were receiving clozapine and one oral anti-psychotic.

In 2017 the Local Government Association carried out a survey[13] on the use of naloxone. Of the 152 local authorities in England, the survey was sent to 134 because some share services. 120 responses were received, covering 135 local authorities because of shared services. The results from the responding local authorities showed that:

- 90% made take-home naloxone available
- 99% which made naloxone available provided it through drug treatment services, 25% did so through hostels and 25%using outreach workers
- 95% which made naloxone available provided it to people using drug treatment services, 79% to family, friends or carers of opiate users, and 64% to opiate users not in treatment

[11] HQIP and Royal College of Psychiatrists (2018) National clinical audit of psychosis
[12] Alcohol Policy UK (2015) The Recovery Partnership Review of Alcohol Treatment Services
[13] Local Government Association (2017) Naloxone survey 2017

- 50% of the 14 respondents which did not currently make naloxone available indicated that they would make it available if there were an increase in opiate overdoses in their area or an increase in drug-related deaths in their area.
- 29% which did not currently make it available reported that the low number of local opiate-related deaths was a factor in their decision, and 21% referred to the low number of local opiate overdoses.

4.3.4 Resource impact

This area is not expected to have significant resource implications.

4.4 Care planning

4.4.1 Summary of suggestions

Care coordinators

Stakeholders highlighted the importance of a named care coordinator to work with all relevant organisations when developing or reviewing the person's care plan, for example substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.

A stakeholder commented that people with severe mental illness should have a care coordinator as part of the care programme approach (CPA) and the mental health team would coordinate the assessment and a multi-agency, multi-disciplinary, integrated package of care to meet their complex health and social care needs. The care coordinator should act as a central point of contact for the person, their carers and other service providers.

Care programme approach

Stakeholders commented that the care programme approach is an existing structure for the coordination of care provided to people with severe mental illness and complex needs. If appropriately implemented, it would support well planned, coordinated care for people with coexisting serious mental health problems and substance abuse.

Long term support following alcohol detoxification

A stakeholder noted the importance of ensuring people who go through detoxification are provided with intensive support to assist them to remain alcohol free. People who are not supported are more likely to relapse. Long term support, such as peer or third sector support, is not well integrated into substance misuse services, is not offered and primary care services are often not informed of support arrangements.

Long term support to maintain contact with services

Stakeholders noted that people with severe mental illness and substance misuse have complex needs and often have chaotic lives meaning they may not engage with services, may miss appointments or self-discharge from accident and emergency or in-patient services. If they are discharged from services for these reasons they are left without support. All practitioners involved in a person's care should discuss a non-attendance or self-discharge before agreeing to discharge them from services.

Discharge plans with a robust re-referral process that can allow rapid re-entry to services, bypassing GP referral, would support more timely access to secondary mental health services.

Families and carers

Stakeholders noted that the families of people with coexisting mental illness and substance misuse should be offered help and support in their own right as they can end up suffering with mental health problems themselves. This should be part of a carer package of care, including assessment. Services also need to ensure that the needs and impacts on the person's children are addressed.

4.4.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Care coordinator	**On acceptance to secondary care mental health services** NICE NG58 Recommendations 1.2.2 and 1.2.3 **The care plan: multi-agency approach to address physical health, social care, housing and other support needs** NICE NG58 Recommendation 1.3.1 **Review** NICE NG58 Recommendation 1.3.9 **Coordinating care** NICE CG120 Recommendation 1.4.9 **Discharge** NICE CG120 Recommendation 1.6.6
Care programme approach	**On acceptance to secondary care mental health services** NICE NG58 Recommendation 1.2.2 **The care plan: multi-agency approach to address physical health, social care, housing and other support needs** NICE NG58 Recommendation 1.3.1 **Coordinating care** NICE CG120 Recommendation 1.4.9 **Joint working** NICE CG120 Recommendation 1.5.3
Long term support following alcohol detoxification	Not directly covered in NICE CG120 or NG58 and no recommendations are presented
Long term support to maintain contact with services	**The care plan: multi-agency approach to address physical health, social care, housing and other support needs**

	NICE NG58 Recommendation 1.3.8 **Discharge or transition** NICE NG58 Recommendation 1.3.11 **Adapting existing secondary care mental health services** NICE NG58 Recommendation 1.5.9 **Maintaining contact between services and people with coexisting severe mental illness and substance misuse who use them** NICE NG58 Recommendation 1.6.5
Families and carers	**First contact with services** NICE NG58 Recommendation 1.1.5 **Carers** NICE NG58 Recommendations 1.2.7 and 1.2.8 **Working with and supporting families, carers and significant others** NICE CG120 Recommendation 1.1.10 **Safeguarding issues** NICE CG120 Recommendation 1.1.16

First contact with services

NICE NG58 Recommendation 1.1.5

Ensure the safeguarding needs of all people with coexisting severe mental illness and substance misuse, and their carers and wider family, are met. (See also the section on safeguarding issues in the NICE guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings.)

On acceptance to secondary care mental health services

NICE NG58 Recommendations 1.2.2 and 1.2.3

1.2.2 Provide a care coordinator working in mental health services in the community to:

- act as a contact for the person
- identify and contact their family or carers
- help develop a care plan with the person (in line with the Care Programme Approach[14]) and coordinate it (see section 1.3).

[14] The Care Programme Approach is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.

1.2.3 Ensure the care coordinator works with other services to address the person's social care, housing, physical and mental health needs, as well as their substance misuse problems, and provide any other support they may need.

Carers

NICE NG58 Recommendations 1.2.7 and 1.2.8

1.2.7 Ensure carers (including young carers) who are providing support are aware they are entitled to, and are offered, an assessment of their own needs. If the carer wishes, make a referral to their local authority for a carer's assessment (in line with the Care Act 2014). When undertaking an assessment, consider:

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

1.2.8 Based on the carer's 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.

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

NICE NG58 Recommendations 1.3.1 and 1.3.8

1.3.1 The person's care coordinator should adopt a collaborative approach with other organisations (involving shared responsibilities and regular communication) when developing or reviewing the person's care plan. This includes substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.

1.3.8 Ensure agencies and staff communicate with each other so the person is not automatically discharged from the care plan because they missed an appointment. All practitioners involved in the person's care should discuss a non-attendance.

Review

NICE NG58 Recommendation 1.3.9 (relevant sections)

Hold multi-agency and multidisciplinary case review meetings annually, as set out in the Care Programme Approach or more frequently, based on the person's circumstances. (A care coordinator in the secondary care mental health team should usually arrange this.)

Discharge or transition

NICE NG58 Recommendation 1.3.11

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

- All practitioners who have been, or who will be, involved are invited to the multi-agency and multidisciplinary meetings (see recommendation 1.3.9) and the discharge or transfer meeting.
- There is support to meet the person's housing needs.
- The discharge plan includes strategies for ongoing safety or risk management and details of how they can get back in contact with services.
- There are crisis and contingency plans in place if the person's mental or physical health deteriorates (including for risk of suicide or unintentional overdose).
- Providers share information on how to manage challenging or risky situations (see also NICE's guideline on violence and aggression: short-term management in mental health, health and community settings).

Adapting existing secondary care mental health services

NICE NG58 Recommendation 1.5.9

Consider the following:

- Crisis and contingency plans for the person with coexisting severe mental illness and substance misuse and their family or carers. Ensure these are updated to reflect changing circumstances.
- Support to sustain change and prevent relapse.
- Discharge planning, including planning for potential relapses, so the person with coexisting severe mental illness and substance misuse knows which service to contact and the service can provide the right ongoing support. (See also NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs.)

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

NICE NG58 Recommendation 1.6.5

1.6.5 Ensure any loss of contact or non-attendance at any appointment or activity is viewed by all practitioners involved in the person's care as a matter of concern. Follow-up actions could include:

- contacting the person to rearrange an appointment
- visiting the person at home
- contacting any other practitioners involved in their care, or family or carers identified in the person's care plan (see recommendation 1.2.4)
- contacting the person's care coordinator within mental health services in the community immediately if there is a risk of self-harm or suicide, or at least within 24 hours if there are existing concerns.

Working with and supporting families, carers and significant others

NICE CG120 Recommendation 1.1.10

Offer families, carers or significant others[15] a carer's assessment of their caring, physical, social, and mental health needs. Where needs are identified, develop a care plan for the family member or carer.

Safeguarding issues

NICE CG120 Recommendation 1.1.16

If people with psychosis and coexisting substance misuse are parents or carers of children or young people, ensure that the child's or young person's needs are assessed according to local safeguarding procedures.

Coordinating care

NICE CG120 Recommendation 1.4.9

Delivery of care and transfer between services for adults and young people with psychosis and coexisting substance misuse should include a care coordinator and use the Care Programme Approach.

Joint working

NICE CG120 Recommendation 1.5.3

Healthcare professionals in substance misuse services should be present at Care Programme Approach meetings for adults and young people with psychosis and coexisting substance misuse within their service who are also receiving treatment and support in other health services.

[15] 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Discharge

NICE CG120 Recommendation 1.6.6

When adults and young people with psychosis and coexisting substance misuse are discharged from an inpatient mental health service, ensure that they have:

- an identified care coordinator and
- a care plan that includes a consideration of needs associated with both their psychosis and their substance misuse and
- been informed of the risks of overdose if they start reusing substances, especially opioids, that have been reduced or discontinued during the inpatient stay.

4.4.3 Current UK practice

Care coordinators

No published studies on current practice were highlighted for this suggested area for quality improvement. However, please note the current practice information below as people on the care programme approach should have access to a care coordinator.

Care programme approach (CPA)

Public Health England reported[16] that, in England at the end of the first quarter of 2018/19, 16% of people using mental health services were on a CPA.

The national clinical audit of psychosis[17] (NCAP) included 8,760 people who were not inpatients on the date it was carried out. 5,711 (65%) of these people were on a care programme approach package. The number of people whose condition was being cared for under a CPA varied across NHS trusts from 20% to 100% of all of their current community patients.

NHS England's mental health community teams' activity data[18] showed that in quarter 1 and quarter 2 of 2018/19, 95.8% and 95.7% of people on a CPA were followed up by community mental health teams within 7 days of discharge from psychiatric inpatient care.

Long term support following alcohol detoxification

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Long term support to maintain contact with services

[16] Public Health England (2018) Severe mental illness profiling tool
[17] HQIP and Royal College of Psychiatrists (2018) National clinical audit of psychosis
[18] NHS England (2018) Mental Health Community Teams Activity

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder knowledge and experience.

Families and carers

The national clinical audit of psychosis[19] (NCAP) reported that 55% of people included in the study did not have a carer. Of those who did, there was a record that their carer's need had been assessed in 55% of cases.

In the 2015 Alcohol Policy UK report[20] 43% of respondents stated that the carers of people with alcohol misuse problems were able to access carers' assessments, 24% said they could not and 33% were unsure if the assessments could be accessed.

4.4.4 Resource impact

This area is not expected to have significant resource implications. However, resource impact assessment for NG58 highlighted that there may be need for additional care coordinators and continuity of care. Also there may be additional costs incurred involving multi-agency and multidisciplinary case review meetings. Costs would depend on local needs and circumstances.

[19] HQIP and Royal College of Psychiatrists (2018) National clinical audit of psychosis
[20] Alcohol Policy UK (2015) The Recovery Partnership Review of Alcohol Treatment Services

4.5 Improving service delivery

4.5.1 Summary of suggestions

Communication and information sharing

Stakeholders noted that most people with coexisting severe mental illness and substance misuse use services from a wide variety of agencies including substance misuse, primary, secondary and community NHS services, social services, police and prison services, housing associations, homeless charities and addiction services. Communication between these services is rare and there is no common record system.

Stakeholders highlighted the importance of sharing information, including risk and care plans. Stakeholders noted that there should be regular communication through care programming, case conferences and other necessary means between the teams involved in people's care.

A stakeholder commented that improving co-ordination between services would assist people who have multiple health and social care problems to remain in treatment and continue to attend services. A large proportion of people identified as having coexisting severe mental illness and substance misuse in acute care do not attend services when they leave hospital and if they are not followed up assertively they are more likely to die.

Commissioning of services

Stakeholders highlighted that commissioning separate services for mental health and substance misuse leads to people being passed between both services depending on need, but neither being resolved. Integration would lead to both conditions being treated as one which could improve outcomes.

A stakeholder commented that regular re-tendering for substance misuse services fragments service provision, unsettling staff and therefore affecting people using services.

A stakeholder felt that variation of commissioning means in some areas people cannot access addiction psychiatrists and that mental health and addictions services do not work together because they are not specifically commissioned to do so.

Older people

A stakeholder felt there should be improvements in the assessment, treatment and care of older people with coexisting severe mental illness and substance misuse as there are few services focused on older people. A suggestion was made to have a coexisting severe mental illness and substance misuse lead for older people

4.5.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Communication and information sharing	**Review** NICE NG58 Recommendation 1.3.9 **Information sharing** NICE NG58 Recommendations 1.4.6 and 1.4.7
Commissioning of services	**Assessment and treatment** NICE CG120 Recommendation 1.8.9
Older people	**Discharge or transition** NICE NG58 Recommendation 1.3.12

Review

NICE NG58 Recommendation 1.3.9

Hold multi-agency and multidisciplinary case review meetings annually, as set out in the Care Programme Approach or more frequently, based on the person's circumstances. (A care coordinator in the secondary care mental health team should usually arrange this.) Use this to check the person's physical health needs (including any adverse effects from medications), social care, housing or other support needs. Involve practitioners from a range of disciplines, including:

- secondary care mental health
- substance misuse
- primary care
- emergency care (if applicable)
- voluntary sector
- housing
- adult and young people's social care.

Discharge or transition

NICE NG58 Recommendation 1.3.12

Reassess the person's needs to ensure there is continuity of care when they are at a transition point in their life. Particular groups who may need additional support include:

- people who move from adult to older adult mental health or social care services.

Also see NICE's guideline on transition between inpatient mental health settings and community and care home settings.

Information sharing

NICE NG58 Recommendations 1.4.6 and 1.4.7

1.4.6 Agree a protocol for information sharing between secondary care mental health services and substance misuse, health, social care, education, housing, voluntary and community services (see the Caldicott Guardian Manual).

1.4.7 Adopt a consistent approach to getting people with coexisting severe mental illness and substance misuse help from the most relevant service by:

- sharing information on support services between agencies
- ensuring all providers know about and can provide information on the services
- taking responsibility, as agreed in referral processes, providing timely feedback and communicating regularly about progress.

Assessment and treatment

NICE CG120 Recommendation 1.8.9

Those providing and commissioning services should ensure that:

- age-appropriate mental health services are available for young people with psychosis and coexisting substance misuse and
- transition arrangements to adult mental health services are in place where appropriate.

4.5.3 Current UK practice

Communication and information

In 2015 Alcohol Policy UK[21] noted that 51% of respondents felt that alcohol services were sufficiently engaged with other agencies, for example when caring for people with complex needs and those with mental health problems. 33% felt alcohol services were not sufficiently engaged and 16% were unsure.

No additional published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Commissioning of services

[21] Alcohol Policy UK (2015) The Recovery Partnership Review of Alcohol Treatment Services

The Advisory Council on the Misuse of Drugs report on the commissioning impact on drug treatment[22] noted that re-procurement of contracts for drug treatment services between service providers and local authorities is a frequent occurrence in England. They carried out a survey of commissioners which include a question on re-procurement:

- 71% reported a negative impact in the 3 months prior to the start of a contract
- 66% reported a negative impact in the 3 months after the start of a contract
- 62% reported a negative impact up to 6 months after contract start
- 44% reported a negative impact a year after contract start
- 23% were still reporting a negative impact after 2 years.

Re-procurement was reported in this survey to be an expensive process for commissioners and providers.

In 2015 Alcohol Policy UK noted in its report[23] that 54% of respondents felt the commissioning process for alcohol services was not sufficiently understood. 69% of alcohol services had been retendered in the previous 3 years.

- 19% felt services had improved as a result of tendering
- 27% felt services were in the process of improving as a result of tendering
- 16% felt services had stayed the same as a result of tendering
- 14% felt services were becoming worse as a result of tendering.

Older people

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.5.4 Resource impact

This area is not expected to have significant resource implications.

[22] Advisory Council on the Misuse of Drugs (2017) Commissioning impact on drug treatment
[23] Alcohol Policy UK (2015) The Recovery Partnership Review of Alcohol Treatment Services

4.6 Partnership working

4.6.1 Summary of suggestions

Multi-agency approach

A stakeholder noted that GPs within substance misuse services can provide support, for example with x-rays and blood tests. They noted that people with severe mental illness and substance misuse often present out of hours when unwell with conditions which could have been easily treated earlier.

Stakeholders noted that inadequate housing or homelessness are common problems for people with coexisting severe mental illness and substance misuse. They need safe, stable and suitable accommodation. Some residential facilities exclude people who misuse substances. The residential facilities that do accept this group usually work with people with challenging mental health, physical health and social care needs meaning substance misuse is often not addressed.

A stakeholder suggested expanding the Making Every Adult Matter (MEAM) role so that people with coexisting severe mental illness and substance misuse are supported through appointments for health, finance, and housing. This should also help with treatment retention and hopefully result in stability.

Joint working

Stakeholders highlighted the need for services to work together to encourage people with coexisting severe mental illness and substance misuse to use services.

It was noted that services need staff suitably qualified in the management of both substance misuse and mental health and there should be clearly defined care management arrangements between specialist drug treatment services and specialist mental health services. This also applies to specific populations, for example pregnant women and people in contact with the criminal justice system.

Stakeholders highlighted the importance of multi-agency arrangements between mental health and substance misuse providers and commissioners to understand the lessons learned from serious incidents.

Stakeholders noted the importance of partnership working across key strategic programmes and approaches and suggested improvements in areas including partner agencies being invited to MDTs and care plans involving joint input from mental health and substance misuse services.

Stakeholders commented that mental health and substance misuse services should have an agreed protocol on joint-working and collaborative care to ensure people with co-existing severe mental illness and substance misuse are able to access the support they need. This should set out the responsibilities and processes for assessment, referral, treatment and shared care.

A stakeholder noted that service need to work together during transitions between substance misuse and secondary mental health services, for example at the point of discharge from one service to the other as this is a critical time when the person may be more vulnerable to relapse or crisis.

4.6.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Multi-agency approach	**Exclusion from services** NICE CG120 Recommendations 1.7.1 and 1.7.2
Joint working	**Partnership working between specialist services, health, social care and other support services and commissioners** NICE NG58 Recommendation 1.4.2 **Pathways into care** NICE CG120 Recommendations 1.4.6 and 1.4.7 **Competence** NICE CG120 Recommendation 1.5.1

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

NICE NG58 Recommendation 1.4.2

Ensure joint strategic working arrangements are in place so that:

- services can offer continuity of care and service provision (for example, when commissioning contracts are due to expire)
- services are based on a local needs or a joint strategic needs assessment
- service quality is monitored and data sharing protocols are in place (see also recommendations 1.4.6 and 1.4.7)

Coordinating care

NICE CG120 Recommendations 1.4.6 and 1.4.7

1.4.6 Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and known to be:

- severely dependent on alcohol or
- dependent on both alcohol and benzodiazepines or
- dependent on opioids and/or cocaine or crack cocaine.

Adult community mental health services or CAMHS should continue to provide care coordination and treatment for the psychosis within joint working arrangements.

1.4.7 Consider seeking specialist advice and initiate joint working arrangements with specialist substance misuse services if the person's substance misuse:

- is difficult to control and/or
- leads to significant impairment of functioning, family breakdown or significant social disruption such as homelessness.

Competence

NICE CG120 Recommendation 1.5.1

Healthcare professionals in substance misuse services should be competent to:

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

Exclusion from services

NICE CG120 Recommendations 1.7.1 and 1.7.2

1.7.1 Do not exclude people with psychosis and coexisting substance misuse from staffed accommodation (such as supported or residential care) solely because of their substance misuse

1.7.2 Do not exclude people with psychosis and coexisting substance misuse from staffed accommodation aimed at addressing substance misuse solely because of their diagnosis of psychosis.

4.6.3 Current UK practice

Multi-agency approach

The making every adult matter (MEAM) website states that MEAM is currently being used by partnerships of statutory and voluntary agencies in 21 local areas across England. It supports people facing multiple disadvantage experience who have a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health.

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Joint working

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.6.4 Resource impact

This area is not expected to have significant resource implications.

4.7 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 8 January 2019.

Suicide prevention

Suicide prevention was suggested as an area of quality improvement. This suggestion has not been progressed within this quality standard. A quality standard on suicide prevention is in development and is expected to publish in September 2019.

Additional and updated guidance

Additional guidance and changes to existing recommendations were suggested. This suggestion has not been progressed because additional guidance or changes to guideline recommendations are outside the scope and remit of the quality standards process.

Training

The training of staff, for example to address both mental health and substance misuse needs and to prevent poor prescribing incidents, was suggested as an area of quality improvement.

This suggestion has not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased training. However, training may be referred to in the audience descriptors.

Electronic patient record systems

The use of electronic records systems and their format was suggested as an area for quality improvement. This area is not within the scope of this quality standard.

Prevention

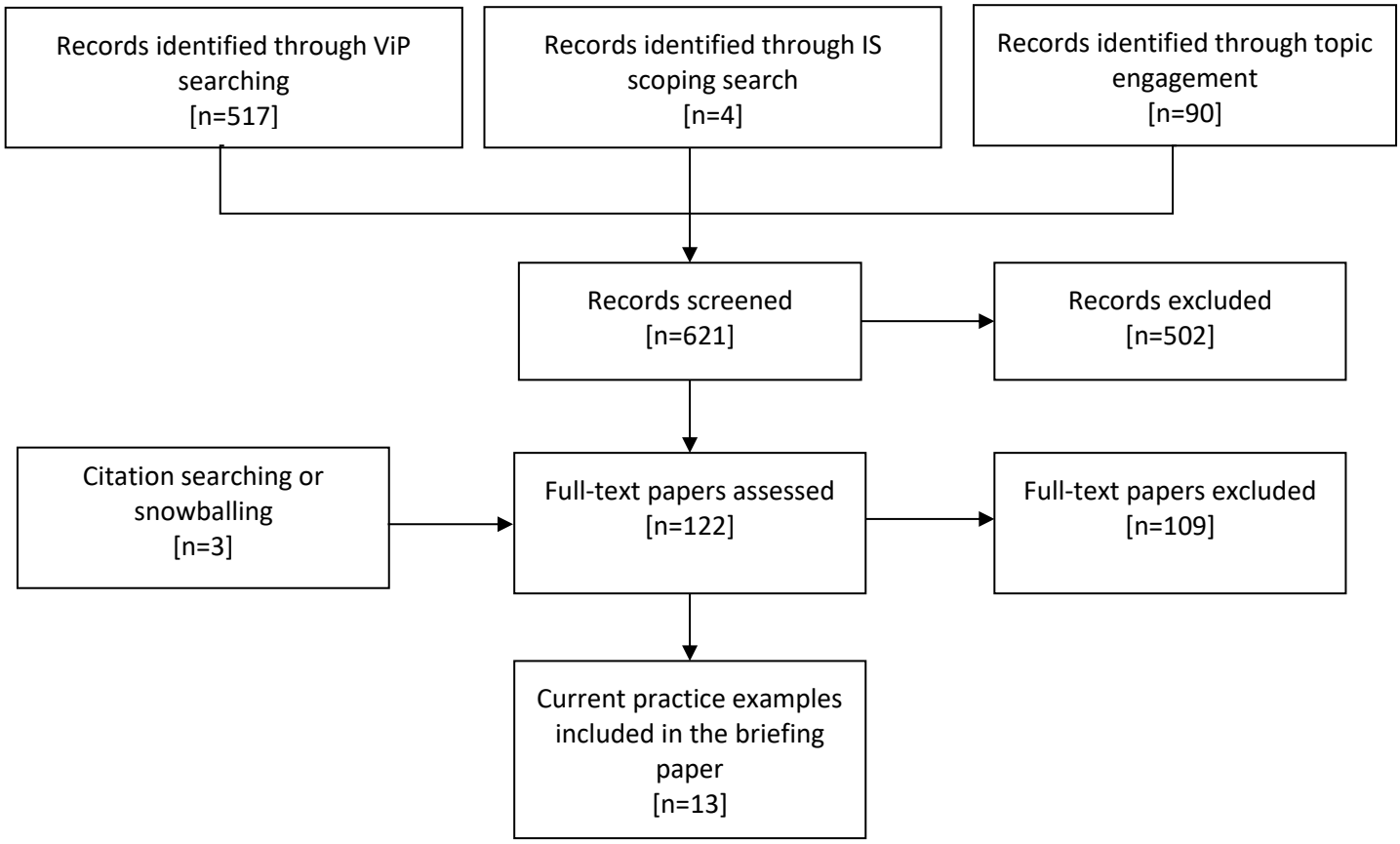
Prevention of substance misuse in people with severe mental illness was suggested as an area for quality improvement. This suggestion has not been progressed as it is outside the scope of this quality standard. Quality standards have been developed

on drug misuse prevention (QS165) and alcohol: preventing harmful use in the community (QS83).

