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Treatment Pathway For People With Co-occurring Needs

A proposal to expand access to mental health support for people in substance treatment services.

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Treatment Pathways for People with Co-occurring Mental Health and Substance Use Needs

Contents

Summary and Context

The purpose of this paper is to unpick the paradoxes in the treatment of people who have issues with their mental health and who use substances and to provide practical solutions to best support them in services. The principle of treating someone's mental health when their mind (physiologically and psychologically) is in the best condition to participate in that treatment is understood. In practice however, mental health and substance use are intertwined and cannot be neatly separated for the purposes of treatment.

We acknowledge the progress made in designing and delivering services to those *most affected* by both substance use and mental health issues (dual diagnosis). However, given the extremely high prevalence of co-occurring mental ill-health and substance use throughout the service user cohort in substance use services it makes sense to address both issues together outside of the relatively small proportion (up to 10%) who receive a formal "dual diagnosis" service.

The recommendations in this paper aim to prevent people from reaching the situation where intensive dual diagnosis services are required and/ or establishing their recovery from their mental health and substance use situation at an earlier stage of treatment.

This paper is designed as a starting point for substance use treatment services to develop pathways that more explicitly support their users' mental health. This reduces reliance on mainstream mental health services which are widely acknowledged to be unable to meet additional at this moment in time. It also encourages the development of mental health services that are tailored to the needs of people who use substances *as a result of* their mental health situation, rather than treating their mental health issues as originating in their substance use.

A note on terminology used in this document. This document draws on literatures from different disciplines and sources – from the last 30 or 40 years, and these contexts are reflected in the terms used to describe use of substances (including alcohol) and to describe people's mental health. Some of the sources use terminology from the medical literature (such as The Diagnostic and Statistical Manual of Mental Disorders, DSM-5) and employ terms which are now considered outdated, stigmatising and pejorative such as "substance abuse", "mental health disorder", and "substance misuse". Historically the combination of mental ill health and substance use labelled people in ways that "doubled down" on the stigma – such as "mentally ill chemical abusers, substance-abusing mentally ill persons" (Ridgely et al, 1987).

These examples are obviously less trauma informed than the language used currently in services and by service users. Although this is not necessarily the language we would

prefer, we have used it when quoting from other documents to preserve the lines of reference and context of the ideas under discussion. Elsewhere we have used more objective terms to describe people's experience of substance use and mental health challenges.

Introduction

It is common for people to have problems with both their mental health and substance use, known as co-occurring conditions. A recent study (GOV.UK, 2022) showed that more than one in every four adults who have serious mental health problems also have a substance use problem. In addition, Weaver et al (2003) reported that the majority of drug (70%) and alcohol (86%) users in community substance use treatment have mental health problems. A report from the Calderdale Recovery Steps (2022) service showed that of all opiate users in treatment, 70% experience mental ill-health. Of these, 60% are treated by GP's (medication), and very few make it into a talking therapy (IAPT). Also, it has been noted that there is a high risk of other health problems and early deaths in people with co-occurring conditions (The Five Year Forward View for Mental Health). Hence, there is a need to consider people with co-occurring mental health conditions and substance use disorders no matter their level of severity to prevent or possibly delay mortality and morbidity. Therefore, it is necessary to understand the meaning of co-occurring substance use disorders and mental disorders.

The term co-occurring disorders emerged in the 1980s (Ridgely et al, 1987) where affected people were often categorised as having dual diagnosis, A co-occurring disorder (COD) or dual diagnosis occurs when you have both a substance use problem and a mental health issue such as depression, bipolar disorder, or anxiety (HelpGuide.org). According to the Centre for Substance Abuse Treatment (2005), COD is diagnosed when an individual meets the clinical criteria for a diagnosed mental health disorder and at least one substance use disorder. In practice, co-occurrence is also used to describe people who experience problems with substance use and some form of mental health concern, which is yet to be diagnosed or is below the threshold of severity for diagnosis but restricts the person's ability to live a full life. This definition helps to highlight the fact that there are some instances where these disorders are not recognised early on or are seen to occur at all. Confusion can occur between clinicians and support staff where a term in mental health treatment also has a similar "lay" meaning but there are specific clinical implications.

In formal, clinical terms, substance use disorders (SUDs) and other mental health challenges frequently co-occur, but this does not imply that one caused the other.

According to research, there are three possibilities for why SUDs and other mental health challenges may coexist:

- SUDs and other mental health challenges can both be influenced by common risk factors: SUDs and other mental health diagnoses can run in families, implying that certain genes may play a role. Stress or trauma, for example, can cause genetic changes that are passed down through generations and may contribute to the development of a mental health challenge or the use of substances as a “coping mechanism”.
- Substance use and SUDs can be exacerbated by mental ill-health: According to research, people suffering from mental disorders such as anxiety, depression, or post-traumatic stress disorder (PTSD) may self-medicate with drugs or alcohol. However, while some drugs may temporarily alleviate some symptoms of mental disorders, drug use may exacerbate these symptoms over time. Furthermore, brain changes in people with mental health diagnoses may increase the rewarding effects of substances, increasing the likelihood that they will continue to use the substance.
- Substance use and SUDs can contribute to the emergence of other mental health challenges.: Substance use can cause changes in brain structure and function, making a person more likely to develop a diagnosable mental health issue (NIMH,2023).

These show that co-occurring psychiatric conditions can present a significant challenge to both psychiatric service providers and society. Substance use and mental health issues have been shown to be independent predictors of underachievement and failure at work and school, difficulty meeting family responsibilities, abuse, violence, criminal behaviour, noncompliance with treatment, incarceration, poverty, and homelessness (Kessler et al., 1994). When these individuals interact with the healthcare system, they often report high levels of unmet needs. In addition, when compared to a single diagnosis, CODs are linked to compulsive substance use behaviour, severity, and treatment resistance (Brady et al., 2004; Margolese et al., 2004). Therefore, it is necessary to provide and implement services to address unmet support needs for people who may be experiencing co-occurring mental illness and substance use disorders in West Yorkshire. Addressing these shortcomings will help people experiencing co-occurrence have their mental health secured, and the economic implications in the long term can be reduced or prevented altogether.

Aim

To present options and suggestions for Humankind (and other services) to develop a pathway to support people with diagnosed and/or undiagnosed mental health problems in substance treatment services who are unable to access “dual diagnosis” or specific “co-occurring mental health and drug/alcohol treatment services”.

Our goal: To help Humankind and others prepare to implement the evidence, learning, and recommendations of the RECO research project which will cover some of the same ground as this report. We also want to look at a broader range of issues so may want to develop pathways that go beyond formally diagnosed problems or problems that require medication alongside substance use treatment.

