Public Health England

Protecting and improving the nation's health

National Policy Guidance PHE - Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers

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Disclaimers

I was a steering group member for the development of the PHE strategy- I am delivering this presentation on behalf of this group

I am editor of Advances in Dual Diagnosis

I am chair of PROGRESS – consortium of consultant nurses and other experts in dual diagnosis

Aims of presentation

- The nature of the problem
- Policy background and models of care
- The strategy and its components
- Implementation tools

Why is it needed?

- There is a high prevalence of co-occurring conditions in mental health and alcohol/drug treatment populations in the community and in prisons

- Those with co-occurring conditions have poorer prognoses, greater levels of unmet need, higher rates of relapse, increased hospitalisation, housing instability, greater risk of being either a victim and/or perpetrator of violence, greater involvement in the CJS, higher costs to services

- Nevertheless they can be excluded from services and support because of their co-occurring problems.

- The guidance has been drawn up by PHE with the support of NHS England and an expert reference group and seeks to address this disparity

ONS report 2015 (Sept 2016)

Deaths related to drug poisoning in England and Wales: 2015 registrations

There were 3,674 drug poisoning deaths involving both legal and illegal drugs registered in England and Wales in 2015, the highest since comparable records began in 1993.

Of these, 2,479 (or 67%) were drug misuse deaths involving illegal drugs only.

The mortality rate from drug misuse was the highest ever recorded, at 43.8 deaths per million population.

Males were almost 3 times more likely to die from drug misuse than females (65.5 and 22.4 deaths per million population for males and females respectively).

Deaths involving heroin and/or morphine doubled in the last 3 years to 1,201 in 2015, and are now the highest on record.

National Confidential Enquiry into Suicides and Homicides by people with mental health problems

http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf

- During 2004-14, 28% of suicides in the UK general population were by people under mental health care,
  a total of 18,172 deaths over the study period
- The type of drug most often taken in fatal overdose in all UK countries is opiates, including both prescribed and illicit drugsOver half the patients who died by suicide had a history of alcohol or drug misuse.
- National differences, with alcohol misuse a more common antecedent of suicide in Scotland and Northern Ireland, drug misuse more common in Scotland. However, a much smaller group was in contact with specialist substance misuse services.
- In England the number of homicides by patients with schizophrenia appears to have risen since 2009
- A related rise may have occurred in "dual diagnosis" patients, i.e. people with severe mental illness and drug or alcohol misuse.
- Most patients who committed a homicide had a history of alcohol and drug misuse

Government and Policy Responses

1999 National Service Framework for Mental Health Service

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf

2002 Practice implementation guides- dual diagnosis

2004 MHSF- 5 years review; “services for people with ‘dual diagnosis’ – mental illness and substance misuse – the most challenging clinical problem that we face”.

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099122.pdf

2006 Dual diagnosis in mental health inpatient and day hospital settings

Guidehttp://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649

Models of care

- The USA model that influenced service development is “Integrated Treatment” (Drake Mueser et al New Hampshire)

- This model advocated a specific team/service where people could get their multi-faceted needs met in one place

- They advocated that this service should be:
  - ✓ Comprehensive
  - ✓ flexible
  - ✓ Long term
  - ✓ stage-wise (motivational) focus tailored to the person
  - ✓ Use assertive outreach approaches to engage

UK model: Mainstreaming

- Given the prevalence was (is) 30-50% of the people using secondary mental health services, having specialist teams (integrated approach) was rejected
- Mainstreaming was advocated “its everyone’s business”
- This model suggested that the mental health (and substance use) workforce should be equipped to integrate substance use and mental health into their routine care plans.
- It advocated “specialists” in each area to provide leadership

Implementation tools for 2002 PIG

- NIMHE national programme- dual diagnosis theme
- Regional leads and networks
- Rise of the dual diagnosis worker
- Capabilities Framework
- Training materials and trainers manual
- E-Learning package
- Accredited courses on dual diagnosis: Manchester, York, Bristol, London,
- www.dualdiagnosis.co.uk

COMO and CODA studies

- RCT of dual diagnosis training delivered to community mental health teams- impact of staff and service users
- COMO- South London- individual staff randomised to training or waiting list (control)
- CODA- teams allocated to whole team v 2 people doing specialist training (the IOP course)
- Outcomes: able to demonstrate statistically significant improvements in staff measures (COMO) but only service user outcome improved was psychiatric symptoms (NB drug and alcohol intake no difference)
- NB In CODA trial- no between team differences at follow-up but in the whole team there was a significant difference in staff outcomes from baseline to follow-up

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Better care for people with co-occurring mental health and alcohol/drug use conditions

A guide for commissioners and service providers

The strategic context

- The guidance supports the implementation of the Five Year Forward View for Mental Health, 2016.

- The guidance supports the Prevention Concordat for Better Mental Health (Prevention Concordat) that focusses on the prevention of mental health problems and the promotion of good mental health. The Prevention Concordat will launch at the end of August 2017.

