Multiple disadvantage and co-occurring substance use and mental health conditions.

June 2022

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Introduction

Substance use and mental health needs are two of the primary concerns for many people experiencing multiple disadvantage. We know that people who experience both issues at the same time (also known as “co-occurring conditions” or “dual diagnosis”) find it difficult or impossible to access the right support for their needs.

Unfortunately, it is clear from discussions with individuals across the MEAM Approach and Fulfilling Lives networks that people with co-occurring conditions face significant barriers to accessing support for either their substance use, mental health problems, or both. Therefore, this briefing will focus specifically on access to appropriate support and treatment for people facing multiple disadvantage with co-occurring conditions.

Recently, there has been much focus on drug treatment, with additional funding allocated for substance use treatment services over the next three years, the publication of Dame Carol Black’s review on drugs and the government’s new 10-year drugs strategy. There has also been much focus on health service reform through the Health and Care Bill, which will put Integrated Care Systems on a statutory footing, placing on them a statutory duty to “have regard to the need to reduce inequalities between patients.” These changes provide an opportunity to influence local health strategies and partnerships to ensure mental health and alcohol/drug needs are addressed at the same time.

However, despite these developments, appropriate support for people with co-occurring conditions remains an unresolved challenge for many local areas. Without appropriate support, individuals’ health, wellbeing and trust in services can be drastically harmed. In this briefing, we:

1. Examine the prevalence of co-occurring conditions among people experiencing multiple disadvantage
2. Explore the existing national guidance around supporting people with co-occurring conditions
3. Investigate the barriers to accessing support for co-occurring conditions
4. Investigate the enablers to accessing support for co-occurring conditions
5. Recommend improvements in policy, commissioning and local practice for people with co-occurring conditions.

This briefing is informed by conversations with local areas from across the MEAM Approach and Fulfilling Lives networks, providing an in-depth understanding of the difficulties faced by support services - including homelessness, drug and alcohol and

mental health services - in meeting the needs of individuals with co-occurring conditions, as well as partnership-working, good practice and changes over time.

In addition to our conversations, a survey of local strategic leads across the networks was carried out exploring the scale and nature of the challenge of co-occurring conditions, access to and quality of services, as well as good practice in local areas.

1. Prevalence of co-occurring conditions and multiple disadvantage

It is extremely common for people facing issues related to multiple disadvantage to also be experiencing co-occurring conditions.

There is no specific measurement of the number of people experiencing co-occurring conditions across the country. This is due to a range of reasons including that a large proportion of those with co-occurring issues do not have a formal diagnosis and are not receiving treatment for either; the absence of a unified national dataset on the delivery of mental health services;[1] and limited data sharing between mental health and substance use agencies. However, research has shown that substance use issues and mental health problems are extremely common amongst people experiencing multiple disadvantage.[2]

A Public Health England (PHE) literature review estimates the majority of drug (70%) and alcohol (86%) users in community treatment experience mental health problems.[3] Research has also shown that as many as 70% of people in prison have two or more mental health disorders[4] and that an increasing number of prisoners report developing a substance use problem in custody.[5] A recent survey conducted with people sleeping rough found that the vast majority of respondents (82%) reported having a current mental health vulnerability and the majority (60%) were defined as having a current drug or alcohol need.[6]

Furthermore, in our conversations with local areas, we found that an extremely high proportion (87%) of people who are supported through the MEAM Approach are estimated to experience co-occurring conditions. A recent report from the Fulfilling

[1] https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf
[2] https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf
[4] https://committees.parliament.uk/publications/7455/documents/78054/default/
[5] https://reform.uk/sites/default/files/2020-01/The%20prison%20system%20-%20final%20version.pdf
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944598/Initial_findings_from_the_rough_sleeping_questionnaire_access.pdf

Lives Programme mirrors our findings, suggesting that 90% of beneficiaries experience both mental ill-health and substance use.[7]

2. National guidance on treatment of co-occurring conditions

There is limited guidance and information on the treatment of co-occurring conditions.[8] [9] [10] The NICE guidance (footnote 10) is clear that both mental health and substance use treatment services should support individuals' needs simultaneously, with mental health services taking the lead responsibility for assessment and care planning. Individuals should not be excluded from mental health, physical health, social care, housing or other support services because of co-occurring conditions.

