Mental Health and Substance Use – Identifying and considering the options for change

This document outlines and considers the key options available for supporting people with co-occurring mental health and substance use conditions. These options aren't mutually exclusive and could be used in combination either alongside each other for the same population or with different models used for different cohorts of need within the concurrent need population. The options described here provide the basis for local consideration and adaptation.

This is an excerpt from the fuller Mental Health and Substance Use Options Appraisal document that can be found on our website. There are also other documents in this series including

- Mental Health and Substance Use – Policy and data sheet
- Integration in the context of Mental Health and Substance Use services
- Mental Health and Substance Use – Outlining the methodology for an options appraisal.

The options described are:

Option 1	Do Nothing
Option 2	Advisory support model
Option 3	Single hub / shared decision-making model
Option 4	In-house provision of support, with links across services
Option 5	Third sector key working model
Options 6	Care Programme Approach
Option 7	Dual Diagnosis Team
Option 8	Integrated mental health and substance use teams.

Each of these options are described overleaf.

Key:

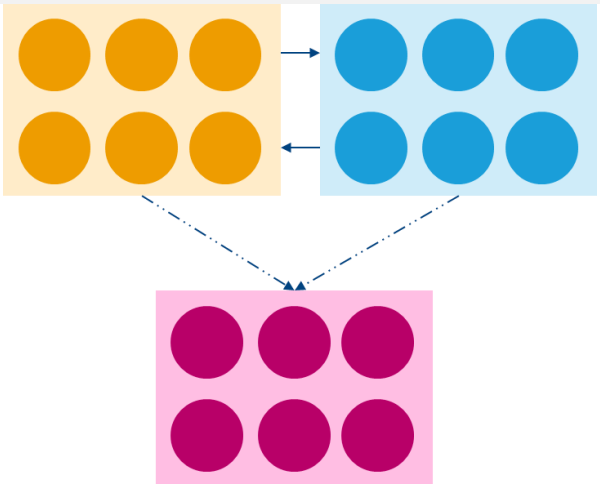
Secondary mental health services

Secondary substance use services

Third sector/additional services

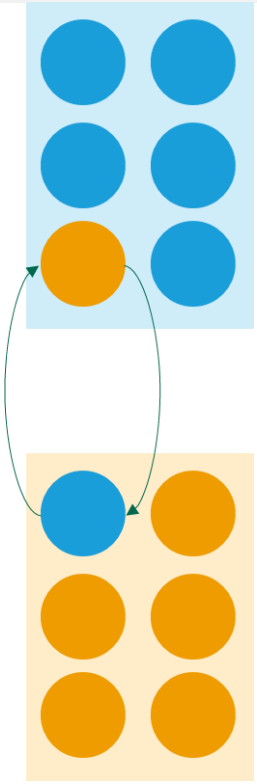
Option 1 Do nothing

Options appraisals need to compare new options against each other as well as the status quo (or 'do nothing differently' option). Below we have included a summary of what the status quo may look like. We recognise that many areas in Scotland will need to adapt the description below to reflect the local processes and features they currently have.

Description	Service outline	Core Features	Enhancements
There are multidisciplinary, but condition specific mental health and substance use services. These services do assessments and formulate care plans independently. Where a concurrent need is identified people are either signposted to direct access or community services or referred to another service. Care is delivered within individual services, with escalation routes to care programme approaches (see option 6) where there are multiple crises.		• Multidisciplinary teams in each individual service that could include professions like social workers and occupational therapists, who are able to make onward referrals to other services for needs in another area • Established roles and responsibilities with regards to assessment, treatment and support within mental health or substance use services • Clear information that enables signposting or referrals to third sector organisations for need that falls outwith the scope, or below the eligibility threshold, of the service	• Standardised referral forms that ensure adequate information is passed with the referral • Professional networks across services to help build understanding of the roles of different services to help assist appropriate signposting and referrals

Option 2 Advisory support model

This option is an advisory support model, where separate teams exist but with planned input into each other's services through the role of an 'advisor' from the other team.

Description	Service outline	Core Features	Enhancements
There are representatives from mental health services (home service) that attend key allocation meetings of substance use services as a way of informing decisions and being a link across services. There are representatives from substance use services (home service) that attend key allocation meetings of mental health services as a way of informing decisions and being a link across services. This does not mean that mental health services provide support for substance use or vice versa. Instead, it enables a more informed assessment of need that is used for onward signposting and referrals to other services.		• Case discussions that facilitate understanding where a case is appropriate to refer across services • Formal feedback mechanisms by advisor to their 'home service' to help them understand and respond to challenges in supporting concurrent need	• Processes to support the advisor to suggest/make links with third sector or primary care services for supporting mild-moderate needs across specialism • Capacity to allow the advisor to provide training and other upskilling activities to the other teams to better equip them to identify need

Quick summary

This model is a relatively low resource model that can contribute to evidence-based improvements to joint working. There are limitations to this model with regards to the depths of integration and the lack of formalised pathways to support co-occurring conditions outside of single statutory services.

Who this model supports

- This model is well placed to support people with high level need, concurrent with a mild to moderate need.
- It allows support staff to understand how to provide their specialist care in the context of co-occurring conditions.
- For example, in cases where a person has high level, but non-dependent stimulant use, along with bi-polar disorder, an addiction specialist can provide advice to the mental health staff regarding indicators of dependency or how stimulant use impacts behaviour.

Services and staff involved

- Statutory community mental health teams
- Statutory substance use services
- Clinical staff within the above - Community Psychiatric Nurses (CPNs) addiction Advanced Nurse Practitioners (ANPs).

What needs to be in place?

For the benefits of this model to be realised there needs to be a willingness to build relationships and networks, as there is no formal element to the relationship building outside of the structured interactions.

Strengths of the model

Fundamentally, this model is about providing advice to a single condition service to support that service to manage co-occurring mental health and substance use. The strengths of this model sit in the ability to support decision making around case allocation and formulation, and the secondary benefits of the emergent relationships and networks across services.

The model has been shown to reduce the number of rejected referrals and speed up the process of allocating a person to the right services. It supports dialogue between services regarding appropriate referrals, and where a referral is not deemed appropriate, there can be constructive discussion around where is the most appropriate place for support.

This model can help develop relationships across services, along with an understanding of different roles and responsibilities between services. We know that strong relationships between staff in different services, and the ability to get advice outside of formal escalation/referral processes, supports better treatment for people with co-occurring needs, and reduces the number of people falling between services.

Outside of specific case discussions, this model can help identify gaps within knowledge/training regarding co-occurring conditions and support the development of improvement plans to fill these gaps.

This model is not too resource intensive, only requiring additional staff time to attend allocation meetings.

Similarly, there are no additional training requirements and can be implemented rapidly with little wider sign-off/input above service manager level.

Limitations of the model

This model does not include any additional changes with regards to how people are supported concurrently or improve pathways between services. It is centred on how decisions are made within the current service landscape. There is minimal shift in the frame of integration, along with remaining within the medical model of service delivery.

Beyond the benefits of relationships and networks between staff in substance use and mental health services, there is no formal collaboration or clear guidance around jointly managing cases. Similarly, the scale of the relationships and networks across staff are small scale, suggesting limits to the benefits of the network effect.

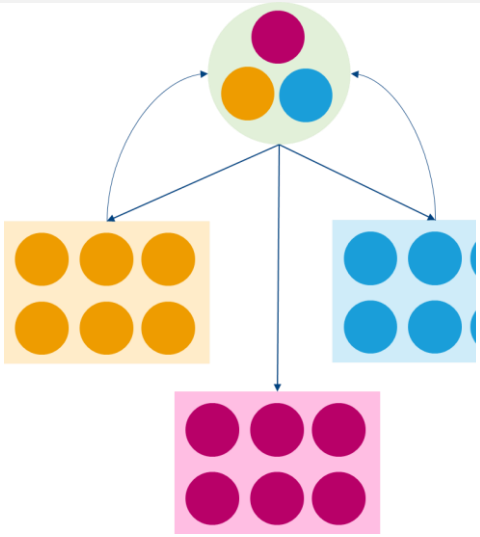
While there is potential benefit in understanding and discussing referrals with regards to access criteria, this model does not change the thresholds for access which remain an identified barrier to support for co-occurring conditions.

The evidence base of this model rests on a theory of change where there is clear evidence that good professional relationships can improve outcomes, and this model supports the building of relationships. However, where the model has been implemented, there is limited evidence to show how it translates into positive outcomes for people.

This model has low barriers with regards to implementation, however, on its own the model only partially meets Mental Health and Medication Assisted Treatment Standards.

Option 3 Single hub / shared decision-making model

Option 3 sees the creation of a separate hub meeting, made up of members from mental health services, substance use services, and the third sector, to jointly assess need and decide most appropriate services to provide care.

Description	Service outline	Core Features	Enhancements
There is a regular multi-agency meeting that includes staff from: • Community Mental Health services • Drug and Alcohol Recovery services • Third sector services Incoming referrals are discussed and allocated to appropriate services. This allows for a 'no rejected referrals' approach whereby if a person is deemed inappropriate for the service they presented at, their situation will be discussed and passed to the appropriate service. It is also a space where staff can bring cases where needs might have changed and require additional input. This doesn't include the provision of fully integrated care between multiple services but is able to facilitate services to communicate in a way that highlights changes in individuals' needs and provide care in a way that is cognisant of other services a person might be receiving.		• Referral to the hub can come via GPs, Advanced Nurse Practitioners, Practice Nurses, Minor Illness or Injury Units (MIIU), other agencies or third sector. • Option to invite additional services into the hub such as housing where deemed important • Commissioned, case holding third sector services equipped to provide psycho-social interventions and key working support are involved	• Development of shared care agreements that note how services will work together to support a person. • Co-location of services • Agreed, single holistic assessment – with agreed responsibilities for collecting information • Links with urgent/unplanned care pathways with regards to discharge • Shared electronic system for notes – or access across systems

Quick summary

This model supports horizontal integration within decision making across a range of services. It also supports a 'networking' effect between services that improves support for people with co-occurring needs.

However, service delivery remains separate and potentially decreases the impetus for services to develop 'in-house' support for co-occurring needs.

Who this model supports

This model is focussed on access and is likely to benefit a wide range of people with regards to getting the right support.

This model is particularly impactful where there are a high rate of rejected referrals because of people not meeting thresholds, and having to be re-referred to another service.

Services and staff involved

- Statutory community mental health teams
- Statutory substance use services
- Case holding third sector services

What needs to be in place?

The multi-agency hub approach needs to be centred on good relationships and a shared understanding of how services need to collaborate around co-occurring conditions. There is a risk that these meetings become a focal point for gatekeeping services.

To realise some of the key benefits there needs to be a well-developed 'case holding' third sector service that can provide key working for people and delivers social support around building confidence and connections, alongside more therapeutic interventions linked to CBT, counselling and motivational interviewing.

Strengths of the model

This model sits within the 'network' frame of integration that supports integrated decision making. At the centre is a multi-agency allocation meeting to discuss case allocation across mental health and substance use services, along with third sector services. A significant strength of this model is in reducing the number of rejected referrals and people falling through gaps. Where it has been implemented in Angus there has been a reduction of rejected referrals to zero for the 3080 referrals received across two hubs between 2023/24. It supports dialogue between services regarding appropriate referrals, and where a referral is not deemed appropriate, there can be constructive discussion around where is the most appropriate place for support.

Linked to this is faster access to services due to referrals not 'bouncing between' services until a decision is reached. This includes better access to third sector services, as they are involved in the conversations and can have an immediate input to how they can help a particular individual alongside statutory services. It also supports better pathways from third sector services into statutory services. In addition to providing a more direct pathway into statutory services from third sector, as third sector services can identify individuals for discussion. In this way, person centred care, and engaging with complex needs is embedded within this model. This model also allows for more proactive informing of people about what is happening with their care, as there is a clear communication process built into it.

Having a multi-agency hub/meeting allows for a more person-centred approach to case allocation, with the inclusion of third sector services also help change the conversation to include psychosocial interventions. Conversations within a multi-agency hub also support transitions between services, whereby previously discussed individuals can have their support discussed again when there is a change, with a focus on what service is best suited to a changed need. This can result in transitions being more planned and seamless, where the receiving service has a more comprehensive understanding of an individual's journey to date.

As with Option Two, this model allows for the development of inter-professional relationships and networks. However, it expands this by including third sector services.

This model requires relatively little additional time or financial investment. As all inward referrals are discussed, this simply transfers the time investment from single service conversations into a multi-agency conversation. Additional investment may be required to provide administrative support for arranging the meetings and travel time.

Ideally, this model would be supported by a single electronic record, accessible by all involved. However, the areas this has been implemented have done so without this. Instead, they use simple information sharing agreements and are able to highlight and share significant information to aid decision making.

Where this model is established, it has been used as evidence for meeting MAT criteria with regards to ensuring access to psychosocial interventions and mental health services.

Option 3 Single hub / shared decision-making model

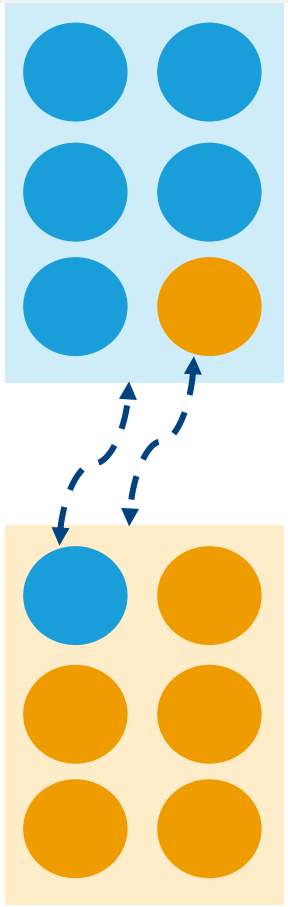
Limitations of the model

This model remains centred on joint decision making and allocation. It does not extend to collaborative service delivery. While there is opportunity to bring a particular case back to the multi-agency discussion, there is no follow-on process for the development of joint/shared care plans. Unlike the Care Programme Approach (Option Six), there is not always an agreed joint treatment plan. Consequently, interventions are still delivered separately. In this respect, there is no formal integration within the organisational frame, and limited integration within the service delivery frame.

Within the context of the 'Four Quadrant model', there potentially remains gaps for people with moderate needs concurrent with higher needs, where thresholds are unclear. Mild to moderate needs can be supported within the third sector in this model, however, the model does not directly address the gaps in service provision whereby single services need to be equipped to support and provide interventions for mild-moderate needs alongside specialist interventions.

Option 4 In-house provision of support, with links across services

This option is similar to the advisory support model but sees direct delivery of support from mental health specialists within substance use teams and vice versa. It enables someone to receive integrated care within each of the two services.

Description	Service outline	Core Features	Enhancements
Having mental health specialists within substance use services to provide targeted mental health support, providing advice and upskilling support to substance use staff. Having substance use specialists within mental health services to provide targeted mental health support, providing advice and upskilling support to mental health staff.		• Agreed screening to allocate between core service and additional specialist support (or further pathways built on top of these core features) • Agreed interventions and support to be provided by the additional specialist support • Regular review points • Clinical supervision across services • Agreed training plan for specialist support • Protected time to provide reflective practice and internal capacity building activities	• Third sector liaison within the team • Capability for direct referral into the other team

Quick summary

This model includes clinical integration through the role of specialists across services that act as a bridge, receiving clinical supervision from their professional specialism while being managed within a different service. Within this model, there is integration at a more organisational level, including funding, reporting and organisational goals.