- The guidance underpins the mental health thread within the new Home Office Drug Strategy, 2017

- The guidance directs the reader towards the clinical guidelines in the new Drug Misuse and Dependence, UK guidelines on clinical management, 2017 (Orange Book)

Scope of the guidance

The guidance covers:

- All substances including alcohol, illicit drugs, tobacco, NPS, OTC drugs
- All levels of dependency, harmful use and states of intoxication
- All mental health problems – common, severe, dementia, personality disorder and dementia
- All ages and settings including in the community and in prisons

The guidance is intended to be used alongside and in support of NICE and other clinical guidance documents

Aims of the guidance

The guidance aims to support local areas to commission effective and timely responses for service users with co-occurring conditions.

It encourages commissioners and service providers to work together to:

- Improve access
- Enable harm reduction
- Improve health
- Enhance recovery
- Provide flexible responses
- Prevent exclusion

What are the key principles?

There are two key principles that should drive commissioning activities

1. Everyone's job

Co-occurring conditions are the norm rather than the exception, and commissioners and providers of 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, drug, and mental health services have an open door policy for individuals with co-occurring conditions. Commissioning enables services to respond collaboratively, effectively and flexibly offering compassionate and non-judgemental care centred around the persons needs which is accessible from every access point.

The priority elements to commission & deliver locally

- an agreed pathway of care enabling collaborative delivery by multiple agencies in response to individual need, enabling people to access the care they need when they need it, in the setting most suitable to their needs
- a named care coordinator for every person with co-occurring conditions
- undertake joint commissioning across mental health and alcohol/drugs supported by strong, senior and visible leadership
- a 24/7 response to people experiencing mental health crisis
- prioritise access to a range of recovery resources, recognising that recovery may require long term support

The nature of care delivery

A framework is recommended based on the following factors:

- strong therapeutic alliance
- collaborative delivery of care
- care that reflects the views, motivations and needs of the person
- care that supports and involves carers (including young carers) and family members
- therapeutic optimism
- episodes of intoxication are safely managed
- stop smoking advice/support is a routine part of care

Actions for commissioners

A number of actions are suggested, key ones include:

- Develop a shared local understanding of co-occurring conditions, a shared vision of interventions and desired outcomes.
- Agree lead or joint lead commissioning across NHS and local authority with senior strategic board oversight of development and implementation of plans.
- Address co-occurring conditions as an integral part of local pathways which are resourced, co-produced with experts by experience, carers and service providers
- Ensure the workforce is competent

Actions for commissioners and providers

- Collaboration across services, with service users, and carers to develop and integrated and holistic offer of support in relation to needs and level of risk identified.

- Develop service criteria that prevents exclusion – support people to get the help they need

- Build in flexibility to engage those with complex needs and chaotic lifestyles

- Ensure the workforce is competent

Actions regarding specific groups

- CJS: Commissioners need to collaborate and consider the needs and demands of who may be in contact with the CJS (courts, police, probation & CRCs, YOS)
- Older adults: Older people are more likely to have co-occurring conditions and be taking multiple medications
  - They need age sensitive harm reduction advice and treatment addressing sensory, cognitive and physical health issues at a pace that suits each individual
  - Multiple assessments may be required from different specialisms in an age sensitive manner, involving carers.
  - Mental health services for older people should provide integrated care with support from drug/alcohol services
  - Safeguarding protocols should be in place, agreed by the local safeguarding leads, to protect older people at risk of abuse

Building local services

In general services should be built around specific needs and work to overcome:

- stigma, mistrust based on past experience, fear regarding childcare/parenting responsibilities, and previous barriers to access

Services should be able to respond to the full range of presenting issues including:

- Mental health, substance misuse, vulnerabilities, housing, domestic abuse, exploitation and abuse

This requires local wide-ranging collaboration in designing and developing effective services and ensuring safeguarding is a paramount issue.

Workforce development

To provide services that can be flexible and effective for people with co-occurring conditions commissioners and providers of mental health services and drug/alcohol services will need to ensure the workforce is appropriately trained and supported.

- Local areas should undertake a training needs analysis to identify and address gaps in the skill mix
- Providers and commissioners need to ensure there are sufficient staff with expertise in co-occurring conditions to provide supervision and clinical leadership
- Workforce development tools include: Leeds capability framework (being updated); Core mental health knowledge and skills framework; PHE public mental health leadership and workforce development framework

Instruments to help commissioning

A number of instruments and processes can help local commissioners respond to the guidance, these include:

- Sustainability and Transformation Planning (STP),
- children and young people's mental health Local Transformation Planning (LTP)
- joint strategic needs assessment (JSNA) processes,
- commissioning for quality and innovation (CQUIN),
- quality premiums, enhanced primary care contracts, alliance commissioning and other payment incentives can help commissioners to develop local solutions

Appendices & practice examples

Appendices provide further information and guidance:

- Implementation questions for commissioners and providers to support them in checking/aligning services with the guidance

- Elements to consider in developing a collaborative care protocol locally.

- Links to good practice examples are provided – there is an invitation extended to submit further examples.

Link to guidance:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf