Mental health and substance misuse

On behalf of the
Recovery Partnership

Definitions

Substance misuse

Substance misuse indicates consumption of psychoactive and intoxicant substances, legal and illegal, at a level which is harmful and/or problematic. This is used in preference to dependence or dependent, which would exclude problematic use where no physical or psychological dependence has occurred, and addiction, which many people feel to be stigmatising and pejorative. Where dependence is used, it should be taken to mean precisely that.

Coexisting mental ill health and substance misuse disorder - dual diagnosis

The terms multiple needs and comorbidity are used to indicate coexisting conditions of substance use combined with mental health problems; a co-morbidity that may describe the majority of people in treatment for drug and/or alcohol use and a significant minority of people accessing statutory mental health services. This condition of coexisting needs is often referred to as 'dual diagnosis'.

While this broad definition is sufficient for the purpose of this briefing, the Department of Health offers a more nuanced definition, which is considered in this briefing.

Recovery

In the context of substance use, the term recovery indicates the sense in which that term is used in the 2010 Drug Strategy: that it is an individual, person-centred journey and that it is a process

rather than an end state. As such, the intention is that the use of the term recovery is not indicative of any particular approach, such as medically assisted recovery or abstinence based treatment.

Concepts of recovery, including differences and similarities between the fields of mental health and substance use are discussed in more detail elsewhere in this briefing.

Dual diagnosis

The particular focus of this report is on the intersection and relationship between coexisting mental ill health and substance misuse. In 2001-2, the Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study team conducted a cross-sectional prevalence survey in 4 urban locations: the London boroughs of Brent and Hammersmith & Fulham, plus inner-city locations in Nottingham and Sheffield.

Their findings suggest that comorbidity or dual diagnosis is extensive across all the services included in this research: Community Mental Health Teams (CMHTs) and (statutory) drug services and alcohol services, where comorbidity is essentially the norm. The findings included the discovery that:

- For clients of drug services, 75% had experienced a psychiatric disorder in the last year;
- For clients of alcohol services, 85% had experienced a psychiatric disorder in the last year;

- For clients of CMHTs, 44% had experienced problem drug use and/or harmful alcohol use in the past year;

- Of clients of drug and alcohol services with comorbidity, 22.4% reported contact with psychiatric services.

Clients of London CMHTs were more likely than those elsewhere to use drugs; this was statistically significant and was attributed by the researchers to the higher general prevalence of substance use in London. There was no significant difference in respect of alcohol, although in total, over half of the CMHT patients in London had used substances harmfully or problematically in the past year.

The researchers found that for many of the CMHT patients, there was limited prospect of successful referral to a drug (rather than an alcohol) service, although it should be noted that this was under the prevailing access criteria of the time and would in most cases not apply if the exercise was repeated today.

This illustrates the point in the opening quote in this report; that when such a large proportion of a service's clients present with complex needs, thinking about meeting those needs through something additional or bolted on to the core service offer is unlikely to meet the needs of all clients and patients.

While the understanding of dual diagnosis as diagnoses of substance use and mental ill health coexisting simultaneously is widely understood, the Department of Health (with the Ministry of

Justice) provides a more nuanced typology of four definitions, all meeting the criteria of dual diagnosis:

- **A primary mental health problem that provokes the use of substances.** For example, someone suffering from schizophrenia who finds that heroin reduces some of his or her symptoms;

- **Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.** For example, the emergence of depression post-detoxification including insomnia and low mood, or the emergence of a psychiatric disorder that to which the individual was vulnerable pre-substance misuse;

- **A psychiatric problem that is worsened by substance misuse.** For example, a person with heightened anxiety of danger from others, who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation;

- **Substance misuse and mental health problems that do not appear to be related to one another.** For example, someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug and/or alcohol use.[1]

However, it should be noted that the term 'dual diagnosis' may bring additional problems alongside ones of definition. The term arguably further stigmatises a cohort already subject to

significant levels of discrimination and there is also the technical but important point that many people that practitioners might describe the term applying to will, in fact, not have had any formal diagnosis.[2]

Introduction

The issue of complex needs and how to best meet the challenges posed arguably falls into the definition of a 'wicked' problem. Wicked problems occur in situations where information is incomplete, where there are multiple actors who may have contradictory or incompatible attitudes or needs and when non-linear, holistic and 'big picture' solutions may be required.

"People with a dual diagnosis are, in effect, a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can fall just below the threshold of all "helping" services."

Psychiatrist, quoted in Turning Point/Rethink toolkit

"When 80% of your clients have complex needs, talking about having dual diagnosis workers is the wrong way round."

DrugScope/Recovery Partnership Mental Health Summit participant

However, while it is often more useful to think in terms of better or worse responses rather than right or wrong ones, wicked problems are not irresolvable problems. Innovation, flexibility, a commitment to continuous review and a willingness to work across organisational boundaries can all contribute to overcoming even the most significant obstacles.

This briefing has several aims. These include:

- To outline the prevalence of dual diagnosis and multiple needs within the subject population and some of the consequences and causes of this;

- To provide an overview of where progress has been made and where it has fallen short;

- To consider the role of mental health services and substance use services as part of a network of potential and actual support providers;

- To give consideration to dual diagnosis and complex needs as one factor in a system of often self-reinforcing exclusions and characteristics;

- To consider four areas where there is either clear potential for progress or else potential for retrograde developments, focussing on the 2002 Dual Diagnosis Guidelines and the proposed review; complex needs and offending, complex needs and young people, and how people with histories affected by complex needs can build a better life for themselves;

- To offer a limited number of practical recommendations for services as well as for central and local government.

The national policy context and environment

2002 - Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide

The first national guidance concerning the treatment of people affected by dual diagnosis was produced by the Department of Health in 2002.[3] The guidance summarises (then) current policies and emerging good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse.

Written primarily from the perspective of integrating treatment for those affected by severe and enduring mental health problems within a mental health setting, it also provided more general guidance for the design and delivery of services for people affected by coexisting substance misuse and mental ill health elsewhere on the spectrum of need.

The guidance states unambiguously that:

> *Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care.* ***This should be delivered within mental health services.*** *[Emphasis in original]. This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance*

misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively.

The guidelines go on to stipulate a number of conditions that should be satisfied to enable effective implementation, including services developing a clear and shared understanding of dual diagnosis and level of local need and the availability of suitably skilled and equipped staff, including staff in assertive outreach, crisis resolution, early intervention, community mental health teams and inpatient services.

The guidance illustrates, with examples, the three main models of services for people with coexisting substance use and mental ill health described in the literature:

- Serial (or sequential): where treatment is provided first for one condition and then the other. For example, this might mean mental health services requiring the client's substance misuse to be stabilised or eliminated entirely before treatment for mental ill health commences.

- Parallel: the concurrent but separate treatment of both conditions. This may require the client to attend two locations, although liaison or colocation offer ways in which this can be reduced and workforce skills be disseminated. This offers the advantage of utilising existing service pathways.

- Integrated: the concurrent treatment of both conditions by a single clinician or team. The guidance points to evaluations from the United States of America that have found this 'hybrid' approach to be the most productive for this client group, while observing that due to differences in the funding and training systems between the UK and the USA, integrated service provision might be achievable without the fully hybrid approach adopted in some locations in the US.

While calling for integration, the guidelines note that several mechanisms might be adopted to achieve this, including specialist dual diagnosis services, specialist dual diagnosis workers within teams, training for whole teams and closer partnership between existing mental health and substance misuse services.

Some commentators, pointing to a comparative paucity of evidence for the efficacy of integrated treatment, have argued that practitioners (presumably alongside commissioners and other stakeholders) have a degree of responsibility to develop the evidence base through 'practice-based evidence' in the absence of a significant body of high quality evidence to inform evidence-based practice. [4]

In addition to the changes in policy and systems above, there have been new entrants to the mental health field, most notably in the form of the Improving Access to Psychological Therapies programme[5], or IAPT. Provided by the NHS or by the voluntary

sector, IAPT services were introduced from 2006 as front-line services offering prompt access to talking treatments – particularly cognitive behavioural therapy - primarily for people affected by mild to moderate mental health problems.

The expectation has always been that IAPT services would have a role to play in responding to people with needs relating to substance use, either due to the IAPT service being accessed as a matter of personal preference by the client, or else through more coordinated structured partnership working or collaboration. DrugScope, along with the National Treatment Agency (now Public Health England) and IAPT produced guidance looking at ways the two sectors can support one another's work in 2012, including information about identification, disclosure, brief interventions and other key principles of good practice.[6]

However, there is limited evidence so far that people with mental health problems associated with alcohol use are benefiting from IAPT either in terms of the numbers accessing the service or the proportion of people who do access it benefiting from their engagement. The Health and Social Care Information Centre's annual Report on the use of IAPT services in England[7] suggests that not only are there very few referrals compared to other cohorts, but also that those who do are the least likely to derive a successful outcome from their engagement. People with mental health disorders relating to substances other than alcohol were omitted entirely due to referral numbers which were lower again.[8]

Initially targeted at working age adults only, the programme has now been extended to all adults; provision for children and young people is being developed separately, as is an extension of the service to people with more severe mental health problems.

Expert views – the Recovery Partnership summit

There was a general consensus that from a clinical perspective, there had been little advance or change affecting clinical practice, service delivery and system design issues in the preceding decade and that, there was little in the old guidelines that was redundant or out of date. However, the guidance relates to organisations and structures that no longer exist, at least in the form indicated in the guidance, and the guidance would also benefit from review to reflect the current mental health and drug strategies (plus related key documents) that have been produced between 2002 and the present day.

Similarly, while in 2002 substance misuse treatment was already being provided by a mixed ecosystem of public and voluntary sector providers (with significant private sector delivery of residential rehabilitation), mental health services were largely provided by the National Health Service. Since then, developments in the commissioning and provision of mental health services has led to a larger role for the voluntary sector and consequently a mixture of provision that looks somewhat like that found in substance misuse treatment, albeit with the NHS retaining a more predominant role. These changes have been mirrored in commissioning arrangements, which are now

several iterations on from the 2002 guidance and which, in the shape of local authorities, have significant new actors.[9]

The Department of Health have agreed to review the 2002 guidance, which is currently being carried out by an expert reference group. A second group, the Mental Health Intelligence Network, will prioritise the accurate mapping of provision of mental health services across England and establishing an effective metric for dual diagnosis.

There was also a consensus that significant progress had been made in service arrangement and delivery, albeit highly localised and patchy. Some concern was expressed that in an environment tending towards ever greater localism, the ability for a national strategy or guidance to have the desired impact of improving provision and standards nationally may face challenges. That this is happening against a background of financial austerity for public services in general (however with a degree of protection for NHS services) made one attendee pessimistic:

> *It might be that the best has already happened; there's more willingness when there are - comparatively - more resources.*

However, most participants agreed with the suggestion that effective cooperation and partnership is almost always possible where there are good personal relationships. The need to maintain relationships in the face of recommissioning and, where necessary, to establish them with new providers was

identified as a novel and unwelcome obstacle, although with the substantial compensation that more active commissioners and commissioning have the ability to design services that reflect and meet local need more closely.

Several participants made the case that workforce development is needed at most if not all levels to improve competencies and also that commissioners and other stakeholders should be supported to develop an understanding of what competencies are required to deliver the services they commission.[11]

Care Services Improvement Partnership – Dual Diagnosis: Developing capable practitioners to improve services and increase positive service user experience

In 2008, the Care Services Improvement Partnership produced a review[12] of effective practice around comorbidity which contained a number of recommendations. These include:

- Training which engenders networking and integrated care pathways across organisational boundaries, mapped against the competencies outlined in Closing the Gap: A capability framework for working effectively with people with combined mental health and substance use problems (Dual Diagnosis);[13]

- Developing protocols with Higher Education providers which identify work-based learning opportunities;

- Developing regional support networks which promote open learning and shared opportunities to explore positive clinical work in dual diagnosis;
- Work rotation and secondments;
- Partnership commissioning and ownership of dual diagnosis posts;
- Developing Across-Service Level Agreements to share learning opportunities;
- Developing an electronic web based learning package and toolkit on dual diagnosis;

Notably, many of these recommendations are still reasonably readily achievable, and at comparatively little cost. Given willingness and a degree of capacity to engage, developing a service-level agreement approach or a local dual diagnosis forum should be within the capacity of many commissioners and service providers.

Separately to the review of the 2002 guidance, the National Institute for Health and Care Excellence (NICE)[14] is developing a guideline expected to be published in late 2016; this is additional to the current NICE guidance on psychosis and coexisting substance misuse.[15] While this is welcome, the scope of the proposed guidance has been limited to people affected by severe mental illness only, while the current Clinical Guideline 120 applies primarily to people with a diagnosis of a psychotic

illness. As indicated by COSMIC and illustrated in the current clinical guidance for substance misuse treatment[16] (the 'Orange Book'), while experience of mental ill health is very common among the population in treatment, psychosis affects relatively few and, in all likelihood, not all of the remainder would meet the criteria of being severely mentally unwell.

While there is a need for up to date guidance for people at every point on the spectrum of severity, it is notable that for people accessing drug and alcohol service, one of the main obstacles to being able to access mental health care and support is one of high thresholds. People who are 'insufficiently' unwell appear to find it particularly difficult to access services, and it is not yet clear whether the planned extension to IAPT will provide an effective solution to this systemic problem.

With a solid grounding in policy, guidance and clinical knowledge and little evidence to recommend sequential treatment, it is perhaps surprising that progress made has been so patchy and that access to services designed to meet the needs of both mental illness and substance misuse remains, in places, problematic. Exploring the matter with services and stakeholders sheds some light.

No Health Without Mental Health and other recent developments

The mental health strategy for England, *No Health Without Mental Health*,[17] establishes priorities framed positively – to improve mental health and wellbeing - and responsively – to

improve services for people with mental health problems. Critically, it introduced the principle of 'parity of esteem' between mental and physical health problems, later established in law by the Health and Social Care Act 2012. The mandate for NHS England[18] anticipates 'measurable progress' towards parity of esteem by March 2015, although it might be noted that there is no (relevant) mention of drugs and only one of alcohol in the document.

Nevertheless, both the mental health strategy and drug strategy recognise that people accessing either service are likely to experience both issues simultaneously and may be at risk of a range of other excluding factors, such as homelessness, offending behaviour, social isolation, unemployment and financial exclusion. Other recent commitments have included the introduction of waiting time standards.[19] While this is a welcome statement of intent, heed should be paid to any risk of unintended consequences, which have arguably appeared elsewhere in the health system.

While the announcement of waiting time standards was accompanied by additional funding to support the application of the standards and £40m to address crisis care for adults and children in particular, it is accompanied by an acknowledgement that while mental ill health represents 23% of all ill health, only 11% of the secondary health care budget is spent on mental health care. Despite the establishment of parity of esteem in law, there is some evidence that spending on mental health may in fact be falling for both adult[20] and children's[21] services,

including, in March 2015, research carried out by the BBC and Community Care magazine which suggests a real terms reduction in funding of over 8% since 2010 in the face of increasing referrals.[22]

Achieving parity of esteem, at least in the sense of funding, may take some time yet. In March 2015 the All Party Parliamentary Group on Mental Health[23] released a report on the progress of parity of esteem, *Parity in progress?*.[24] While welcoming the policy intent and areas where progress has been made or at least a route map identified, the report considers three areas in detail and, generally, finds that much remains to be achieved. There is a very welcome focus on training, crisis care (including the Mental Health Crisis Care Concordat), the integration of mental and physical health care, the connections between public health structures and mental health, but it is silent on the still pressing matter of closer integration of mental health care and substance misuse treatment.