Commissioning advice published by Public Health England,[11] sets out that commissioners and providers of mental health and drug and alcohol services have a joint responsibility to meet the needs of individuals with co-occurring conditions. The guidance, published in 2017, sets out two key principles:

- ***Everyone's job.*** *This principle describes how commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.*

- ***No wrong door****. The guidance also encourages providers in alcohol and drug, mental health and other services to have an open door policy for individuals with co-occurring conditions, and to make every contact count. Treatment for any of the co-occurring conditions should be available through every contact point.*

Unfortunately, there are very few examples available to evidence that national guidance is being followed and specifically if individuals are being offered treatment. All of the areas we spoke with offer mental health treatment and substance use support services, and many had commissioned services or taken initiatives across multiple services in an effort to more effectively support people facing

[7] https://www.fulfillinglivesevaluation.org/download/324/evaluation-findings/6608/summary-full-report-and-case-studies-improving-access-to-mental-health-support-for-people-experiencing-multiple-disadvantage-2020.pdf
[8] https://webarchive.nationalarchives.gov.uk/20121012200956/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060435.pdf
[9] https://findings.org.uk/PHP/dl.php?f=NICE_120.txt&s=dy&sf=mx
[10] https://www.nice.org.uk/guidance/ng58
[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

multiple disadvantage, including those with co-occurring conditions and other complex needs. However, almost all the local leads suggested that their area was not meeting the needs of people facing co-occurring conditions.

As a result, people facing multiple disadvantage with co-occurring conditions can struggle to access support. Almost 93% of respondents in our survey of the MEAM Approach and Fulfilling Lives leads reported that accessing mental health services was "a real challenge" or "quite a challenge" for people experiencing substance use needs. Just over 47% of respondents reported similarly when asked the same question about accessing substance use services for people with mental health needs.

3. Barriers to appropriate support for people with co-occurring conditions

Despite the prevalence of co-occurring conditions and the impact it has on the health and wellbeing of individuals, interview and survey respondents reported numerous barriers and poor practices that prevented individuals from accessing the services and support they need. In this section we explore professional stakeholders' perspectives on these challenges:

- *Refusals of access*

As set out in Figure 1 below, a range of barriers to accessing or maintaining support from mental health, drug and alcohol services were cited. Examples include being discharged from mental health services for regularly missing appointments, and being discharged for attending appointments while intoxicated. In our survey responses both of these were reported as very common reasons for mental health services to refuse access to support. Other 'frequent' or 'very frequent' barriers included anti-social behaviour and referrals being refused when the individual was known to the receiving service/practitioner and deemed 'not suitable' for the service.

However, the most commonly cited barrier involved having co-occurring conditions, with mental health services saying they could not support someone until they had addressed their substance use issues, and in some circumstances until they were completely abstinent. Respondents were less likely to state that substance use services would refuse support to someone having a mental health issue.

Figure 1 – Reasons stated for support being refused or ended (n=17)

Reason for support refused/ended	Rejected referral	Co-occurring condition	Behaviour	Missed appointment
Number of respondents citing reason as 'frequent' or 'very frequent' for refusal/ending of **mental health services**	5	16	12	15
Number of respondents citing reason as 'frequent' or 'very frequent' for refusal/ending of **substance use services**	2	2	6	8

With regard to mental health, interviewees from substance use and homelessness services noted that the main barriers tended to occur at the referral and assessment stage when, if a person had substance use issues, their treatment pathway often stopped.

Interviewees reported that counselling provision via Improving Access to Psychological Therapies (IAPT) was generally not able to provide flexible treatment for people with co-occurring conditions and in some local areas, IAPT providers would not accept referrals made directly by a substance use professional. Respondents also provided examples of Community Mental Health Teams (CMHT) assessing people as ineligible for treatment due to their substance use or perceived complexity, regardless of whether or not their alcohol or other drug consumption was stable. Stakeholders reported particular difficulty getting assessments that might activate legal duties of care, such as under the Mental Health Act or the Care Act, and the need for a strong advocate to make this happen.

Discussions with mental health practitioners suggested that in many cases mental health support was refused due to a person's level of complexity or behaviour, rather than their substance use per se, with practitioners citing that the therapies on offer did not meet the level of need of these individuals. As a result, despite wanting those individuals to receive help, secondary mental health professionals do not always feel they are best placed to provide it.

In practice, this can mean that some people's needs are seen as 'too complex/ challenging' for mainstream mental health services, but are not considered acute enough for specialised services. In this way individuals' access to support is determined by placing the onus on individuals to 'fit' the needs of the service, rather than encouraging the system to flex and meet the needs of individuals.

Unfortunately, this gap leaves some people with no support, despite needing both mental health and substance use interventions.

Case Study

John has a diagnosis of paranoid schizophrenia and has been in and out of prison 17 times since the age of 18. John is now 38. He has a long history of support from Community Mental Health Teams (CMHT). He was housed in supported accommodation but was deemed a fire risk due to his smoking. The CMHT feel they have exhausted all their options with trying to work with John.

When John is in prison, he is able to access the treatment he needs and stabilises on medication. He is then released and turns to alcohol which it is believed he uses to manage his mental health. Alcohol then worsens his mental health, resulting in self-neglect and a reduced ability to manage his own needs.

The CMHT maintain their position on his alcohol use, saying that if he reduces or abstains they will be able to work with him. John works with the local substance use service and is on a methadone prescription. However, over the past 14 months John has had three prison sentences.

- *Accessibility*

The environments and processes that substance use and mental health support services adopt can lead to generic offers of support being made to individuals, with limited consideration given to their personal circumstances. As a result, people with co-occurring conditions are expected to engage with support in the same way as the general population, with little appreciation given to the practical reality of the lives of individuals within this group.

The staff we spoke with felt this was particularly the case for appointment times and service locations. Locations that are not easily accessible or discreet, and appointments during “traditional” opening hours (i.e. not out-of-hours), can serve as major barriers for people experiencing multiple disadvantage to access these services. An example we repeatedly heard was individuals being told their cases are being closed or they must return to the referral stage, if an appointment is missed. It was noted that individual mental health professionals are obligated to follow internal rules which might mean they feel compelled to discharge a patient, for example if they miss several appointments.

The recently published Drug Strategy encourages joint commissioning so that access to mental health support can be provided in and out of drug and alcohol treatment services for people with co-occurring conditions.[12] It is hoped this will support with improving accessibility for this cohort.

Furthermore, it is clear that there is not one uniform way of experiencing co-occurring conditions and multiple disadvantage. Someone's race, gender, sexuality or experience of poverty can affect their likelihood of experiencing these issues, how they experience them, and their ability to access support for them. Additional structural barriers, and a lack of understanding of people's needs, are in place for many groups. For example, women experiencing multiple disadvantage can find accessing substance use or mental health services particularly difficult at times. This may be due to experiences of abuse, violence and trauma, or childcare issues.[13] Similarly, services can fail to understand the needs of people from minoritised communities or to provide culturally appropriate services. As a result, some people may feel coerced into accessing services or locations where they feel uncomfortable or have had previously poor experiences.

Further examples of accessibility issues include the offer of support for substance use needs through group work, which can be intimidating; long waiting lists for new referrals, which can lead to people disengaging; and in some areas, needing to attend daily medication pick-ups from pharmacies as a result of decisions around clinical risk and vulnerability.

Respondents told us that scarce resources exacerbate these issues. Stakeholders across sectors noted that staffing levels have not kept pace with the increasing demand on mental health services, resulting in services sticking to 'traditional' mainstream models of support. As was recently discussed in our briefing on alcohol and multiple disadvantage, without time for support staff to build relationships and offer a more personalised support plan, some people facing multiple disadvantage find it difficult to comply with criteria set by services for commencing and maintaining treatment support.[14] Individuals may not be in a position to keep appointments or follow all the set rules, and can therefore be discharged from services. Such inflexible provision disproportionately impacts people facing multiple disadvantage and co-occurring conditions.

[12] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives
[13] https://www.mappingthemaze.org.uk/wp/wp-content/uploads/2017/09/Mapping-the-Maze-executive-summary-for-publication.pdf
[14] http://meam.org.uk/wp-content/uploads/2021/11/Alcohol-and-MD-Final.pdf

- *Appropriateness of care*

Treatment services for people with co-occurring conditions are important and delivered by committed teams of professionals. However, at times, there can be a mixed standard of support provided to people with co-occurring conditions when they are able to access treatment. The staff that we surveyed considered that the support that people facing multiple disadvantage received was in need of improvement, reporting that few or none of their clients' needs were being met by mental health services (15/17 areas say needs of clients not met) or drug and alcohol services (10/17 areas say needs of clients not met). This can often be the result of reduced government funding for treatment over time, or the impact of restrictions placed on treatment teams by organisational policies.

Respondents suggested that mental health services can often provide inflexible support based on a clinical, diagnosis-led model that is not holistic and often unsuitable for people facing multiple disadvantage. This was reported to lead to a lack of sufficient consideration of people's wider needs and to exclude people from support. Expert psychologists that we spoke with expressed it would be more favourable if mental health services adopted a method and perspective that reflected the growing levels of co-morbidity that people facing multiple disadvantage experience, such as substance use, housing issues, poverty and trauma. This would prompt improved coordination and access to care and support from multiple services alongside mental health. It was felt that the focus on specific clinical mental health issues meant that individuals with co-occurring conditions largely did not receive access to the coordinated support they required.

The support offered by some local substance use treatment providers was also mixed and in some cases acted as a barrier to people getting the support they need. Our research found examples including the lack of rapid access to prescriptions, long waits for new referrals and a lack of outreach. Furthermore, with only limited resource for training around mental health, substance treatment professionals reported feeling out of their depth when someone presented with considerable mental health and substance use issues. They stated they felt the need to make quick referrals to mental health services when they believed their client presented with mental health issues. This lack of sufficient time and resource within substance use providers can mean that they are unable to provide personalised responses that consider individuals' specific circumstances.

- *Outcome measurements*

Interviewees reported that outcome measurements set by mental health and substance use commissioners can frequently act as disincentives to support people with co-occurring conditions. Given that these services are commissioned and measured with a focus on either a person's substance use or mental health needs, it can sometimes be difficult to prioritise and address interrelated issues beyond these. It was reported that by narrowly looking at each issue in isolation, commissioners do not facilitate partnership-working or provide the flexibility needed to support people experiencing co-occurring conditions or to focus on systemic change. Stakeholders saw an important role for commissioners in reframing outcomes and performance indicators in a way that facilitates a more holistic understanding of recovery and acknowledges the multiple needs of people with co-occurring conditions.

- *Capacity / resourcing*

There have been substantial cuts to substance use services over recent years that have resulted in cuts being made to service provision. Scarce time and resources have led to higher individual caseloads for frontline staff.[15] Local areas reported that workers feel obligated to focus on 'core business', with less time to support interrelated issues and offer personalised support, both of which disproportionately affect individuals with more complex needs and those facing co-occurring conditions. Funding and monitoring mechanisms for drug and alcohol teams reinforce this, by regularly measuring performance by number of clients and narrow outcomes rather than capturing an individual's holistic progress.

Additional investment has been recently announced alongside the government's new Drugs Strategy. This includes £533 million over the next three years to community treatment and recovery, £115 million to support people with housing and employment needs, and £120 million to support people leaving prison and serving community sentences. It is hoped the money will be used to support people in treatment and recovery and build the workforce. The strategy's ambition to address mental health system gaps by working with the NHS to improve the skills of the workforce in relation to drugs and alcohol will support this work.[16]

[15] https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

[16] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

- *Utilising primary mental health care*

The level of coordination between primary and secondary mental health care was also seen as an issue that prevented individuals with co-occurring conditions getting appropriate holistic support in the community. Mental health interviewees that we spoke with told us that there is a perceived communication gap between Primary Care Networks (PCNs) and Mental Health Trusts (MHTs), and in some places PCN staff were not adequately trained to assess people with complex mental health needs, resulting in an over-reliance on referrals to specialist secondary mental health care.