It requires a high level of cultural readiness to be effective, along with changes to funding. It also risks establishing a siloed role within services, who may become perceived to be a 'co-occurring conditions specialist' within the team.

Services and staff involved

- Statutory community mental health teams and substance use teams
- Staff within these teams providing direct support
- Staff in a clinical supervision role
- Key referrers and those assessing referrals

Who this model supports

- High impact model for people with high level needs, concurrent with a moderate need.
- This model supports people with fluctuating needs or those at risk of an escalated need.
- There is particular benefit for people in mental health services with an increased risk of drug dependency.

What needs to be in place?

A well-established understanding across all services regarding the roles and responsibilities in supporting co-occurring mental health and substance use. This includes roles and responsibilities in specific treatments and interventions for different levels of need, and an understanding of how these are delivered alongside other support for co-occurring need. This will involve agreeing thresholds for treatment and support across services.

The third sector are not explicitly outlined as part of this model, but where it is working in Nottingham there are embedded third sector workers who offer person-centred support, along with signposting.

Agreed assessments and trusted referrers that allow for assessments done in one service to be accepted by another without having to reassess or screen.

The ability to integrate funding at a service level is required to underpin the financial structures to employ mental health specialists in substance use services, while funding line management responsibilities within the mental health team, and vis versa.

Similarly, integrated reporting mechanisms will be required to ensure that the benefits of the model are represented as benefits across both services.

Strengths of the model

Individuals have a greater level of choice within this model as they can be supported in either mental health or substance use services, and able to receive support for co-occurring needs up to a high level of need within a single service. For example, it is often the case that people do not want to be treated within substance use services due to the associated stigma, within this model an individual can be treated within mental health services for substance use up to a high level.

Continuity of care and smooth transitions are supported by the integrated nature of this model that allows for direct referrals and immediate access to an additional specialist. Having clinical staff from another specialism within the team (e.g. clinical substance use staff within the mental health team) allows for planned transitions for people into higher tier services, as the substance use specialist can refer from the mental health team into the substance use team or acute mental health services. This provides 'diagonal integration' in supporting co-occurring conditions. This is also the case where individuals are transitioning away from services, this model can provide a 'step down' service where one of the conditions has de-escalated but is still requiring some input.

It is important to note that while other models might have the provision for such transitions, the defining feature of this model is that there is more of a collaborative approach where service silos are bridged by clinical relationships, supporting trust and positive communication; enabled by agreed assessment tools and decision support.

Interprofessional networks are shown to improve quality of care for people with co-occurring mental health and substance use, within this model (in contrast to the above) these networks are formalised within the model. One area this model is being implemented, the additional specialist has it written into their job plan to conduct training and staff development activities.

Limitations of the model

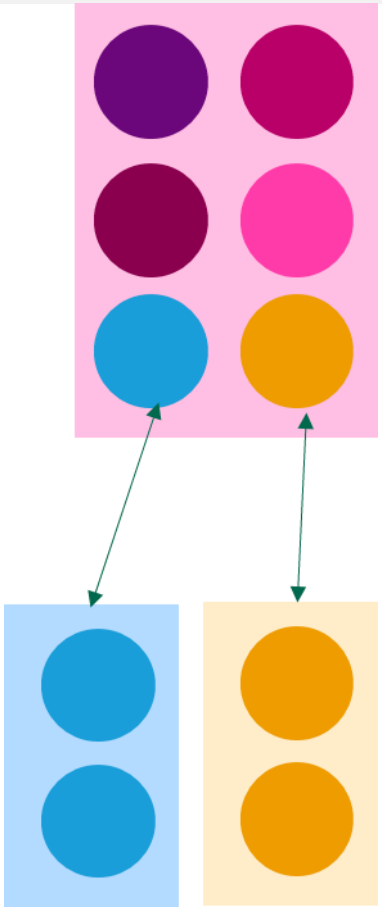
There is a risk that all individuals with co-occurring conditions are assigned to the professional with the additional expertise. If this occurs, it will likely reduce instances of true collaboration and create a silo within the service itself. The aim of this model is not to create a 'co-occurring conditions' specialist role but to embed additional expertise within a service to allow for the skills mix to support people with co-occurring needs and to facilitate links to other services.

Due to the high level of integration, this model requires significant investment to establish, including cultural change activities and training.

Option 5 Third sector key working model

This model sees a third sector organisation act as the case holder in the care for people needing both mental health and substance use support.

Description	Service outline	Core Features	Enhancements

A third sector organisation that supports both mental health and substance use needs is the central key working/case holding organisation that coordinates care, with clear escalation pathways into secondary care services (without discharging them).
 	