Experience of people using services

Areas relating to the experience of people with severe mental illness were suggested as areas of quality improvement. These suggestions have not been progressed as they are included in service user experience in adult mental health services (QS14).

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Access to services					
1	Faculty of Public Health	Key area for quality improvement 2 Make a sensible separation of MH and substance use. • don't use substance misuse as a barrier to accessing to specialist MH support. • Ensure that MH needs do not act as a barrier to Drug Treatment • Be aware of and able to respond 'on top' use – including alcohol • Ensure links to Crisis response and Police and Ambulance emergency response. – Have Crisis Plan in place	A significant issue is refusal of MH assessment on the basis of the presenting symptoms being drug or alcohol induced because the person was intoxicated.	Some people are always intoxicated, that's their daily state, it is their 'normal' and needs to be accounted for in assessing the MH. This is complex and will require consultation with substance misuse experts about what you could reasonably expect to be a result of the drug use and what is MH. Prison health services will need to make use of the NICE Quality Standard. There is evidence that prison health services make premature assumptions about the nature of observed substance-related behaviour which might mask serious psychosis and other serious mental illnesses	Coexisting severe mental illness and substance misuse: community health and social care services NICE guideline [NG58] Published date: November 2016: Recommends - working across traditional institutional boundaries
2	Faculty of Public Health	Key area for quality improvement 3 Quick access to low threshold services where possible for co-occurring, and the separate conditions. • Provide information for service users and families	Problems can escalate if support at a low level is delayed or not available.	Evidence indicates that failure to do this leads to escalating demand on more specialist acute services.	Coexisting severe mental illness and substance misuse: community health and social care services NICE guidance 2016 recommends: Ensure people with coexisting severe mental illness and substance misuse, their family or carers are given accurate information about relevant local services (including, for example, community or family support groups)

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		• Look at behaviour change / trauma informed approaches			Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings: Published date: March 2011 - When working with adults and young people with known or suspected psychosis and coexisting substance misuse, take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism.
3	Hampshire County Council – Public Health Team	Access/referral criteria to services	Specific reference should be made of the need for primary and secondary mental health services to have a clear access criteria policy in place in regards to both alcohol/drug dependency and intoxication This should similarly apply to substance misuse services in regards to mental illness. The inclusion of example policies/case studies would support local providers and	Evidence suggests mental health services exclude people because of their alcohol/drug dependency. This is also true of for those excluded from alcohol and drug services due to the severity of their mental illness	The Home Affairs Committee report on mental health and policing found that people in crisis, even those being taken to a place of safety, are withheld support because of alcohol and drug use being applied as exclusion criteria https://publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			commissioners implement this.		
4	Inclusion Midlands Partnership Foundation Trust	Key area for quality improvement 1 Do not exclude people with severe mental illness because of their substance misuse.	Service users with co-existing severe mental illness require the support and expertise from both services. Working together will increase positive outcomes for service users and their families	Across our area this varies greatly. We often receive correspondence that advises us that until the service user has been abstinent of substances (usually for 3 months) they cannot be supported by the mental health teams.	No national data
5	Opportunity Nottingham	Key area for quality improvement 1 Access to mental health and substance misuse treatment	There is evidence that both mental health and substance misuse services exclude on the grounds of a coexisting diagnosis. This is further compounded in the presence of additional complex needs such as homelessness. “No wrong door” is a sound principle, but requires both doors to be visible and accessible in the first place. “professional” referral only, long waiting times and inflexibility over appointments creates a series of barriers ensuring it is	Sheffield Hallam university. The mental health needs of Nottingham’s homeless population. An exploratory study (2018) identified routine overt and covert exclusion, “The main reasons respondents had been unable to access services were a combination of: high demand / the way in which services are accessed (as indicated by issues with waiting lists and appointments); lack of information about the services that exist and how to access them; and barriers associated with individuals' characteristics and needs (as indicated by exclusion because of dependency).” Current guidelines do not attend to the specific needs of this population, despite their potentially higher risk for co-existing mental health problems and substance abuse, which may be underestimated within research evidence to date.	Please see latest substance misuse statistics, showing prevalence of mental needs in this population and the gap between needs and needs met. https://www.gov.uk/government/publications/substance-misuse-treatment-for-adults-statistics-2017-to-2018/alcohol-and-drug-treatment-for-adults-statistics-summary-2017-to-2018 Individuals with intellectual disabilities (also known as learning disabilities) are at greater risk of mental health difficulties and require specific considerations regarding prevention, assessment and management (See NICE guideline NG54: https://www.nice.org.uk/guidance/ng54/resources/mental-health-problems-in-people-with-learning-disabilities-prevention-assessment-and-management-pdf-1837513295557)

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			implausible that those with complex problems will access support. Quality standards regarding access should pay specific attention to individuals with intellectual disabilities and / or Autism, e.g. how many individuals with learning disabilities and / or Autism are accessing services and in what way services are adapting to meet their needs.		There is evidence that individuals with autism and / or learning disabilities may require special consideration by services because of differences in their presentation to individuals who abuse substances but do not have autism / learning disabilities, e.g. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4990150/ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4493816/ https://www.cdd.unm.edu/autism/pdfs/ImagineConference/2018-slides/Drinking-Drug-Use-3-slide.pdf https://journals.sagepub.com/doi/abs/10.1177/002221940103400410
6	Public Health England	All mental health services in all settings to ensure assessment and management of risk - even if people are intoxicated. Intoxicated people should not be excluded because of their substance use.	It is very common for people to experience problems with their mental health and alcohol and drug use (co-occurring conditions) at the same time. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment. Accurate assessment enables risks to be identified and	Evidence from service user and provider surveys show that patients with co-occurring conditions often experience exclusion from mental health services due to substance use, or from addiction services due to mental health needs. This can result in conditions deteriorating and exacerbate mental health crises. Death by suicide is common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems.	Public Health England is working with NHS Digital to improve the mental health dataset, to incorporate an accredited drug and alcohol screening tool and to collect data on prevalence of drug and alcohol use conditions with the adult mental health service population. See PHE (2017) Better care for people with co-occurring mental health, and alcohol and drug use conditions

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			minimised, intoxication may increase risk in some areas (e.g. suicidality or self-harm). Assessment of need enables services to initiate and coordinate a multi-agency response which is appropriate and supportive.		
7	Royal College of General Practitioners			There are obvious and longstanding issues around which services people can access - the importance of the "no wrong door approach" and not being excluded from particular services because of comorbidity.	
8	SCM1	Key area for quality improvement 2 Potential exclusion from one or other service(s) on the sole basis of co-existing conditions	Lack of staff competence and confidence or a lack of joined-up pathways for people with co-existing conditions can lead to exclusion from treatment and services and, ultimately, chance of recovery. NICE guidance is clear that individuals should not be excluded from either secondary mental health or substance misuse services on the	Public Health England (PHE) 'Better Care for people with co-occurring mental health and alcohol/drug use conditions' refers to evidence that patients can still be refused a service by either secondary mental health services or substance misuse services on the sole basis that they have a co-existing condition. This identified area for improvement forms the basis of the PHE guidance for improved commissioning and provision of services.	Public Health England (PHE) – Public Health Outcomes Framework (PHOF) measure 'Concurrent contact with mental health services and substance misuse services for drug misuse' - https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth

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			sole basis of co-existing conditions.		
9	South London and Maudsley MH FT	Key area for quality improvement 3 **Access to both mental health and drug services for people who are street homeless**	The most prevalent health problems among homeless individuals are substance misuse (62.5%), mental health problems (53.7%) or a combination of the two (42.6%). https://www.mentalhealth.org.uk/statistics/mental-health-statistics-homelessness Another report shows that 80% of homeless people in England reported that they had mental health issues, with 45% having already been diagnosed with a mental health condition. PHE (2018) Adults with complex needs (with a particular focus on street begging and street sleeping)https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/680010/evidence_review_adults_with_complex_needs.pdf	Homelessness and Dual diagnosis can be interrelated and each reinforced by the other. Action is required to help people to access and navigate the range of physical and mental health and substance misuse services they require in order to sustain stable accommodation. PHE (2018) Homelessness: applying All Our Health https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health Homeless people are significantly more likely to be unemployed, have poor mental health, have long-term physical health issues and significant alcohol and drug use compared to the general population	There is a high incidence of dual diagnosis in this group https://www.mungos.org/wp-content/uploads/2017/12/Nowhere_safe_to_stay.pdf) The mortality rate in this group is also high: Dying on the Streets: the case for moving quickly to end rough sleeping St Mungos 2018 https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/homelessness-kills-2012/

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			Homeless people find it particularly difficult to access help, e.g.:Alcohol and Mental Health: *Policy and Practice in England.* Institute of Alcohol Studies and Centre for Mental Health, 2018		
Identification and assessment					
10	Action on Smoking and Health	Embedding smoking cessation support in treatment pathways for individuals with coexisting severe mental illness and substance misuse	NICE guidance (NG58) for improving services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse recognises the importance of a multi-agency care plan which address several determinates of physical and mental health.[i] In recommendation 1.3.3 of this guidance,[i] smoking is cited as a behaviour which should be addressed in care plans. It is vital that smoking also be considered a core area for improvement in any quality standard relating to coexisting severe	Whilst smoking prevalence in the general population has fallen from around 27% in the mid 1990s to 19% by 2014,[xi] over the same period rates among those with a mental health condition have not fallen, with smoking rates estimated to have remained at around 40% for the same 20-year period.[xii] The most recent available data reflects this dire need for improvement, with smoking prevalence amongst adults with a serious mental health condition at an average of 40.5%.[xiii] Successive comprehensive tobacco control strategies have made a real difference to smoking rates in the general population but have had limited impact on people with mental ill health, and it is clear that a more targeted and comprehensive approach is needed. Compared with the general population, those with a mental health condition are more likely to smoke and more likely to	Please see Public Health England's Local Tobacco Control Profiles, which features national data on smoking prevalence amongst adults with serious mental health conditions: https://fingertips.phe.org.uk/profile/tobacco-control

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			mental illness and substance misuse. Smoking rates among people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions.[ii] This association becomes stronger relative to the severity of the mental condition, with the highest levels of smoking found in psychiatric in-patients.[ii,iii] For example, smoking rates are around 60% in those with probable psychosis,[iv,v] and up to 70% for people in psychiatric units.[iii] In addition, among people experiencing substance misuse, the smoking rate is estimated to be around 88%.[vi] As a result of high smoking rates, people with a mental health condition also have high	be heavily dependent. Even using a restricted definition of a mental health condition, around one third of all tobacco smoked in the UK is consumed by those with a mental health condition.[ii] Despite high rates of smoking and levels of addiction in this population, people with mental health conditions are no less likely to want to quit smoking but they expect to find it more difficult than the general population.[xiv] Health professionals often have low expectations about the potential for behaviour change among people with a mental health condition, seeing it as too difficult an issue to tackle. This lack of ambition among the workforce for the physical healthcare of those with a mental health condition is significant, as prompts from health professionals have been shown to be an important driver in quit attempts among all smokers.[xv] There is evidence that on a per consultation basis, primary care professionals are significantly less likely to provide smoking cessation treatment to smokers with a mental health condition compared to those without.[xvi] There is also evidence of significant gaps in practice relating to addressing smoking as an issue, with staff who have received relevant training being twice as likely to report discussing smoking with their patients compared to staff with no training.[xvii]	