Further developments include the introduction of payment by results (PbR – with or without a social impact bond) across a range of settings, including drug and alcohol treatment (in 8 formal pilots and additional activity by local authorities)[25], mental health (including the introduction of mental health clusters, one of which is a broad cluster encompassing dual diagnosis)[26], labour market interventions [27]support, rough sleeping,[28] support to ex-offenders[29] and, shortly, probation.[30]

While some projects have not yet started, of the ones that have, it may be some time before final evaluations are published. As things stand, the impact on performance appears to be less than transformational, although it may be more encouraging in some aspects more than others. One of the challenges that PbR may face as it develops is how to manage the tension between the need to keep payment models simple and outcomes few, as suggested by the experience of PbR services in the UK and elsewhere on the one hand, and on the other, the need to ensure that models do not create perverse incentives or result in 'creaming and parking'[31] and sufficiently reflect the very deep complexity that many people present with when they access health or other public services.

Novel psychoactive substances

Novel psychoactive substances (NPS, sometimes inaccurately referred to as 'legal highs') have emerged in the United Kingdom over the last decade or so. They are generally been designed to evade existing drug legislation and often mimic, or at least are marketed as mimicking, the effect of 'traditional' illicit substances. They can broadly be categorised into synthetic cannabinoids, stimulant-type substances and hallucinogens.[32]

They are relatively affordable and are widely available, primarily via the internet, through 'head shops' and, anecdotally, through other outlets, occasionally including newsagents, petrol stations and even fish and chip shops. The widespread availability and sale over the internet has consequences in that users and potential users are less affected by geographical location and

connections to existing (and often urban rather than rural) supply networks.

There has been significant media, clinical and political interest in NPSs, but little is known so far about usage and prevalence;[33] the findings from DrugScope's *State of the Sector*[34] report suggest that while services are seeing increased use of NPS, this is rarely happening at the scale or extent one might expect.

Fields where NPS has caused particular concern include services in contact with young people, and prisons. The low cost, potency, plus widespread and online availability may make NPS tempting for young people, particularly as the (often) licit status may lead people to mistakenly assume a degree of safety. This is, needless to say, incorrect. Many NPS are both potent and highly toxic.

Novel psychoactive substances may be particularly attractive to children and young people lacking access to the (often urban) social networks and markets required to access traditional illicit substances. While some surveys have pointed to relatively high levels of usage among young adults, it is difficult to get a sense of the actual level and prevalence of use of NPS among children and young people.

Two things do however seem relatively clear at the moment. While use of heroin and crack cocaine has been consistently falling, the people who might otherwise have used them do not on the whole appear to have switched to NPS. However, there is increasing concern about the injecting of mephedrone, including

among some people who are or were heroin users, and there are additional challenges and health concerns with regard to 'chemsex' and men who have sex with men – a cohort which is probably underserved other than for a limited number of specialist services.

More generally, NPS appear to have attracted a largely new cohort of people into trying psychoactive substances, a challenge the scale of which may not be fully understood yet. Both anecdotally and according to a recent report by the Royal College of Psychiatrists,[35] there is evidence that it is small but increasing. While the limited data relating to mephedrone from the Crime Survey of England and Wales suggest that mephedrone has had limited penetration of the potential market, the 2013-14 annual report of the National Poisons Information Service implies a very large increase in telephone enquiries and TOXBASE accesses relating to unidentified 'legal highs' or NPS, with the increase in queries about synthetic cannabinoids particularly striking.[36]

For prisons, problems have included difficulties in detecting or intercepting NPS, and the (current) inability to detect NPS and their metabolites in mandatory drug testing. The latter will be addressed with a new test to come into effect this year. NPS are believed to be responsible for an increasing number of fatalities: from 9 in 2007 to 60 in 2013.[37] They are also understood to be factors in incidents where people have required emergency medical treatment both in the community and in custody as well

as, according to the Prison Officers' Association, attacks on prison staff.[38]

In addition to the evidence review referred to above, the emergence of NPS has met with responses from (among others) the Advisory Council on the Misuse of Drugs, the Home Office's Expert Panel[39], the Ministry of Justice in the context of the prison estate,[40] the Home Affairs Committee[41] and a commissioning toolkit from Public Health England.[42]

Significantly, the Government response to the report of the expert panel marks a departure from the recent set of legislative responses, which have tended to ban specific substances while leaving the door open to modified but effectively similar substances to remain in or enter the market. While this has ensured a proportionate response that pays notice to evidence and expert opinion, it has increasingly looked unresponsive in the face of a market which is extremely fast paced and responsive to legislative barriers. The proposed blanket ban should address this aspect.[43] At a local level, at least one council, Lincoln City, has banned the consumption of the NPS in the city.[44]

The Crisis Care Concordat

Care and responses for people in mental health crisis are reviewed at greater length elsewhere in this briefing. However, the Crisis Care Concordat[45] is a recent and highly significant development in policy and, crucially, practice in its own right. The Concordat is a national agreement between local services and

agencies that have a role in meeting the needs of people in crisis. 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Concordat in February 2014. The Concordat focuses on four themes:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.

- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.

- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

While developed at a national level, to be effective the Concordat requires local implementation. It requires local authorities and other stakeholders, including local mental health trusts, all three emergency services, housing associations and third sector providers to come together to develop a Mental Health Crisis Declaration setting out how crisis care and support will be provided, by whom and which settings, at a local level. The

Concordat website includes an interactive map[46] where national progress can be followed and local developments investigated.

Making Every Adult Matter

As part of the Making Every Adult Matter (MEAM) coalition, DrugScope worked with Clinks, Homeless Link and Mind to improve services and policy for people experiencing multiple and complex needs, which often mean people struggle to access the services they need, and live chaotic lives.

Through the Voices from the Frontline project, the MEAM coalition is working with people with personal experience of multiple needs – and those who support them – to influence national policymakers. In doing this, it's drawing on the experiences of local areas working with the MEAM Approach – a non-prescriptive framework for developing better services for people with multiple needs. Three pilot projects that ran from 2011 demonstrated both improved outcomes and significant cost savings through adopting a co-ordinated approach. More widely, MEAM is supporting the Big Lottery Fund's Fulfilling Lives programme, providing practical support to 12 areas across England.

MEAM defines people experiencing multiple and complex needs as:

> ***Experiencing several problems at the same time**, such as mental ill health, homelessness, drug and alcohol misuse, offending and family breakdown. They may have one main*

need complicated by others, or a combination of lower level issues which together are a cause for concern. These problems often develop after traumatic experiences such as abuse or bereavement. They live in poverty and experience stigma and discrimination.

Having ineffective contact with services. *People facing multiple needs usually look for help, but most public services are designed to deal with one problem at a time and to support people with single, severe conditions. As a result, professionals often see people with multiple needs (some of which may fall below service thresholds) as 'hard to reach' or 'not my problem'. For the person seeking help this can make services seem unhelpful and uncaring. In contrast to when children are involved, no one takes overall responsibility.*

Living chaotic lives. *Facing multiple problems that exacerbate each other, and lacking effective support from services, people easily end up in a downward spiral of mental ill health, drug and alcohol problems, crime and homelessness. They become trapped, living chaotic lives where escape seems impossible, with no one offering a way out.*[47]

The MEAM coalition had estimated that there were 60,000 people in the UK to whom the characteristics above apply. More recent research by Heriot-Watt University on behalf of Lankelly Chase[48] found almost 60,000 people in England were affected

by all three of substance misuse, offending and homelessness, with far larger numbers affected by one or two domains of severe and multiple disadvantage. Mental ill health was excluded due to insufficient data, but the research nevertheless provides an indication of the numbers of people facing multiple and complex needs.

The research including the cost findings was referenced in the March 2015 budget Red Book,[49] with a commitment made to exploring the benefits of merging and pooling budgets around services for people with complex and multiple needs, including homelessness, mental ill health and addiction.

Sector views – DrugScope State of the Sector

In February 2015, DrugScope released the second annual *State of the Sector* report[50] on behalf of the Recovery Partnership. Mental health, and in particular, access to mental health services was prominent for the degree and frequency of concern expressed by survey participants and interviewees.

Some key findings include:

- Access to mental health services was nearly universal, with only 4% stating their clients were unable to access them, 22% of respondents thought that it had worsened over the last year, with several developing in-house provision to compensate for difficulty and/or delays in accessing specialist mental health support.

- 86% of survey respondents indicated that more than half of their clients presented with mental health support needs.
- Difficulty in accessing mental health support broadly fell into two categories:
    - A gap in provision at the mild to moderate end of the mental illness spectrum, where the Improving Access to Psychological Therapies (IAPT) programme is perceived as sitting on the one hand and community mental health team (CMHT) provision on the other. Several participants and interviewees raised the prospect of individuals too unwell for IAPT but not well enough to be able to access CMHT services. The extent to which the planned extension of IPAT might be able to bridge this gap remains to be seen.
    - Where people are declined access to mental health care due to continuing substance misuse, often being required to stabilise or reduce their substance intake or to achieve abstinence before treatment will be provided. In reality, this may have the effect of excluding people entirely from mental health support due to the complex and often mutually reinforcing relationships between the person's substance use and mental ill health.

The examples above illustrate, understandably given the participants, the perspective of the drug and alcohol treatment

sector. It is not inconceivable that a similar exercise undertaken solely with mental health service providers would find comparable views: that access to drug and/or alcohol treatment is declined those suffering from poor mental health.

Needless to say, more positive examples of cooperation and co-delivery are included, although some respondents have urged caution when putting services out to tender; where both mental health services and substance misuse treatment are provided by a CMHT, partnership working is likely to be inherently strong. Where services are recommissioned and split, stakeholders will need to be mindful of the need to retain partnership working across organisational and data management boundaries.

Case study – Turning Point Hertfordshire Complex Needs Service

Turning Point[51] is one of the country's largest providers of services for people with a range of social and health related disadvantages, with activities ranging from mental health, learning disability, substance misuse, primary care, the criminal justice system and employment support. Its services routinely support, treat and work with clients with complex needs at practically every point of the spectrum. As such, it is notable that currently only one service is specifically commissioned as multiple needs provision: the Hertfordshire Complex Needs Service.[52]

This service provides community support to people affected by a range of complex needs, including mental ill health, substance

misuse, learning disability and offending behaviour many of whom also face challenges around housing, employment and social security benefits. It also provides support to families and carers. The origins of the service lie in meetings between local authority commissioners and carers. These revealed that within the county there were many people with multiple needs who were not in receipt of any services, instead relying either on themselves or on friends, family and social networks.

The aim was not merely to add capacity, but also to provide a prompt response – the service is open access – and also to help people navigate and make better use of services that are already in existence, including statutory mental health services and substance misuse treatment. By utilising a pooled budget (health and social care monies together) the Joint Commissioning Team commissioned the 'Complex Needs Service' which was designed to improve access to provision for those who might otherwise be excluded, despite some current partner services initially being uncertain of the scale of the unmet need.

The crucial component of the process from need being identified to service being commissioned lies in activist commissioning. The traceability of evidence from assessment to implementation is precisely the direction envisaged in the post-2010 health and public health reforms but, at least at this early stage, examples of this approach translating into new service models appear relatively scarce.

Summary and recommendations

At the time of writing, there is considerable activity in the field of mental health, much of it relating to guidelines, standards and policy rather than clinical developments. This renewed emphasis on mental health is welcome (and arguably overdue).

There have been significant policy and financial commitments to improving both the way that mental health services are resourced and provided and also the way in which they work to address the needs of people with coexisting substance misuse and mental health problems. These have not yet translated into positive change for people trying to access support for both conditions, or for one or the other separately;

While it would be simplistic to think that substance misuse treatment and mental health care worked better together when the funding and commissioning arrangements sat more closely together, separating them so distinctly does not, at the moment, appear likely to encourage greater connectivity;

Experts and stakeholders consulted argued that it would also be over-simplifying to think that the two aspects of treatment and care were more joined up when mostly delivered by NHS services, structural changes, including the greater involvement of the voluntary sector in the provision of both substance misuse treatment and mental health care and support have created a somewhat fragmented system;

People are finding support for coexisting substance misuse and mental health problems difficult to access, despite the welcome addition of (relatively) new services like IAPT. Barriers include:

- People falling between IAPT at the mild to moderate end and CMHTs at the more severe end;

- Mental health (and, potentially substance misuse services) declining access or offering access on a conditional or sequential basis;

It is not clear that one route to greater integration is better than the others, although the extent of co-morbidity across mental health and (particularly) substance misuse services suggests that merely adding a single dual diagnosis worker to a service may not meet all needs, unless perhaps their role is specifically as a service navigator.

- Commissioners should ensure that there is adequate provision to meet the mental health needs of those in substance misuse treatment and recovery communities;

- Individuals with complex needs should be included in service design at a local level – although local authorities should be mindful that highly socially excluded people might be hard to identify and may need support to engage;

- Policy makers and commissioners should examine what needs to be done to align the funding and commissioning of services for people with complex needs;

- These should include strengthening the statutory guidance for Joint Strategic Needs Assessments and Joint Health and

Wellbeing Strategy[53] to make an explicit requirement to work with local Clinical Commissioning Groups to ensure that mental health care is coordinated or integrated with substance misuse and that the needs of people with coexisting substance misuse and mental ill health are assessed and met;

- Examining how pooling budgets and/or sharing incentives could offer a solution. The Troubled Families programme has given a suggestion of how political leadership backed by a relatively small incentive from central government can act as a mechanism to translate national priorities to a local level;

- Ensuring that where Payment by Results mechanisms are used, incentives are aligned and reflect both local need and the complexity of clients worked with;

- Public Health England and NHS England should strengthen the resources available to Clinical Commissioning Groups[54] and Health and Wellbeing Boards to support the development of more integrated adult specialist services;

- Experts and stakeholders interviewed as well as the case study above have stressed the role of activist commissioners and the impact that they can have in shaping local services; their role and activity should be supported by government through the provision of training, benchmarking and the dissemination of good practice;

- The efficacy of an expanded IAPT service in meeting the needs of people with complex needs and/or more severe mental ill health should be evaluated and used to inform future decisions;

- All services and stakeholders engaged emphasised that the key to effective partnership working and integration lies in people and professional relationships; policy can encourage, enable and facilitate but cannot replace that vital element. Commissioners and service providers alike can bring individual services more closely together through forums, through adopting a case management approach and through developing service level agreements;

- Workforce development and competencies should be improved – across all professions involved;

- The question of resourcing may not just be about where money sits, how it is used and what other assets and resources are involved. It may also be about levels and amounts. While the commitments to waiting time and access standards are welcome (as is the additional funding to support them) it is not clear that, taken at a system level, parity of esteem is close to being achieved. Ongoing, active assessment of where and how resources are being allocated is essential;

- Improving data collection should be prioritised, including improving access to and refining the Mental Health Minimum Data Set.

Use of the Mental Health Act, crisis provision and places of safety

Context

As described by the Centre for Mental Health,[55] the Mental Health Act 1983 (MHA):

> *is one of the few pieces of legislation that allows the deprivation of liberty by confinement to an institutional setting or via measures of control in the community for people who have committed no crime nor that are suspected of doing so. It can compel people to receive treatments they might not voluntarily accept, and all of this will be done with the best intentions.*

The use of sections 135 and 136 of the MHA has been of particular interest to policy makers, practitioners and other stakeholders in recent years. This is an unsurprising consequence for any legislation that gives the police the ability, with a warrant, to enter someone's place of abode and, potentially, to remove them to a place of safety or, without a warrant, to take them from a public place to a place of safety, in both cases for up to 72 hours.