Mental health services from across the MEAM Approach and Fulfilling Lives networks have developed approaches to bridge these gaps, including system-wide training about commissioned services offered by Mental Health Trusts, and commissioning a greater number of specialist staff within primary care settings. Other examples include multi-disciplinary teams of mental health specialists providing input at case-conference meetings with GPs, which help to support people whose needs are too complex for PCNs to respond to, but not complex enough for MHT thresholds.

However, one of the biggest gaps reported by GPs is the increasing number of people who do not fit a clear referral pathway because of the complexity of their needs. Significant numbers of people are falling into a gap between Improving Access to Psychological Therapies (IAPT) services and specialist mental health services. People who present with mental health needs alongside other issues such as substance use can find that local IAPT services are unable to offer an appropriate service. As a result, individuals are often referred to secondary care where they may be told their conditions are not 'severe' or 'high-risk' enough to meet the rising thresholds of these specialist services.[17] Without access to secondary care, this leaves a gap for many individuals.

- *Partnership working*

The importance of cross sector partnerships was a common theme to emerge in our conversations with local areas. Almost all respondents to the survey (15/17) reported that homelessness, substance use and mental health services could do better in their partnership working. Particular challenges in communicating and joint-

[17] https://www.kingsfund.org.uk/sites/default/files/2020-07/Mental%20Health%20and%20PCNs%20online%20version_1.pdf

working with mental health services were highlighted by substance use and homelessness services.

Part of this related to the perceived clash in approaches to care (discussed above) and a lack of knowledge between staff of different services' concerns and priorities. Better partnership working could support staff to understand different perspectives and benefit from each other's expertise.

Formal and informal mechanisms for partnership-working between mental health and other services varied widely across the areas we spoke to. In some areas, partnership working between public services and mental health consisted solely of informal, ad hoc interactions between practitioners, with formal meetings only taking place when crises occurred. In others, specific co-occurring conditions forums, multi-agency meetings such as 'ward rounds,' and cross-sector training provided a helpful structure for communication. However, where these existed, engagement by mental health practitioners was often reported to be patchy.

In most cases, the improved coordination between services for people with co-occurring conditions is provided by dedicated specialists embedded in teams to work with people with co-occurring conditions (often known as 'dual-diagnosis workers' or 'specialist mental health workers'). These tended to act as a gateway, providing a useful link between housing, substance treatment and mental health. However, these roles are generally small in number, with high caseloads, and funded for limited periods of time. Furthermore, while they have benefits, specialist roles can disincentivise the wider system from making changes by removing the immediate drive or perceived need for wider change around approaches to supporting people with multiple disadvantage and co-occurring conditions.[18]

Case Study

Andrew has a long-standing mental health diagnosis of schizophrenia/psychosis and has been hospitalised on a number of occasions over the years.

He has a mental health social worker, psychiatrist and is well known to the mental health teams because of his repeated hospital admissions under Section 136 of the Mental Health Act. He also has a substance use worker (he has used Class A drugs for many years) and a Housing First navigator.

At a recent Multi-Disciplinary Team (MDT) meeting the mental health workers refused to see Andrew because of his erratic behaviour which they attributed to

[18] http://meam.org.uk/wp-content/uploads/2021/10/mental-health-thematic-report.pdf

drugs. This included home visits as well as appointments at the mental health service. He was temporarily barred from substance use support because of his presentation and threats to staff, leaving Housing First as Andrew's only support. Unfortunately, due to specific and credible threats made to his navigator, Housing First had to pull out as well.