This organisation builds relationship across social and community services, as well as in-house capacity to provide specialised support – in collaboration with statutory services providing short- or medium-term clinical interventions where required.
		• Third sector keyworker to:
		  • Help set realistic and achievable goals – including non-medical outcomes
		  • Develop an integrated package of care and support – that blends high level therapeutic interventions with social/emotional support
		  • Promote the client's independence & empowerment
		• Can be accessed through drop-in services in the community
		• Agreed 'referrer' status for third sector staff into secondary services which provides direct referral pathways into secondary care from the third sector organisation
		• Service level agreements allowing for information sharing
		• Agreed thresholds for involvement in secondary services
		• 'No discharge' policies within secondary care to allow for flexibility around re-accessing services – secondary care does not discharge individuals who are supported by the third sector organisation to enable easier access to secondary care as the need arises
		• Third sector access to EMIS and DAISy data recording systems to utilise and input into relevant data systems
		• Collective reporting requirements across all parties.
			• Integration of all primary care mental health/substance use functions outside of GP practices
			• Prescribing functions within the third sector
			• Inclusion of peer support workers

Quick summary

This approach emphasises the person-centred and the social model of care by centring care coordination within community based, third sector services. It can support significant horizontal integration and provide a shift away from a medical model, enabling seamless care for complex needs.

There are limitations with regards to vertical integration, access to higher tier services, as these are not included within the model, meaning that gaps will likely remain.

Who this model supports

This model best supports people with complex needs (e.g. have significant additional needs beyond mental health and substance use). Along with people who are no longer in active addiction and, looking at moving into recovery and sustainable community transition.

People in this situation may require periods of more high intensity treatment through their recovery journey. This model supports the re-engagement of higher-tier services to be brought into a circle of care when required; while retaining continuity of care within communities.

Services and staff involved

- Third sector support workers who support caseloads of people
- Third sector staff who work in ‘drop-in’ type services such as Recovery Cafes
- Duty workers within statutory services
- MDTs within statutory mental health and substance use services

What needs to be in place?

Due to the highly integrated and flexible nature of this model, there needs to be agreed and well understood roles and responsibilities across all services. Along with agreed assessment criteria and trust in the assessments from other organisations. This includes clear guidance and support for professionals around when to engage other services, facilitated through strong professional networks.

It will also be essential for third sector services to have access to electronic systems such as EMIS and DAISy.

Integrated reporting mechanisms will be required to ensure that the benefits of the model are represented as benefits across both services.

Strengths of the model

This model centres on community-based support, providing coordination and collaboration to support psychosocial, person-centred care, utilising clinical services where required. There is coordination across the whole system, meaning that integration occurs at both a service and funding level. This allows for a more holistic approach to supporting people and emphasises both prevention and longer-term recovery.

Through having third sector services act as keyworkers, this model has the potential to provide a higher level of wrap-around support designed to meet the needs of the patient, with less expectation that the individual navigate complex services with exclusionary criteria.

There is a move away from the medical model and towards a social and 'life-course' model whereby clinical services are engaged and re-engaged with as one element of wider support, when required. Similarly, having no discharge policies has the potential to limit the impact of transitions between services (e.g. waiting times associated with re-accessing services).

Evidence does suggest better outcomes where statutory and non-statutory services collaborate around treatment; there is also evidence around the importance of care navigation across both third sector organisations; and third-stat sector interfaces, which this model will enable.

Given that third sector providers are the case holders and are the primary care/support providers, this model has the potential to reduce staffing pressures in statutory services and supports more frequent points of contact with people which can support prevention.

Limitations of the model

There is no explicit vertical integration into acute services or with physical health, outside of those already established (which are often limited for co-occurring conditions) within this model. Therefore, additional work would be required to establish pathways across clinical services to ensure there is ongoing collaboration linked to co-occurring mental health needs within the medical frame.

There will potentially be a high investment cost linked to commissioning processes for any new services. This might include work to understand what services will be required, bringing together services to discuss and agree service specifications, and engaging around the new model. There may be costs associated with extra management support for implementing changes, ongoing training and any additional staff required.

Option 6 Care Programme Approach

This option is a specific model provided for within a legislative framework, led by psychiatry with an MDT put together to support the individual following a joint needs assessment.

Description	Service outline	Core Features	Enhancements
The Care Programme Approach (CPA) is a legislative framework used to assess and support individuals with mental health and substance use issues. A psychiatry led intervention that can be used to support people who have had multiple crises. A holistic, multi-agency assessment is carried out to identify the range of needs a person has. An MDT is then convened to agree a care plan, detailing responsibilities within the team.		• A care co-ordinator whose role includes keeping in touch with the service user and monitoring arrangements • A regular review (at least every 6 months), making changes as necessary. This may be more frequent, depending on an individual circumstances, eg whether in-patient or out-patient	• Clear and agreed transition for people out of the care programme approach, that retains much of the collaboration across services

Quick summary

This model provides collaboration around specific cases, with integrated assessment and delivery of care across different services. It is a clinically led model and includes an explicit care-coordination role.

It is aimed at people with high level needs across mental health and substance use and have experienced multiple crises. Therefore, is limited in terms of being considered a comprehensive model for supporting co-occurring conditions.

Services and staff involved

- Assigned care co-ordinator
- Mental Health representative
- Substance use representative
- Social Work
- Criminal Justice Social Work Service.

Who this model supports

- This model is used to support people with high level of need across mental health and substance use and can include other teams that can support psychosocial needs.
- It is often used when people experience multiple crises.
- There is also an ‘Enhanced CPA’ which supports ‘Restricted Patients’.