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			mortality rates compared to the general population. Smoking is the single largest contributor to the 10-20 year reduced life expectancy for those with long standing mental health conditions.[ii] For some people with mental health conditions smoking can feel like 'self-medicating' with individuals reporting that it is an important way for them to deal with stress. However, this relief is temporary, linked to relieving withdrawal from nicotine, and smoking can actually exacerbate symptoms.[vii,viii] As well as the extensive benefits to physical health of quitting smoking, there is also evidence showing benefits to mental health. Smoking cessation is associated with reduced depression, anxiety and stress as well as	The higher levels of addiction among those with a mental health condition means they are less likely to have a successful quit attempt. This makes professional support and access to appropriate medication and alternative sources of nicotine (such as e-cigarettes) even more important in managing the physical symptoms of nicotine addiction. Too few people are using adequate levels of nicotine and more needs to be done to improve access to combat false perceptions of harm from nicotine held by both professionals and smokers. Smoking cessation support must therefore be embedded in all settings and treatment pathways relating to individuals with mental health conditions. There is also a significant need for greater and more consistent training of all healthcare professionals engaging with people experiencing mental ill health. For those who are moving in and out of mental health services where smoking rates are very high it can be the norm that people around you smoke. This can undermine attempts to quit but where peer groups quit together success rates can improve. There is a major opportunity to make better use of peer support models in smoking cessation	

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			improved positive mood and quality of life compared with continuing to smoke.[viii] The impact of smoking cessation on anxiety and depression appears to be at least as large as antidepressants.[viii] Furthermore, nicotine increases the metabolism of drugs so when a person stops smoking the dosage of some anti-psychotic medications can be reduced.[ii,ix] In addition to the health impact of smoking, there are considerable economic costs arising from smoking in people with mental health conditions. The NHS spends approximately £720m per year in primary and secondary care treating smoking-related disease in people with mental health conditions.[ii] These costs arise from an annual estimated 2.6 million avoidable hospital admissions, 3.1	support. While these models are increasingly a mainstream part of mental health provision, they remain rare in supporting people to quit smoking. Though Government attention has turned to the need to support people with mental health conditions to stop smoking,[xviii] with specific targets around the implementation of NICE Guidance PH48, more targeted action is required to bring down smoking prevalence rates after more than 20 years of no improvement. However, action needs to go beyond treatment pathways in mental health trusts. Smoking cessation support should be embedded in all pathways relating to people with mental ill health in order to achieve long overdue progress in reducing smoking prevalence amongst those who have been disproportionately affected by its harms for so long. It is therefore key to include the embedding of smoking cessation support in this quality standard.	

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			million GP consultations and 18.8 million prescriptions. The majority of these service costs arise from people diagnosed with anxiety and/or depression. A separate study which estimated the economic cost of smoking in people with mental health conditions found that it amounted to £2.34 billion in 2009/10 in the UK, of which, about £719 million (31% of the total cost) was spent on treating diseases caused by smoking. Productivity losses due to smoking-related diseases were about £823 million (35%) for work-related absenteeism and £797 million (34%) was associated with premature mortality.[x] Therefore, given the substantial health benefits stopping smoking can have for individuals with mental ill health, the extremely		

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			high smoking prevalence rate amongst individuals experiencing substance misuse and mental ill health and the health burden this inflicts, embedding smoking cessation support should be considered extremely important to this quality standard.		
11	Faculty of Public Health Alcohol Special Interest Group	Key area for quality improvement 1	Improved identification and recording of alcohol use in patients with severe mental illness. Failure to adequately screen patients for alcohol use prevents interventions to improve their physical and mental health, impairs the response to psychotropic medication and prevents interventions to reduce the risk of suicide.	Alcohol and drug misuse is recorded in 54% of all suicides in people experiencing severe mental illness. Recording of alcohol consumption has improved but is still only 87%. 11% of those screened required an intervention for hazardous or harmful drinking, 68% of those offered an intervention would accept it.	(Better care for People with Co-occurring Mental Health and Alcohol/Drug Use Conditions. PHE, 2017) National Clinical Audit for Psychosis. Royal College of Psychiatrists. 2018 NHS Greater Glasgow and Clyde Audit of PsyCIS Deceased , Cause of Death Unascertained Deaths Matched for Age and Sex: Audit of Care Audit details available on request as separate file.
12	Faculty of Public Health Alcohol Special Interest Group	Key area for quality improvement 4	Better screening for physical health problems by the mental health services as this group are more likely to have physical co-morbidity.	A wide range of physical health problems impact on the patients' physical and mental health and wellbeing and their ability to engage with treatment. The National Clinical Audit for Psychosis showed wide variation in monitoring for a range of conditions.	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-core-audit-report-2018/

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				Failure to monitor is likely to result in failure to treat.	
13	Inclusion Midlands Partnership Foundation Trust	Key area for quality improvement 2 Undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services.	This is important for timely referrals to mental health services	We attempted to introduce tools to support our staff in knowing when to refer to mental health services. However we were then informed that the mental health teams did not use the tools we'd implemented. Within our teams we have Consultant psychiatrists and RMN's they have attempted to refer into mental health services but again these referrals have been returned. We have also advised of our concerns regarding deteriorating mental health of our service users and these have not been listened to, resulting in service users being sectioned.	
14	Leicestershire Partnership NHS Trust	Key area for quality improvement 3	Identification and assessment	There are few tools that are used within assessment and those that are used are currently different across organisations a standard model would improve recording and understanding Audit and DAST are identified but not always used within mental health assessments	Nice guidance on alcohol and drugs calls for use of tools but not always implemented.
15	NHS England & NCD	Key area for quality improvement 1 All people with severe mental health problems should be assessed for substance misuse problems, including alcohol.			
16	NHS England & NCD	All people with coexisting MH and substance misuse should have their physical health monitored routinely in			

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		primary care or in secondary care if they are an inpatient. We would expect early identification in pathways, more prominent outlined within guidance for SM e.g. EIP and schizophrenia and emphasis on the high risk in those with PH needs (NHSE SMI and primary care guidance should cover substance misuse as well).			
17	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 1	Assessing the needs of both substance misuse and mental health issues consistently at the initial assessment of needs is crucial by all mental health practitioners in a consistent manner.	There appears to be a lack of consistent assessment of substance misuse in mental health services. This is a major risk as a large number of completed suicides have substance misuse as a component	Alcohol and treatment services have increasing numbers of people with mental health presenting in treatment (2018) now being recorded via NDTMS Substance misuse treatment for adults: statistics 2017 to 2018 Statistics on alcohol and drug misuse treatment for adults from PHE's national drug treatment monitoring system (NDTMS).
18	Opportunity Nottingham	Key area for quality improvement 2 Assessment	People should receive face to face assessments. Ideally mental health and substance misuse services should carry out joint assessments. Where that cannot be facilitated assessments should be shared, with due regard to professional competencies and opinion	Service users repeatedly cite having to repeat their "story" as a significant barrier to treatment. There is evidence that Mental health assessments can contradict rather than compliment substance misuse assessments, and vice versa, resulting in no service taking responsibility "Drug and/or alcohol abuse was a key factor rendering them ineligible, or 'too complex' for mental health services. Yet dual diagnosis was very common amongst survey and interview	Sheffield Hallam university. The mental health needs of Nottingham's homeless population. An exploratory study (2018)

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				respondents. At times this left respondents caught between health services and drugs services as each deemed the other to be the primary need requiring treatment." – Sheffield Hallam 2018	
19	Royal College of General Practitioners			Recognition of alcohol related brain damage - improve recognition, diagnosis and support. Consider the role of a specific support worker sitting between dementia services and substance misuse	
20	Royal College of General Practitioners			Better screening for physical health problems - more likely to have physical co morbidity NHS Screening to be done by sms services Consider role of GPs within substance misuse services who are unable to use all their knowledge to make diagnoses and decisions - they Could help support need for X-rays/ bloods – NB This patient group attend medical services poorly and then often out of hours when unwell frequently with conditions which could have been simply treated earlier in the process	
21	Royal College of General Practitioners			Issues around who actually assesses/treats - often in the past, this been the least experienced practitioners when it should be the most experienced. Big overarching issues that are clearly of foundational importance - but perhaps not within NICE remit include - availability of housing, training,	

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				employment, GP health care and effective probation input.	
22	RCPsych	Key area for quality improvement 1 Screening and assessment of coexisting severe mental illness and substance misuse	There are good examples of good practice for assessment of both mental illness and substance use. Due to the vulnerability of this group, screening and assessment of this group of people is essential.	The number of people with severe mental illness and substance misuse is high and this has been treated differently across the country with some mental health teams not accepting referrals for patients with active substance use disorders.	
23	RCPsych	Key area for quality improvement 2 Management of coexisting severe mental illness and substance misuse	There are good examples of good practice for management of both mental illness and substance use. Due to the vulnerability of this group, screening and assessment of this group of people is essential.	The number of people with severe mental illness and substance misuse is high, and this has been treated differently across the country with some mental health teams not accepting referrals for patients with active substance use disorders.	
24	SCM2	All people who come into contact with mental health (MH) services are screened and assessed for substance use (including emergency and criminal justice contact points).		For NG58 consultation with service users and advocacy groups highlighted that people in mental distress may be denied access to MH support because of current intoxication, current use or dependence and or historical substance dependence. The outcome of screening is often to exclude patients rather than providing guidance and support.	See also https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf
25	SCM3	Key area for quality improvement 1	To provide safe care for people with SMI that are using substances.	Other NICE and best practice guidelines have identified the importance of robust assessment of substance use See eg	HQIP National Clinical Audit of Psychosis.

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		Robust assessment of substance use for everyone with a possible severe mental illness/psychosis to include the core components identified in NICE (2011) Coexisting SMI and SM (CG120) ie substances used, quantity, frequency, pattern of use, route of administration, duration of current level of use – assessment of dependency also readiness to change (crucial to identifying appropriate interventions)	To identify potential impacts of substance use on mental health, physical health and social circumstances. Substance use can be a significant factor for a variety of risks including suicide and homicide (see National Confidential Inquiries into Suicide and Homicide by People with Mental Illness). To help differential diagnosis (disentangling which symptoms may be due to mental illness, substance use or a combination) To trigger pharmacological intervention where appropriate. Unless a good assessment is conducted misdiagnosis and inappropriate care/treatment may be provided.	NICE (2007) Drug Misuse: Psychosocial Interventions (CG51); Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug Misuse and Dependence: UK Guidelines on Clinical Management – also DH guidance (eg 2002, 2006, 2008, 2016), PHE (2017) (etc)*** However, the extent to which a robust assessment is completed is practice is variable potentially resulting in poor quality/unsafe care and poorer outcomes. The HQIP National Clinical Audit of Psychosis: Core Audit Reports report high levels of 'monitoring' of alcohol and substance misuse consumption however, the criteria are not stringent. It can be argued that brief screening information is insufficient for safe, comprehensive care planning.	PHE Risky Behaviours CQUIN – this measures alcohol screening for adults (18+) admitted to mental health inpatient unit for at least one night and recorded in patients notes. A proportion of the eligible group will be people with severe mental illness. This CQUIN is for the period 2017-19. [***DH (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide DH (2006) Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings DH (2008) Refocusing the CPA DH (2016) Improving the Physical Health of People with Mental Health Problems PHE (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions]
26	South London and Maudsley MH FT	Key area for quality improvement 1	Individuals with dual diagnosis often have complex assessment and treatment needs however	To integrate appropriate tools and mechanisms within service structures and systems which would ensure that assessment are routinely completed and outcomes properly reflected in care and	People with serious MH needs die 15-20 years younger due to poor physical health, use of long term medication and the way the mental health services are structured.