Despite repeated threats to harm others, Andrew is not considered to need mental health inpatient treatment. Substance use and the generic housing options team are now his only support. All agencies agree that his mental health is his main issue, but the mental health team expect Andrew to address his heavy substance use before they will consider working with him on a regular basis.

There was a particular challenge between mental health, substance use, police and homelessness services. A common example we heard about included a lack of coordination around crisis situations in homelessness accommodation settings. Support from mental health crisis teams and police was reported to be inconsistent during these periods. Mental health teams sometimes did not attend when asked. At its worst, homelessness stakeholders reported that police and mental health teams dismissed mental health crises as drug-induced, meaning that people did not receive the support they needed and accommodation teams were left to respond to needs that they are not equipped to deal with.

Case study

Sahel was experiencing a mental health crisis while living in hostel accommodation.

The staff at the hostel called the mental health crisis team and were asked if Sahel had taken any drugs. As Sahel had recently taken drugs, the crisis team advised the hostel to phone back once the drugs had worn off. After numerous calls to the crisis team and no visits from any mental health teams, Sahel's condition worsened and he was sectioned under the Mental Health Act with the assistance of the police.

Sahel was already known to mental health services and no support was given to hostel staff to deal with the situation.

- *Trauma*

The role of trauma in the context of co-occurring conditions is often inadequately acknowledged. Trauma and mental ill-health are often the drivers and accompaniment of much addiction.[19] Traumatic experiences can provoke responses which can become deeply embedded within a person. Despite this, inquiring about trauma and acting in a trauma-informed way is not always standard practice.

[19] https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

Considering the role of trauma may enable services to better engage with people's needs.

A lack of understanding of how trauma affects behaviour can also result in people experiencing multiple disadvantage being refused assessments and access to services when symptoms of trauma such as drug use, behavioural problems and violent relationships are assumed to be "lifestyle choices" and the person to be "difficult," "untreatable," or "not appropriate" for the service.

4. Enablers to appropriate support for people experiencing co-occurring conditions

Despite the challenges, our conversations with local leads across the MEAM Approach and Fulfilling Lives networks also identified a series of enablers to appropriate support for people facing co-occurring conditions. In this section we explore a selection of these:

- *Specialist roles, teams and services*

As noted above, in many cases, improved access and support to substance use and mental health services for people experiencing multiple disadvantage has been secured via specialist roles, teams and services, rather than mainstream services.[20]

Respondents noted that the focused and holistic work that specialist services and teams are able to do with individuals is extremely valued. The types of support provided include specialist co-occurring conditions practitioners, mental health street outreach teams, homeless mental health navigators and specialist mental health service workers. These teams were seen as successful at advocating for people and linking them with mainstream mental health services, while at the same time providing individuals with the time and focus they needed to build trust. Respondents agreed that the introduction of their expertise in wider services increases access to more flexible and relevant support, and can rapidly make a difference to the lives of people they support. For example, unlike mainstream mental health services, assertive mental health outreach teams worked flexibly with people regardless of their substance use or behaviours and with a deep understanding of co-occurring conditions.

However, respondents had mixed feelings regarding specialist services and cited a range of barriers these can present. Firstly, the capacity of specialist services was

[20] http://meam.org.uk/wp-content/uploads/2021/10/Year-Four-final-report.pdf

universally overstretched, and these teams and specialists tend to be funded for short periods of time. Respondents explained how this meant specialist services are only able to reach a small proportion of those most in need of their services and are focused on cases of the highest risk for a fixed period.

Secondly, there was a perception amongst respondents that mainstream services were incentivised to refer more complex individuals to the specialist team. As a result, strong pathways into mainstream mental health services did not appear to be developing, and people facing co-occurring conditions often continue to be excluded from local mainstream mental health services. In this way, mainstream services avoided improving their own processes, entrenching siloed ways of working. This is mirrored by findings in the MEAM Year 4 evaluation report.[21]

Therefore, specialist services can present barriers to changes to the wider system by removing the drive or the need for the rest of the system to change in order to meet the needs of people experiencing co-occurring conditions. The specialist commissioned services were seen to be helpful for a small cohort of individuals, but fell short of addressing the systemic challenges that prevented all those with co-occurring conditions from getting the support they need.