This provision naturally raises questions of efficacy (is the provision achieving the aim of facilitating the assessment, care and control of someone appearing to be in distress?) and proportionality (is the provision being used fairly and appropriately?). As the Centre for Mental Health review of the MHA makes clear, when considering both section 135 and 136, an important factor to consider is that the former are always planned, by virtue of requiring a warrant. The latter are more

likely to be unplanned and the consequence of an emergency call or through other police contact with a member of the public.

Recent developments

Key recent publications and developments include:

- A Government consultation on the Operation of sections 135 and 136 of the Mental Health Act 1983,[56] including a report by the Centre for Mental Health reflecting the views and experiences of service users, professionals and carers;

- The first revised Mental Health Act Code of Practice since 2007,[57] which is due to come into effect on 1st April 2015. This wide-ranging document includes significant sections on Deprivation of Liberty Safeguards, the use of the Mental Capacity Act 2005, police powers and places of safety. The Code states that intoxication should not be used on its own as a reason to exclude an individual from a health-based place of safety, and that young people should not be taken to a place of safety in a police station, unless there is no suitable alternative, considering the needs and best interests of the child or young person. While multiple needs, substance misuse and dual diagnosis are referred to in the Code, it is primarily in the sense of describing what is within and without the scope of the MHA and when the care plan approach (CPA) should be used.

2013 saw two significant developments: *A Criminal Use of Police Cells?*[58] and guidance for commissioners[59] from the Royal

College of Psychiatrists. The former found that while existing guidance emphasised that police stations should only be used as a place of safety on 'an exceptional basis', just over 25,000 people detained under section 136 in 2011-12, 9000 had been taken to a police station rather than a health based place of safety.

The latest figures from the Health and Social Care Information Centre[60] (HSCIC) suggest that progress has been made since the earlier part of the decade:

Year	2011-12	2012-13	2013-14
Place of Safety Orders	25,035	22,000	23,300
Police Station	9,000 (36%)	7,900 (36%)	6,000 (26%)
Hospital	16,035 (64%)	14,100 (64%)	17,000 (74%)

Less encouragingly, the same HSCIC data suggest that of 755 people under 18 detained under section136, 236 or about 31% were taken to police stations rather than a health-based place of safety in 2013-14, rather more than the corresponding figures for adults. Figures for both adults and those under 18 suggest that police vehicles were by far the most common means of transport to places of safety with ambulances being used in a minority of cases.

The data also show a continuing increase in the use of other sections of the Mental Health Act, with an increase in the number detained of 30% over the course of 10 years. This is combined with a comparatively shallow but consistent decline in the availability of NHS overnight mental health beds, from a recent high of 23,740 in the 3rd quarter of 2010-11 to an all-time low of 21,446 in the third quarter of 2013-14. By comparison, there were 35,692 overnight mental health beds available in 1998-99. The Care Quality Commission (CQC), in a survey of health-based places of safety for people detained under section 136 carried out in 2014,[62] found that the areas where people were more likely to be taken to health-based places of safety were those with the greatest availability of those places – supply and demand may play a significant role in determining a person's destination.

However, CQC also found that many providers of health-based places of safety maintained policies that effectively excluded intoxicated people and those with 'disturbed behaviour' from places of safety, leaving the police with little option but to take a vulnerable person in crisis to a custody suite instead. It appears that in some cases this is as a matter of policy rather than risk assessment and mitigation, and that exclusion could be, in the case of alcohol, irrespective of the amount consumed. CQC saw merit in exploring options other than police stations and hospitals as places of safety.

As with many others, CQC saw a role for Health and Wellbeing Boards in assessing the need for and provision of health-based

places of safety, although so far most Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies tend to mention mental health in passing and crisis care rarely if at all – which largely reflects the position with drugs and alcohol.[63] Usefully, CQC map their findings against current standards, including Code of Practice: Mental Health Act 1983 (the version current to March 2015), the Crisis Care Concordat and standards and guidance produced by the Royal College of Psychiatrists. Their findings suggest a reasonable degree of compliance although with clear room for improvement. It is not possible to discern from the report the variance between those adhering most closely and those adhering least.

Police mental health blogger Inspector Michael Brown ('Mental Health Cop') has written extensively on places of safety and the use of section 136 of the Mental Health Act.[64] From a police officer's perspective, he has highlighted the variance between areas and given some consideration both to what might underlie regional or police force differences and the relative ease of arresting someone for an offence compared to using the Mental Health Act. He also makes the observation that until there is a shared understanding of what section 136 is actually for, and how it sits in relation to the use of criminal law and arrest, liaison and diversion and street triage, comparing one area to another on a largely quantitative basis is likely to be unrevealing.

In 2014, the Independent Commission on Mental Health and Policing, chaired by Lord (Victor) Adebowale, Chief Executive of Turning Point, published a report commissioned by the

Metropolitan Police Commissioner. The report focussed specifically on how the Metropolitan Police Service (MPS) works with people with mental health problems or in mental health crisis, reviewing 55 cases over 5 years involving people with mental health problems. 5 cases had resulted in death in custody, 5 in serious injury and 45 in death prior to or immediately after contact with the police.

The Commission found that in most cases, any failure could be attributed to a failure in coordinated responses, individual mistakes, lack of training and resources and discriminatory or prejudiced attitudes towards those affected by mental ill health. The report includes a range of recommendations which, while based on findings from London and produced at the request of the Metropolitan Police Service (MPS), would be beneficial for other police services to consider. Among the recommendations is that NHS England should work with Clinical Commissioning Groups to ensure the adequate provision of Liaison Psychiatry and that the police would benefit from an expanded Mental Health Liaison Officer role, supported by expert teams based on assessments of local need.[65]

Sector views – DrugScope State of the Sector and mental health summit

Attendees formed a consensus that despite definite signs of progress, more can be done. When people are intoxicated and aggressive, the default is to take people to police stations, whereas if they are intoxicated and subdued, hospitals tend to be used. There was agreement that this scenario tended to be

disproportionately the case where substance misuse had been assumed to be a factor, citing an All Party Parliamentary Group report which found that intoxicated people are frequently blamed for their situation by health services with a tendency to disregard coexisting mental health problems. In the Code of Practice due to take effect from April 2015, if admittance to a hospital based place of safety is removed, the individual who made the decision will be recorded, along with their reasons for doing so.

One participant was keen to emphasise the role that substance misuse services can play in places of safety: while the national Drug Interventions Programme has ended, comparable work is still taking place in many parts of the country, which could provide both a form of support to the expanding activity around liaison and diversion and also in providing more tailored and skilled interventions around places of safety. A further participant was keen to see a move away from the police station and hospital dichotomy towards more community provision and services for people with chronic problems leading to multiple crises.

In DrugScope's *State of the Sector* 2014-15, few people referred directly to the availability of and access to health based places of safety or the use of section 136 of the Mental Health Act more generally. However, several made the case that access to mental health care below crisis point is, subjectively, becoming increasingly difficult as thresholds appear to be increasing.

Summary and recommendations

There are signs that through its increased profile and, in particular, through the work of the Crisis Care Concordat, progress is being made in addressing the availability of health based places of safety. However, there clearly remains much to be done both for adults and, in particular, for young people who may be required to spend time in police stations or adult mental health facilities. This is clearly inappropriate and poses unnecessary risks. A similar situation exists for people who are intoxicated, who in some locations appear to be firmly excluded from health-based places of safety rather than risk assessed.

- The recommendations of the Independent Commission on Mental Health and Policing should be considered applicable to all police service areas;
- Health and Wellbeing Boards, Clinical Commissioning Groups and NHS England should work together to ensure that there is sufficient crisis provision in place, including Liaison Psychiatry and health-based places of safety;
- As anywhere can legally be a place of safety, the viability of moving away from the narrow health-based or policing-based place of safety model should be explored;[66]
- Providers of places of safety should ensure their policies meet the needs of people who are intoxicated, and people with disturbed behaviour. Risk assessment should be preferred to hard and inflexible excluding criteria;

- Providers of places of safety should ensure that staff understand the adverse mental health behaviours that are associated with NPS use;

- Where someone is not accepted into a health-based place of safety, the name of the decision maker and the reason for their decision should be recorded as a matter of routine.

Prison and offender health care

Context

For many people in crisis, their first contact with support and/or mental health services is with the emergency services and sometimes in a custodial setting. For many others, effective diversion at an earlier point could have kept them out of the criminal justice system to a greater or lesser extent. Recent developments in crisis care, places of safety, the use of the Mental Health Act and the roll-out of the Liaison and Diversion Pilots called for in the Bradley Report of 2009[67] are considered briefly and separately from offender healthcare itself.

Recent data for the prevalence of substance misuse, mental ill health and comorbidity is limited and fragmented. However, there is undoubtedly a high incidence of one or the other or both within the prison population:[68]

Characteristic	Total	Male	Female
Prisoners having mental health problems	80%		
Sentenced prisoners having two or more mental disorders (defined as drug or alcohol dependence, personality disorder, psychosis and/or affective disorder)		72%	70%
Sentenced prisoners having four or more mental disorders		14%	18%
Sentenced prisoners having a neurotic disorder		40%	63%
Sentenced prisoners having a psychotic disorder		7%	14%
Sentenced prisoners previously having been admitted to a psychiatric hospital		8%	15%
Offenders have learning difficulties or learning disabilities which interfere with their ability to cope with the criminal justice system	20-30%		
Young prisoners aged 15-21 have a mental disorder	95%		
Young prisoners aged 15-21 have at least two mental disorders	80%		

Liaison & diversion

One of the most effective ways of meeting the needs of people with mental health problems, whether singly or in conjunction

with substance misuse needs, is to prevent them from entering the criminal justice system in the first place.[69] Commissioned by the Ministry of Justice and published in April 2009, the Bradley Report[70] made 82 recommendations for change, aimed at addressing the over-representation of people with mental health problems in the prison system.

Arranged thematically around the 'offender pathway' and emphasising that there are exit routes from the criminal justice system available at each point, the report addresses separately the key points on the pathway: early intervention, arrest and prosecution; the court process; and prison, community sentences and resettlement. Early intervention in the form of liaison and diversion – mental health services accessible to the police in custody suites or on the streets and aimed at the identification, assessment and referral of clients[71] - is particularly relevant and has, the report states, been supported by Government since 1990. The report recommends the systematisation and standardisation of what had previously been variable provision of liaison and diversion services.[72]

In his report, Lord Bradley emphasised that drug and alcohol dependence as well as other vulnerabilities should be brought within the scope of liaison and diversion, and described the role in the context of the offender pathway:

> *A process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual*

is best placed to receive treatment, taking in to account public safety, safety of the individual and punishment of an offence.

By April 2015, 50% of the population of England will be covered by liaison and diversion schemes operating within a standardised framework. A review five years on[73] has found significant progress made against most recommendations, and growing evidence that most of the reforms and innovations are having positive, beneficial effects. However, much remains to be done, and the authors of a review of deaths of young people in custody argue that more needs to be done to divert young people affected by substance misuse and mental ill-health (among other offending-related factors) away from the criminal justice system and particularly the prison system, which they describe as an 'over-used' response to a range of social problems that should be addressed elsewhere and earlier.[74]

Offender healthcare

Prison-based health care, including mental health care and substance misuse treatment, has been through several major reforms since the 1980s, with significant progress being made in mental health care in particular, and more recently, substance misuse treatment in prisons. Summit attendees argued that mental health care among the prison population had benefited significantly from being the object of persistent, high-level political attention, which had not always been the case with substance misuse treatment in prisons.

Background

Historically, HM Prison Service was responsible for managing and delivering all primary health services in prisons. Policy work undertaken by previous governments going as far back as 1995 had highlighted a number of weaknesses of this arrangement, including equitability and a lack of non-conformance with United Nations requirements relating to the treatment of prisoners, which include that 'prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'.[75] CARAT (Counselling, Assessment, Referral, Advice and Throughcare) services were subsequently established in 1999.

Also in 1999, the then Chief Inspector of Prisons, David (now Lord) Ramsbotham produced a report addressing the subject of suicide and self-inflicted deaths in prison.[76] This, among other things, established the four principles of 'healthy prisons', which still prevail:

- Safety – Prisoners, particularly the most vulnerable, are held safely;
- Respect – Prisoners are treated with respect for their human dignity;
- Purposeful activity – Prisoners are able, and expected, to engage in activity that is likely to benefit them;

- Resettlement – Prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

From April 2003, funding responsibilities for prison primary health care were moved from the Home Office to the Department of Health, subsequently then being devolved to primary care trusts between 2004 and 2006. In 2006, the first Integrated Drug Treatment Systems were rolled out in prisons, supported by new documentation from the Department of Health[77] (and in part prompted by the threat of class legal actions); a key objective was to enable the provision of a range of evidence-based treatment including substitute prescribing and psychosocial interventions comparable to those available in a non-custodial setting. The guidance made an explicit reference to the role of specialist treatment in contributing to reduced risk of self-harm and suicide.

More recently, Lord Patel conducted a review[78] of drug treatment in prison. His report found that funding for substance misuse services in prisons increased 15-fold between 1997 and 2010 and included a number of recommendations, some of which are reflected in recent developments. These include the emphasis on 'through the gate' work and in connecting prison based services (of all sorts) with their community based counterparts.

Mental health care in prisons has arguably been developed and implemented in a more ad hoc and less systematic way, with much reliance on in-reach. A 2009 evaluation of prison in-reach

services,[79] while acknowledging an increase in the size of in-reach teams and the prioritisation of reflecting developments in non-custodial settings, pointed to demand outstripping supply and increased caseloads, noting that 'team leaders thought that in-reach was an excellent idea but that it was poorly resourced and had been generally poorly implemented.'

In April 2012, the National Drug Treatment Monitoring System (NDTMS) was extended to prisons for the first time; this has the potential to substantially increase the understanding of people's journeys from prison to community services and, where applicable, back again. In a further development, responsibility for commissioning all health services, including mental health services and substance misuse services, was transferred to NHS England in April 2013.

The criminal justice system and mental health

While recent, comprehensive data about mental ill health in prisons is limited, most forms of mental ill health are more prevalent in the prison population than in the wider community. In 1997, Singleton *et al* found that almost 90% of prisoners had some form of mental ill health, while the Department of Health found in 2007 and that 10% and 30% of male and female prisoners respectively had previously had one or more acute admissions to hospital. The same study found experience of trauma to be particularly prevalent within the female prison estate, although also very substantial within the male estate.

In guidance produced on behalf of the Ministry of Justice, the prevalence of personality disorders was indicated as being up to

70% in the prison population; a multiple of the prevalence in the wider population of between 4% and 11%.[80]

The criminal justice system and substance use

Contact between drug users and the criminal justice system is widespread and significant. People who misuse substances are reported to engage in much higher levels of criminal activity than non-drug users, and studies have found that drug use may intensify, motivate and perpetuate offending behaviour; the highest levels of drug use are found amongst the most prolific offenders. [81]

Prisoner surveys have consistently found that a majority of prisoners report having used drugs and/or alcohol prior to custody. A large-scale survey of prisoners carried out in 1997[82] used the Alcohol Use Disorders Identification Test (AUDIT) to assess levels of hazardous drinking, defined as an established pattern of alcohol consumption which confers a risk of physical and/or psychological harm.

