NICE National Institute for Health and Care Excellence

NICE Pathways

Coexisting severe mental illness and substance misuse: community health and social care services overview

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http://pathways.nice.org.uk/pathways/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services
Pathway last updated: 21 December 2016

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.

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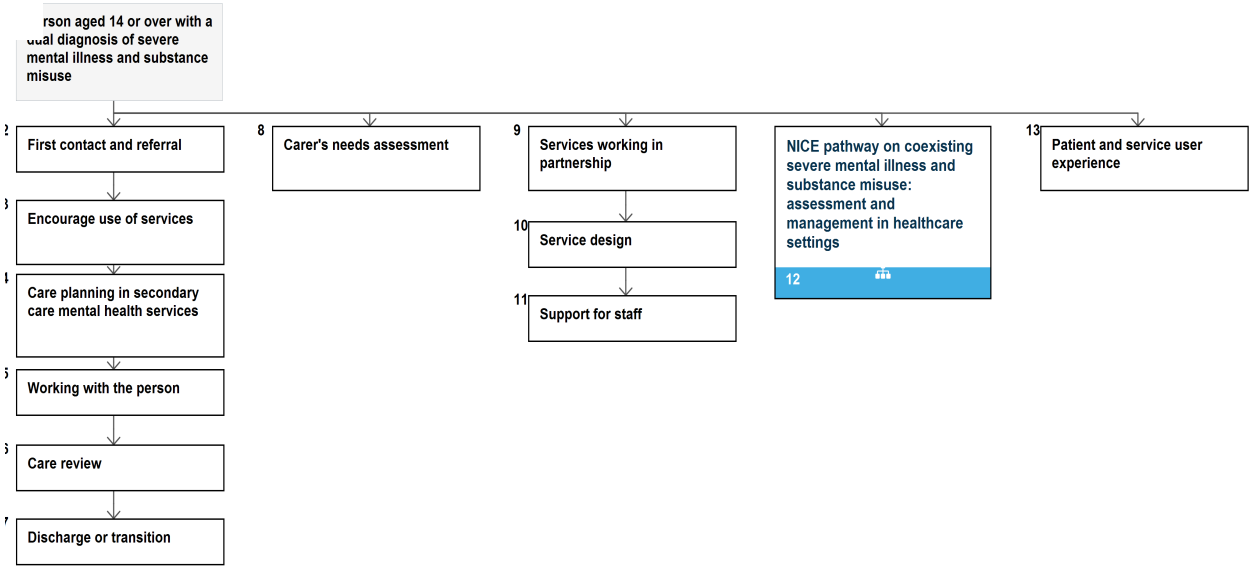

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1 Person aged 14 or over with a dual diagnosis of severe mental illness and substance misuse

No additional information

2 First contact and referral

These recommendations are for all staff who may be the first point of contact with young people and adults with coexisting severe mental illness and substance misuse working in:

- health (including urgent care and liaison services)
- social care
- public health
- voluntary and community sector organisations
- housing (for example, homeless shelters or temporary accommodation)
- criminal justice system (NICE is developing a guideline on the mental health of adults in contact with the criminal justice system, publication expected February 2017).

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

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

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

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

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

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

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

Ensure the person is referred to and followed up within secondary care, and that mental health services take the lead for assessment and care planning.

For more information on how to support people with a mental illness and a physical health problem, see also the NICE pathway on multimorbidity.

3 Encourage use of services

Recognise that even though building a relationship with the person and seeing even small improvements may take a long time, it is worth persevering. It involves:

- showing empathy and using a non-judgemental approach to listen, identify and be responsive to the person's needs and goals
- providing consistent services, for example, where possible keeping the same staff member as their point of contact and the same lead for organising care
- staying in contact by using the person's chosen method of communication (for example, by letter, phone, text, emails or outreach work, if possible).

Explore with the person why they may stop using services that can help them. This may include:

- fragmented care or services
- inflexible services (for example, not taking into account that the side effects the person may experience from medication may affect their attendance at appointments)
- inability to attend, because, for example, services are not local, transport links are poor, or services do not provide childcare
- not being allowed to attend, for example because they have started misusing substances again
- fear of stigma, prejudice or being labelled as having both mental health and substance misuse problems
- feeling coerced into using treatments or services that do not reflect their preferences or their readiness to change

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- previous poor relationships with practitioners
- other personal, cultural, social, environmental or economic reasons.

Help those who may find it difficult to engage with services to get into and stay connected with services. Start and maintain contact using proactive, flexible approaches (see working with the person [See page 7], in this pathway).

Recognise that people with coexisting severe mental illness and substance misuse are at higher risk of not using, or losing contact with, services. There are specific populations who are more at risk. These include men, young people, older people and women who are pregnant or have recently given birth. It also includes:

- people who are homeless
- people who have experienced or witnessed abuse or violence
- people with language difficulties
- people who are parents or carers who may fear the consequences of contact with statutory services.

4 Care planning in secondary care mental health services

On acceptance to secondary care mental health services

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

- act as a contact for the person
- identify and contact their family or carers
- help develop a care plan with the person (in line with the Care Programme Approach) and coordinate it. The Care Programme Approach is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.

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

Coordinating care and support

The person's care coordinator should adopt a collaborative approach with other organisations (involving shared responsibilities and regular communication) when developing or reviewing the

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person's care plan. This includes substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.

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

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

Consider covering behaviours in the care plan that may affect the person's physical or mental health, in addition to their substance misuse (see the NICE pathways on drug misuse and alcohol-use disorders) . Pay particular attention to:

- diet (see the NICE pathways on diet)
- physical activity (see the NICE pathway on physical activity)
- smoking (see the NICE pathway on smoking)
- consequences of drug or alcohol misuse practices (see the NICE pathways on hepatitis B and C testing, HIV testing and prevention and needle and syringe programmes)
- sexual practices (see the NICE pathway on preventing sexually transmitted infections and under 18 conceptions).

Explore any barriers to self-care to help the person loom after their own physical health. Address these barriers in the care plan.

Consider incorporating activities in the care plan that can help to improve wellbeing and create a sense of belonging or purpose. For example, encourage sport or recreation activities, or attendance at community groups that support their physical health or social needs. Ensure activities take account of a range of different abilities. Consider, for example:

- the gym
- education opportunities
- volunteering

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- use of personal budgets (if applicable) for learning new skills, such as those that might support a return to employment.

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

See also working in partnership [See page 11], in this pathway.

5 Working with the person

Involve the person (and their family or carers if the person wants them involved) in developing and reviewing the care plan (as needed) to ensure it is tailored to meet their needs. This includes offering the person information about the services available so they can decide which ones would best meet their jointly identified needs and goals. Also involve practitioners from:

- adult or child and adolescent mental health teams and substance misuse services
- other health and social care disciplines such as medicine, pharmacy, nursing, social work, occupational therapy and housing.

Ensure the care plan:

- Is based on a discussion with the person about how their abilities (such as the extent to which they can take part in the activities of daily living) can help them to engage with services and recover.
- Takes into account the person's past experiences (such as their coping strategies to deal with crises).
- Lists how the person will be supported to meet their identified needs and goals. This includes listing any carers they have identified to help support them, and the type of support the carer can provide. (See also providing interventions and programmes: ensure interventions meet individual needs in the NICE pathway on behaviour change).
- Takes into account the concerns of the person's family or carers.
- Recognises and, if possible, reconciles any goals the person may have decided for themselves if they differ from those identified by their service provider.
- Is optimistic about the prospects of recovery.
- Is reviewed at every contact.

Share a copy of the care plan with the person's family or carers (if the person agrees). In line with local information sharing agreements, share copies with other services as needed (see

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also working in partnership [See page 11], in this pathway, for recommendations on confidentiality and data sharing).

Consider the following approaches to keep people involved in their care plan:

- Practical one-to-one support, for example in relation to housing, education, training or employment.
- Support to develop self-care skills, for example, to help them develop their budgeting skills so they know how to allocate enough money to buy food. Or support to help them develop their cooking skills.
- Practical help with tasks that are important to the person for example, housework or occupational support.
- Support at appointments, for example:
    - arranging or travelling with them to hospital outpatient appointments or attendance at support groups
    - arranging for an advocate to accompany them at their appointments and provide independent advocacy (for recommendations about encouraging people to stay in contact with services, see also encourage use of services [See page 4], in this pathway, and recommendations on loss of contact or non attendance below).

Loss of contact or non-attendance

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

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

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

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6 Care review

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

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

Ensure the care plan is updated in response to changing needs or circumstances.

7 Discharge or transition

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

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

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

- young people who move from child and adolescent mental health services to adult health or social care services (see also the NICE pathway on transition from children's to adults' services and identification and referral for young people, specific issues when assessing and treating young people and competence of professionals working with young people in the NICE pathway on coexisting severe mental illness and substance misuse: assessment and management in healthcare settings)
- looked after children
- people who move from adult to older adult mental health or social care services.

See also the NICE pathway on transition between community or care home and inpatient mental health settings.

8 Carer's needs assessment

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

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

Based on the carer's assessment:

- Advise the carer that they may be entitled to their own support. For example, using a personal budget to buy care or to have a break from their caring responsibilities.
- Give information and advice on how to access services in the community, for example respite or recreational activities or other support to improve their wellbeing.

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9 Services working in partnership

Work together to encourage people with coexisting severe mental illness and substance misuse to use services. Consider:

- using an agreed set of local policies and procedures that is regularly reviewed by key strategic partners
- working across traditional institutional boundaries
- being responsive to requests for advice and joint-working arrangements
- sharing the response to risk management.

Ensure joint strategic working arrangements are in place so that:

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

Consider including the needs of people with coexisting severe mental illness and substance misuse in other local needs assessment strategies, for example, on housing, employment projects, alcohol, drug services or crime prevention.

Agree joint care pathways to:

- Meet the health, social care or other support needs and preferences of people with coexisting severe mental illness and substance misuse, wherever they may present.
- Give people access to a range of primary healthcare and social care providers including GP practices, pharmacies, podiatrists, dentists, social workers, housing, housing support or benefit advisers.
- Ensure people have prompt access to local services (including direct referrals if possible).
- Ensure staff follow people up to make sure their needs are being met.
- Ensure continuity of care to support people at different transition points in their lives.

Ensure referral processes and care pathways within and across agencies are consistent and that governance arrangements are in place. This includes local care pathways to meet the physical health, social care, housing and support needs of people with coexisting severe mental illness and substance misuse.

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Information sharing

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

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

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

10 Service design

Adapting existing services

Ensure existing health and social care services (including substance misuse services) are adapted to engage with and meet the needs of people with coexisting severe mental illness and substance misuse.

Secondary care mental health services

Adapt existing specialist services to meet both a person's coexisting severe mental illness and substance misuse needs and their wider health and social care needs. Do not create a specialist 'dual diagnosis' service.

Offer interventions that aim to improve engagement with services, support harm reduction, change behaviour and prevent relapse. Take advice from substance misuse services (if applicable) about these interventions. (See the NICE pathways on coexisting severe mental illness and substance misuse: assessment and management in healthcare settings, psychosis and schizophrenia, bipolar disorder, self-harm, alcohol-use disorders and drug misuse.)

Offer individual, face-to-face or phone appointment sessions to encourage people with coexisting severe mental illness and substance misuse to use services. Offer phone sessions to their family or carers. Sessions could cover:

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- how the person is coping with their current mental health and substance use and its impact on their physical health and social care needs
- progress on current goals or changes to future goals
- ways to help the person stay safe
- monitoring symptoms
- getting support from (and for) their family, carers or providers.

Determine how often the sessions take place based on the person's needs.

Consider the following:

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

Making services inclusive

Ensure secondary care mental health services:

- Do not exclude people with severe mental illness because of their substance misuse
- Do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse
- Adopt a person-centred approach to reduce stigma and address any inequity to access to services people may face (see consent, capacity and treatment decisions and advance decisions and statements in the NICE pathway on coexisting severe mental illness and substance misuse: assessment and management in healthcare settings, and the NICE pathway on service user experience, for the principles of using a person-centred approach).
- Undertake a comprehensive assessment of the person's mental health and substance misuse needs (see also recognition in all settings and assessment in the NICE pathway on coexisting severe mental illness and substance misuse: assessment and management in healthcare settings).

Involve people with coexisting severe mental illness and substance misuse, their family or carers in improving the design and delivery of existing services (see care planning [See page 5], working with the person [See page 7] and carer's needs assessment [See page 10], in this

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pathway). This may include them providing training, developing interventions to help people or taking part in steering committees.

Provide local services in places that are easily accessible, safe and discreet. Bear in mind any perceived stigma involved in being seen to use the service. Consider flexible opening times, drop-in sessions, or meeting people in their preferred locations.

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

11 Support for staff

Raise staff awareness of the needs of people with coexisting severe mental illness and substance misuse, including the fact that they may be traumatised. Ensure they can meet those needs.

Ensure the care coordinator in secondary care mental health services is supervised and receives professional development to provide or coordinate flexible, personalised care.

Recognise that different attitudes towards, or knowledge of, mental health and drug- or alcohol-related problems may exist between agencies and that this may present a barrier to delivering services. To overcome this:

- challenge negative attitudes or preconceptions about working with people with coexisting severe mental illness and substance misuse
- develop leadership skills so staff can challenge attitudes and preconceptions (for example see Hughes L (2006) Closing the gap: a capability framework for working effectively with people with combined mental health and substance use problems (dual diagnosis), CCAWI, University of Lincoln and Care Services Improvement Programme, University of Lincoln, Lincoln).

Ensure practitioners have the resilience and tolerance to help people with coexisting severe mental illness and substance misuse through a relapse or crisis, so that they are not discharged before they are fully equipped to cope or excluded from services.

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12 NICE pathway on coexisting severe mental illness and substance misuse: assessment and management in healthcare settings

See Coexisting severe mental illness and substance misuse: assessment and management in healthcare settings

13 Patient and service user experience

NICE has produced pathways on:

- patient experience
- service user experience.

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Glossary

relapse

a recurrence or exacerbation of a person's mental health problems, a return to substance misuse, or both

severe mental illness

includes a clinical diagnosis of: schizophrenia, schizotypal and delusional disorders, or bipolar affective disorder, or severe depressive episodes with or without psychotic episodes

substance misuse

refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage; this may include low levels of substance use that would not usually be considered harmful or problematic, but may have a significant effect on the mental health of people with a mental illness such as psychosis

misuse substances

refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage; this may include low levels of substance use that would not usually be considered harmful or problematic, but may have a significant effect on the mental health of people with a mental illness such as psychosis

specialist services

refers to secondary care mental health services and dual diagnosis services

Sources

Coexisting severe mental illness and substance misuse: community health and social care services (2016) NICE guideline NG58

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider

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public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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Contact NICE

National Institute for Health and Care Excellence
Level 1A, City Tower
Piccadilly Plaza
Manchester
M1 4BT

www.nice.org.uk

nice@nice.org.uk

0845 003 7781

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