Nevertheless, culture change for mainstream services is often incremental and takes time, and as such many stakeholders see specialist services as necessary for supporting people experiencing multiple disadvantage.

- *Secondments, placements and embedded staff*

A number of stakeholders reported positive results from cross-sector staff placements. In some areas, this took the form of jointly–funded placements of mental health nurses in drug and alcohol teams.

In addition, long-term shadowing or one-day-a-week placements between local mental health and substance use organisations to build relationships between services and workers were seen to be very positive. It improves immediate direct support to individuals experiencing co-occurring conditions but over longer periods also helps break down cultural barriers and differences between organisations.

Directly hiring mental health specialists to work in substance use services, and vice versa, was seen to be a positive step in some areas, although funding for those posts can be difficult. In one area, the substance use service had seen benefits from

[21] http://meam.org.uk/wp-content/uploads/2021/10/Year-Four-final-report.pdf

employing two mental health nurses as staff members. They could support individuals directly but were also in a much better position to directly refer clients to mental health services, such as community mental health teams, without the need to go through a GP. Other examples included specialist mental health as well as substance use workers co-locating in GP practices a few days a week to support clients.

- *Training and upskilling staff*

A number of areas reported that they benefitted from cross-sector training opportunities, whether it was mental health training for drug and alcohol teams, or training on supporting people with substance dependence for mental health practitioners. This can help professionals improve how and when they refer individuals to other agencies and how to determine the most appropriate route for support.

- *Commissioning*

Improving commissioning practices was seen as crucial to changing the current status quo for people with co-occurring conditions. Treatment services may be commissioned by CCGs, local authorities, PCCs and prison governors, and so there is a need to collaborate across sector boundaries. Stakeholders suggested that all commissioners should use their influence to strengthen local accountability around adherence to co-occurring conditions policies, in order to challenge poor practice. Joint commissioning between health, substance use and homelessness was needed to develop truly shared outcomes and clear, visible pathways to achieve them.

A range of existing and new policies should help to drive local join-up. The Community Mental Health Framework encourages closer working between professionals in local communities to help eliminate exclusions based on a person's diagnosis or level of need. It encourages more flexible models where care can be stepped up or down from different agencies based on a person's needs and on the intensity of input and expertise required at a specific time.[22] The recently published Drugs Strategy and Dame Carol Black's review on drugs recommend that the DHSC introduce a national Commissioning Quality Standard that will require local authorities to work with health, housing and employment support, and criminal justice partners.

[22] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

- *Building system flexibility*

Many interviewees described how small flexibilities or tweaks in the system helped people with co-occurring conditions receive better support. A common example involved allowing homelessness or substance use staff to make referrals to mental health services without going through a GP. In general, it was noted that creating direct referral pathways between the organisations can make a real difference.

Interviewees also emphasised the exceptional value of flexible, non-judgemental and peer-led social spaces for non-therapeutic support for this group, outside of mental health and formal drug and alcohol treatment. The emphasis on flexibility, open-ended support, lack of conditionality, community engagement, and respect were seen as key to these services' successful outcomes.

System flexibility could also mean creating a single 'front door' or co-locating services to make them easier to access. One survey respondent described a successful mental health hub opened during COVID-19, bringing together local A&E psychiatric liaison teams and a co-occurring conditions worker. Post-lockdown, there were plans to make the move permanent and expand with a crisis café and the addition of other services, including housing.

- *Co-occurring conditions in the wake of COVID-19*

In March 2020, government issued the 'Everybody In' directive, instructing local authorities to accommodate everyone who was rough sleeping, living in night shelters or in hostels where they couldn't self-isolate, in emergency self-contained accommodation. From the outset, the ability of mental health and substance use services to adapt to support people placed in these new environments was a primary concern.

However, with thousands of people placed in emergency accommodation it presented an enormous opportunity for substance use and mental health services to improve engagement. Many individuals with substance use and/or mental health difficulties were in appropriate housing for the first time in years and it provided the chance for staff across services including mental health and substance treatment to better coordinate their support.