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		Detection, assessment and intervention for substance misuse in people with mental illness from all age groups	comprehensive assessments that consider mental health, substance use, physical health, social care needs are often not completed with up to 50% of substance use in people with serious mental illness remaining undiagnosed. Where assessments are completed, the standard is poor. Substance misuse accompanying mental illness is associated with higher rates of self-harm and suicide, violence, hospitalisation, homelessness, crime and poorer engagement, physical health. The few tools that exist for assessing dual diagnosis needs and risks differ across services and are often not used in a consistent way. Inadequate assessments can result in care plans that don't	risk management plans that are implemented in a timely fashion. To link clinical care pathways for coexisting problems with assessment documents and care plans that link to electronic patient record systems to provide evidence based on interventions documented	Parity Of Esteem https://www.rcn.org.uk/clinical-topics/mental-health/parity-of-esteem/improving-care-for-clients-with-a-severe-mental-illness Substance misuse treatment for adults: statistics 2017 to 2018 https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018 College Report on Substance Misuse in Older People: *Our Invisible Addicts* https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr211.aspx Healthcare professionals in all settings should routinely ask service users about their drug and alcohol use. In addition, an assessment of dependency should be conducted Drug misuse: opioid detoxification [NICE clinical guideline 52] and Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence [NICE clinical guideline 115])

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			match the actual needs of the person Clinical care pathways can often be written documents (often not embedded in electronic patients records) that are not reflected in frontline practices. These are often not monitored routinely and substance misuse services for alcohol are harder to access as services experience budget cuts leading to less focus on specific groups such as people with coexisting problems		
27	Turning Point	Young people self-medicating their undiagnosed mental health with low priority drug use	Earlier interventions, diagnosis and mutli professional support, significantly improves the long term outcome for these service users		
Interventions					
28	Addaction	3/ In addition there are many clients who seem to exceed the thresholds for IAPT (in relation to their mental health need even when they are not being excluded due to using substances) who do not meet			

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		thresholds for secondary care.			
29	ADASS	Key area for quality improvement 4	Best practice for the treatment and recovery of people with problematic alcohol and substance use	There is an opportunity to review current recovery and treatment pathways that are commissioned by local government and the NHS	
30	Faculty of Public Health	Additional developmental areas of emergent practice Trauma informed practice			
31	Leicestershire Partnership NHS Trust	Key area for quality improvement 5	Focus on recovery rehab	Limited rehab is available to dual diagnosis and those offering dual diagnosis are expensive and often lack the skills to meet complex clients and there is a need for homeless populations	Dual diagnosis rehabs are available Manage complex need
32	NHS England & NCD	Key area for quality improvement 2 All people with coexisting severe mental ill-health/problems should have access to the full range of interventions for substance misuse and treatment of their MH condition; this should be delivered through close joint working between MH services and substance misuse services			
33	North West Boroughs Healthcare NHS Foundation Trust	Additional developmental areas of emergent practice	Group support for people with severe mental health and problematic substance use	Liaison with local recovery college to produce tailored sessions for those attending	Local developments in Knowsley Merseyside and Halton in Cheshire working alongside substance misuse services

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34	Royal College of General Practitioners			Vital importance of actually treating people (in the broadest sense) properly - as exemplified by the ethos of Competent Compassion - which should be foundational in any healthcare organisation	
35	Royal College of General Practitioners	Improving access to specialist psychiatric/psychology services.	A very high proportion of patients have profoundly disturbed backgrounds including trauma and abuse. In particular, a history of Adverse childhood events (ACE) is almost universal	Evidence-based treatments for psychological sequelae of past trauma including ACE and conditions such as PTSD exist but provision is hopelessly inadequate. The IAPT programme for example specifically excludes patients with substance misuse as well as self-harm or suicidality. The result is that the underlying causes of both mental illness and substance misuse are often not addressed	Much work concerning ACEs comes from the USA (https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences and suggests that modalities such as Cognitive Behavioural Therapy and Eye Movement Desensitisation and Reprocessing (EMDR) can be effective, especially as part of a holistic support package A 2017 systematic review published in the Lancet (The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis Lancet Public Health 2017;2: e356–66) highlights the strong links between ACE exposure and subsequent mental illness and substance misuse
36	Royal College of General Practitioners	Reducing hazardous prescribing	Poly-pharmacy is extremely common in patient with mental illness and when combined with alcohol or substance misuse serous or even fatal consequences can follow. There are well	Reducing mortality from drug-related deaths is a key priority and there is also evidence of high morbidity including addiction from prescribed drugs, in particular Gabapentinoids (Pregabalin and Gabapentin) and Benzodiazapines. Patients with mental illness have a higher risk in any case from suicide and self-harm from overdose is one of the	Opiate substitution programmes using Methadone or Buprenorphine (Subutex) have a proven track record in reducing harm including mortality from Heroin addiction.(https://publichealthmatters.blog.gov.uk/2017/08/04/actions-were-taking-to-prevent-drug-related-deaths/)

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			over 3000 drug-related deaths in England and Wales annually with numbers rising steadily - and many are in this patient group. Deaths from Heroin and alcohol addiction are also rising	commonest presentations at A/E departments. Availability of opiate substitution treatment and alcohol detoxification are patchy and often inadequate with long waiting lists for both	Alcohol is often a component of overdoses and increases risk of mortality. Alcohol detoxification and rehabilitation can reduce harmful drinking Guidelines for safe prescribing of drugs such as anti-psychotics have been published by the Royal College of Psychiatrists (https://www.rcpsych.ac.uk/pdf/10-year%20report.pdf) and for reducing harm from Gabapentinoids (https://www.prescriber.co.uk/article/guide-to-the-management-of-gabapentinoid-misuse/)
37	Royal College of General Practitioners			A shift by commissioners to recognising treatment as individualised. For people with severe mental illness and substance misuse stability on a script for an extended period of time can be hugely life changing – can sometimes find themselves in a system that is driving abstinence for all	
38	SCM 2	Treatment from mental health service to include advice, guidance and support on reducing harm or achieving abstinence from substance use appropriate to the service user's needs and level of motivation.		MH are ideally placed to deliver some basic substance use specific interventions in the context of the ongoing management of severe mental illness (SMI). People with SMI may not want to go to specialist addictions services because they do not consider their substance use to be problematic. There will be a training need for MH staff here. NG 58 highlighted that specialist dual diagnosis teams are not effective and the need was for all staff to do a little	

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				more rather than to aspire to some super specialism.	
39	South London and Maudsley MH FT	Key area for quality improvement 2 **Access to harm reduction strategies, including Take Home Naloxone, for those under the care of mental health services**	Take Home Naloxone (THN) has been shown to significantly reduce fatal overdoses and also to be safe and cost-effective: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2015) Preventing Fatal Overdoses: A Systematic Review of the effectiveness of Take-Home Naloxone. In 2015, UK regulations increased the availability of injectable naloxone to be supplied by addiction services without a prescription to drug users, their family, friends and peers. Health England (2015): (Take-home naloxone for opioid overdose in people who use drugs -Local Government Association (2018). Report of the Naloxone survey 2017) Mental health services however have not been	Despite being largely preventable, opiate overdose remains a major cause of death in England. 1,829 out of 2,310 drug related deaths recorded in 2017 were attributed to 'any opiate' on the death certificates (59% involved heroin and morphine, 18% involved methadone and 4% fentanyl) ONS (2018). Deaths Related to Drug Poisoning in England and Wales: 2017 registrations 2017 [16/08]: www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations.)	The 2017 clinical guidelines state that systematic reviews have found that pre-provision of naloxone to heroin users can be helpful in reversing heroin overdoses. DOH (2017) Drug misuse and dependence: UK guidelines on clinical management. www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management A 2013 study found that distribution of naloxone to heroin users was cost-effective and "resulted in fewer overdoses or emergency medical service activations" Coffin PO & Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. Ann Intern Med. 2013 Jan 1; 158(1):1-9 An Evaluation of the take-home naloxone programme for people being released from prisons demonstrated significantly reduced deaths in this group. Strang J, Bird SM, Parmar MKB. Take-home emergency naloxone to prevent heroin overdose deaths after prison release: rationale and practicalities for

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			keen to develop systems for providing THN to opiate users upon discharge from hospital or in the community, still restricting naloxone use to emergency incidents where opiate overdose is diagnosed or suspected. Improved access to THN is needed to prevent unnecessary deaths particularly for people discharged from hospital following reduced use, cessation, detoxification or stabilisation; those yet to access or reengage with addictions services or those that do engage chaotically and who may also be at high risk of overdose due to low tolerance.		the N-ALIVE randomized trial. J Urban Health. Oct 2013; 90(5):983-996
Care planning					
40	Faculty of Public Health	Key area for quality improvement 1 Ensure that the needs and impacts on any children that the client has parental / care responsibility for are			

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41	Faculty of Public Health Alcohol Special Interest Group	Key area for quality improvement 3	Patients who are detoxified are provided with intensive support to assist them to remain alcohol free.	Evidence suggests that many patients are detoxified in a range of settings. A large number of detoxifications are unplanned and unsupported. Patients who are not supported are more likely to relapse into drinking. Long term support (e.g. peer support or other third sector support) has not been well integrated into addiction services and is not offered or provided to patients and primary care services are frequently not informed of support arrangement.	http://www.shaap.org.uk/images/dying-for-a-drink-text_for_web.pdf
42	Inclusion Midlands Partnership Foundation Trust	Key area for quality improvement 4 The person's care coordinator should adopt a collaborative approach with other organisations (involving shared responsibilities and regular communication) when developing or reviewing the person's care plan. This includes substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.	A high standard of patient care. All organisations involved in the care and support of the service user are fully informed of the plan and are aware of their own responsibilities. The service user is at the centre of the care plan and is aware of who is involved. Better outcomes for service users	Again this varies across the area. Both agencies complete their own care plan rather than completing it jointly. This could be seen as duplication for the service user. Quite often substance misuse teams will need to follow up/request assessments/updates from mental health services. Substance misuse services have called multi-agency meetings but these haven't been attended.	
43	Inclusion Midlands Partnership Foundation Trust	Key area for quality improvement 5 Ensure agencies and staff communicate with each other so the person is not	Better outcomes for service users. This would stop service users having to be re-referred to services.	In some areas Clinical Team Meetings are well attended by both services in other areas this has been met with resistance.	

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		automatically discharged from the care plan because they missed an appointment. All practitioners involved in the person's care should discuss a non-attendance.		We're often told that the service user is being discharged rather than being included in the discussion. Then substance misuse service and the GP are left holding the risks.	
44	NHS England & NCD	Key area for quality improvement 4 Families of people with coexisting MH and substance misuse should be offered help and support in their own right as they often end up suffering with mental health problems themselves; this should be part of a carer package of care (including assessment etc)			
45	Opportunity Nottingham	Key area for quality improvement 4 Discharge from services and specifically robust re-referral plans.	Individuals with co-existing serious mental illness and substance use are at high risk of being discharged due to lack of engagement. This can lead to them being left without any services, particularly if they also become homeless. The requirement to begin the referral process from the beginning, i.e. via the G.P. means can then be a barrier to access if the person's mental health has	Individuals are discharged without clear plans regarding relapse prevention or how to re-access services. Another quality marker would be whether there is a local policy regarding decisions about discharging people who have not engaged, such as: https://www.sabp.nhs.uk/application/files/5415/3323/0210/235_16_Engagement_and_Disengagement_Policy_-_Updated_July_2018.pdf	There is evidence that disengagement from services can have devastating consequences for individuals: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696379/ Substance misuse is one of the factors associated with increased risk of disengagement from mental health services: https://www.ncbi.nlm.nih.gov/pubmed/19037573 Locally it is a common pattern that people have been discharged from local mental health services due to lack of engagement Being discharged leads to no access to medication or

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			deteriorated and / or their substance use has escalated. Having discharge plans with a robust re-referral process that can allow rapid re-entry to services and by-pass referral via G.P. would support more timely access to secondary mental health services.		therapeutic support and no monitoring of mental health, which increases the likelihood of relapse or crisis as early warning signs go unnoticed. When it becomes evident (for example to homelessness services or the criminal justice system) that an individual is experiencing an acute mental health difficulty, it can takes weeks to re-engage services as the individual may not attend the G.P., even with support to make and attend appointments. In some cases, the weeks spent attempting this contribute to a delay in appropriate treatment for the individual. In two cases in the past two weeks in Nottingham, homeless individuals previously known to services have faced such barriers to accessing secondary mental health care and have then required detention under the Mental Health Act. There is evidence for how services can reduce the likelihood of disengagement: https://www.ncbi.nlm.nih.gov/pubmed/23632442
46	Opportunity Nottingham	Key area for quality improvement 3 Use of the Care Programme Approach	The Care Programme Approach is an existing structure for the coordination of care provided to people with severe mental illness and complex needs. Appropriately	Locally, there is much anecdotal evidence that CPA is not used as intended in either the community or inpatient settings. For example, service users are often not involved in their care plans and in some cases are not able to access copies of their care plans despite asking. Individuals said to be under CPA	We have tried to seek data on this both locally and nationally but have not identified any – it is likely that this is an issue that data is not collected about or shared as it would highlight shortcomings in services.