The RECO project is a significant study (funded by the National Institute of Health Research) which is a “Realist Evaluation of service models for CO-existing serious mental health and substance use conditions”. The study was set up by Prof. Elizabeth Harris at the University of Leeds (now at Napier University) and is due to report later in 2023. From the RECO Study webpage: “Services for people with co-existing serious mental health and alcohol/drug conditions are complex systems with outcomes that could be affected by numerous compounding factors such as the type and severity of the mental health or alcohol/drug condition, the interplay between the two conditions, peoples’ age, gender and ethnicity, as well as previous experiences of seeking help. Realist approach generates and tests programme theories which are used to understand complex interventions by synthesising relevant literature and/or analysing relevant data. Applying realist approaches will offer the potential to describe *why* interventions or services for COSMHAD, are successful or unsuccessful, within complex social systems through focusing on “what works, for who, in which circumstances.”

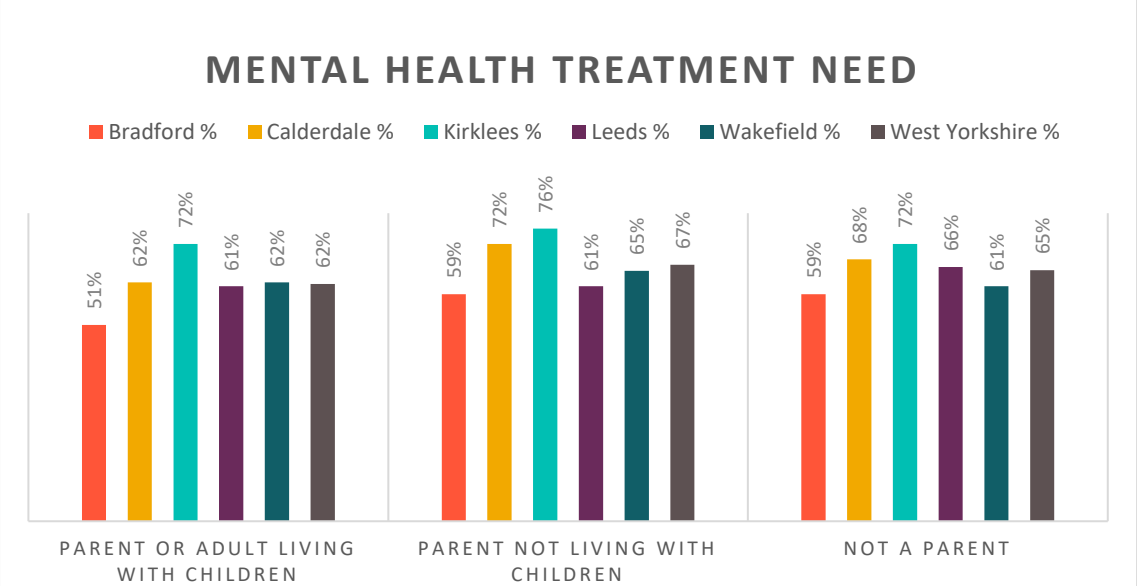
Prevalence rate of people with co-occurring mental health issues and substance use disorders in the UK.

In the UK, the Office for Health Improvement and Disparities (2021) reported that between April 2020 and March 2021, 275,896 adults sought drug and alcohol treatment. This represents a slight rise compared to the previous year (270,705). Also, they noted that the number of adults entering treatment from 2020 to 2021 was 130,490, which was similar to the previous year's figure (132,124), meaning that the number of people entering treatment has remained relatively stable after falling steadily from 2013 to 2014.

Furthermore, the Office for Health Improvement and Disparities (2021) reported that nearly two-thirds (63%) of people starting treatment said they had a mental health need. When looking at the 4 substance groups, the proportions of people reporting a mental health need were:

- 57% of people in the opiates group
- 64% of people in the non-opiate only group
- 64% of people in the alcohol only group
- 71% of people in the non-opiate and alcohol group

A quarter (25%) of people who had a mental health need were not receiving any treatment to meet this need. Of those receiving mental health treatment, over half (55%) received it in a primary care setting, such as a GP surgery.



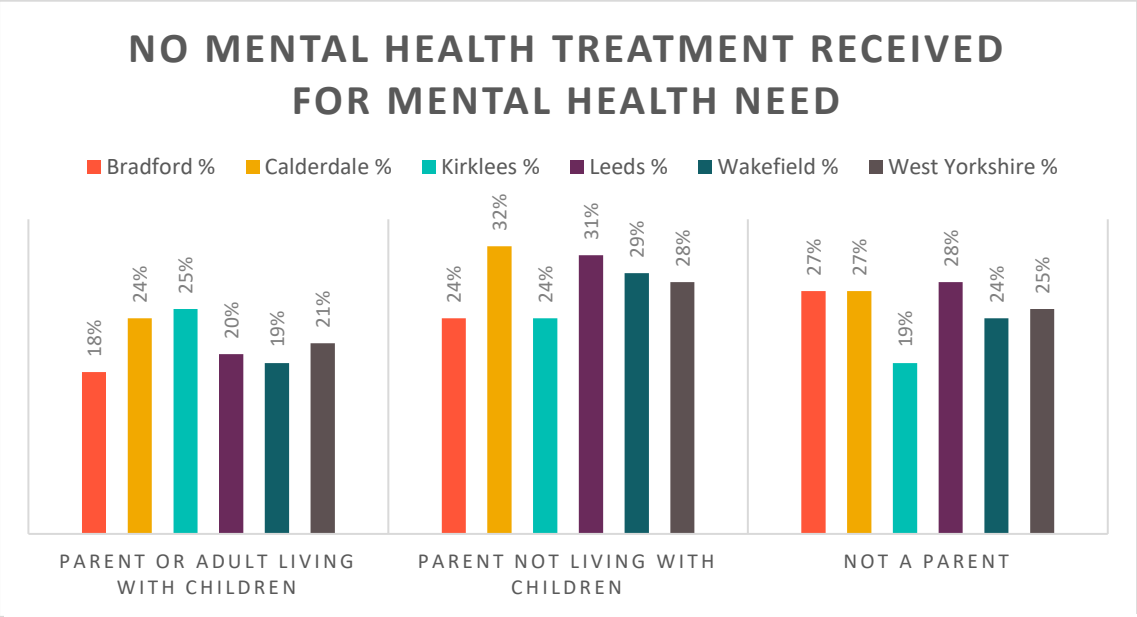


Figure 1 Levels of mental health need and unmet mental health need by local authority source: [NDTMS - Parental substance misuse] data packs for the West Yorkshire authorities (2019-20)

West Yorkshire data shows some variation between authorities in terms of the levels of mental health need as a proportion of the treatment population as a whole. The variation is around 20% between the lowest (Bradford) and highest levels of prevalence (Kirklees). The variation between districts in terms of unmet need for mental health services among the treatment population is smaller (around 10%).