Research conducted in MEAM Approach areas during the lockdown found that while mental health services had shown less flexibility than other services, the rapid

adaptations by both substance use and mental health services in many areas were both impressive and vital to protecting the wellbeing of individuals.[23]

Common changes included placing co-occurring conditions workers in emergency accommodation, rapid assessments and daily virtual contact with substance use services, prescription deliveries and OST prescriptions covering longer periods of time.

While we are beginning to understand the short-term impact on services, the longer-term impact of the crisis on people experiencing multiple disadvantage and who have co-occurring conditions are not yet known.

5. Conclusion and recommendations

In our conversations with local areas we have spoken to many people who express concern at the way the system is working for people experiencing co-occurring conditions. Overall, the picture appears to be that access to appropriate support remains extremely difficult, leading to poor health, wellbeing, housing and offending outcomes and significant levels of unmet need for these individuals.

Systems that keep the commissioning, design and delivery of substance use treatment and mental health services separate from one another inevitably struggle to meet the needs of people experiencing co-occurring conditions.

However, despite repeated challenges and frustrations, professionals are passionate about trying to tackle these issues and as a result improvements are being developed and good practice is emerging in some local areas. In order to help drive this forward, we have produced a series of recommendations:

- *Accountability*

1. The Joint Combatting Drugs Unit should ensure that new funding and treatment services available through the Drugs Strategy are planned (nationally and locally) in collaboration with the Department for Health and Social Care and Mental Health Teams to reflect the specific needs of people with co-occurring conditions.
2. Integrated Care Partnerships (ICPs) and Integrated Care Boards (ICBs) must view co-occurring conditions as a health inequality and consider integrating with substance misuse providers and other services that impact upon co-

[23] http://meam.org.uk/wp-content/uploads/2020/06/MEAM-Covid-REG-report.pdf

occurring conditions such as housing, criminal justice and the wider voluntary sector.

3. The Department of Health and Social Care should introduce measures to begin recording where, when and how often individuals are refused mental health treatment due to an existing substance use issue. This should include IAPT services. If individuals are seeking support but not receiving it then they need to be supported to access help elsewhere.
4. The Department of Health and Social Care should better demonstrate how areas can implement existing national guidance around co-occurring conditions, through examples of local best practice and pathways of support.

- *Local partnerships*

5. Local areas should be encouraged to develop local action plans targeted at improving access to support and services for people facing multiple disadvantage and co-occurring conditions. A partnership approach should be taken to the development of these plans with the involvement of key strategic agencies such as substance use providers, the mental health trust and local authority. A new Commissioning Quality Standard, recommended by Dame Carol Black, should help to drive better local join-up.
6. Representation in this work should be as wide as possible, not limited to just mental health and substance use providers and including homelessness and criminal justice partners.
7. An agreement of what the problem currently looks like as well as an agreement on "what good looks like" for the system should be developed. This needs to be influenced by individuals with lived experience as core members of the partnership.
8. There should be a commitment to 'no wrong door' principles across all local support agencies. All outreach staff should record and refer individuals to a local triage system where they believe an individual has co-occurring issues.
9. Every substance use treatment service and community mental health team should have clear assessment and referral pathways for people facing co-occurring conditions.
10. Local areas may find the MEAM Approach framework and the MEAM System Intervention Tool helpful for shaping and guiding such work.

- *Commissioning*

11. Where appropriate, services for people likely to be facing co-occurring conditions should be commissioned jointly, for example, outreach services to people rough sleeping, or services for people newly released from prison.
12. Local areas should place a greater focus on co-occurring conditions in future Joint Strategic Needs Assessments, developing a better understanding of the scale of the issue in local communities, the levels of unmet need, and stronger evidence to advocate for the introduction of local solutions.
13. To help eliminate exclusion based on a person's co-occurring conditions, local areas should commission more flexible and multi-agency service models centred around an individual's needs. The Community Mental Health Framework should help to deliver this.