For male prisoners on remand, 58% were found to be hazardous drinkers, rising to 63% for sentenced prisoners. The corresponding figures for women were 36% and 39%. More recent research from 2007[83] using the Fast Alcohol Screening Test (FAST) to identify dependent drinkers found similar levels of dependent drinking, but also found that younger offenders aged 17 to 24 were more likely to be dependent and that over the three year period considered, the percentage of dependent drinkers had increased in that age range.

Both studies also found substantial levels of drug use. In the case of the Arrestee Survey, 52% of those interviewed reported drug use in the month prior to arrest, and 30% were dependent on heroin and/or crack cocaine. Singleton et al in 1997 found that for male prisoners on remand, 27% had used no substances (including solvents but excluding alcohol) in the month prior to arrest, compared to 34% of sentenced prisoners. The corresponding figures for women were 34% and 45%, although female prisoners (and particularly those on remand) were more likely to have used heroin, crack cocaine and/or non-prescribed methadone, and less likely to have used amphetamines and/or powder cocaine. The 2007 Arrestee Survey confirms a similar overall picture, while noting an overall decline in the proportions using heroin and/or crack cocaine, a change which appears to reflect changes in drug use patterns in the wider population during that time.

Recent research by the Home Office has argued that the heroin 'epidemic' of the 1980s and 1990s and the eventual success of the treatment response is at least in part responsible for the increase in (acquisitive) crime during that period and the fall in levels of offending since.[84]

While the suggestion that of mostly acquisitive crime directly attributable to drug misuse may have fallen, more recent developments within the custodial estate give cause for concern. The 2013-14 report by Her Majesty's Chief Inspector of Prisons[85] pointed to areas of concern including novel psychoactive substances that are not detected by the current mandatory drug test (although one that directs more substances and metabolites

will be introduced in 2015); the synthetic cannabinoids often sold as 'Spice' and 'Black Mamba' were cited as a cause for concern at 37% of the prisons inspected. The same report found that almost a third of prisoners found it easy to get hold of drugs in prison.

Recent developments

Seen in the context of around two decades of development, considerable process has been made. Mental health care and drug treatment is available in every prison, is required to be evidence-based and to reflect the best practice in non-custodial settings. However, there are more troubling signs, particularly in the male prison estate.

Having fallen for some years, suicide and self-harm in the prison estate have increased, with data collated by the Howard League suggesting that rates of suicide are higher now than for several years.[86] The Secretary of State for Justice has indicated an eagerness to see specialist mental health units established in prisons,[87] although conversations with stakeholders suggest that while the renewed focus on mental health is welcome, to think about addressing the current problems through units rather than at whole prison level may be to underestimate the scale of the challenge.

In a system where having one mental health problem (including substance misuse) is common and having two unexceptional, having the capacity, structures, provision and environment to enable a 'whole prison' approach to supporting and improving

mental health and wellbeing should be adopted. This is particularly pressing in the case of young offenders, whom the data suggest are particularly likely to be experiencing mental ill health and/or substance misuse and where the labelling or scarring effects of prison may mean that additional and sustained support is made available to enable the individual to build a positive, non-offending life post imprisonment.

Meanwhile, seizures of controlled drugs in prisons have increased, with almost 4,500 in 2013-14. It is not clear whether the variable is more effective methods of finding and intercepting drugs, more drugs in the prison estate, or a mixture of both. Discussions at the mental health summit and separately with stakeholders have also pointed to an increased number of 'blue light' incidents thought to relate to novel psychoactive substances (NPS) as being a cause of concern.[88]

This is echoed by the annual report of HM Chief Inspector of Prisons[89] (HMCIP) who stated that the increased availability and use of NPS in prisons was not just problematic in terms of the direct effects of the substances themselves but also as a consequence of debt to other prisoners and the associated bullying. Synthetic cannabinoids alone (and particularly the brands marketed as 'Spice' or 'Black Mamba') were cited as a concern in over a third of prisons inspected; DrugScope's State of the Sector 2014-15 found that synthetic cannabinoids were the substance or group of substances that had shown the largest increase in use in prisons, ahead of other NPS and diverted medication.

While HMCIP's report was generally positive about the availability and quality of substance misuse treatment in prisons, it was observed that recovery work in a number of prisons was "undermined by enforced reduction or inflexible prescribing, which did not adhere to best practice guidelines".

Conversations with stakeholders and practitioners have also pointed to what several have described as a serious staffing shortage in the prison estate resulting in prisoners being locked in their cells for longer than expected and with reduced ability to move around to access services and activities – something reflected in the report of HMCIP and supported by reductions in the prison staff headcount.

In March 2015, the House of Commons Justice Committee released a report into prison planning and policy.[90] While the focus of the report is at an essentially structural and strategic level, there are a number of salient observations and recommendations. These include concerns around overcrowding and staffing – both levels and morale, and a consideration of the evidence around the optimum size of prisons. Particular concern was expressed about the plan to develop large secure colleges for young offenders at a time when that part of the population is declining. The Committee also urged more integration between prison work, learning and skills.

While the Committee found that assaults and self-harm had increased but only marginally, the instances of 'concerted indiscipline'[91] had risen very substantially, with more in the first 9 months of 2014 than in any of the preceding 3 years. The

Committee also noted encouraging developments in substance misuse, and particularly the reduction in the proportion of prisoners testing positive falling from 24 percent in 1996/97 to just over 7 per cent in 2013/14 while observing that the use of mandatory drug testing in prisons has fallen somewhat. The Committee also heard evidence that a lack of staff and increased time spent locked in cells had contributed to a range of increased negative outcomes including suicide, self-harm and violence.

Rates of self-harm in the female estate continue to be 'disproportionately high', even though 'safety outcomes in women's prisons improved and this coincided with the introduction of better first night and other support procedures, better substance misuse services and better mental health care'.[92] The Corston Report[93] is regarded as having a significant and positive impact in reducing harm and risk in the female estate, and was itself commissioned after an increase in the suicide rate in the female estate.

However, female prisoners continue to report poorer mental health than male prisoners across the domains of self-harm, suicide attempts, psychosis, and anxiety and depression. In addition, while there were limited differences for alcohol consumption, women are more likely to have used Class A drugs in the 4 weeks prior to arrest and more likely to have offended to support someone else's drug use. [94]

Sector views – DrugScope State of the Sector and mental health summit

21 prison service managers participated in DrugScope's State of the Sector survey, conducted on behalf of the Recovery Partnership. In comparison to some of the views expressed by respondents from community and residential service, respondents from prison services were comparatively positive, although with concerns about prison staffing overall:

> *Prison-based substance misuse treatment, is relatively stable. But, if you look outside substance misuse within prisons, everything you hear is about prisons regressing. I've worked in prisons for 30 years and I've seen them develop from being absolute hell holes to being relatively humanely managed places… it's a constant battle because of staff shortages or lockdowns or because somebody has taken away the meeting rooms, or somebody else has moved a load of drug dealers onto the drug free wing. So all of those day-to-day battles are harder than they have been for many years.*

Mike Trace, Chief Executive, RAPt, in a comment that was echoed by a service manager interviewed:

> *Our teams are finding it more difficult when prison officer posts are underfunded and where there are staff shortages; while we may have enough staff in our office, there might not be enough officers to escort prisoners or to supervise a group session. It feels like the morale among*

the prison staff is low; that has an effect in addition to the questions of numbers. It's quite frustrating for our practitioners.

Senior stakeholders also expressed concern about the effect of the withdrawal of experienced non-clinical staff, arguing that the positive contribution made by officers and other staff with the time and ability to take an interest in prisoners and their welfare should not be underestimated. This point was strongly reflected in the 2013-14 annual report of HM Chief Inspector of Prisons.

The most recent report of the Prison Service Pay Review Body confirms that out of a workforce of almost 35,000, 10,000 posts have been lost between 2010 and 2013, with half of those, or 5,000 staff, leaving between March 2013 and March 2014. The latest report also suggests a 'churn' (people entering or leaving posts within 12 months) of 13.4%. This is the highest level of churn on record and is almost double that of the previous year.

Taken in conjunction with staffing levels, an increased lack of stability may bode poorly for the care and support of inmates. Deleting 30% of posts (not accounting for any replacement contractor posts) seems unlikely to improve the ability of staff to devote time to rehabilitative activity or particularly conducive to safe and effective management of prisons more generally.

Case study – HMP New Hall, Spectrum CIC

HMP New Hall is a closed female prison in West Yorkshire. It holds adult female prisoners of all categories as well as young

offenders and juveniles on Detention and Training Orders. It has a capacity of 415. While the prison is currently running somewhat under capacity, like most prisons this has not always been the case.

Health care is provided by a partnership of agencies from the public, voluntary and social enterprise sectors. Spectrum CIC,[95] a social enterprise, provides primary care services in HMP New Hall: access to a general practitioner as well as clinical substance misuse and pharmacy services. In its last Care Quality Commission (CQC) inspection, it was rated as meeting all national standards[96]. Spectrum also provides clinical services at Askham Grange, a smaller open female prison in North Yorkshire and a sister prison of New Hall; prisoners from New Hall may be transferred there, depending on their sentence and their risk assessment.

Within New Hall, secondary mental health services are provided by Nottinghamshire Healthcare NHS Trust and substance misuse psychosocial services by Turning Point. In addition to providing primary care, Spectrum also provide initial emergency response; it is a 24hr a day, 7 day a week service.

The three-way split of primary care, psychosocial interventions and secondary mental health care is typical of most prisons. Spectrum's on-site manager states that in HMP New Hall, the services work effectively together and, where relevant, with services in the community; this is confirmed both by the CQC report and by the most recent unannounced inspection by HM Chief Inspector of Prisons.[97] While different recording systems

and databases are used, information is shared appropriately, promptly and regularly.

As in community settings, the effectiveness of partnership working was ascribed not just to systems and structures but also to the quality of the working relationships between the three services and beyond. While this appears to work well in HMP New Hall, as in any other situation, partnership working and cooperation could be weakened in the event of a clash of personalities or – potentially – commercial pressures.

Unlike many prisons, HMP New Hall has had limited problems with NPS, although the limited (and unconfirmed) experiences staff have had have been concerning for staff and inmates alike. All new prisoners are asked about mental ill health in reception; as might be expected, the proportion of women presenting with a mental illness is high. A similar proportion – around half- have problems with drugs and/or alcohol misuse on entering the prison.

Having piloted a recovery wing, HMP New Hall now seeks to embed the recovery ethos throughout the prison, via access to regular and well attended recovery clinics, which are accessed by self-referral. Turning Point, supported by Spectrum, also offer peer support and mentoring. Prison staff have an important role to play in supporting engagement in these and other activities; stakeholders elsewhere have highlighted the problems that shortages of officers can cause.

All prisoners in contact with Spectrum will receive an appointment with an appropriate service that will be local to them upon release, regardless of whether they are still in medically assisted recovery or are abstinent. This happens as a matter of routine, although the appointments are not always followed up. As a fall back, people are given contact details of a range of local services should they wish to self-refer in future. Pre-release support is offered by an in-reach service offering access to a range of services including Together Women,[98] a specialist service that works with women ex-offenders and Shelter,[99] the housing advice provider. As in many other parts of the country and for many people leaving prison, despite the availability of housing advice, securing accommodation continues to be a very significant challenge and obstacle to successful resettlement in the community.

Under the current healthcare contracts in HMP New Hall, there is no lead provider; each service is responsible for its own work and accountable directly and only to its commissioner. Spectrum believe that this arrangement has worked well. In State of the Sector 2014-15, DrugScope found that there was a tendency for prisons to move to integrated health care with a lead provider to which the other providers – if still in place – would be subcontracted.

This arrangement has much to commend it, but the move towards it risks introducing, prior to the award of contract, competitive and commercial pressures into hitherto harmonious and cooperative environments. This is, of course, not unique to

prisons and reflects to a large degree the experience of community services.

Summary and recommendations

Seen in a longer-term context, health services for offenders have improved significantly. The centralisation of commissioning under NHS England, the prioritisation of mental health care and the shift to more integrated health care in prisons, or at least systems with a designated lead provider, are likely to be beneficial.

But, while much progress has been made, it is impossible to ignore the many warning signs, with suicide and violent incidents increasing. Stakeholders ascribe this, at least in part, to the loss of non-specialist and non-clinical staff, primarily prison officers with the time and inclination to get to know and take an interest in prisoners as well as facilitating their movement and attendance at specialist interventions. The positive impact they have made in the past and could do again should not be underestimated.

Finally, while the political interest in mental health and the principles of parity of esteem is most welcome, thinking in terms of specialist units within prisons appears to be a misreading of the characteristics of the prison population and the problem at hand.

- The next government should ensure that continuity of post-sentence support is prioritised;

- Calling for additional resources at a time of near-universal austerity is problematic, but the experience of stakeholders is that an apparent shortage of prison officers is not only depriving prisoners of important human contact but is also hampering the ability of specialist services within prisons to provide an effective service;

- Prioritising high-quality mental health care in prisons alongside high quality treatment for substance misuse is a welcome and much needed development. Developing structures that make explicit the connections between the two (very often) overlapping needs and diagnoses is essential, as is ensuring that measures are taken to respond to the risks posed by NPS in general and synthetic cannabinoids in particular;

- The proposals for mental health units in prisons as currently outlined (albeit in very general terms) seem flawed. Reframing them as a whole-prison approach intended to meet the needs of all prisoners would show a better understanding of the level of demand for interventions;

- While a substantial proportion of the population will shortly be covered by the Liaison and Diversion Pilot schemes, the roll-out should be maintained. There appears to be a particularly pressing case to ensure that every possible effort is made to divert young people affected by substance use needs, mental ill health or both away from

the criminal justice system and, in particular, away from the prison system;

- Where they still exist, Drug Interventions Programme services could act as infrastructure that Liaison and Diversion services could be folded into.

Young people

Context

Services for young people have been the subject of considerable attention recently. A number of factors have contributed to this. In announcing the establishment of the Children & Young People's Mental Health & Wellbeing Taskforce, Norman Lamb MP, the Minister for Care, described child and adolescent mental health services (CAMHS) as 'dysfunctional' and 'crying out for a complete overhaul'. He argued that if mental health services were often seen as 'Cinderella services', CAMHS was 'the Cinderella service of a Cinderella service'. He also spoke of the perceived institutional bias against mental health services more generally, a bias which the new requirement for parity of esteem is intended to mitigate.

While mental health and CAMHS specifically have been the subject of considerable national policy interest, as above, it is not yet clear that this has resulted in substantive changes at service level; in a response to a parliamentary question in January 2015, Lamb confirmed[100] that Primary Care Trust programme funding for CAMHS has fallen every year since 2009-10, although he was careful to add that the figures available fail to capture all the activity and excluded likely other sources of funding for specialist services, including local authorities.

Other stakeholders have come together to support the strengthening of activity around CAMHS, including the Children and Young People's Mental Health Coalition, a group of interested organisations from a number of sectors, established in 2009.[101]

Key developments

The Children and Young People's Mental Health and Wellbeing Taskforce

In mid-2014, Norman Lamb, Minister of State for Care and Support, convened a Children and Young People's Mental Health and Wellbeing Taskforce[102] to review the provision of child and adolescent mental health services, or CAMHS.

Lamb was speaking after the release of an NHS England report into Tier 4 CAMHS services which highlighted the incidences of young people being treated in hospital due to a shortage of community provision and also significant localised shortages of bed spaces in the South West and North East of England. The shortage of beds in the former location was apparently reflected in a well-publicised incident in November 2014[103] in which a 16 year old girl was held in a police station under the Mental Health Act as no NHS beds or spaces in any other health-based place of safety were available, a position the police and other local stakeholders are working to remedy.[104]

The report of the taskforce[105] is organised thematically around:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency

- Developing the workforce

The report also acknowledges some of the challenges CAMHS and related services face:

- Significant gaps in data and information and delays in the development of payment and other incentive systems;
- The treatment gap – only 25-35% of people with a diagnosable condition access support;
- Difficulties in access – referrals, waiting times and complexity of cases have increased;
- Complexity of current commissioning arrangements – lack of leadership and accountability means services can slip through the gaps;
- Access to crisis, out of hours and liaison psychiatry services are variable and in some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.
- Specific issues facing highly vulnerable groups of children and young people and their families who may find it particularly difficult to access appropriate services.

Observing that 75% of mental health problems in adult life arise before the age of 18, the taskforce makes a moral, social and economic case for change. Some of the recommendations, such

as waiting time targets, reflect announcements already made, but others are new and potentially wide-reaching, such as the move to a 'one-stop shop' model of community service provision and transition-age services to avoid the 'cliff edge' encountered on turning 18. Perhaps surprisingly, while drugs and alcohol are mentioned, the role of specialist treatment and the incidence of coexisting substance misuse and mental ill health receive little attention.

Report of the House of Commons Health Committee into Children's and adolescents' mental health and CAMHS

Post-dating the announcement of the CAMHS Taskforce, the Health Select Committee produced a substantial report[106] which welcomed the establishment of the Taskforce and highlighted several current areas of concern. These included:

- A lack of robust and comprehensive data meaning that those planning and running CAMHS services have been 'operating in a fog';
- Despite the Committee hearing compelling evidence of the value of early intervention, this has been somewhat neglected with many services appearing to rely in peripheral or insecure funding;
- That the public health reforms in 2013 should present new opportunities for strengthening the role of local authorities, although there are limited signs of this happening so far;

- Some Tier 3 (specialist outpatient services) report increased waiting times and increased referral thresholds – a finding reflected in DrugScope's *State of the Sector* for adult services;

- Frozen or reduced budgets.

The Committee was most critical in its findings concerning Tier 4 specialist inpatient provision, arguing that there are 'major problems' with access and that children and young people's safety was being compromised while waiting for a space to become available. The Committee found that NHS England had not made sufficient progress in its role as the national commissioning organisation for in-patient services, and that more investment and consistency in Tier 3.5 services, designed to bridge the gap between community and specialist treatment should be prioritised.

Perhaps surprisingly given the apparent move towards more integrated services, the Committee was largely silent on the matter of drug and alcohol misuse among children and young people.

Sector views – DrugScope State of the Sector and mental health summit

In 2014, DrugScope extended its *State of the Sector* survey to young people's services for the first time. 47 services responded, primarily specialist substance misuse services but

also on behalf of families services, CAMHS, other integrated services and safeguarding teams.

Compared to adult services, which were surveyed separately, there was stronger support for the idea that (where relevant) retendering had led to services that better reflected local need, that quality had been prioritised and that services better reflected good practice. Albeit based on a limited sample size, the responses also give an indication of the diversity of funding the sector benefits from. One respondent was keen to highlight this as a weakness rather than a strength, arguing that receiving relatively small sums from many sources can make services appear marginal and easy to lose sight of.

Respondents raised a number of challenges, with several arguing that integration with CAMHS was the most pressing need, which was paralleled by one respondent expressing a concern that while closer integration is important and likely to be beneficial, care will need to be taken to ensure that the pendulum doesn't swing too far in the other direction and that specialist substance misuse treatment is overlooked.

Some of the comments were reflected by Ryan Campbell, Chief Executive of KCA, who was interviewed as the leader of an organisation with significant experience of delivering a range of services for children and young people:

> *The young person's sector has always been under resourced compared to adult services. It's often expected to work with a wider set of needs because young people*

tend to come to services not as a drug user, as an alcohol user, but as a person who's having problems in their lives generally and substance misuse is part of that. We tend to get much less money for clients than we would do as an adult service. So that's a challenge. I don't think that challenge has particularly changed.

At the Recovery Partnership summit, participants were keen to emphasise the connectedness between CAMHS and adult services – that while most problems are apparent by age 18, services for under-18s only receive around 6% of the mental health budget. That point was however qualified by the observation that while many people misuse substances in their teenage years and early adulthood, the majority of them subsequently stop or significantly reduce their use. There may be a risk of inefficiently allocating scarce resources as a result; there is a need, if possible, to improve service's ability to recognise the 5% who go on to develop problems. Alternative methods of supporting health and wellbeing may be effective, including whole-school approaches to resilience.

Stakeholder opinion and experience reflected the findings of the Health Committee – that funding for Tier 1 and 2 support has been reduced, leading to raised thresholds for Tiers 3 and 4. The natural consequence of this has been to increase both the difficulty of accessing a service and lengthier days once access has been granted.

Participants welcomed the forthcoming National Occupational Standards for Children & Young People's Health Services,[107] and

particularly welcomed the prominence given to CAMHS and young people's services more generally on the political agenda.

Summary and recommendations

As Norman Lamb has suggested and the Health Committee has confirmed, there are many reasons to be concerned about the condition of CAMHS, young people's specialist drug and alcohol treatment and integrated services. While the findings of *State of the Sector* are unable to shed much light on funding, they suggest that specialist young people's treatment has a somewhat positive outlook compared to adult community and residential services, DrugScope (with the UK Drug Policy Commission) has previously highlighted the risks facing young people's specialist treatment in terms of funding:[108] DrugScope is currently undertaking research to try to quantify this.[109]

Turning to CAMHS more specifically, there are several causes for concern. These include insufficient and out of date data, a shortage of beds locally and nationally, raised thresholds for entering services, particularly at Tier 3 and 4 and reduced funding, apparently at all tiers. Access to crisis care and places of safety appears to be particularly problematic, although via the Crisis Care Concordat, progress is being made.

On the demand side, the impact of novel psychoactive substances seems somewhat difficult to assess; there are signs that their impact is small but growing. Whether the planned legislative changes that will be introduced to counter their widespread availability will work remains to be seen. While the 2008 financial crisis and subsequent recession have not

resulted in the widespread public health, mental health and substance misuse crises of previous recessions, policy makers and commissioners should be alive to the continuing risk that tough economic and labour market conditions might yet have health and mental health consequences and that, for some people, these may be serious and long-term.[110]

- The Government has committed to conducting a new prevalence survey of mental ill health in young people; this should be conducted at the earliest opportunity;

- Similarly, government must ensure that there continues to be an informed understanding of substance misuse underpinned by regular, robust and methodologically consistent research;

- There should be a continued commitment to supporting the work of the Crisis Care Concordat at the CAMHS level;

- The recommendations of the CAMHS Taskforce, should be taken forward by the incoming government;

- The difficulties presented by having multiple commissioners and funding streams are complex, arguably more so than for adult services. This has been highlighted in DrugScope's *State of the Sector* 2014-15 as posing a risk, not merely adding complexity. Stakeholders should build on developing work around pooled budgets and commissioning at a local level, in lieu of any national framework.

Building a better life for yourself

Concepts of recovery have become far more prominent in recent years, first in the field of mental health and subsequently in substance misuse. As Bell and Roberts argued in 2013[111] however, this development has taken place separately and largely in isolation. In their paper, Bell and Roberts look for areas of common ground .

Recovery in substance misuse

Recovery is at the heart of the 2010 Drug Strategy and is described as offering a more positive and ambitious vision for people affected by drug misuse than had been the case in previous strategies.

The strategy defines recovery as involving:

> *three overarching principles– wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people.[112]*

While adding that:

> *Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. Medically-assisted recovery can, and does, happen. There are many thousands of people in receipt of such prescriptions in our communities today who have jobs, positive family lives and are no longer taking illegal drugs or committing crime.*

This could be seen as implying a degree of dissatisfaction with long-term prescribing of opioid substitutes, something consistent with public pronouncements by the Prime Minister and other senior ministers.

However, the acknowledgement of recovery as a process rather than an end state is broadly aligned with the UK Drug Policy Commission's Consensus Statement from 2008,[113] which posited that:

> *The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.*

What both definitions share is an emphasis on participation and wellbeing as well as the narrower sense of simply addressing substance misuse. Supporting a more positive narrative in which recovery is framed in an asset-based sense, encompassing active participation and quality of life, is helpful in countering a prevailing narrative and understanding which is still to a large extent centred around anti-social behaviour, offending and blood -borne viruses – significant problems though they remain.

The components of recovery are included in the drug strategy as 'recovery capital', described as the resources that can help the individual start and sustain the process of recovery:

- Social capital - the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
- Physical capital - such as money and a safe place to live;
- Human capital – skills, mental and physical health, and a job; and
- Cultural capital –values, beliefs and attitudes held by the individual.

Crucially, these attributes can not only be drawn on to support recovery, but are in turn supported by recovery. The Development of a patient reported outcome measure for addiction recovery (PROM-AR) project, led by researchers at the Department of Addictions at King's College London, is seeking to develop a validated tool to measure progress in recovery. Some conceptualisations of recovery from substance misuse have prioritised one aspect of completion of treatment, clinical presentation or substance intake or another as being the defining characteristic.[114] The output of PROM-AR seeks to broaden this to quality of life measures that reflect the wider changes individuals recovering from substance misuse themselves associate with recovery.

Recovery in mental health

Recovery in mental health has followed a somewhat different trajectory. It is, in terms of policy at least, also a less contested term. Rather than prioritising being symptom-free or the clinical management of symptoms, it focuses on how the person would like to live, and can be summarised as involving hope, control and opportunity.[115] Generally, recovery tends to be regarded as being achieved when the individual in question decides that it has, rather than being measured against government policies and strategies.

There are, however, considerable similarities. Directly analogous to recovery capital in the Drug Strategy, the Mental Health Foundation identifies the following as factors that can support recovery in mental health:

- Good relationships;
- Financial security;
- Satisfying work;
- Personal growth;
- The right living environment;
- Developing one's own cultural or spiritual perspectives;
- Developing resilience to possible adversity or stress in the future.[116]

The above list illustrates the reality that while there may be differences in the way that recovery is understood across both sectors, there is significant commonality in the sense that recovery is about, among other things, a substantive improvement in quality of life.

Employment and recovery

The employment rate in the UK is currently at an all-time high of over 73%[117] (although this includes people classed as self-employed regardless of how viable their self-employment is, people on insecure or zero hours contracts and people on some government schemes). This is slightly higher than the rate at the time of the economic crash in 2008. However, the employment rate for people with severe mental ill health is considerably lower at around 6%,[118] improving this was identified as a priority in the annual report of the Chief Medical Officer.[119] The proportion of people with some substance misuse needs is also low: while around 19% of people accessing treatment in 2013-14 were in employment, this drops dramatically if one only counts people in treatment for heroin and/or crack cocaine misuse.

The role of employment in improving and protecting health and wellbeing more generally has become an accepted tenet of both this and the previous government.[120] One of the founding documents of this often articulated but occasionally over-simplified notion is an evidence review conducted in 2006 on behalf of the government. This review found that, broadly, there is persuasive evidence that supports the idea that employment

improves health and wellbeing in addition to meeting economic and financial needs.

The authors however offer some often overlooked caveats – that the nature and quality of work is important. It is not clear that unpleasant, low-status, low-paid, insecure or antisocial jobs bring about an improvement in health and wellbeing and some evidence that they may actually be harmful. In 2014, the London Drug and Alcohol Network conducted a survey of and series of interviews with a large number of job seekers with experience of treatment for substance misuse which echoed the findings of the evidence review, including the finding that not all 'better' jobs (in terms of pay, security, status and so on) were felt to be positive environments for recovery from substance misuse. [121]

Unfortunately, due to the tendency to disengagement from the mainstream job market, 'bad' jobs tend to feature disproportionately in the jobs that people move into from treatment, where they move into work at all. These might be predominantly in the 'secondary' labour market, where pay, security, terms and conditions, hours of work, routes of progression and so on are typically lower or more limited to those found in the 'primary' labour market.

Waddell and Burton also observe that the social setting and context should be taken into account. The geographical distribution in which people with barriers to employment relating to substance misuse tend to live in economically disadvantaged localities is a further factor in both reducing the potential job

entry rate and, in all likelihood, the type of jobs people are able to eventually secure.

The Marmot Review recognises the importance of good work, establishing three priorities of improving access to good jobs and reducing long-term unemployment across the social gradient; making it easier for people who are disadvantaged in the labour market to obtain and keep work; and improving the quality of jobs across the social gradient.

Marmot also highlighted 10 components of good work that protect and promote health and wellbeing:

- freedom from precariousness;
- having some control over work;
- having appropriately high demands;
- fair earnings and job security;
- opportunities for training, learning and promotion;
- preventing social isolation, discrimination and violence;
- sharing information and decision-making;
- reconciling work and other demands;
- reintegrating sick and disabled people.

Marmot observes that a range of approaches to promoting good work are needed, from labour market programmes to facilitate access to encouragement, incentivisation and ultimately enforcement when ensuring that employers follow guidance and legislation and actively promote physical and mental wellbeing at work.[122]

National policy context

Supporting people with histories of substance misuse into employment is one of the stated aims of the 2010 Drug Strategy, the Social Justice Strategy[123] and other key government strategies and policies. The Disability and Health Employment Strategy and No health without mental health pay great heed to the importance of employment.

The 2010 Drug Strategy states that the 'public sector must play its part through both direct recruitment and procurement contracts'. This is a welcome call – employment would not only be a benefit to employer and employee but would also provide more positive, employment and recovery focussed case studies. However, local authorities in England have experienced a reduction in their spending power of roughly 27% between 2010 -11 and 2014-15[124], with less affluent areas (which in many cases will have a disproportionately high proportion of people with histories of substance misuse) tending to be more affected than those with relatively affluent populations. Expecting local authorities to recruit from a cohort traditionally seen as hard to reach, high-risk and likely to be in need of ongoing support at a time of historic reductions to funding may have been optimistic.

Case study – Central and North West London NHS Trust - Individual Placement and Support

Individual Placement and Support (IPS) is an evidence-based employment intervention. Originating in the field of mental health in the United States of America, it has a 20 year history of outperforming more traditional deficit-based or 'train and place' interventions, including in peer-reviewed multi-site, multi-country trials.

Central and North West London NHS Trust (CNWL) introduced IPS into its mental health services in 2004; it was later one of the first services to introduce IPS to substance misuse services, in 2009.[125] CNWL's service has out-performed the comparable mainstream interventions that have run during that decade, and most positively of all, has succeeded in supporting people into more than entry level jobs, but also into the professions, associate professions and into skilled trade.

By focusing on job quality and, crucially, the individual aspirations and wishes of the client, IPS is able to avoid some of the pitfalls that prioritise (any) job entry above all else. IPS involves embedding employment specialists within clinical teams, thereby (ideally) gaining the support and trust of clinical staff, and also involves working people at any stage of their recovery journey; the only qualifying criterion is that the individual is interested in working, even if they happen to be staying in a secure ward at the time.

IPS rests on 8 key principles; fidelity to these can be externally evaluated; the evidence suggests that adherence to the principles is associated with higher performance:

- It aims to get people into competitive employment
- It is open to all those who want to work
- It tries to find jobs consistent with people's preferences
- It works quickly
- It brings employment specialists into clinical teams
- Employment specialists develop relationships with employers based upon a person's work preferences
- It provides time unlimited, individualised support for the person and their employer
- Benefits counselling is included.[126]

Despite its high performance with a typically underserved and hard to help customer group, CNWL's IPS service has found it a challenge to retain long-term funding, particularly for its work in its substance misuse settings. However, in the Government's Disability and Health Employment Strategy,[127] there is a commitment to make IPS more widely available within IAPT services. Wider availability of IPS is very welcome, but given the question of how many, or how few, people with needs relating to

substance misuse make use of IAPT services, there may still be a substantial number of people without access to the type of service that could make a transformative difference to their employment prospects and subsequently their wellbeing and recovery.