Although Kirklees has the highest levels of mental health treatment need it has the lowest levels of unmet need overall. Calderdale with the second highest level of mental health need has the highest levels of unmet need overall.

The figures for West Yorkshire are in line with national figures (see *Figure 2* overleaf). There is a discrepancy, however between the data and what we have learnt anecdotally, which is that it is difficult to access mental health services for people in substance treatment. One possibility is that “mental health treatment” in NDTMS includes GP prescribed medication whereas service users and staff think that what would be more effective is access to face to face, professional support from a mental health practitioner. This is an area worth exploring in more detail.

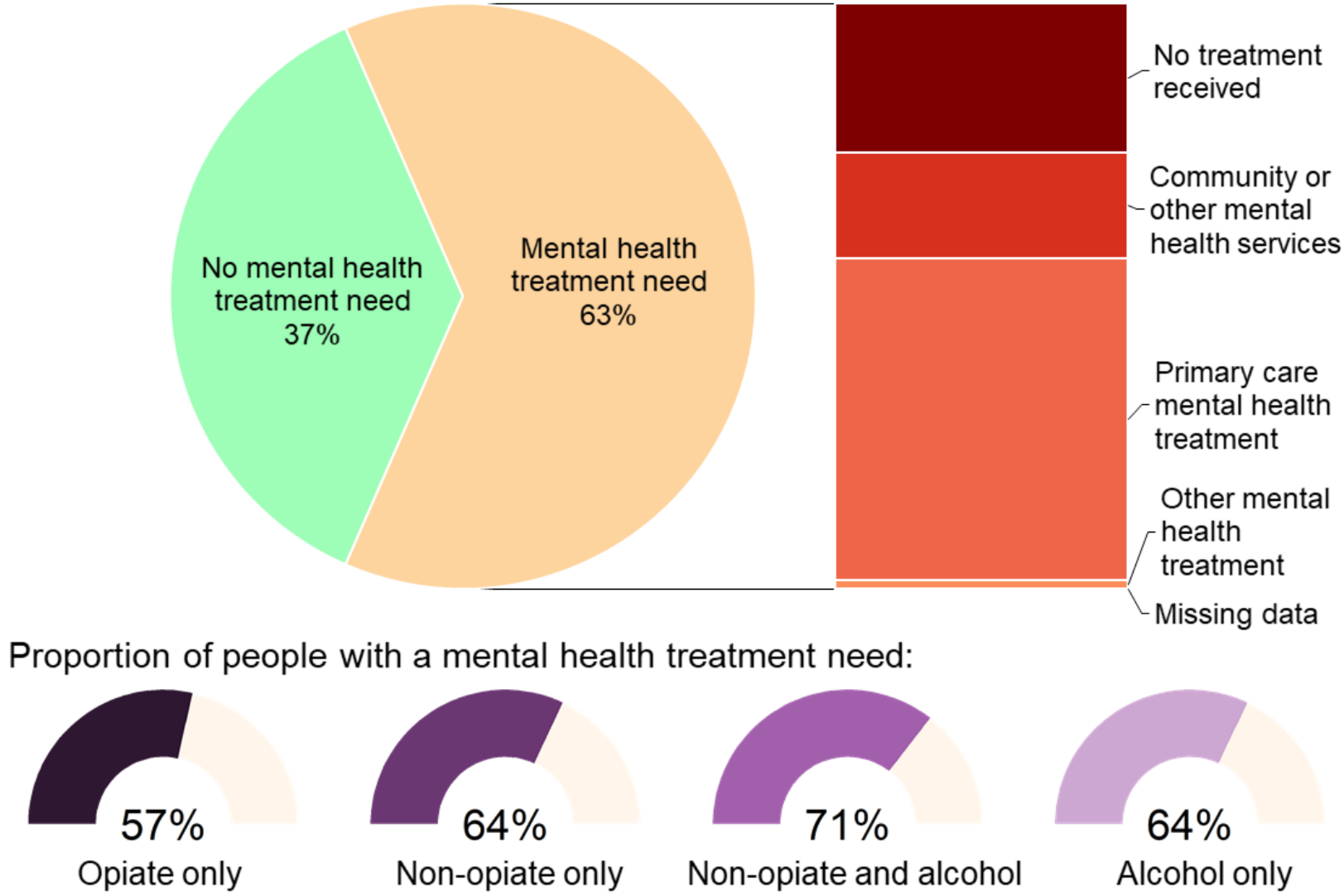


Figure 2: Mental health need and treatment received for people starting treatment in 2020 to 2021 (Office for Health Improvement and Disparities, 2021)

Causes of co-occurring mental and substance use disorders.

The causes (aetiology) of the high prevalence of substance use disorders (SUD) in patients with mental illness is unclear. Mueser et al (1998) reviewed the evidence for several theories of increased comorbidity, and organised aetiology of co-occurring mental and substance use disorders according to four general models: Common Factor Models, Secondary Substance Use Disorder Models, Secondary Psychiatric Disorder Models, and Bidirectional Models.

- **Common Factor Models**: High rates of comorbidity are caused by a person's vulnerability to both illnesses. Increased comorbidity can be explained to the degree that particular factors can individually raise the risk of developing both disorders. Genetics and antisocial personality disorder have both been examined as possible risks. Also, a variety of other factors may independently increase vulnerability to both mental illness and SUD. The two examples noted by Mueser et al (1998) were socioeconomic status (SES) and cognitive function. Furthermore, common risk factors include social isolation, poor interpersonal skills, poor cognitive skills, school and vocational failure, poverty, lack of adult role responsibilities, lack of structured daily activities, association with different cultures, and living in neighbourhoods with high rates of drug availability (Anthony & Helzer, 1991; Berman & Noble, 1993; Jones et al, 1994; Keith et al, 1991).

- **Secondary Substance Use Disorder Models**: According to Weaver et al (2003), various models contend that mental illness makes patients more prone to developing SUD. These models can be generally categorised into two types: models of psychosocial risk factors, and the biologically-based model of heightened sensitivity to the effects of substances in mental illness—the super sensitivity model. The three psychosocial risk factor models that support the idea that SUD is secondary to mental illness include: the alleviation of dysphoria model indicating that people with mental illness are prone to dysphoric experiences (the outward expression of a profound state of unease) that make them also prone to use psychoactive substances, the multiple risk factor model based on the observation that several well known risk factors for SUD, including dysphoria, are

common consequences of mental illness, and the self-medication model which refers to when people use certain drugs to treat unpleasant symptoms (Khantzian, 1997).

- **Secondary Psychiatric Disorder Models:** The theory that SUD can lead to mental illness has been of debate since the rise of recreational drug use in the 1960s (Glass & Bowers, 1970; Stone, 1973). Most of this debate has focused on the effects of drugs such as stimulants, hallucinogens, and cannabis because of their psychotomimetic effects (Schuckit, 1989) which is to say that those substances imitate the symptoms of psychosis. In contrast, there is general consensus that alcohol misuse does not cause schizophrenia or bipolar disorder but may actually mask its onset (Goodwin & Jamison, 1990; Hays & Aidroos, 1986). Thus, the fact that alcohol misuse is not considered a cause of secondary mental illness limits the potential importance of secondary psychiatric models, given the high prevalence of alcohol use disorders in mental illness.

- **Bidirectional Models**: Bidirectional models suggest that persistent, interactive effects between mental illness and SUD are responsible for the increased rates of comorbidity. For example, SUD might trigger mental illness in a biologically susceptible individual, which is then exacerbated by continued SUD due to socially learned cognitive factors such as beliefs, expectations, and motives for substance use (Graham, 1998). Despite the intuitive appeal of bidirectional models and evidence that SUD exacerbates the course of mental illness (Drake & Brunette, 1998), these models remain theoretical and untested.

Assessment of co-occurring mental and substance use disorders

Assessment of co-occurring mental and substance use disorders involves the following:

1) Comprehensive history taking, including personal, psychiatric, family, social, substance use history, medical history, and mental state examination.
2) Physical examination, including review of systems, and laboratory studies (full blood count, electrolytes/urea/creatinine, etc).
3) Use of assessment instruments/questionnaires, for example (further initial information in the hyperlinks):
    a. Addiction Severity Index (ASI)
    b. CAGE Questionnaire
    c. Alcohol Use Disorder Identification Test (AUDIT)
    d. Mental Health Screening Form III
    e. Columbia-Suicide Severity Rating Scale
    f. Michigan's Alcoholism Screening Test
    g. The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A)
    h. The University of Rhode Island's Change and Assessment Scale
    i. Drug Use Disorder Identification Test
    j. Psychiatric Research Interview for Substance and Mental Disorders (PRISM)
    k. Structured Clinical Interview for DSM-V (SCID-5)
    l. Symptom Checklist-90-Revised
    m. Inventory of Depressive Symptoms
    n. Montgomery Asberg Depression Rating Scale
    o. Young Mania Rating Scale
    p. Angst Hypomania Check List.

Model of care for people with mental health and substance use disorders.

Mental health concerns and problems with substance use can interact in many ways and vary according to different circumstances, including the type and severity of substance use and mental health concerns (Scottish Government, 2007).

In a similar vein, the kind of support, services, and care pathways that are required vary. For instance, the Four Quadrant Model is one of several typologies created to help people understand how mental health and substance use intersect (Department of Health, 2004). The model showed the severity of substance use and mental health on the x and y axes, as well as examples of the challenges and potential support that might be needed in each quadrant.

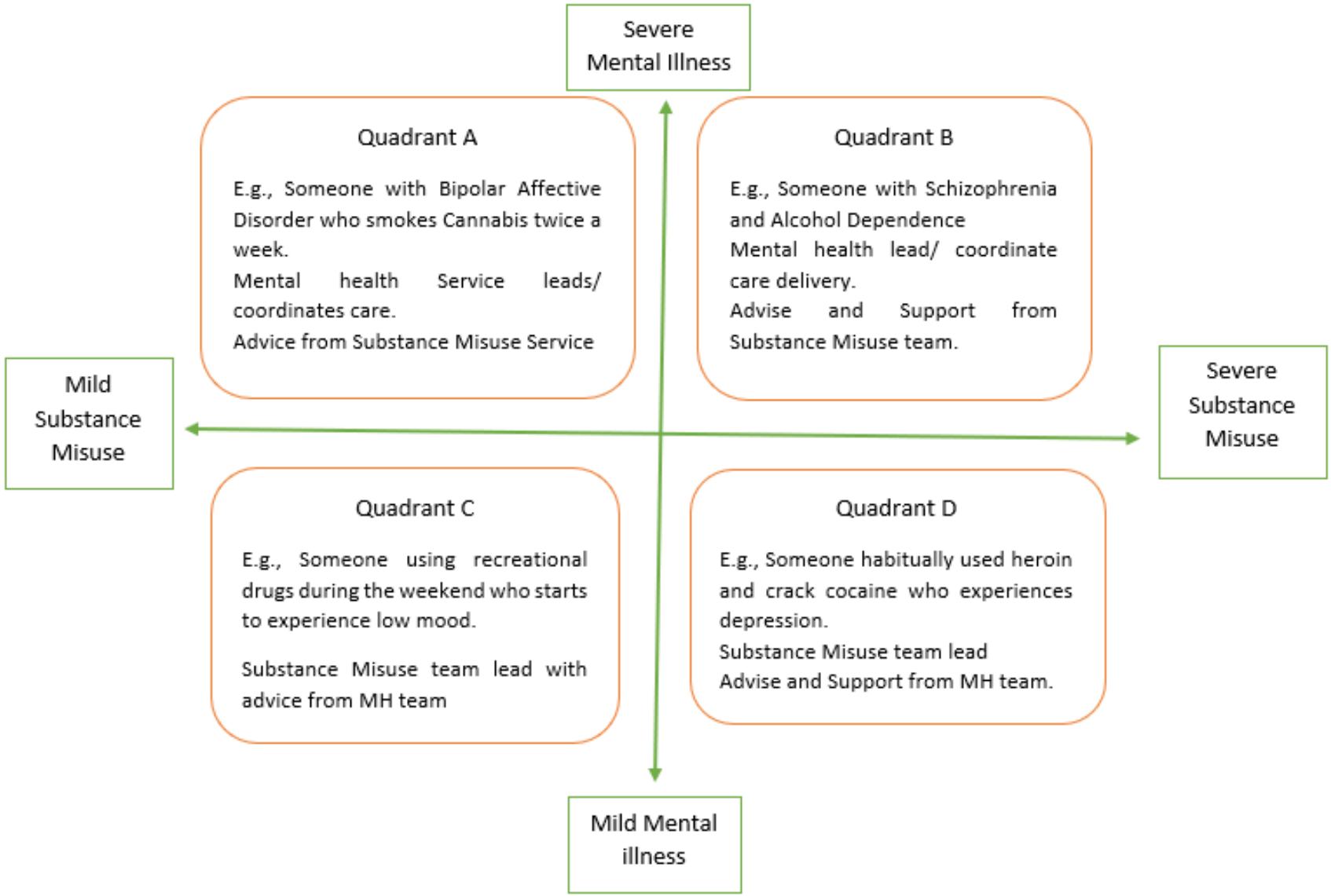


Figure 3: Graph of the Four-quadrant model of dual diagnosis. Source: Alcohol and Drug Policy (2015)

Policies to support people experiencing co-occurring mental health and substance use disorders.

The difficulties faced by individuals with co-occurring substance use and mental health issues were brought into focus over the past two decades (Hughes & Kipping, 2008). As a result, a variety of policies have been developed to help providers meet the complex needs of service users. These policies are:

a) **Mind the Gaps**: A 2003 report, which highlighted the need for improvements to promotion and prevention activities, education and awareness, efficacy of care and treatment services, and strategic planning (Scottish Advisory Committee on Drug Misuse—SACDM, 2003).

b) **Mental Health in Scotland: Closing the Gaps** (2007): Made a number of recommendations including: frontline staff in substance use services should be trained in suicide awareness and prevention. The report also recommended that all substance use and mental health services should have an assessment tool in place to assess comorbidity and help match care appropriate to the level and type of need. It was also suggested that substance use services should develop skills in psychological therapies, and that mental health services should take the lead on the coordination of care in the case of people with severe and enduring mental health conditions, whose needs are best met within specialist mental health care (Scottish Government, 2007).

c) **The Mental Health Strategy** in 2017 (Scottish Government, 2017) and the **Rights, Respect and Recovery: Alcohol and Drug Treatment Strategy** in 2018 (Scottish Government, 2018) outlined how services should treat people. This includes trauma-informed approaches that recognise the link between substance use, mental health, and adverse experiences; staff and systems that do not stigmatise people who use substances; and person-centred services that wrap around the individual, not the other way around.

d) **National Mission to Reduce Drug Related Deaths and Harms**: A 2021 report focusing on ensuring that people are able to make an informed choice about the support and treatment they need, and that they are able to access this when they need it through rights-based and person-centred models of care.

e) The **Mental Health Transition and Recovery Plan**, published in 2021: The plan aims to provide better coordination of support for people with co-occurring substance use and mental health concerns. This plan is supported by the Mental Health Strategy 2017-2027.

f) The **Mental Health Strategy 2017-2027**, which details two actions relating to co-occurring substance use and mental health concerns. These are:

    a. Action 27 – "Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problematic substance use and a mental health condition."

    b. Action 28 – "To offer opportunities to pilot improved arrangements for dual diagnosis for people with problematic substance use and an associated mental health diagnosis" (Scottish Government, 2017b).

g) The **Medication Assisted Treatment (MAT**) standards were published in 2021 and provide a framework of clearly defined principles that all services and organisations responsible for the delivery of care must adhere to, in order to meet the needs of people who use substances. Standard nine of MAT focuses on mental health, and states that "all people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery" (Scottish Government, 2021). It highlights numerous criteria for both mental health and substance use services, which aim to support people with co-occurring substance use and mental health concerns, with the aim of avoiding sequential treatment and limiting dropout between services. Also, Standard 10 of MAT (Scottish Government, 2021b) focuses on trauma-informed care, with the acknowledgement that the majority of people accessing MAT are likely to have histories of complex trauma which may be intrinsically linked to the individual's drug use. Trauma-informed services aim to promote recovery and improve outcomes for individuals and their families, staff, and services.

h) **Changing Lives** in 2022 aims at improving care through more integrated working between mental health and substance use services. This report includes several key principles specifically relating to mental health and problematic substance use. The "No Wrong Door" message is particularly strongly made. The report also highlights that mental health support should not

be conditional on people receiving treatment for their dependency, recovery, or abstinence.

i) A 2017 **Public Health England Commissioning Guide** (Public Health England, 2017) highlights that people with co-occurring substance use and mental health concerns often found themselves excluded from services, and emphasises the aims of **Everyone's Job** (where all providers of mental health and substance use services have a joint responsibility to meet the needs of individuals with co-occurring conditions) and **No Wrong Door** (as highlighted in the Scottish Drug Deaths Taskforce Changing Lives report (Scottish Drug Deaths Taskforce, 2022).

Treatment for people with co-occurring mental health issues and substance use disorders – system responses.

Many of the patients in drug and alcohol treatment services who have mental health issues already receive pharmacological and psychotherapeutic mental health treatments. In addition, there were a lot of patients with comorbidities whose requirements were not really met or had not been known. Resources must be allocated so that substance treatment services can provide evidence-based therapies to a much larger percentage of these patients (Hall & Farrell, 1997). In addition to general adult psychiatry, models of collaborative working with local general practitioners and psychotherapy services should be created and assessed (Weaver et al, 2003).

Key Recommendations:

1) Develop a shared local understanding of co-occurring conditions, including prevalence and likely demand, as well as a shared vision, aspiration, and desired outcomes.
2) Agree upon a lead or joint lead commissioner with authority to commission across NHS (mental health services) and local authority public health (alcohol, drugs and tobacco services) sectors. If this is a shared role, commissioners will need to work in close collaboration.
3) Agree upon an appropriate senior strategic board to oversee commissioning activity and monitor outcomes, supported by shared or aligned quality governance structures.
4) Undertake joint commissioning across mental health and alcohol/drugs/tobacco services with a named lead. The lead commissioner(s) should work closely with National Offender Management Service (NOMS) and NHS England commissioners to ensure continuity of care between community and prison settings for all those with co-occurring conditions moving between community and criminal justice care.
5) Ensure that co-occurring substance use and mental health conditions are addressed as an integral part of all relevant care pathways locally, which should be adequately resourced, co-produced with experienced experts and carers, and signed up to by all relevant providers (not just mental health and alcohol/drug

treatment providers). Ensure effective response to the full range of mental health and alcohol/drug needs, maximising opportunities for engagement and eventual recovery.

6) Commission an effective and compassionate 24/7 Urgent and Emergency Mental Health Care (UEMHC) response for all ages which includes adequate health-based places of safety (HBPoS) provision—including for those in states of intoxication—and offers screening and further interventions as necessary to keep people safe and connect them with other services for longer term care.
7) Monitor providers particularly closely on the effectiveness of their response to intoxicated people in mental health crisis. This group is frequently excluded from services because their condition is not judged to be severe enough. In addition, monitor providers on their response to people with particular risk and vulnerability such as children and young people, people living with children, people who are homeless or at risk of becoming homeless, and people experiencing domestic abuse. Consider incentivising contracts to support engagement and positive outcomes for people with additional risk/vulnerability factors.
8) Make sure that commissioning involves experts by experience and carers (including young carers) in decisions about services and care. Capacity building and investment in user/carer involvement may be needed to ensure that involvement is effective and meaningful.
9) Ensure commissioned providers have staff that are supported and competent at effectively meeting all presenting needs with respect, compassion, and belief in the possibility of recovery, following the evidence base/NICE guidelines. There should be an appropriate level of clinical expertise to oversee and ensure quality of service provision for this group in both sets of services.
10) Ensure that the increased risk of suicide for people with co-occurring conditions is well understood locally—that local suicide prevention plans include a strong focus on alcohol and drug use, and that the local suicide multi-agency partnership group is involved with commissioning decisions and service developments.
11) Collaborate across services with input from experts by experience and carers (including young carers) to develop an integrated ‘offer’ of care which addresses physical health, social care, housing, and other needs as well as mental health and alcohol/drug/tobacco use. This offer should recognise that increased levels

of need, risk, and vulnerability will require increased support, and should take account of specific needs.

12) Review service access criteria with experts by experience. Make sure they are not used to exclude people based on levels of alcohol and/or drug dependency, or on diagnoses (or lack of diagnoses) of mental illness but are used to actively support people to get the help they need.
13) Make sure local arrangements enable reporting and investigation of serious untoward incidents and management of risks. Quality governance and local safeguarding for the co-occurring group should be shared across mental health and alcohol/drugs services.
14) Consider what changes might be needed to enable practitioners to work assertively and flexibly to engage (and assertively re-engage), particularly supporting people with chaotic lifestyles and complex needs to manage appointments. This may require extended opening hours, offering a drop-in service, co-locating with or operating satellite services alongside other key services such as homelessness or domestic abuse services, using text reminders, and/or daily ‘check-ins’.
15) Ensure comprehensive assessment and NICE-compliant interventions are available, delivered by competent, adequately trained and supervised practitioners.
16) Ensure mental health practitioners are competent to respond to presenting alcohol and drug use conditions, and alcohol and drug practitioners to respond to presenting mental health needs.
17) Ensure that alcohol and drug recovery and community engagement in all forms (harm reduction, 12 Step, SMART, peer support workers, expert by experience and mutual aid groups, family and carer groups), and smoking cessation services are assertively promoted across all mental health services for those with co-occurring alcohol and drug use conditions.

Implementation of care for co-occurring mental health and substance use disorders.

The following guidance should be followed by commissioning and delivery care to ensure better implementation:

a) It is everyone's job—meeting co-occurring alcohol/drug and mental health needs should be the core business for both alcohol, drug, and mental health services, supported by wider health and social care services.
b) Commissioners and providers should agree upon a pathway of care and routinely measure outcomes which will enable collaborative delivery of care by multiple agencies in response to individual need.
c) Every person with co-occurring conditions should have a named care coordinator to help manage the multi-agency care plan (for people with severe mental illness this should come under the care programme approach (CPA) – see note on terminology below).
d) Joint working across sectors needs strong, senior, and visible leadership underpinned by shared child and adult safeguarding and quality governance arrangements.
e) People should be able to access the care they need when they need it and, in the setting, most suitable to their needs.
f) There should be a 24/7 response to people experiencing mental health, alcohol, and drug use crises, including intoxicated individuals, with episodes of intoxication being managed safely, and an established plan to help people access ongoing care and manage future crisis episodes.
g) Commissioners should ensure that local pathways exist which enable people to access appropriate services, e.g., for homelessness, domestic abuse, or physical healthcare.
h) Services should be commissioned to help people access a range of recovery support, and all stakeholders should recognise that recovery is a highly individual process which can often occur with stops and starts and may take many years.
i) Care pathways should meet the specific needs of people in prison, children, young people, older adults, and other vulnerable groups.
j) All contact should be conducted with compassion and convey optimism and belief in the possibility of recovery.

k) Factors in the delivery of effective care include a strong therapeutic alliance, therapeutic optimism, and care that reflects the views, needs and priorities of the person.
l) Advice and interventions to help people stop smoking should be a routine part of care.
m) Carers (including young carers) should be able to access support and care. Better care for people with co-occurring mental health and alcohol/drug use conditions is needed.
n) Delivery of better care requires a workforce with the requisite skills, knowledge, and values.

Improving workforce to support the components of care – provider responses.

Studies conducted by Weaver et al (2003) suggested that regular care workers need to be able to perform at least the basic management of comorbidity. To achieve this, staff are likely to need further training in the assessment of drug and alcohol problems (and in the use of appropriate assessment tools), as well as in motivational techniques to improve patient engagement in substance use treatment and to achieve harm reduction goals. Interventions to address these skill deficits need urgent evaluation.

Also, improved education has been rightly identified as a key component of response to comorbidity (Banerjee et al., 2002). There is also a need to provide, develop, and evaluate new service-based assessment, treatment, and management approaches that can assist mental health and substance use services in providing evidence-based treatment to a much higher proportion of their patients with comorbidity problems.

Recommendations

A. The Use of trauma-informed care for people experiencing mental health and substance use disorders.

Trauma-informed care is an approach to providing support and services that recognises the impact of trauma on people's lives. This approach emphasises safety, trustworthiness, choice, collaboration, and empowerment. It aims to promote healing and prevent re-traumatisation by understanding and addressing the psychological and emotional effects of trauma. Trauma-informed care is used in a range of settings, including healthcare, mental health, addiction treatment, education, social services, and criminal justice systems.

Trauma-informed care is a critical component of the treatment of coexisting mental illness and substance use disorders. The following are some ways trauma-informed care can be applied in context:

1) Screening and assessment: Individuals with coexisting conditions need to be evaluated for past and current trauma to develop a care plan that addresses both disorders and considers the impact of trauma-informed care, including using validated screening tools to identify past trauma and to monitor for emerging symptoms.
2) Understanding the link between trauma and substance use: Trauma survivors often use substances to cope with the aftermath of traumatic experiences. Trauma-informed care acknowledges the potential link between substance use and trauma, and treatment plans specifically address both disorders together.
3) Creating safety: Substance use treatment providers need to create a safe environment that promotes healing, recovery, and self-recovery. Trauma-informed care emphasises creating an environment with open and honest communication to ensure empowerment and collaboration with the individual.
4) Promoting trust: Trust is a crucial part of trauma-informed care, and this is especially crucial when treating coexisting conditions like co-occurring mental illness and substance use disorders. Traumatised people may have trust issues, but trust is necessary for individuals to work with their providers effectively. Thus,

there is need to communicate clearly, be transparent about the treatment process, and follow through on their commitments to change.

5) Coordination by mental health providers: Mental health providers need to understand the importance of trauma-informed care when treating individuals with coexisting mental illness and substance use disorders. Coordination between users and mental health providers to ensure that all aspects of an individual's diagnoses and treatment are addressed critically.
6) Training and retraining of skilled drug/alcohol workers: Training of drug/alcohol workers to carry out low-intensity psychological interventions.

Overall, incorporating a trauma-informed approach in treating coexisting mental illness and substance use disorders can help individuals to address the underlying causes of their conditions while promoting healing, recovery, and resilience.

B. Theoretical approach to integrated and comprehensive care pathway to address both mental health and substance use disorders for Drug & Alcohol workers.

Step 1: Assess and Evaluate

- Conduct a thorough assessment of the individual's mental health and substance use history, including frequency, duration, and type of substances used.
- Evaluate individual's readiness for change, motivation, and potential for relapse.
- Identify any occurring medical or psychological conditions that may affect treatment planning.

Step 2: Develop a Person-Centred Plan

- Collaborate with the individual to achieve goals and develop a comprehensive care plan tailored to their specific needs and preferences.
- Address both mental health issues and substance use in the plan.
- Identify appropriate treatment priorities, strategies, and interventions based on their goals and level of functioning.
- Consider supportive services such as case management, peer support, and family support sessions to enhance treatment outcomes.

Step 3: Provide Integrated Care

- Provide evidenced treatment for both mental health and substance use issues.

- Utilise Low-intensity Psychological Therapy and screening tools, e.g., the CAGE questionnaire.
- Design interventions addressing co-occurring mental health and substance use disorders, such as motivational, cognitive-behavioural therapy, and integrated dual-diagnosis.
- Address the root cause of use by incorporating holistic interventions such as mindfulness, exercise, nutrition, etc.

Step 4: Evaluate Progress

- Conduct ongoing monitoring and evaluation of the individual's progress, both mental and substance use treatment.
- Use objective measures to evaluate the effectiveness of the interventions and necessary adjustments as required.
- Ensure that both the individual and caregivers are part of the evaluation process to support long-term recovery.

Step 5: Ensure Continued Support

- Include comprehensive aftercare services to prevent relapse, encourage coping strategies, and promote overall mental health and well-being.
- Develop a relapse prevention plan in collaboration with the individual, including identifying triggers and developing strategies to manage them.
- Develop connections with support groups and other community groups for long-term support.

N.B. By following these steps and repeating the cycle as required, Drug and Alcohol workers can provide continuous holistic care to people with co-occurring mental health and substance use problems so as to achieve long-term recovery goal

C. Practical approach to integrated and comprehensive care pathway to address both mental health and substance use disorders for Drug & Alcohol Workers

The Clinical Problem(s)
1) Persistent substance use 2) Early stage of mental illness 3) Poor functioning
Goal of treatment
1) Recovery: The primary goal of drug and mental health services is to help individuals achieve and maintain long-term recovery from drug addiction and mental illness. The focus is on helping individuals attain a life that is free from drug misuse and mental illness symptoms. 2) Sobriety: The goal of drug addiction treatment is to help individuals achieve and maintain sobriety. This can involve treatment modalities such as

detoxification, medication-assisted treatment, individual and group therapy, and 12-step programs.

3) Improved psychological and emotional well-being: Mental health services seek to improve individual psychological and emotional well-being by addressing the underlying causes of mental illness. The goal is to help individuals manage their symptoms more effectively and live a more fulfilling life.
4) Improved physical health: Many individuals who struggle with drug use and mental health issues also suffer from physical health problems. Treatment aims to improve their physical health and overall quality of life.
5) Improved functioning: Treatment may be geared towards improving an individual's ability to function in daily life, including managing finances, relationships, and work responsibilities.
6) Relapse prevention: Another important goal of drug and mental health services is to help individuals develop strategies to prevent relapse and maintain long-term recovery. This may involve teaching individuals coping skills, problem-solving techniques, and self-care strategies.

Identify most appropriate low intensity psychological interventions (LIPI) modality

Consider client's preference and available resources. Tick all that apply:

□ Self-help: written

□ Self-help: online

□ Guided self-help: telephone

□ Guided self-help: video conferencing

□ Face-to-face individual (number of sessions 5)

□ Face-to-face group (number of sessions _____)

□ High-intensity treatment where indicated (provide details):

Plan intervention

What resources are available within your service and what additional resources are needed (e.g., psychoeducation materials, handouts, online resources).

List helpful resources for intervention (hard copy, online)

- Contact Us – Humankind (humankindcharity.org.uk)
- Contact Us | Samaritans

Some examples of low intensity psychological interventions include:

1) Psychoeducation—providing information about mental illness and substance use problems, as well as strategies for managing symptoms.
2) Guided self-help—structured self-help programs based on evidence-based interventions such as cognitive behavioural therapy or mindfulness.
3) Brief behavioural activation—a short-term therapy that encourages patients to engage in activities (such as exercise, socialising with friends, hobbies,

or creative pursuits that promote positive emotions and reduce negative emotions.
4) Brief motivational interviewing—a technique that helps patients identify and overcome barriers to behaviour change.
5) Peer support—structured support groups led by trained peers who have lived experience with mental illness or substance use problems.
6) Family support programs—sessions for families to share their experiences and ways they have been coping with mental health and substance use disorders.

Outcome Monitoring

What measures will be used to monitor treatment targets?

1) Addiction Severity Index (ASI): The ASI is a screening tool used to evaluate the severity of substance use problems in individuals.
    - ❖ A semi-structured interview of frequency of substance use and associated problems, lifetime and current (past 30 days).
2) Beck Depression Inventory (BDI): The BDI is a widely used tool for measuring the severity of symptoms of depression.
    - ❖ The Beck Depression Inventory (BDI, BDI-IA, BDI-II) is a 21-question multiple choice self-report inventory, with items rated from 0 to 3 according to frequency in past week.
    - ❖ Cut off score on the BDI-11: 0 to 13 (minimal depression), 14 to 19 (mild depression), 20 to 28(moderate depression), 29 to 63 (severe depression).
3) Brief Psychiatric Rating Scale: (BPRS)
    - ❖ The BPRS is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations, and unusual behaviour. Each symptom is rated 1 to 7, and depending on the version, between a total of 18 to 24 symptoms are scored.
4) CAGE Questionnaire: The CAGE questionnaire is a 4-question screening tool that may be used to help in the screening process for alcoholism.
    - ❖ Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

How often will the measures be administered (e.g., baseline and every session)? They should be administered at the initial assessment and in the waiting room before every session.

Treatment Session Plan

Session 1: Explain the process (sessions) and provide psychoeducation about mental illness and substance use disorders. Introduce them to techniques that can help them to cope with stress and steps to abstinence or substance use reduction. Plan to practise these techniques to improve sleep and reduce body sensations of tension and aches.

Session 2: Review sleep patterns and use of de-arousal techniques. Introduce challenging beliefs about worry (positive, controllability). Plan to practice postponing the worry especially for those with depressive symptoms, as well as continuing with progressive muscle relaxation.

Session 3: Review practicing postponing worry and troubleshoot any difficulties with the task. Introduce and teach mindfulness and attention training. Plan to complete the attention training diary as homework.

Session 4: Review completion of the attention training diary. Troubleshoot any difficulties with the task. Introduce active coping and teach problem-solving and accepting uncertainty. Continue to practice the strategies that have been taught.

Session 5: Review progress with strategies and discuss relapse prevention. Encourage ongoing commitment to the strategies. Consider planning a 1-month follow-up session.

Referral to other services?

□ Not currently required

□ Required (provide details)

□ May be required (to be determined following the LIPI)

□ Consider referral to higher intensity services if symptoms persist or worsen after treatment

References

Alcohol and Drug Policy (2015) The complexity and challenge of ‘dual diagnosis’

Anthony, J. C., & Helzer, J. E. (1991). Syndromes of drug abuse and dependence. In L. N. Robins & D. A. Regier (Eds.), Psychiatric disorders in America: The Epidemiologic Catchment Area Study (pp. 116– 154). New York: Free Press

Banerjee, S. Clancy, C. & Crome, I. (eds) (2002) Coexisting Problems of Mental Disorder and Substance Misuse (Dual Diagnosis): An Information Manual. London: Royal College of Psychiatrists Research Unit.

Brady, T.M., Krebs, C.P., Laird, G., 2004. Psychiatric comorbidity and not completing jailbased substance abuse treatment. The American Journal on Addictions 13, 83–101

Centre for Substance Abuse Treatment (2005). Substance abuse treatment for persons with co-occurring disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration

Comorbidity: Substance Use and Other Mental Disorders(2018) [Online] Available from: <Comorbidity: Substance Use and Other Mental Disorders | National Institute on Drug Abuse (NIDA) (nih.gov)> [Accessed February, 2023]

Department of Health (2004) Dual Diagnosis Good Practice Guide, Mental Health Policy Implementation Guide

Drake, R. E., & Brunette, M. F. (1998). Complications of severe mental illness related to alcohol and drug use disorders. In M. Galanter (Ed.), Recent developments in alcoholism, Vol. 14: The consequences of alcohol (pp. 285–299). New York: Plenum

Dual Diagnosis: Substance Abuse and Mental Health (2023).[Online] Available from:<Dual Diagnosis: Substance Abuse and Mental Health - HelpGuide.org > [Accessed February, 2023)

Glass, G. S., & Bowers, M. B. (1970). Chronic psychosis associated with long-term psychotominmetic drug abuse. Archives of General Psychiatry, 23, 97–103.

Goodwin, F. K., & Jamison, K. R. (1990). Manic depressive illness. New York: Oxford University Press.

Gov.uk(2020) Adult substance Misuse Treatment Statistics 2020-2021.[Online] Available from: <Adult substance misuse treatment statistics 2020 to 2021: report - GOV.UK (www.gov.uk)> [Accessed February, 2023]

Graham, H. L. (1998). The role of dysfunctional beliefs in individuals who experience psychosis and use substances: Implications for cogitive therapy and medication adherence. Behavioural and Cognitive Psychotherapy, 26, 193–207.

Hays, P., & Aidroos, N. (1986). Alcoholism followed by schizophrenia. Acta Psychiatrica Scandinavica, 74, 187–189.

Hill, D. Penson, W.J. & Charura, D. (2016). Working with Dual Diagnosis: A Psychosocial Perspective. London: Palgrave Macmillan.

Hill, D. & Salisbury,P.(2021) A Bitter Pill to Swallow:Exploring and Understanding Drug Misuse in UK. Preprint. Available from:< (PDF) A Bitter Pill to Swallow: Exploring

& Understanding Drug Misuse in the UK (researchgate.net)> [Assessed February 2023)

Hughes, L., & Kipping, C. (2008). Policy context for dual diagnosis service delivery. Advances in Dual Diagnosis, Volume 1 Issue 1, Pavilion Publishing

Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H.U., Kendler, K.S., 1994. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the national comorbidity survey. Archives of General Psychiatry 51, 8–19

Khantzian, E. J. (1997). The self-medication hypothesis of substance uses disorders: A reconsideration and recent applications. Harvard Review of Psychiatry, 4, 231–244

NIMH (2023) Transforming the understanding and treatment of mental illnesses. Available from: **<**NIMH » Substance Use and Co-Occurring Mental Disorders (nih.gov)> [Accessed February, 2023]

Margolese, H.C., Malchy, L., Negrete, J.C., Tempier, R., Gill, K., 2004. Drug and alcohol use among patients with schizophrenia and related psychoses: levels and consequences. Schizophrenia Research 67, 157–166

Gov.UK(2022) Mental Health and Substance Use Co-occurring Disorders [Online] Available From: <Mental Health and Substance Use Co-Occurring Disorders | MentalHealth.gov> [Accessed February,2023]

Mueser, K. T., Drake, R. E. & Wallach, M. A. (n.d.) I. Severe Mental Illness and Comorbidity: Alan S. Bellack, Chair.

Public Health England. (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions.

RECO Study webpage - https://medicinehealth.leeds.ac.uk/dir-record/research-projects/1296/the-reco-study-realist-evaluation-of-service-models-and-systems-for-co-existing-serious-mental-health-and-substance-use-conditions accessed May 2023

Ridgely MS, Osher FC, Goldman HH, et al: Chronic Mentally Ill Young Adults with Substance Abuse Problems: A Review of Research, Treatment, and Training Issues. Report of the Task Force on Chronic Mentally Ill Young Adults with Substance Problems. Baltimore, Md, University of Maryland, Department of Psychiatry, 198

Schuckit, M. A. (1989). Drug and alcohol abuse: a clinical guide to diagnosis and treatment (3rd ed.). New York: Plenum

Scottish Advisory Committee on Drug Misuse (SACDM). (2003). Mind the gaps: meeting the needs of people with co-occurring substance misuse and mental health problems.

Scottish Government (2007) Mental Health in Scotland: Closing the Gaps

Scottish Government. (2017a). The Mental Health Strategy 2017-2027.

Scottish Government. (2017b). The Mental Health Strategy 2017-2027. p 5.

Scottish Government. (2018). Rights, respect and recovery: alcohol and drug treatment strategy

Scottish Government (2021a) Standard 9 - Medication Assisted Treatment (MAT) standards: access, choice, support.

Scottish Government (2021b) Standard 10 - Medication Assisted Treatment (MAT) standards: access, choice, support

Scottish Drug Deaths Taskforce (2022) Final Report Drug Deaths Taskforce

Stone, M. H. (1973). Drug-related schizophrenic syndromes. International Journal of Psychiatry, 11, 391–437.

Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry Sep 2003, 183 (4) 304-313

Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N., Ford, C., & Comorbidity of Substance Misuse and Mental Illness Collaborative (Cosmic) Study Team (2003) Comorbidity of Substance Misuse and Mental Illness in Community Mental Health and Substance Misuse Services. British Journal of Psychiatry, 183 (4) October, pp. 304–313.