What needs to be in place?

There requires a high level of coordination of services/professionals at a locality level.

At a professional practice level, those involved need to have a high level of understanding around the roles and responsibilities of supporting people with co-occurring conditions.

The model is centred on joint decision making and agreement of care plans, however, for these to be successful, there needs to be a high level of collaborative practice across services. This includes strong communication and relationships. This model does not, like the others, involve ongoing collaboration and explicit bringing together of services (outside of specific cases) and therefore the cultural/relational element will need to be already there for this approach to be effective.

Strengths of the model

This is a legalistic framework that includes clear outlines and processes required to deliver. It is also something that professionals are familiar with, therefore, within this model broad roles and responsibilities are clearly understood, with case specific roles and responsibilities agreed collaboratively.

As a psychiatry led approach, this model provides integration within the clinical frame along with service delivery. Such integration is the foundation for integrated packages of care that are agreed and monitored, based on a systematic assessment of health and social care needs by a range of professionals. This facilitates delivery of support for co-occurring needs that is collaborative across services, with clear identification of where mental ill health and substance use intersect in a problematic way and the formulation of support that can directly address this.

The role of the care coordinator supports continuity of care and reduces the burden on individuals and their loved ones to follow up with services regarding support. Further to this, they can monitor the arrangements to ensure adherence to the plan. There are also regular reviews where changes can be made as appropriate.

There is clear process for information sharing that is backed by supportive legislation that requires all services involved in the care of an individual should have shared access to relevant documentation, so in this model there is a higher threshold for data sharing and information governance than previously discussed models.

Limitations of the model

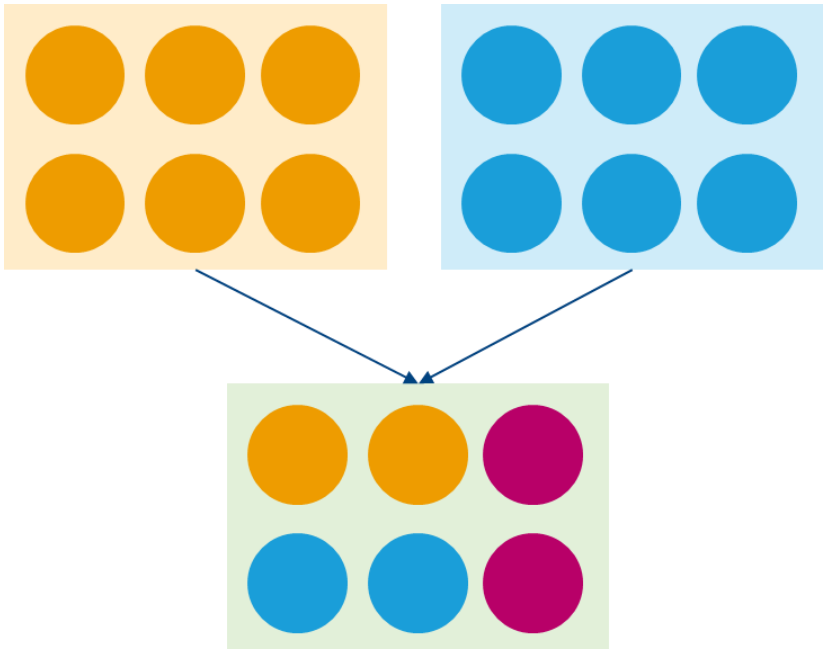
The Care Programme Approach is a reactive model put in place where there has been multiple crises. Therefore, mostly covers people with high threshold needs. This can result in people with significant co-occurring needs not meeting the thresholds for the CPA approach due to not meeting the criteria, having undiagnosed conditions or experiencing crises that are brought on by social/non-clinical stressors.

There are two levels of CPA, a standard and ‘enhanced’ CPA for more severe cases. Evidence from reviews of CPA usage show that individuals on a standard CPA are often deprioritised at times of increased service pressure, resulting in them not being seen as regularly as they should and breakdowns in care co-ordination. Similarly, there are significant challenges regarding co-ordinating care between different agencies that cause delays.

The role of psychiatry in leading this approach can disincentivise its use due to low capacity within psychiatry or the perceived high resource involved in convening the required professionals.

Option 7 Dual Diagnosis Team

This option relates to the creation of a specific team that provides care for people with concurrent mental health and substance use support need, providing integrated secondary care for those individuals, and often bringing together statutory and third sector organisations and services.

Description	Service outline	Core Features	Enhancements
An integrated team that has a specific caseload of people with concurrent mental ill health and substance use. The team offers assessment and treatment for co-occurring mental health and substance misuse.		• Team includes nurse consultant, recovery worker, specialist dual diagnosis worker, peer mentor and link worker. • Mechanism for identifying concurrent cases. • Communication pathways with core services, including sharing care plans.	• Relationships with commissioned third sector organisations providing longer term, intensive support as an alternative to going back into core services.

Quick summary

This model establishes a dedicated co-occurring conditions team that delivers integrated care and allows for a dynamic, flexible response.

It remains with the medical model, focused on statutory services. And the development of a separate service may exacerbate existing siloed working, or great new gaps.

Who this model supports

This model supports people across the Four Quadrants. With benefits for those with high level mental health and substance use needs, as they will have access to both clinical specialists within the same service.

Services and staff involved

- Psychiatrist with mental health and substance use specialism
- CPNs and ANPs
- Mental health and addiction social work staff

What needs to be in place?

To mitigate some of the risks, there will need to be robust and agreed identification mechanisms for people with co-occurring conditions who require the service. These will need to be established across a range of services to ensure quick access (rather than using the new service as simply escalation from mental health or substance use services).

Strengths of the model

This model brings together a specialist clinical team to support co-occurring conditions, providing integrated services at a clinical and service delivery level, and requires integrated funding.

A dedicated co-occurring conditions team can provide collaborative assessment and formulation, with a joint care plan that addresses how mental ill health and substance use need to be seen together.

Joint delivery of services within a dedicated team also enables joint delivery of care, supporting flexibility and continuity. Vertical integration is enabled through this model as there are escalation routes from both mental health and substance use specialists, though it is not explicit.

From a workforce development point of view, having a dedicated team for co-occurring conditions builds specific expertise, that is embedded through ongoing practice, reflection and coaching. Similarly, it can reduce or simplify training approaches as there is a specific team to focus on, rather than looking at the whole workforce and developing multi-tiered approaches within separate services. Additionally, having staff within a single service facilitates the formalisation of cross-specialism professional networks and learning.

There are also benefits of having a dedicated team with regards to building pathways across services, insofar as connections and relationships with other parts of the system such as acute care can be established with just one service, rather than having to negotiate and develop processes for multiple services.

This model ensures joint consideration of mental health and substance use at a planning level through the requirement to merge resources, including staff, into a new service.

Limitations of the model

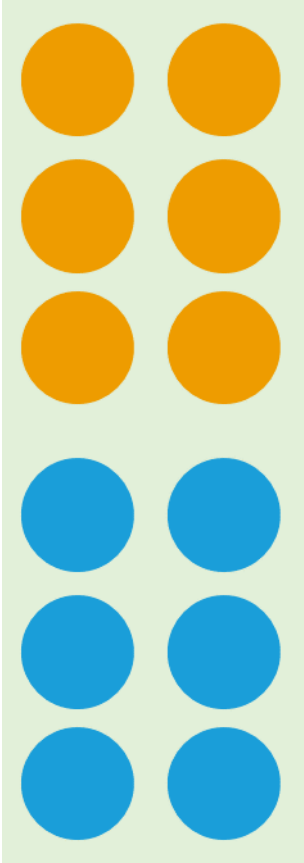
With this model the challenge of thresholds remain with regards to setting the threshold for referral to the dedicated team, and how individuals are managed where there is uncertainty or disagreement about whether a person meets a threshold, or even where their condition fluctuates across a threshold. Alternatively, there is a risk that caseloads are unmanageable as all individuals with any level of mental health and substance use need are referred to the dedicated team. There is a requirement for mental health and substance use services to provide a certain level of support for people with co-occurring conditions.

The Way Ahead: rapid review specifically notes that "We would not favour separate Dual Diagnosis teams in Scotland, and we have knowledge of such a team failing in one of our major cities. Our evidence from the literature review suggests there are other effective ways to improve services in keeping with the "Everybody's Job" and "No Wrong Door" principles."

With regards to system investment, there is a potential barrier linked to the perceived removal of resources away from separate mental health and substance use services to form the dedicated dual diagnosis team (the team includes nurse consultant, recovery worker, specialist dual diagnosis worker, peer mentor and link worker).

Option 8 Integrated mental health and substance use teams

This option sees full integration of mental health and substance use services who can provide just mental health support, just substance use support, or concurrent support depending on individual need.

Description	Service outline	Core Features	Enhancements
Integration of all secondary mental health and substance use services. All referrals into the integrated team are discussed by both mental health and substance use specialists. Assessment and formulation is done by an appropriate professional, with input from other staff where required. Treatment is provided in a flexible way across the MDT, who are able to respond to changes in mental health and substance use needs.		• Single point of access to mental health and substance use services • Agreed assessment tools that cover a range of clinical needs	• Involvement of third sector staff and peer workers within the team

Quick summary

This model of integrated care sees mental health and substance use professionals formulating care plans together, with interventions delivered collaboratively. It allows for a wide spectrum of needs to be met within a single service.

This model is centred on statutory services and helps close gaps in secondary services, but challenges around access and coordination across community services that can support longer term recovery are not addressed.

Who this model supports

This model supports people across the Four Quadrants. With benefits for those with high level mental health and substance use needs, as they will have access to both clinical specialists within the same service.

There is additional benefit within this model to support people who meet the threshold for either mental health or substance use services, to be able access support across the whole integrated team.

Services and staff involved

- All clinical, administrative and support staff from Community Mental Health Teams and Substance Use Services.

What needs to be in place?

Due to the high level of change, there would need to be very strong and explicit leadership from the IJB and Health Board to ensure that there was a co-ordinated programme of improvement. This would include clinical leadership that is aligned on the approach, with a shared understanding of the benefits of an integrated team.