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			implemented, it would support well planned, coordinated care for individuals with coexisting serious mental health problems and substance abuse. There are measurable quality indicators of whether CPA is being used as intended, such as: • Designated care coordinator in place. • CPA reviews happening at least annually or more often if required. • Involvement of other agencies (such as specialist substance misuse services) in CPA reviews. • A care plan that includes the individual's goal and evidence of their involvement. A risk assessment in place.	do not always have allocated care coordinators.	There is some evidence of both the shortcomings of CPA implementation and the wish of service users to be involved in their care, which can be found here: https://www.mentalhealth.org.uk/sites/default/files/CPA_research_study.pdf
47	Public Health England	There should be a named person who can coordinate care packages and act as a central point of contact for the person and their carers	Where multiple needs are identified it is essential that the range of services involved are coordinated in a	People who have complex needs must have access to care that can comprehensively meet those needs. In addition, people value consistency and stability in their treatment and support.	See PHE (2017) Better care for people with co-occurring mental health, and alcohol and drug use conditions

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		(including young carers) and the other service providers. For people with severe mental illness this would be led by and managed within the care programme approach (CPA) process by a mental health team to coordinate assessment and a multi-agency, multi-disciplinary, integrated package of care to meet the complex health and social care needs of the individual.	coherent manner. There should be clear lines of communication between the care coordinator, individual patient, professionals, and the carers and family. There should be clarity around the treatment plan, responsibilities for each component of it, and regular review.	There is evidence that mainstream mental health teams that integrate the mental health and substance use interventions have better outcomes. This aligns with the NICE guideline on severe mental illness and substance use which provides more detailed guidance.	
48	Royal College of General Practitioners	Addressing DNA and early discharge	SH	It is very hard to gather data on the extent of DNA and self-discharges by patient with mental illness and substance misuse. CCGs do not routinely have access to hospital statistics and patients may not be classified in a way that allows their identification. Services that can reduce the problem such as assertive outreach for mental illness and substance misuse are often unavailable and their use is patchy across the country. Homeless patients in particular may not be contacted because of lack of phone or fixed address, patients with Opiate or Alcohol addiction may self –discharge because their withdrawal symptoms are not recognised.	There is good evidence that an assertive outreach approach can help to keep patients with complex mental health needs safer and on suitable medication. A similar approach should work for homeless patients and those with alcohol and Opiate addiction and would prove cost-effective because such patients are often high users of emergency services Research in South London is looking at assertive outreach for those presenting to hospital with alcohol-related problems CLAHRC BITE: Supporting people who frequently attend hospital because of alcohol-related problems

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49	Royal College of General Practitioners	Safe housing for complex needs patients	Inadequate housing or actual homelessness are common problems in this group of patients. This means that many are at a “maslow” level of survival - effectively precluding work at higher levels such as psychological needs, relationships and self-esteem. Substance misuse may even be a practical response to ongoing discomfort and danger	Inadequate, temporary or hostel accommodation is the norm for many patients – and is often dependent on abstinence. An alternative model “housing first” considers housing to be a basic right to which support services are added. Originating in the US, but now adopted in several countries including the UK, Housing First has been shown to be an effective first step in addressing underlying issues of mental health problems and substance misuse	Homeless link have a housing first link on their website (https://www.homeless.org.uk/our-work/national-projects/housing-first-england) to register and provide support for UK projects adopting this approach. There is information on commissioning, designing and delivering a service. A 2018 House of Commons briefing paper describes the model and recommends that it be much more widely used file:///C:/Users/rayres/Downloads/CBP-8368.pdf
50	SCM1	Key area for quality improvement 5 Involvement (with appropriate permission) of carers and/or relatives in risk assessment and care planning	Many national guidance and policy documents, including NICE guidance, highlight the importance of supporting and involving carers and/or relatives – across secondary mental health and substance misuse services broadly and in the care of people with co-existing conditions specifically. There is well-established best practice guidance in mental health, developed by Carers	Feedback from carers at a local level (e.g. through stakeholder engagement) suggests practice in this area remains inconsistent and sometimes poor. In particular, professionals’ willingness to take into account the knowledge and understanding of carers and/or relatives when assessing risk or planning care has been identified locally as an area for improvement.	Survey of adult carers in England - https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-user-surveys/social-care-carers-survey-2018-19 (N.B. The focus of this survey relates to adult social care – but may have some relevance)

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			Trust (Triangle of Care), which sets out the importance of this.		
51	SCM2	MH services to lead and provide treatment for a person with co-existing mental health and substance misuse within the CPA framework.		See above. MH have the appropriate expertise to lead and operate in service framework that can be more assertive in meeting the needs of this client group. The CPA framework provides a co-ordinating mechanism in which joint work with addictions services can be held.	
52	Turning point	Clear and well demarcated health care professionals linked to diagnosis	The experience for the service user and health professions is a general lack of joined up care and responsibility for these service users.		
Improving service delivery					
53	ADASS	Key area for quality improvement 1	Commissioning standards for people with coexisting severe mental illness and substance misuse.	There is an opportunity to bring together best practice in the planning and development of efficacious support and care for people with coexisting needs.	
54	Faculty of Public Health Alcohol Special Interest Group	Key area for quality improvement 2	Improved co-ordination between acute care, community addiction services and primary care would assist patients who have multiple health and social care problems to remain in treatment and continue to attend services.	A large proportion of patients identified in acute care failed to attend services on leaving hospital. Those not followed up assertively were more likely to die. Patients are more likely to attend GP for care than any other service. GPs who are not fully informed of plans to manage alcohol misuse are unable to support the patient to continue in treatment.	Co-existing Severe Mental Illness and Substance Misuse: Community Health and Social Care Services. NG 58. November 2016 http://www.shaap.org.uk/images/dying-for-a-drink-text_for_web.pdf
55	NHS England - NCD	Key area for quality improvement 5			

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		The teams involved in the care of people with severe MH problems and coexisting substance misuse, especially when the problems are long term, should ensure regular communication through care programming/case conferences or other means and this should include mental health services, substance misuse services primary care, secondary physical health care if they are involved.			
56	NHS England			Commissioning of services sit with Local Authorities, whose budgets are significantly under pressure, Since the provision of drug and alcohol services is not a statutory right, there has been a significant decrease in the number of services available for substance misuse and mental health. As a result of budget pressures, where services do exist they are often not an appropriate quality standard, this is particularly the case for detox and inpatient units. Few services include specialist MH staff able to support individuals with mental illness as well as an addiction; good quality will only be achieved through an integrated function of these services with the treatment of substance misuse in patients with SMI needing to take precedent over anything else.	PHE are currently running consultation for a paper on "Good practice of how integrated substance misuse treatment services can meet the needs of alcohol users" as part of their Expert group on alcohol treatment. Members of the group include a wide range of experts in health and social care, clinical practice and research and so we would encourage any consultation going forward to be mindful of the outcomes of this PHE consultation as well. Key highlights include: strong leadership and a joint strategic approach; pathways and services to be developed with service users in mind; and reducing barriers e.g. inequalities.
57	North West Boroughs	Key area for quality improvement 5	Improved joint working for mental health,	Regular re-tendering for substance misuse services appears to fragment	Public Health England (2018) An evidence review of the outcomes that

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	Healthcare NHS Foundation Trust		physical health and substance misuse services	service provision every time this happens and the impact on staff can be unsettling and this will be felt by service users	can be expected of drug misuse treatment in England
58	Royal College of General Practitioners			Better joint working between substance misuse teams and mental health ideally with a named link psychiatrist and a dual diagnosis specialist nurse who is integrated within both teams.	
59	Royal College of General Practitioners	Communication barriers between agencies	Most patients with mental health and substance misuse receive services from a wide variety of statutory and voluntary agencies. This may include the NHS, Social Services, the Police and prison service, housing associations, homeless charities and addiction services and many others such as food banks and religious groups. Few of these communicate with others and there is no common record system. The result is patchy care and frequent miscommunication. Patient with multiple needs must navigate multiple agencies and appointments often in	The need for multiple appointments and differences between services causes confusion for patients, means that they may miss appointments - and important details about medication, health crises, suicide risk and substance misuse may not be passed on. For example, medication may be stopped or started in prison with no communication to the GP who is looking after the patient immediately on discharge, opiate use and substitution therapy may be provided in a charity providing specialist services again without involving the GP and patients may be admitted to hospitals with none of this information available.	Communication is key to managing care for complex needs patients who need a joined up and integrated approach, preferably via a “one-stop shop” where everything is available in a single place The Nuffield Trust found that a one stop shop approach was effective in improving care for elderly patients with complex needs) https://www.nuffieldtrust.org.uk/research/patient-centred-care-for-older-people-with-complex-needs There are many studies showing that an appropriately supported general Practice can act as a “one stop shop” for patients with complex needs and this may be the most sustainable model for the UK including a 2018 report from Kings highlighting the critical importance of including primary care in services for the homeless https://www.kcl.ac.uk/sspp/policy-institute/scwru/res/hrp/hrp-studies/HEARTH/mapping.aspx

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			different places across a city or community		
60	RCPsych	Key area for quality improvement 3 Commissioning of services for people with coexisting severe mental illness and substance misuse	Again there are areas of good practice and areas where patients do not get access to services, there are no addiction psychiatrists, mental health services and addictions services are not working together or not providing any support for patients, as they are 'not specifically commissioned to provide this service'.	Improving commissioning across the country for people with coexisting severe mental health and substance misuse is vital to improve quality and reduce deaths.	
61	SCM1	Key area for quality improvement 3 Appropriate sharing of information, including of risk and care plans, between substance misuse and secondary mental health services	Information sharing – particularly assessment of risk and the content of care plans – underpins a joined up and collaborative pathway for people with co-existing conditions, as recommended by Public Health England (PHE) and in NICE guidance. This includes having robust information sharing protocols in place, staff understanding, confidence and competence in applying them and communication	Public Health England (PHE) 'Better Care for people with co-occurring mental health and alcohol/drug use conditions' recommends the prioritisation of "collaborative delivery of care", which is underpinned by proactive information sharing. The Turning Point report, 'Dual Dilemma', identifies "clear and transparent communication at service level" as one of a number of recommendations for improved services for people with co-existing conditions. In particular, a local small-sample audit of patients with co-existing conditions (n=25) identified sharing information in referrals about a patient's assessed risk as an area for improvement.	

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			channels to enable collaborative delivery.		
62	South London and Maudsley MH FT	Key area for quality improvement 5 **workforce development of mental health services for older people in the assessment, treatment and care of older people with substance misuse**	There are few services offering skilled assessment, treatment and recovery focused care for older people with substance misuse and mental illnesses such as depression and dementia	This area of need has already been highlighted in Public Health England Guide for commissioners and service providers https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services It highlights the following areas necessary as part of integrated care -harm reduction interventions for the prevention of alcohol related brain injury -working with other medical specialities to assess and treat multiple physical co-morbidity -interventions for carer support and family therapy -interventions that improve social needs such as appropriate living conditions, activities of daily living and social activities -having safeguarding protocols in place, agreed by the local safeguarding leads, to protect older people at risk of abuse	The development of integrated care for older people with mental illness and co-existing substance misuse has been successful at South London and Maudsley NHS Foundation Trust Royal College Report on Substance Misuse in Older People: *Our Invisible Addicts* https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr211.aspx Meeting the training needs of staff working with older people with dual diagnosis https://www.emeraldinsight.com/doi/full/10.1108/17570971111155603 Development and implementation of a dual diagnosis strategy for older people in south east London https://www.emeraldinsight.com/doi/abs/10.1108/17570971111155595 Cognitive impairment in older people with alcohol use disorders in a UK community mental health service https://www.emeraldinsight.com/doi/abs/10.1108/ADD-06-2016-0014
63	Turning point	Commissioning and joint working between the CCG and Local Authorities	The treatment system is becoming increasingly fragmented. Clarity in expectations of a collaborative treatment		

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			to support the service users		
Partnership working					
64	Addaction	1/Joint working is the key to improving our offer to clients in this cohort, joint assessments and reviews, co-located clinics and coming together for training and sharing learning.			
65	ADASS	Key area for quality improvement 2	Treatment of coexisting mental illness and substance misuse in the community	There is an opportunity to review and ensure that support is co-ordinated between the NHS and Local Government, and under both the MHA and Care Act.	
66	Faculty of Public Health	Key area for quality improvement 1 Allocation of staff qualified in management of both substance use and mental health. • Ensure clearly defined care management arrangement between specialist Drug Treatment Services and Specialist MH services • For pregnant women – ensure clearly defined care management arrangements with MH, Drug Treatment and Midwifery Services	RMHNs would be better placed to care co-ordinate individuals with mental ill health and substance misuse problems	The symptoms of both are tangled a lot of the time, especially with situations like chronic cannabis use and paranoia in schizophrenia, or amphetamine use in the manic phase of bi-polar. Clinicians report particular difficulties in assessing people with borderline personality disorder and a substance misuse problem, and it is important that people have access to experienced and properly qualified practitioners in this field	Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings: Published date: March 2011 Refer all adults and young people with substance misuse or suspected substance misuse who are suspected of having coexisting psychosis to secondary care mental health services or CAMHS for assessment and further management.

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		• Work with criminal justice partners, through the gate and police custody			
67	Faculty of Public Health	Key area for quality improvement 4 Avoiding over assessment by numerous people better to have allocation of lead care co-ordinator for each individual. • Ensure clearly defined care management arrangement between specialist Drug Treatment Services and Specialist MH services • Develop person centred assessment – focus on need and recovery – not thresholds to treatment	As people with mental ill health and substance misuse problems cut across services - additional assessment can be a barrier to access to appropriate services.	There can be a gap for people in this position leading to delayed access to services and clients passed between services without appropriate sharing of information and support.	Coexisting severe mental illness and substance misuse: community health and social care services NICE 2016 recommends – providing consistent services, for example, if possible keeping the same staff member as their point of contact and the same lead for organising care. Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings: Published date: March 2011 - Delivery of care and transfer between services for adults and young people with psychosis and coexisting substance misuse should include a care coordinator and use the Care Programme Approach.
68	Hampshire County Council – Public Health Team	Joint arrangements for the investigation and reporting of Serious Incidents	More specific reference should be made for the development of multi-agency arrangments across both mental health and substance misuse providers and commissioners to understand the lessons learned from serious incidents where issues relating to co-occurring conditions played a role	Evidence suggests that people with co-occurring conditions have a heightened risk of other health problems and early death.	Citied in PHE (2017), Better care for people with co-occurring mental health and alcohol/drug use conditions (p8.)

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			The inclusion of example processes and procedures would support the local providers and commissioners implement this.		
69	Inclusion Midlands Partnership Foundation Trust	Key area for quality improvement 3 Work together to encourage people with coexisting severe mental illness and substance misuse to use services. Consider: • using an agreed set of local policies and procedures that is regularly reviewed by key strategic partners • working across traditional institutional boundaries • being responsive to requests for advice and joint-working arrangements • Sharing the response to risk management.	Clear processes for both organisations. A commitment from both organisations to work together. A high standard of patient care.	Both organisations currently have their own Joint working protocols. We're in the process of working these into one where both organisations have input. Due to the geographical area and that we work with two NHS providers local policies and procedures can differ.	
70	Leicestershire Partnership NHS Trust	Key area for quality improvement 1	Integration with substance services Within mental health services	Commissioning of separate services for mental health and substance misuse leads to service users being passed between both services depending on need, but neither being resolved. Integration would lead to both conditions being treated as one which could improve outcomes	Increasing service users with dual diagnosis Increase in use of mental health beds for clients with substance misuse issues National inquiry into homicides and suicides recognises that higher suicide rates and untreated service users based on one service model 2017

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71	Leicestershire Partnership NHS Trust	Key area for quality improvement 4	Treatment	There is one pathway for dual diagnosis and that contains psychosis in pathway 16 other categories do not include substances and therefore services can withdraw treatment based on use of substances as is not part of pathway. Assertive outreach teams have larger populations along with early intervention yet staffing does not include drug workers	Patients with dual diagnosis fall into all categories of mental health and guidance needs to change to meet this need. Care pathways
72	Opportunity Nottingham	Key area for quality improvement 5 Partnership working: Suggested quality improvements might include: • The number of Multi-disciplinary meetings held with partner agencies held to inform care planning / assessment etc • Numbers of partner agencies invited to MDT's • Numbers of care plans that involve joint input from both mental health and substance misuse services • Information sharing agreements in place between mental health and substance misuse services	Partnership working can lead to: • Improved outcomes for service users • Better information sharing • The reduced need for service users to tell their story more than once or undergo repeat assessment • Better information sharing between services • Combined expertise and input from front line services that will lead to better holistic packages of care • Multi-disciplinary meetings are effective	Partnership working is central to a number of key strategic programmes and approaches. For example: Closer joint / partnership working is a key element of the STP that recommends closer alignment between health and social care services The MHCLG funding for Rapid Rehousing Pathways as part of its Rough Sleeping Strategy draws heavily upon the use of a navigator model, as utilised within the Big Lottery Funded Fulfilling Lives programme. The use of navigators is a clear demonstration of how linking up access to services (and therefore access to partnership working) leads to better outcomes for service users The Big Lottery funded Fulfilling Lives programme clearly outlines the benefits of a partnership approach in terms of improved service user outcomes	http://www.stpnotts.org.uk/media/116400/sustainabilitytransformationplanexecutivesummary.pdf (Page 6) http://meam.org.uk/2018/10/17/mhclg-announce-funding-for-navigators-as-part-of-rapid-rehousing-pathways/ See annex A: Fulfilling lives Programme narrative

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73	Public Health England	Local mental health and substance use services should have an agreed protocol on joint-working and collaborative care to ensure clients and patients with co-existing substance use and mental health conditions are able to access the support they need. The protocol should outline how organisations will collaborate, share responsibilities and information and ensure regular communication when developing or reviewing the patient's care plan. The protocol should include mental health and substance use services and may also include primary and secondary health care, social care, local authorities and organisations such as housing and employment services.	Collaborative care should be supported by commissioned care pathways which span mental health, alcohol and drugs and wider health and social care needs, and agreed outcomes which all providers are contracted to deliver.	A report by the Making Every Adult Matter (MEAM) coalition describes a persistent failure of services to work collaboratively to support people with multiple and complex needs, and the inadequacy of a support system which "treats people based on what it considers to be their primary need, be that mental ill-health, dependence on drugs and alcohol, homelessness or offending." http://meam.org.uk/ There is evidence that mainstream mental health teams that integrate the mental health and substance use interventions have better outcomes.	See PHE (2017) Better care for people with co-occurring mental health, and alcohol and drug use conditions
74	Royal College of General Practitioners			Expand the MEAM role - patients with sms and severe mental health problems need supporting to appointments of which they have many across health, finance, and housing. MEAM would be able to help with treatment retention and then hopefully stability.	

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75	SCM1	Key area for quality improvement 4 Careful management of transitions / 'hand offs' between substance misuse and secondary mental health services, e.g. at point of discharge from one service to the other, and between young people and adult services	Discharge from or transition between services is a critical time at which a patient may be more vulnerable to relapse or crisis, if not well managed. NICE guidance indicates that discharge or transition for people with co-existing conditions should be planned and coordinated across services. Particular groups requiring additional support are identified as young people moving to adult services, looked after children and people moving from adult to older adult services.	Feedback from experts by experience (service users and carers) at a local level, e.g. through stakeholder engagement, suggests this is an area for improvement. Public Health England (PHE) 'Better Care for people with co-occurring mental health and alcohol/drug use conditions' sets out that discharge/transition planning should be built in to the care plan in order to deliver better services for this patient group.	
76	SCM 2	Mental health and addictions services to have locally agreed and shared protocols for joint working.		This point is made in every piece of guidance documentation in this topic area. The commissioning split of Clinical Commissioning Groups (MH) and Local Authorities (addictions) is a major barrier to achieving this.	The PHE guidance highlights this: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf
77	SCM2	Mental health services to have staff competent to assess substance misuse and treatment needs and addictions services to have staff competent to recognise		All of the above predicated on having a competent workforce. A first step is working on staff attitudes to see that mental health and substance use are intimately connected and can't be disaggregated in a way that suits	

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		mental health issues and mental health treatment needs.		commissioned services or attitudes that separate the “deserving” and “undeserving” mentally ill.	
78	SCM3	Key area for quality improvement 3 SM services and 2ndry care MH services should develop joint working/protocols setting out responsibilities and processes for assessment, referral, treatment and shared care - these should be flexible to accommodate the needs of people with severe mental illness	While many people with SMI will not be ready to make changes to their substance use (eg Barrowclough et al 2010) and/or formal SM treatment may not be appropriate (care/treatment should then be provided by MH), some will want to make changes, and some will need to be in treatment with specialist SM services because of the nature of their use (eg dependent opioid use). Specialist SM services need to be flexible and support people to engage so that their needs can be met – otherwise they will not engage and gain the potential benefits. Similarly pathways for people with possible psychosis from SM to MH need to be clear. The extent to which SM services work	The frequent re-commissioning of SM services, reductions to SM funding, with consequent reductions in the numbers of staff with MH expertise and the capacity to work more flexibly, as is required for working with people with more complex needs such as psychotic disorders, have made it difficult for SM services to work with this group /this group to access and make use of the treatment options on offer within SM services (eg group work is often the mainstay of treatment, case loads are very high). SM services are now largely provided by third sector agencies so shared electronic records and organisational structures rarely exist making joint working more of a challenge. A focus on payment by results may also militate against SM services wanting to work with people with more challenging needs.	Reports that highlight challenges resulting from system changes (commissioning/funding) ACMD Commissioning Impact on Drug Treatment report highlights the challenges of providing joined up support for people with MH and SM problems linked to changes in commissioning https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.pdf The Alcohol Treatment Review also highlighted the challenges for services working with people with ‘dual diagnosis’ (linked to budget cuts and commissioning changes) http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/alcohol_treatment_review_-_final_draft.pdf This Centre for Mental Health and Institute of Alcohol Studies report (based on survey and seminar) highlights challenges in joint working between MH and SM https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/CentreforMentalHealth_InstituteofAlcoholStudies_report_Apr2018.pdf

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			collaboratively with MH services (and vice versa) is very variable.		NCISH has consistently highlighted the need for MH and SM services to work closely together. Their reports have noted the small proportion of people in treatment with SM services at the time of death by suicide (NB only some will have psychosis but this may be indicative of a broader issue).
79	South London and Maudsley MH FT	Key area for quality improvement 4 **Providing Stable and Suitable Accommodation for service users with dual diagnosis**	Some residential facilities exclude people who use substances fearing that they may create problems for others who live and work there. Those that do accept dual diagnosis clients tend to be housing and working with people that have very challenging mental health, physical health and social care needs. Residents in staffed accommodation who continue to use, don't receive adequate support and care with regards to their substance use and can often lose their placement if they continue to use during their stay.	People's unmet needs (homelessness, lack of stable housing, social isolation, or problems obtaining benefits) may lead them to have a relapse in their mental health or may affect their physical health. (NICE 2016 - Co-existing severe mental illness and substance misuse: community health and social care services NG58) Dual diagnosis clients are a vulnerable group, more likely to suffer homelessness, live in poor housing in deprived areas, or have their homes abused by others to use or sell drugs, as venues for substance misuse or drug dealing. NICE 2016 - https://www.nice.org.uk/guidance/ng58 Sustained recovery is essential to an individual's ability to maintain stable accommodation and vice versa. http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20%20Working%20towards%20recovery_%20getting%20problem%20drug%20users%20into%20jobs.pdf	People that experience psychosis with co-existing substance misuse should not be excluded from staffed accommodation solely because of their substance misuse, and those living in such accommodation should receive treatment for both their psychosis and substance misuse with the aim of helping them maintain stable accommodation. (NICE 2011 Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings CG120) https://www.nice.org.uk/guidance/cg120 Sustained recovery is only achievable through a partnership-based style involving a range of services, particularly housing, employment and mental health. HM Government (2017) Drug Strategy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

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			The staff are usually unqualified support workers with minimal if any training and experience for working with the complex needs that dual diagnosis clients often have. Statutory sector professionals have sometimes performed a vital role in supporting them (e.g providing advice on keeping a substance free environment and on the safe management of intoxication and withdrawals) but such good practice examples are rare and inconsistent		Drug misuse and dependence - UK guidelines on clinical management (2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf
Additional areas					
80	SLAM	Additional developmental areas of emergent practice			South London and Maudsley NHS Foundation Trust have a dual diagnosis strategy that has implemented the following objectives 1. Establishment of dual diagnosis leads for each service line within the Psychological Medicine and Older Adults Clinical Academic Group 2. Establishment of Commissioning for Quality and Innovation (CQUiN)

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					targets for the screening of alcohol misuse on in-patient wards for older adults 3. Establishment of care pathway for dual diagnosis accompanying alcohol misuse https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr211.aspx
Suicide prevention					
81	Turning point	Suicide prevention pathways and access to treatment	Highlighting the vulnerability of this service users group often excluded from crisis interventions due to their substance use		
Additional or updated guidance					
82	Addaction	2/ Although the guidance is clearly focused on severe mental illness, this in some ways is a shame as we find there are just as many barriers getting support for clients with common mental health problems, for example IAPT services having very restrictive criteria that is not in line with the IAPT positive practice guidelines for working with substance misuse.			
83	Inclusion Midlands Partnership Foundation Trust	Additional developmental areas of emergent practice		Guidelines on supporting service users with a lower level of mental health and substance misuse.	