The current government, like previous ones, also provides employment as one of the conditions of claiming social security. This can broadly be described as having two tiers: Jobcentre Plus and, later, access to outsourced provision, with the second tier having two strands: Work Programme and Work Choice. The former being 'mainstream' employment support for the long-term unemployed and the latter being specifically for people with disabilities.

The Work Programme is a national labour market programme aimed at the long term unemployed and those with significant barriers to employment. While most referrals take place after 9 or 12 months of unemployment, people with mental health problems, substance misuse problems, affected by homelessness and/or other disadvantaging characteristics can volunteer to be referred at 3 months. Prisoners are referred to the Work Programme immediately upon release (assuming they make a claim for Jobseeker's Allowance) and, at least in theory, will receive a through the gate service from Work Programme providers prior to release.

The Work Programme is delivered by a small number of 'prime' or top-level contractors, mostly from the voluntary sector; their work is supported by supply chains of other education, training

and employment services from the private, voluntary, public and social enterprise sectors. While the outsourcing of employment support has been a characteristic of the current government and the ones recently preceding it, the evidence that the private and voluntary sectors can outperform the public sector Jobcentre Plus is limited.[128]

As a result of previous programmes which have revealed a tendency for those closest to work to be offered the most support and those furthest from work the least (known as 'creaming and parking'), DWP introduced a new differential payment model with the Work Programme. Largely using the type of benefit claimed along with a limited number of other characteristics as proxy indicators for need, the intention has been to incentivise providers to support the 'hardest to help' by offering substantially more money. This approach has not been an unreserved success.

Work Programme performance data are collected around people experiencing mental ill health (unlike drug and alcohol misuse, it is included in the Public Sector Equality Duty),[129] and while they are not usually included in the performance statistical releases, they are retrievable via DWP's tabulation tool.[130] Of 152,200 referrals of people with mental health problems to the Work Programme, 10,150 or around 6.7% have resulted in a job outcome. This is a somewhat lower outcome rate than people with health problems other than 'mental and behavioural disorders'[131] and significantly lower than the rate for people with no health problems recorded. Some stakeholder groups have expressed the concern that participating in the Work

Programme, which is predicated on a strict conditionality regime, may be detrimental to people with mental health problems.[132] What seems beyond question is that the Work Programme has not met expectations for people with disabilities and health problems.[133]

More recently, pilot activity has been announced in four areas to trial different approaches to supporting people affected by mental ill health into employment,[134] supported by £6m from the Department for Communities and Local Government and a further £6m from the pilot areas themselves. Separately, Social Investment intermediary Social Finance[135] is working with a number of local authorities to develop social-investment supported IPS services, backed by the Cabinet Office Outcomes Fund[136] and the Big Lottery.[137] This will enable the social investment approach to be trialled at scale for specialist mental health employment projects and could, potentially, be brought within DWP-funded provision in a post-Work Programme environment after 2017.

Barriers to employment

These will vary very significantly from person to person. For example, while limited qualifications and work experience are likely to be barriers to employment for many people with histories of drug and alcohol misuse, there are many highly qualified and highly experienced people recovering from substance misuse and mental ill health.

Personal barriers to employment can include drug and alcohol addiction itself, a history of offending, housing problems, low self -confidence, self-esteem and motivation, becoming discouraged workers, physical and mental health problems, poor employment histories, low skill and qualification levels, learning disabilities, behavioural problems and poor access to information.

Structural barriers can include the cost of labour market participation, stigma and employer attitudes (2/3 of UK employers surveyed in 2008 wouldn't employ a former opiate/ crack cocaine user),[138] absence of a compelling competing narrative despite positive employer experiences, (local) labour market conditions, inadequate macro measures, a scarcity of effective interventions, as well as policy, activity and funding silos.

An important consideration for stakeholders in employment and employment support is that many employers already employ (knowingly or otherwise) people with histories of or current needs relating to substance misuse, something that is rarely acknowledged beyond offering generic occupational health type support. One employer that has acknowledged and acted on the potential for substance misuse related needs in their current workforce is Tata Steel in South Wales. Since 2011, they have worked with local agency Kaleidoscope.[139] That a major employer in a safety-critical industry should take the health and wellbeing of its employees seriously is welcome and not untypical. However, this is not necessarily something that would scale to all sizes of employer, even if the demand was there. DWP has started to introduce Fit for Work, a service that, in

effect, can fulfil the role of occupational health for employers otherwise unable to provide access. The website provides limited information for employers, employees and general practitioners around drugs and alcohol in the workplace; a helpline and face to face service is also available.

A further potential disincentive for employers is that it is not always clear what 'reasonable adjustments' in the workplace might mean in context of mental ill health. Required by the Equality Act 2010[141] what constitutes a reasonable adjustment may be reasonably clear in some instances and much less so in others. Risk averse employers might find this lack of clarity concerning.

For people with barriers relating to drug and alcohol misuse, statistics are not recorded as a matter of routine. There are, however, exceptions in the form of the two drug and alcohol Work Programme pilots running in three locations in England.[142] Announced by the Secretary of State for Work and Pensions in January 2013,[143] one of these pilots involves a significant variation to the payment by results payment model, the other involves no additional money but instead focuses on greater cooperation within Work Programme supply chains and the additional involvement of specialist agencies. Both pilots are being formally evaluated by a third party. No performance data have been released although based on discussions with local stakeholders, there seem unlikely to have been transformative performance gains.

A further factor may be the exclusion of substance dependency (other than where originally prescribed) from the Equality Act 2010 and predecessor legislation. This means that drug and alcohol dependence joins a limited number of other conditions in being absolutely excluded, the others being hay fever, voyeurism, exhibitionism, a tendency to physically or sexually abuse of other persons, a tendency to steal and a tendency to set fires.[144]

Expecting a legislative change to result in an immediate and significant change of attitude and behaviour on the part of employers (and those providing goods and services) would probably be overly optimistic. Any change to bring (for example) former substance dependence into the Act would also in all likelihood be contentious in some quarters. What it could achieve though is providing people with defined rights and a route of redress, and more importantly, could send a message about how government and society want and require people recovering from substance misuse to be treated. The Americans With Disabilities Act of 1990 provides an example of how some protection can be extended without, as some might see it, rewarding or protecting people for undesirable behaviour.[145]

Social security

Social security makes an important contribution to providing people with the time and space to make improvements to their health and wellbeing. With many people affected by substance misuse, mental ill health or both being unemployed, out of work benefits like Jobseeker's Allowance (JSA) and Employment and

Support Allowance (ESA) are vital forms of support, on a temporary or long term basis.

However, the benefits system is a complex network of centrally and locally administered safety nets, safeguards, protections and entitlements. It also naturally interacts with employment and volunteering, often to the detriment of both. In the case of the former, the difficulties and risks of cancelling and restarting claims can be problematic. In the case of the latter, people often believe (or are told) that volunteering while on benefits is strictly prohibited, where in fact volunteering is not only often allowed but in many cases is—or should be—actively encouraged as part of the Jobcentre Offer..

The Government (like previous ones) has acknowledged the complexities and inconsistencies in the social security system and has sought to address some of them through a large-scale process of welfare reform. The Government describes some of the principles behind its programme of welfare reform in the following terms:

- Making it pay to work (through Universal Credit and other changes);

- Unconditional support for disabled people that need it, help for those that can work to gain work (people are supported through the new Personal Independence Payment, or PIP. The Government has the objective of supporting more disabled people into work and “are working to make sure those that can work do”);

- Preparing the long term unemployed for the world of work (through the Work Programme, the Youth Contract and through Help to Work).[146, 147]

However, while the commitment to providing support for those permanently or temporarily unable to work due to ill health seems clear, it has proved somewhat more challenging in operation. The introduction, from late 2012, or a more rigorous conditionality regime (the things a claimant must do to remain eligible for social security) accompanied with more stringent penalties for breaching it (up to 3 years in the case of Jobseeker's Allowance) has posed problems for increasingly large numbers of both JSA and ESA claimants.

As with Work Programme performance data, there is very limited information currently available about the number of people with health needs relating to substance misuse that have had their personal benefits stopped (known as sanctioning). There is more known about ESA claimants with mental health problems though: while they constitute 46% of the ESA caseload, over 60% of sanctions have been applied to people with a primary condition of mental ill health.[148] In essence, people with mental health problems are disproportionately likely to receive a sanction; organisations working with other disadvantaged groups have made similar claims, which is supported by evidence from similar regimes overseas and growing evidence from the United Kingdom.[149, 150]

Key development – Universal Credit

Universal Credit is a new benefit that combines 6 current welfare benefits into one. It has a number of distinguishing characteristics, including:

- Single payments, monthly payments to one member of the claimant household (by default);
- Replaces income related JSA, income-related ESA, income support, Child Tax Credit, Working Tax Credit and Housing Benefit/LHA;
- Is an in and out of work benefit, rising and falling as other household income changes;
- Is measured against 'real time' information from Her Majesty's Revenue and Customs (HMRC) about tax and income;
- Overall effect will produce financial winners (around 2/3 of claimants) and losers (around 1/3 of claimants);
- Some will see work incentives strengthen, for others they will weaken;
- Will significantly reduce the current non-take up of benefits;
- 4 conditionality groups reflecting health related barriers to employment and parent/carer status;

- Includes a conditionality easement of up to 6 months for people in or entering treatment for substance misuse.

So far, Universal Credit has been rolled out slowly. While it is now available in many parts of the country, 'complex' claimants (for example, those with mental or physical health problems or people who misuse substances) have been excluded.

DWP acknowledges that many people are likely to require support when faced with a single, monthly payment (likely to be substantially larger than the smaller, more regular, split payments that they may have become accustomed to) for the first time, or even on an ongoing basis. They are developing products and services intended to support people through the process:

- Universal Support[151] (formerly the Local Support Services Framework) – locally designed and assembled partnerships that will support claimants on the basis of a single intervention or sustained support;

- Alternative Payment Arrangements[152] – where payments can be split between more than one member of the household, can be made more often or can involve the rent component being paid directly to the landlord, where applicable. For alternative payment arrangements and budgeting support, mental ill health and substance misuse are indicated as 'Tier 1' factors likely to mean the individual will be highly likely or have a probable need for Alternative Payment Arrangements.

While the acknowledgement that some people are highly likely to need support, as 'complex' claimants have so far been excluded, the efficacy of this in practice is yet to be seen.

Housing

DrugScope's State of the Sector 2013 and State of the Sector 2014-15 have highlighted the importance of housing to successful and sustained recovery from substance misuse. It makes an equally important contribution to maintaining mental health and recovery from mental ill health.

However, in much of England, accessing suitable and stable accommodation is problematic—for example, in 2013-14, 10% of people accessing treatment had no fixed abode, and a further 14% had some other form of housing problem. Some aspects of welfare reform have been unhelpful in this respect, primarily the untethering of housing benefit from actual local rents, the introduction of the local housing allowance cap and overall benefit cap (which has had a particularly stark effect in high-cost areas like the South East) and 'withdrawal of the spare room subsidy', sometimes known as the 'bedroom tax'.

There is also anecdotal but persuasive evidence that some private landlords, alarmed by direct payments to tenants under Universal Credit, are withdrawing from letting to social security claimants. For local authorities and social landlords, the position is somewhat different, with higher levels of arrears and higher costs of recovering arrears featuring among current concerns. There are also some signs that many social landlords are considering changing allocation policy. While the nature of any

changes is as yet unclear, it seems possible that they may be to the detriment of tenants seen as, financially if in no other way, risky.[153]

Aside from the issues of capacity and financial viability, a number of recent developments offer hope for the future. Housing First,[154] a model that originated in the United States but familiar to many in the United Kingdom is now operating at some scale, and is being robustly evaluated. There is a very clear sense that while not a panacea, Housing First models may offer a means to improve the way that support is tailored to the individual, or at least maintain quality and outcomes in the face of significant budgetary pressure.

Key reform – Universal Credit and supported housing

Supported housing costs have in recent history been paid for by a mixture of rent (often funded from housing benefit) and Supporting People[155] funding. While Supporting People funding from central government has enjoyed a degree of protection, the ring fence was removed by the previous government in 2009, meaning that local authorities have been largely free to spend it as they see fit.

This has led to vastly different responses from area to area. While some local authorities have protected investment, others have been unable to. There may also have been a drift away from more expensive types of supported accommodation towards other forms of housing support, such as floating support or tenancy sustainment. Without much in the way of a systemic

overview of the scale and nature of these changes, the effect of any impact is difficult to gauge. What we know from the work of Homeless Link, the membership organisation for the homelessness sector (a major provider or supported housing) is that there appears to have been a net reduction in funding and in bed spaces.[156]

Universal Credit and other aspects of welfare reform such as the benefit cap and withdrawal of the spare room subsidy also pose challenges to the viability of supported housing. Ministers have been unequivocal in their desire to ensure that all who need supported housing or other forms of housing support can continue to access it, but settling on a definition that protects both the tax payer and vital services has proved difficult. The government is currently conducting a major exercise to learn more about the sector – its size, location and requirements – before considering the next move.

Homelessness and health

Homelessness, and especially rough sleeping, is, unsurprisingly, associated with extremely poor health. The classic scenario is that of tri-morbidity – poor physical health, poor mental health and substance misuse.[157] Health interventions for homeless people and rough sleepers in particular have often been somewhat ad hoc and dependent on location. Some recent developments may bring a significant and sustained improvement in this.

The Faculty for Homeless and Inclusion Health[158] is a multi-disciplinary body that has brought together clinicians, service providers, people with experience of rough sleeping and other stakeholders to improve health care for homeless people. Through producing the first set of standards for homeless health care for commissioners[159] and through working with stakeholders like Public Health England, they are changing the way that commissioners and funders think about health care for homeless people and other highly marginalised groups.

In a parallel development, the benefits of specialist provision in hospitals and on discharge is better understood, following pioneering work in recent years in London, Liverpool and elsewhere. Homeless people, generally experiencing far worse physical and mental health than the wider population and experiencing additional vulnerabilities associated with their circumstances, have more unplanned admissions to hospital, arrive at hospital in worse health and spend longer as inpatients. Discharging people to the street rather than breaking the cycle is to ignore golden opportunities to intervene. Organisations such as Pathway[160] are changing this. Support from the Department of Health, albeit on a pilot basis, to enable a large scale trial of hospital discharge services[161] has been welcome, but the effort must be sustained.

However, there is a substantial and growing cohort for whom solutions are often particularly difficult to find – non-UK citizens. In London, UK nationals generally make up fewer than half of the street population.[162] The remainder, many of whom are from

the central and eastern European countries that joined the European Union in 2004 and 2007, will have varying degrees of entitlement to public funds and consequently accommodation and support. The rules around this are complex[163] and proving entitlement can be non-trivial. While there are a limited number of charitably-funded projects in London and elsewhere working specifically with this group[165] and also reconnection projects that aim to support people to return to their home country,[165] the options for this cohort are limited. Research by the Centre for Research on Nationalism, Ethnicity and Multiculturalism at Roehampton University has highlighted some of the social and cultural determinants that can lie behind rough sleeping, alcohol misuse and engagement with services.[166]

Sector views – DrugScope State of the Sector and mental health summit

The importance of facilitating not just an improvement in health and/or clinical management was emphasised at the Recovery Partnership summit.

The role of campaigns as a method of overcoming obstacles was discussed at some length. People affected by mental ill health are frequently the subject of stigma from employers and the wider public. Friends and family can be the source of stigma but also the subject. All of this applies at least as much to people with histories of substance misuse, while those affected by coexisting conditions often face 'double stigma' – the stigma associated with one factor being piled on top of that of the other.

People with mental health problems have, however, benefited from large, national campaigns seeking to change perceptions and tackle prejudice. The largest and most recent example is Time to Change,[167] a campaign by Mind and Rethink Mental Illness. The campaign was established in 2009, and has run continuously since. The scale and duration of the campaign mark it out from anything that has been provided in the context of substance misuse or people with multiple needs.

Summit participants had a number of observations. An evaluation of Time to Change[168] showed that its impact had differed from sector to sector, having a much more significant effect on public opinion compared to that on health professionals, for example. Participants felt that it had had a limited employment effect, possibly shifting attitudes towards employers with employees who experience mental ill health, but not necessarily making them more likely to recruit someone with a history of mental illness. However, addressing stigma, negative attitudes and prejudice is akin to turning an oil tanker – positive gains should be welcomed where they arise.

A further benefit of Time to Change has been to mobilise a large number of campaigners and supporters. One of the members of the partnership has seen its directory of campaigners expand from 3,000 to 30,000 over the course of Time to Change. How viable an analogous campaign in the field of substance misuse might be is open to question. Considering the assets currently available however, many of the growing number of highly visible, locally active mutual aid, peer support and other recovery-

focussed organisations are already engaged in local campaigns to celebrate recovery and address stigma. Recent studies have pointed to the efficacy of countervailing, positive recovery stories in overcoming stigma and prejudice.[169]

The role of people who use services, or experts by experience, in the design, commissioning and delivery of the service they use or have used is also of interest. Participants at the summit commented that the experience of bringing together long-established groups focused separately on mental health and substance misuse had proved challenging. Some participants connected this to, among other things, service cultures and also conceptions of recovery: one focussed on sustained engagement, the right to treatment and participation; one (often but not always) emphasising exit from services and absence of clinical symptoms.

DrugScope has, along with its partners in the MEAM coalition, been developing tools to support the engagement of people who use services and experts by experience in service design and policy considerations around multiple needs.[170] With strong service user involvement heritages across both the substance misuse and mental health fields, these sectors are well placed not only to take this forwards but also to show real leadership in service delivery and policy activity.

Summary and recommendations

The recovery agenda is increasingly embedded in both the substance misuse and mental health spheres. If there is a challenge at all, it may lie in ironing out the conceptual differences to produce something closer to a shared understanding that can be used to inform commissioning and service design.

Employment can play a crucial role in promoting and protecting health and wellbeing and can, with some caveats around the quality and nature of work and the timing it is engaged in, promote recovery. However, the rate at which people enter work remains very low, and very few people affected by substance misuse, severe mental ill health or coexisting needs succeed in finding work.

The social security system provides vital protection and supports recovery by giving people the time and space to address their health needs as well as to be an active participant in society. However, for an increasing number of people with vulnerabilities and health related needs, the system is no longer working in an equitable way, but instead is causing hardship and requiring people to undertake activity which is quite inappropriate for their health needs and circumstances.

Housing supports recovery – in reference to Maslow's hierarchy of needs, it is one of the foundations on which further progress is built. The combination of a housing supply problem (in some areas) and welfare reform (with different reforms having more or less of an effect depending on the area) have been unhelpful. Furthermore, there are signs that the vital network of supported

housing is struggling. Research by Homeless Link suggests that capacity is shrinking with no sign of a compensatory reduction in demand, and until the matter of funding is resolved, the entire sector should be considered potentially at risk.

Rough sleeping has increased substantially in the last 5 years.[171] While funding for services working with rough sleepers, people with housing support needs and people at risk of homelessness has been protected by central government, in the current environment local authorities have not been able to pass that protection on. The additional difficulties faced by the substantial number of rough sleepers with limited or no recourse to public funds adds a significant challenge to services, communities and, of course, to the rough sleepers themselves.

- A shared vision of recovery should be reflected in future government policy. This should be informed by genuine and meaningful engagement with the communities that have the most significant stake: people affected by substance misuse, mental ill health or both;

- Labour market programmes should be improved. In the shape of IPS there is a proven, evidence-based and high performing model that could and should be made more widely available. While there is limited evidence to favour local over national commissioning, there is a strong case that local commissioning would support the work inclusion of people with substance misuse and mental health related barriers by bringing together interested

commissioners, providers and other stakeholders in a way that national programmes appear to struggle to do;

- Amend the Equality Act 2010 along the lines of the Americans With Disabilities Act;

- Provide clear guidance to employers about what 'reasonable adjustments' could include in the case of mental ill health. If the Equality Act was amended, this too would need reflecting in guidance to employers;

- Undertake a thorough review of JSA and ESA sanctions and their effect on disadvantaged groups;

- The future of the supported housing sector should be secured by addressing the current uncertainties about funding – this is not just a question of money but also one of producing a workable definition that protects both parties. Until this is done, there should be a commitment from central government that existing projects will be protected financially from any changes to the benefit entitlements of their clients or tenants;

- The major Time to Change campaign has shown that a large, sustained and well-resourced public-facing campaign can have some effect in shifting attitudes. Nothing similar has ever been carried out in the context of substance misuse. In fact, most media representations and some official campaigns do effectively the opposite by presenting people who misuse substances as threatening, dishonest

and unhealthy. This ‘othering’ seems unlikely to yield improvements in public or employer attitudes and may be helpfully countered by a broad-based campaign to promote a positive narrative.

Annexe - The clinical context – prevalence and scale

Both mental ill health and substance use are, at the population level, comparatively common although the effect experienced by the individual spans a considerable spectrum.

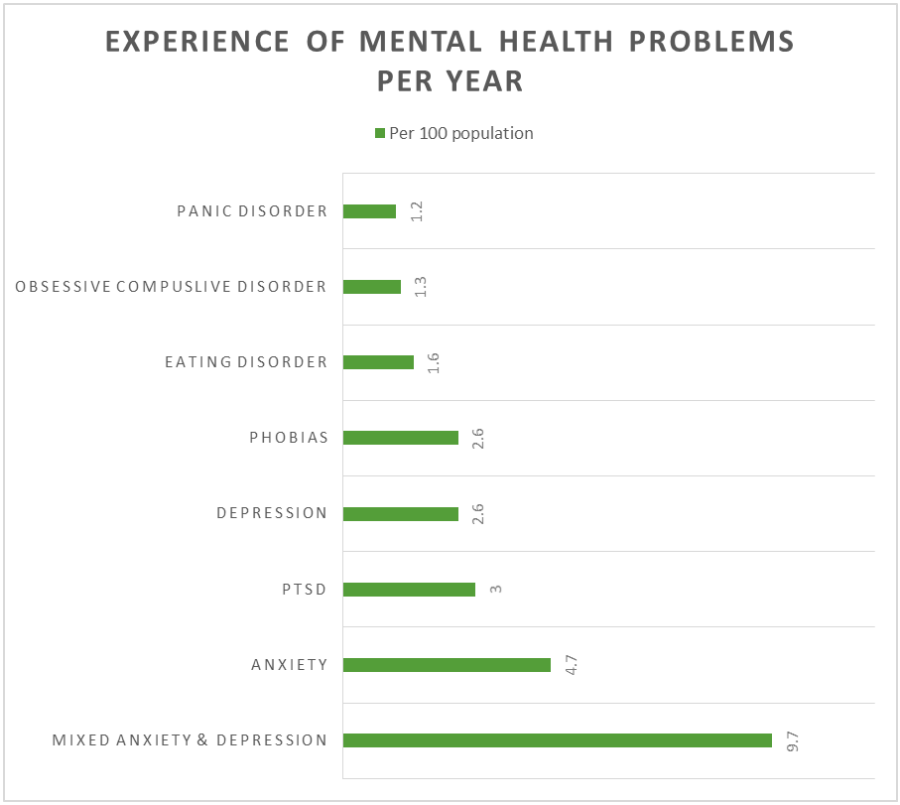
Mental health

Around a quarter of the population will, in the course of a year, experience some form of mental ill health, with depression and anxiety being most common. Women are more likely to experience treatment for a mental health problem than men. For many people who experience mental health problems, their first episode is likely to be during adolescence. Of particular current salience is the prevalence of mental illness and personality disorders within the prison population; combining both measures, mental ill health is the norm rather than exception.

Analysis by the Health and Social Care Information Centre (HSCIC)[172] reveals that the number of people who had formal contact with secondary mental health services increased to 1,746,698 in 2013-14 from 1,590,332 in 2012-13, or approximately 1 in 28 adults. Of these, 6% or 105,270 spent some time as a hospital inpatient in 2013-14, a slight decrease in both absolute and percentage terms from the preceding year, when the corresponding figures were 6.6% and 105,224. While the median length of stay as an inpatient was 23 days, at the end of 2013-14 half the people in hospital had been there for more than 117 days.

The Adult Psychiatric Morbidity Survey (APMS),[173] a regular survey of UK households (i.e. excluding those in prisons or

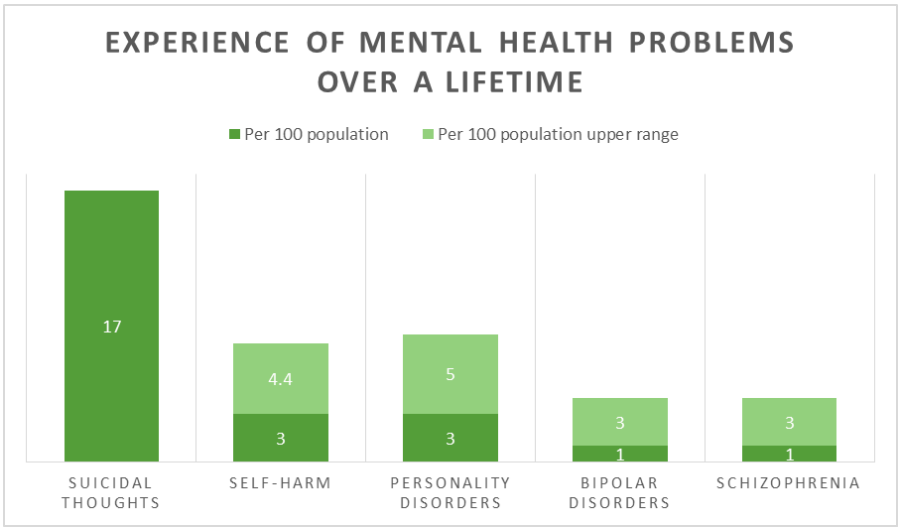
hospitals) last carried out in 2009 by the NHS Information Centre (now the Health and Social Care Information Centre, or HSCIC), indicates the incidence of common mental health problems over the course of a year:



Suicidal thoughts and self-harm are considered over the course of a lifetime rather than per year. 16.7%, or around 1 in 6 adults who participated in the survey indicated that they had had suicidal thoughts at least once in their lifetime, with 5.6%, or more than 1 in 20, saying that they had attempted suicide. For people who completed the form themselves, the peak age for

suicidal thoughts in men was 15-24, compared to a highest suicide rate among men aged 40 to 44 when considering registered cause of death only. For women the peak age for suicidal thoughts was 16-24 while the highest female suicide rate was in 50 to 54-year-olds. Male suicide rates in 2012 were around three times higher for men compared to women, at 18.2 male deaths compared with 5.2 female deaths per 100,000 population, and suicide is now the most common cause of death for males aged between 20 and 34 years.[174]

Separate research provides comparable measures for



personality disorders,[175] bipolar disorder and schizophrenia.[176] Estimates of lifetime prevalence of bipolar disorder, personality disorders and schizophrenia vary and are thus expressed as a range:

Personality disorder

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is produced by the American Psychiatric Association and is regarded as one of the two leading authoritative sources on psychiatric disorders. Personality disorders are defined as follows:

> *The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose a personality disorder, the following criteria must be met:*
>
> - *Significant impairments in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning.*
> - *One or more pathological personality trait domains or trait facets.*
> - *The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.*
> - *The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or sociocultural environment.*

- *The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication).*

While personality disorders have often been regarded as impossible to treat, more recent trials suggest that some personality disorders may respond positively to interventions.

Mental health needs of young people

The Chief Medical Officer's 2012 Annual Report[177] looks at mental health problems in children and young people in some detail, referring to Child and Adolescent Mental Health Surveys in 1999 and 2004 which found that 10% of children and young people under the age of 16 had a diagnosable mental disorder. Among the 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem while among the 11 to 16 year olds the prevalence was 13% for boys and 10% for girls.

The most common problems were conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (anxiety and depression) and autism spectrum disorders. While the report notes that there was no change in prevalence between 1999 and 2004, the incidence of mental health problems in children and young people rose between 1974 and 1999. The report notes the absence of robust epidemiological data more recent than 2004 but suggests increased hospital admissions and helpline calls related to self-harm as proxy

indicators that could reasonably be interpreted as meaning that the prevalence of mental health problems is increasing.

The report draws on evidence indicating that child mental health problems are persistent, with 50% of adult mental illness being apparent before reaching 15 years of age, and 75% before 18. There is also a strong association between experience of mental illness as a child or young person and social disadvantage. This in itself is problematic: there appears to be a clear mechanism by which disadvantage and mental health problems could be passed from one generation to the next in the absence of effective and timely interventions.

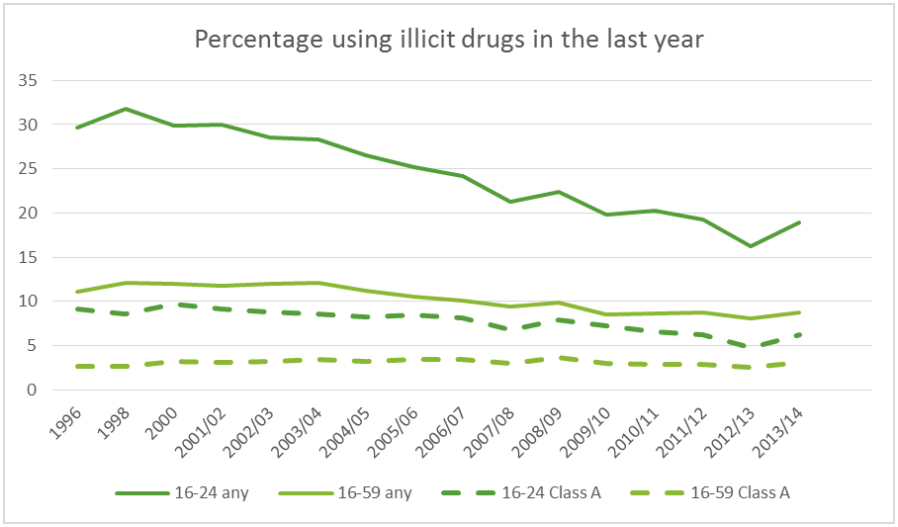
Substance misuse

For drug and alcohol misuse, the picture is again one of an impact on a socially significant scale. Findings from the 2013/14 Crime Survey for England and Wales[178] suggest that around 1 in 11, or 8.8% of adults aged 16-59 used any illicit drug in the previous year (an estimated 2,700,000 people), a slight increase compared to the previous year. The proportion of people aged 16-24 taking any illicit drug in the previous year was roughly double that of the broader population, at 18.2%.