Strengths of the model

This model brings together secondary mental health and substance use services into a single team. It can be described as a 'comprehensive' model with reference to senior clinicians, training/supervision and additional MDT members being required to be established from the perspective of co-occurring conditions. This model has many of the strengths as the above with regards to joint assessment, formulation and delivery. However, there is the additional benefit of having access to the full spectrum of support within the same service – i.e. the skills mix across the whole team can support people with all level and dynamics of need (within the context of statutory services).

While there are significant implementation challenges within this model, one benefit is the continuation of legacy pathways across the whole system (especially vertically integrated pathways), being able to be used across both mental health and substance use services. This will facilitate access for people with co-occurring conditions as someone being support primarily for substance use, can utilise community mental health team escalation pathways once services have integrated.

Culturally, this model will facilitate the development of a shared language and approach for supporting people with co-occurring mental health and substance use conditions.

Limitations of the model

This approach remains within the medical model of care, focusing on statutory services that provide clinical interventions for co-occurring conditions.

This model represents a significant service change that may require a period of engagement and feedback. Within the context of constrained resources at all levels, and high demand for changes this represents a limitation. From a structural and technical perspective there would need to be new clinical governance and staff management structures, along with bringing together the electronic systems from both services.

From a cultural and change management perspective there would need to be investment in developing an integrated team culture and dynamics. Along with establishing and embedding collaborative processes as there is a risk that despite new governance, staff replicate previous dynamics of siloed, condition specific working.

References

The findings in this paper have been developed from a combination of the below references, along with the experience and insights developed as part of the Mental Health and Substance Use: Improving Our Response programme.

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Examples of existing co-occurring national mental health and substance use guidelines or guidance

Author(s)	Year	Title/link	Type	Setting
NICE	2022	Integrated health and social care for people experiencing homelessness	NICE Clinical Guideline	UK
Scottish Government	2021	Medication-assisted Treatment (MAT) standards	Standards	Scotland
Turning Point	2021	The SUMH Resource Pack Working with people with coexisting Substance Use & Mental Health (SUMH) issues A good practice guide for practitioners	Guidance	UK
Substance Abuse and Mental Health Services Administration	2020	Substance Use Disorder Treatment for People With Co-Occurring Disorders: Updated 2020 [Internet].	Treatment Improvement Protocol	USA
NICE	2019	Coexisting severe mental illness and substance misuse	NICE Quality Standard	UK
Public Health England	2017	Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers	Guidance	UK (England)
Clinical Guidelines on Drug Misuse and Dependence	2017 (update)	Drug misuse and dependence UK guidelines on clinical management p.73	Guidance	UK

Author(s)	Year	Title/link	Type	Setting
Independent Expert Working Group				
NICE	2016	Coexisting severe mental illness and substance misuse: community health and social care services	NICE Clinical Guideline	UK (England & Wales)
Welsh Government	2015	Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem	Guidance	UK (Wales)
Public Health England	2015	Service user involvement: A guide for drug and alcohol commissioners, providers and service users	Guidance	UK
NICE	2011	Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings	NICE Clinical Guideline	UK (England & Wales)
Institute of Medicine	2006	Coordinating Care for Better Mental, Substance-Use, and General Health – Improving the Quality of Health Care for Mental and Substance-Use Conditions – NCBI Bookshelf (nih.gov)	Quality Report	USA
Department of Health	2002	Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide	Guidance	UK

Examples of Overviews/Reviews/Reports

Author(s)	Year	Title/link	Type	Setting
Scottish Government (Social Research)	2022	Co-Occurring Substance Use and Mental Health concerns in Scotland - A review of the literature and evidence	Rapid Review	UK
Northern Ireland Assembly Research and Information Service	2021	Mental ill health and substance misuse: Dual Diagnosis	Narrative overview of relevant literature	UK (NI focus)
Wiktorowicz and colleagues	2019	Models of Concurrent Disorder Service: Policy, Coordination, and Access to Care – PubMed (nih.gov)	Scoping Review	Canada
Yule and Kelly	2019	Integrating Treatment for Co-Occurring Mental Health Conditions (nih.gov)	Narrative overview of	USA

Author(s)	Year	Title/link	Type	Setting
			relevant literature	
All Party Parliamentary Group for Complex Needs	2018	People powered recovery (Report researched by Turning Point, which provides secretariat to the APPG for Complex Needs)	Report	UK
Canadian Executive Council on Addictions	2008	On the Integration of Mental Health and Substance Use Services and Systems – Summary Report	Analysis identifying key facilitating factors, challenges and other issues relevant to integration discussions or processes	Canada

Examples of UK initiatives

Author(s)	Year	Title	Notes	Setting
Nottingham City Place-based Partnership	2022	Changing futures- information about programme focused on people with complex needs related to at least 3 of the following: homelessness, substance use, mental ill health, contact with criminal justice and domestic abuse. Team includes Lived Experience Ambassadors and paid Peer Mentors.	November 2023 interim report outlines recommendations for frontline delivery and for system change	England
South London and Maudsley NHS Foundation Trust	2019	Improving care for older people with co-existing mental disorders and alcohol misuse	Details a 10 year project to improve care drawing on upon 3 NICE advice products: 1) Alcohol Use Disorders: Prevention (PH24) guidance 2) Coexisting severe mental illness and substance misuse: community health and social care services (NG58) Guidance 3) Alcohol-use disorders: diagnosis and management (QS11) Quality Standard.	England