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				Guidelines on the process across mental health and substance misuse for serious incident reporting.	
84	NHSE	NICE has already published guidelines on psychosis and substance misuse however this does not include our definition of SMI, which would include any severe mental health problem, such as severe personality disorder and severe eating disorders.			
Staff training					
85	Hampshire County Council – Public Health Team	Improving service delivery: Support for staff	More emphasis is required within the existing quality standards for mental health and substance misuse providers and commissioners to undertake a joint training needs analysis and develop an agreed workforce development programmes for staff working with service users who have co-occurring conditions to address gaps in the skill mix. This should align with the recommendations set out with the PHE (2017), Better care for	Services are commissioned to respond mainly to one presenting need and staff lack the skills to address other needs.	PHE (2017), Better care for people with co-occurring mental health and alcohol/drug use conditions sates that delivering effective care to people with co-occurring conditions requires a workforce with the requisite values, knowledge and skills. This includes appropriate skills to be able to provide supervision and clinical leadership.

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			people with co-occurring mental health and alcohol/drug use conditions (p37.) The quality standards should include links to suggested tools and resources that organisations could develop this		
86	Inclusion Midlands Partnership Foundation Trust	Additional developmental areas of emergent practice		National training for professionals	
87	Leicestershire Partnership NHS Trust	Key area for quality improvement 2	Training Mental health and substance misuse staff have little training and therefore little understanding of condition	Training of staff from students to consultants will improve the care offered and near misses over poor prescribing.	Improve outcomes based on staff offering joint advice safer prescribing practice within mental health when patients are admitted and currently using methadone.
88	Public Health England	Delivering effective care to people with co-occurring conditions requires a workforce with the requisite values, knowledge and skills. Local areas should undertake a training needs assessment to gather data on where the gaps lie and develop comprehensive workforce development plans.	People working in mental health and substance use services will require different levels of skills and knowledge depending on their role and seniority. (See NICE guidance ng58) There will also need to be sufficient people with expertise in co-	Investing in the workforce so it can help improve health and wellbeing across the whole population as well as for those with mental illness is an important priority. This requires a workforce that has: • confidence – belief in its capability to improve mental health and substance use • competence – the ability to apply knowledge, skills and values effectively in practice	See PHE (2017) Better care for people with co-occurring mental health, and alcohol and drug use conditions

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		a) The workforce in mental health services should be trained, supervised and supported to enable them to assess substance use needs and provide advice, guidance and support on reducing harm or achieving abstinence from substance use in line with the individual service user's needs, and level of motivation. The workforce in drug and alcohol services should be trained, supervised and supported to enable them to identify mental health needs, provide advice, refer to appropriate mental health services and support clients to access and engage.	occurring conditions to be able to provide supervision and clinical leadership. (In line with 'Public mental health leadership and workforce development framework: Confidence, competence, commitment' PHE 2015)	• commitment – valuing the centrality of mental health to all health and social Outcomes (including drug and alcohol treatment goals) and commitment to improving it within everyday practice.	
89	SCM3	Key area for quality improvement 2 Staff training/competence - for staff in MH services - for staff in SM services This to be accompanied by good supervision, advice, consultation	Regardless of professional background the extent to which health and social care professionals receive training about substance use generally and coexisting severe mental illness and substance misuse in particular in pre-registration/undergradu	Despite NICE and other national guidance consistently highlighting the importance of staff training/development of competences and the provision of supervision and consultation (so that expertise is available to support practice and the embedding of learning into practice) (eg NICE 2011, DH 2002, DH 2004, DH 2006, Home Office - Drug Strategy 2017, PHE 2017), the extent to which these are available/required by organisations is limited.	Local organisations/training institutions collate data on staff training, I am not aware of any systematic, robust national data reporting. This Centre for Mental Health and Institute of Alcohol Studies report

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			ate training is very limited. Staff are therefore often ill equipped for working with this group. In some situations this has potentially life-threatening consequences eg poor management of physical dependence. In others rather than staff working in line with best practice (eg focus on engagement, working motivationally, being flexible, developing goals collaboratively with the service user) a directive, inflexible approach may be taken which can be counter-productive.	At a time when resources are limited training and staff development receive less priority or 'tick box' provision (often e-learning) is provided, that does not support genuine learning. With SM services now largely being provided by 3rd sector agencies the level of expertise for working with people with severe mental illness in these services is generally limited. They also have limited expertise to enable provision of specialist SM advice for complex MH cases	recommends that all trainee psychiatrists receive training/placements in addiction services https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/CentreforMentalHealth_InstituteofAlcoholStudies_report_Apr2018.pdf This BMJ opinion article cites data relating to reduction in specialists working in SM services https://blogs.bmj.com/bmj/2017/05/25/colin-drummond-cuts-to-addiction-services-in-england-are-a-false-economy/ NB This is also relevant to challenges of joint working (below)
90	Turning point	Development of medical specialist roles in addiction psychiatry	This is role is becoming increasingly rare and can be supported in the Third Sector		
Electronic patient record systems					
91	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 2	Electronic patient record systems use free text assessment questions rather than embedding specific coexisting mental health and	Using a standard substance use assessment screen (Modified CAGE) alongside specific assessment tools (Alcohol Use Disorders identification test – AUDIT) when substance misuse is identified as this can produce quality	McManus, S., Meltzer, H., & Campion, J. (2010). Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research.

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			substance misuse. Use the electronic patient record to embed substance misuse standard practice in mental health services	information about the nature and frequency of alcohol and other substances presenting at mental health service assessments	Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., ... & Ford, C. (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry, 183(4), 304-313.
92	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 3	Using an electronic patient record system to detail care plan to address coexisting needs	There appears to be variability in the plans for people with substance misuse problem in mental health services that do not link to NICE Guidance CG120 or NG58	Local audits of service user care plans 2017-2018
93	North West Boroughs Healthcare NHS Foundation Trust	Key area for quality improvement 4	To link clinical care pathways for coexisting problems with assessment documents and care plans that link to electronic patient record systems to provide evidence based on interventions documented	Clinical care pathways can often be written documents that are not reflected in practices on the frontline. These are often not monitored routinely and substance misuse services for alcohol are harder to access as services experience budget cuts with less focus on specific groups such as people with coexisting problems	Alcohol treatment inquiry: summary of findings Report on the findings and recommendations of Public Health England's inquiry into the fall in numbers of people in treatment for alcohol dependence.(2018)
Prevention					
94	ADASS	Key area for quality improvement 3	Preventing substance misuse for people with mental illness	There is an opportunity to explore and model best practice and evidence to identify and prevent the non-prescribed use of substances by people with mental health needs.	
95	Royal College of General Practitioners	Additional areas:		More research on rehab for this cohort who do have potential to recover brain functioning in various extents if they remain alcohol free	
Experience					

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96	Faculty of Public Health	Key area for quality improvement 5 Involve people with coexisting severe mental illness and substance misuse, their family or carers in improving the design and delivery of existing services	Knowledge about needs and appropriate service provision can be more effective if engaging clients and their families. Especially for individuals with complex needs. It is important for the process of diagnosis to consider the housing and financial circumstances of people with a severe mental illness and a substance misuse problem, given the evidence about the value of maintaining a safe home and avoiding even short stays in street level hostels	There can be significant delay in accessing the most appropriate service and in ongoing access to appropriate services.	Coexisting severe mental illness and substance misuse: community health and social care services NICE 2016 - Recommends being responsive to requests for advice and joint-working arrangements
97	SCM1	Key area for quality improvement 1 Confidence, professional curiosity, competency and attitude of staff in substance misuse and secondary mental health services	NICE guidance indicates that stigma remains a key issue for people with co-existing conditions and that professional curiosity and non-judgemental attitude can ensure co-existing conditions are identified at an early stage and appropriate treatment and services provided.	A local small-sample audit of patients with co-existing conditions (n=25) identified 'professional curiosity' and lack of understanding of the pathway and protocols as a potential barrier to patients accessing the services and treatment that may have benefitted them. Public Health England (PHE) 'Better Care for people with co-occurring mental health and alcohol/drug use conditions' recommends that "Treatment for any of the co-occurring conditions is available	

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			Lack of confidence in and/or understanding of mental health or substance misuse can lead to a patient being referred elsewhere for assessment or intervention and, potentially, being lost between services.	through every contact point" and this will require broader competencies of staff.	
98	SCM3	Key area for quality improvement 4 Take time to engage the person, build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism	Developing a collaborative therapeutic relationship with the service user underpins care/treatment and is essential for positive outcomes to be achieved. People with SMI and SM problems are often difficult to engage in services. As well as stigma and discrimination in society, some staff have negative attitudes towards this group. Additionally, service users may not be ready to make changes to their substance use (eg Barrowclough et al 2010) which is challenging for staff.	Stigma and discrimination are associated with both MH and SM. These also exist within services. Staff often see people with SMI and SM as 'revolving door' patients, 'lost causes' 'will never change'. Key to changing the experience of service users and enabling them to see the possibility of change is treating them with respect and remaining optimistic and hopeful about change. NICE QS 14 SU experience in MH emphasise the importance of optimism, empathy, dignity and respect – these are particularly important for this patient group	None known – any PROMS that could be considered by patient group? This Centre for Mental Health and Institute of Alcohol Studies report highlights stigma facing people with comorbid problems https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/CentreforMentalHealth_InstituteofAlcoholStudies_report_Apr2018.pdf Hughes/Revolving Doors preparatory work for national e-learning resource – obtained service user experiences. This included experiences relating to poor joint working between MH and SM (see above) and also attitudes. Contact E.C.Hughes@leeds.ac.uk

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			Being optimistic is important – the most unlikely people change		
99	SCM3	Key area for quality improvement 5 Involve the person in developing and reviewing their care plan- when developing a treatment plan take account of the person's readiness to change (NICE 2011 and 2016)	NICE QS 14 SU experience in MH notes that service users should be actively involved in shared decision making. Many service users may not be ready to stop/reduce their substance use (eg Barrowclough et al 2010) – this should be respected and plans developed with them that focus on their choices. This supports continued engagement and collaboration. Working in a way in which the healthcare professional assumes a position of expertise and 'tells' the person what they need to do is counter-productive and likely to result in arguments and disengagement.	Staff often expend time and energy trying to 'make' service users change – eg stop using substances, attend SM services. This is damaging to the service user – worker relationship and often counter-productive, inhibiting rather than promoting change.	None known – any PROMS?
No comments					
100	Royal College of Nursing	No comment			

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101	Royal College of Paediatrics and Child Health	No comment			

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