As indicated on the chart below, the proportion of people using the drugs traditionally regarded as being the most personally and socially harmful – heroin and crack cocaine – is comparatively small. However, seen in a broader context, prevalence of heroin and/or crack cocaine use of around 9.4 per 1000 people[179] is still high in comparison with other European

countries.[180] Cannabis remains by far the most widely consumed illegal psychoactive substance; recent studies have pointed to a complex interplay between the increased potency of cannabis in the form of 'skunk' and mental ill health (particularly psychosis, a presentation relatively rarely seen in adult substance misuse services where depression and anxiety predominate) and cannabis's legal status in the United Kingdom.[181]

Consumption of alcohol is more widespread. Research carried



out by the Office of National Statistics (ONS) in 2012[182] suggests that substantially over half of the men surveyed and just over half of the women had consumed alcohol in the preceding 7 days, although once again, this should be seen in the context of a continuing downwards trend.

In addition to the considerably different levels of prevalence, there are also some significant demographic differences. While substance dependency (rather than substance use) is disproportionately prevalent in less affluent areas (and less affluent households within those areas), alcohol consumption generally increases the higher up the income distribution one goes, with more of the top income quintile tending to drink more across the key measures of at all in the last week, for five days out of the last seven and heavy drinking - defined as consuming 8 units or more in one session for men, 6 for women.

Paradoxically however, while the consumption of alcohol appears to have little correlation to the economic demographics, alcohol related harm does, with increased harm tending to be concentrated on the more deprived; other lifestyle factors and health inequalities appear to outweigh or at least leverage the contribution to ill health made by alcohol consumption alone.[183]

While around twice as many 16-24 year olds have used drugs in the last year compared to the broader population, peak alcohol consumption is the range of 45-64 years of age. However, for heavy drinking (defined as above), younger people feature most prominently, with 43% of men and 35% of women meeting the criteria. In essence, people aged 16-24 are less likely to drink frequently but more likely to drink heavily.

Young people and substance misuse

The reductions in adult substance misuse are in large part driven by reductions in substance misuse on the part of children

and young people. Findings from *Smoking, drinking and drug use among young people in England in 2013*[184] suggest that while there is little change from the two years immediately preceding, there has been a decline of roughly 50% across all measures (i.e. ever used, used in the last year, used in the last month) since 2001. This is broadly consistent for both sexes, all ages and all drugs and volatile substances with the exception of cannabis, where there has been a less pronounced decrease, and methadone, which has fluctuated at an extremely low level. For males and females, the number who have never taken drugs has been on a generally upwards trend. Broadly the same trends can be seen for alcohol consumption.

Social determinants of mental ill health

Sir Michael Marmot's landmark review *Fair Society, Healthy Lives*[185] has brought the matter of health inequalities and health equity into sharp relief. This is reflected in, for example, the Public Health Outcomes Framework,[186] which has at its core the ambition of improving the health of the poorest, fastest. By framing mental ill health and mental wellbeing in the context of Amartya Sen's capability approach, the Institute of Health Equity's thematic paper on the social determinants of mental health provides a means to understand mental health[187] from an asset-based perspective.

Making the case that mental ill health, including substance misuse are shaped by the economic, social and physical environment of the individual and that inequalities and deprivation are detrimental to mental health, the authors make

an argument for policy interventions that is both moral and economic. In particular, the authors argue against focusing solely on those in most need, instead adopting a universalist approach proportionate to need. Emphasising the significance of stressors encountered at an early age and the consequent risk of stress-related behavioural responses including drug and alcohol abuse leading to dependency similarly makes the case for a whole-life approach to addressing inequality. This approach should focus on key determinants analogous to the recovery capital approach adopted as a component of addressing substance misuse: poverty, unemployment, poor education and social isolation.

Troublingly, the Institute for Health Equality's companion paper *The impact of the economic downturn and policy changes on health inequalities in London*, published in 2012[188] indicates a range of harms that might be associated with the post-2008 economic downturn and subsequent period of austerity. These include increased mental ill health, decreased wellbeing, increased domestic violence, increased infectious disease and, as a lagging indicator, increased mortality due to heart disease. However, while the evidence for increased risk of violence and homicide in economically straightened times is substantial, this effect does not appear to have applied so far in London, where rates have fallen year on year between 2007 and 2014.

About DrugScope and the Recovery Partnership

DrugScope is the national membership organisation for the drug and alcohol field and is the UK's leading independent centre of expertise on drugs and drug use. We represent more than 300 member organisations involved in drug and alcohol treatment, supporting recovery, young people's services, drug education, prison and offender services, as well as related services such as mental health and homelessness. DrugScope is a registered charity (number 255030). Further information is available at: http://www.drugscope.org.uk/

DrugScope, the Recovery Group UK and the Substance Misuse Skills Consortium formed the Recovery Partnership in May 2011 to provide a new collective voice and channel for communication to ministers and officials on the achievement of the ambitions set out in the 2010 Drug Strategy. The Recovery Partnership is able to draw on the expertise of a broad range of organisations, including interest groups as well as service user groups and voices. More information is available at: http://www.drugscope.org.uk/partnersandprojects/Recovery+Partnership

References

1. Department of Health/Offender Health, 2009, A Guide for the Management of Dual Diagnosis in Prisons,
2. Ian Hamilton, (2014),"The 10 most important debates surrounding dual diagnosis", Advances in Dual Diagnosis, Vol. 7 Iss 3
3. Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide
4. Ian Hamilton, (2014),"The 10 most important debates surrounding dual diagnosis", Advances in Dual Diagnosis, Vol. 7 Iss 3
5. http://www.iapt.nhs.uk/about-iapt/
6. DrugScope & National Treatment Agency (2012), IAPT positive practice guide for working with people who use drugs and alcohol http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf
7. Health and Social Care Centre (2014) Psychological Therapies, Annual Report on the use of IAPT services: England– 2013/14 http://www.hscic.gov.uk/catalogue/PUB14899/psyc-ther-ann-rep-2013-14.pdf
8. Email from HSCIC to DrugScope, September 2014.
9. DrugScope (2012) The Public Health Reforms: What they mean for drug and alcohol services http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/PublicHealthReform.pdf
10. http://www.yhpho.org.uk/default.aspx?RID=198654
11. For example, see Public Health England, Royal College of Psychiatrists, Royal College of General Practitioners Substance Misuse and Associated Health (2014) The role of addiction specialist doctors in recovery orientated treatment systems http://www.nta.nhs.uk/uploads/the-role-of-addiction-specialist-doctors.pdf
12. Care Services Improvement Partnership (2008) Dual Diagnosis: Developing capable practitioners to improve services and increase positive service user experience http://www.dualdiagnosis.co.uk/uploads/documents/originals/CapablePractitioners.pdf
13. Hughes, Liz (2006) Closing the Gap: A capability framework for working effectively with people with combined mental health and substance use problems (Dual Diagnosis) http://eprints.lincoln.ac.uk/729/1/uoa12eh05.pdf
14. NICE (2015) Severe mental illness and substance misuse (dual diagnosis): community health and social care services https://www.nice.org.uk/guidance/indevelopment/gid-phg87/documents
15. NICE (2011) Psychosis with coexisting substance misuse https://www.nice.org.uk/guidance/cg120/resources
16. Department of Health (England) and the devolved administrations (2007). Drug Misuse and Dependence: UK Guidelines on Clinical Management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf
17. Department of Health (2011) No Health Without Mental Health, A cross government mental health outcomes strategy for people of all ages https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
18. Department of Health (2013) The Mandate
19. Department of Health (2014) Achieving Better Access to Mental Health Services by 2020 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf
20. http://www.theguardian.com/society/2014/mar/12/mental-health-funding-changes-lives-risk

21. http://www.theyworkforyou.com/wrans/?id=2014-12-16.218865.h&s=mental+health#g218865.r0)

22. http://www.communitycare.co.uk/2015/03/20/mental-health-trust-funding-8-since-2010-despite-coalitions-drive-parity-esteem/

23. http://www.rethink.org/get-involved/campaigns/all-party-parliamentary-group-on-mental-health

24. APPG on Mental Health (2015) Parity in progress? http://www.rethink.org/media/1307442/APPG%20parity%20in%20progress%20-%20FINAL.pdf

25. http://webarchive.nationalarchives.gov.uk/20130802095348/http://recoverypbr.dh.gov.uk/

26. https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14 http://www.communitycare.co.uk/2015/03/20/mental-health-trust-funding-8-since-2010-despite-coalitions-drive-parity-esteem/

27. http://www.nao.org.uk/report/the-introduction-of-the-work-programme/

28. https://www.gov.uk/government/news/new-5-million-payment-by-results-deal-to-get-rough-sleepers-off-londons-streets--5

29. https://www.gov.uk/government/statistics/final-results-for-cohorts-1-payment-by-results-prison-pilots

30. https://www.gov.uk/government/policies/reducing-reoffending-and-improving-rehabilitation/supporting-pages/transforming-rehabilitation

31. 'Creaming' occurs when those who are likely to be most responsive to an intervention or from whom the provider will derive the greatest financial benefit are prioritised over other clients who are, by contrast, 'parked' or given a lesser service.

32. DrugScope (2014) Business as Usual http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/BusinessAsUsual.pdf

33. Mephedrone, a banned Class B substance since 2010, salvia and nitrous oxide have recently been added to the Crime Survey of England and Wales.

34. DrugScope (2015) State of the Sector 2014-15 http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SoSFinal2015.pdf

35. Royal College of Psychiatrists (2014) One new drug a week http://www.rcpsych.ac.uk/pdf/FR%20AP%2002_Sept2014.pdf

36. National Poisons Information Service (2014) Annual Report 2013/14 http://www.npis.org/NPISAnnualReport2013-14.pdf

37. Home Office (2014) New Psychoactive Substances in England: A review of the evidence https://www.gov.uk/government/publications/new-psychoactive-substances-in-england-a-review-of-the-evidence

38. http://www.independent.co.uk/news/uk/cannabis-substitute-drugs-black-mamba-and-spice-are-a-recipe-for-violence-in-prisons-9984954.html

39. New Psychoactive Substances Expert Review Panel (2014) The Report of the Expert Panel https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368583/NPSexpertReviewPanelReport.pdf

40. https://www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison

41. Home Affairs Committee (2013) Drugs: new psychoactive substances and prescription drugs http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/819/819.pdf and Government response https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307865/New_psychoactive_substances_and_prescription_drugsPRINT.pdf

42. Public Health England (2014) New psychoactive substances: a toolkit for substance misuse commissioners http://www.nta.nhs.uk/uploads/nps-a-toolkit-for-substance-misuse-commissioners.pdf

43. https://www.gov.uk/government/speeches/drugs-policy

44. http://www.lincoln.gov.uk/home/legal-highs-ban/124105.article

45. HM Government (2014) Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

46. http://www.crisiscareconcordat.org.uk/explore-the-map/

47. http://meam.org.uk/multiple-needs-and-exclusions/

48. Bramley, Fitzpatrick et al (2014) Hard Edges: Mapping severe and multiple disadvantage http://www.lankellychase.org.uk/assets/0000/2858/Hard_Edges_Mapping_SMD_FINAL_VERSION_Web.pdf and appendices http://www.lankellychase.org.uk/assets/0000/2876/Hard_Edges_Appendices_FINAL.pdf

49. HM Treasury (2015) Budget 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413949/47881_Budget_2015_Web_Accessible.pdf

50. DrugScope (2015) State of the Sector 2014-15 http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SoSFinal2015.pdf

51. http://www.turning-point.co.uk/

52. http://www.turning-point.co.uk/hertfordshire-complex-needs-service.aspx

53. Department of Health (2012) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

54. For examples of resources currently available, see http://www.england.nhs.uk/ourwork/forward-view/

55. Centre for Mental Health (2014) Review of Sections 135 & 136 of the Mental Health Act: The views of professionals, service users and carers on the codes of practice and legislation http://www.centreformentalhealth.org.uk/publications/review_of_sections_135_136.aspx?ID=714

56. The consultation documents, literature review, government response and supporting documents can be found here https://www.gov.uk/government/consultations/review-of-the-operation-of-sections-135-and-136-of-the-mental-health-act

57. Department of Health (2015) https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

58. Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales (2013) A Criminal Use of Police Cells http://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf

59. Royal College of Psychiatrists (2013) Position Statement PS2/2013 http://www.rcpsych.ac.uk/pdf/PS02_2013.pdf

60. http://www.hscic.gov.uk/article/5164/Mental-Health-Act-Hospital-based-Place-of-Safety-orders-increase-whilst-police-station-orders-decrease

61. Department of Health indicator KH03, now published by NHS England

62. Care Quality Commission (2014) A safer place to be http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014_07_FINAL%20for%20WEB.pdf

63. For a summary of HWB priorities, see http://www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE

64. https://mentalhealthcop.wordpress.com/2015/01/31/are-we-under-using-section-136/

65. Independent Commission on Mental Health and Policing (2014) Report http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/10_05_13_report.pdf

66. This has recently been announced as a Home Office pilot, to run in Sussex for 12 weeks: https://www.gov.uk/government/news/home-secretary-launches-alternative-place-of-safety-pilot

67. Department of Health (2009) The Bradley Report http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf

68. Public Health England (2015) Reducing Smoking in Prisons https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412567/Reducing_smoking_in_prisons.pdf

69. Where contact with the criminal justice system has already occurred (or in scenarios where a criminal sanction may effectively be 'non-negotiable'), there is also evidence that short prison sentences are associated with higher reoffending rates and that orders or suspended sentences with a requirement for alcohol, drug and/or mental health treatment are associated with more favourable outcomes. See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399389/impact-of-short-custodial-sentences-on-reoffending.PDF

70. Department of Health (2009) The Bradley Report http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf

71. For the 2013-14 service specification, which provides detailed information of the role profiles and staff grades, see http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/04/ld-ser-spec-1314.pdf

72. Information about liaison and diversion, including the Single Operating Model, can be found at http://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-cases/

73. The Centre for Mental Health (2014) The Bradley Report five years on http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_five_years_on.pdf

74. Inquest (2015) Stolen Lives and missed opportunities: The deaths of young adults and children in prison http://inquest.org.uk/pdf/reports/INQUEST_T2A_report_final.pdf

75. National Offender Management Service, NHS England and Public Health England (2013) National Partnership Agreement http://www.justice.gov.uk/downloads/about/noms/work-with-partners/national-partnership-agreement-commissioning-delivery-healthcare-prisons2013.pdf

76. Her Majesty's Inspectorate of Prisons for England and Wales (1999) Suicide is Everyone's Concern: A Thematic Review http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf

77. Department of Health (2006) Clinical Management of Drug Dependence in the Adult Prison Setting

78. Prison Drug Treatment Strategy Review Group (2009) Reducing Drug-Related Crime and Rehabilitating Offenders https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216012/dh_119850.pdf

79. The Offender Health Research Network (2009) A National Evaluation of Prison Mental Health In-Reach Services http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf

80. Ministry of Justice/National Offender Management Service (2011), Working with Personality disordered offenders: A practitioners guide https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/working-with-personality-disordered-offenders.pdf

81. Ministry of Justice Analytical Services, 2013, Gender differences in substance use and mental health amongst prisoners, Light et al https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf

82. Department of Health, 1997, Psychiatric morbidity among prisoners: Summary report, Singleton et al http://discover.ukdataservice.ac.uk/catalogue/?sn=4320

83. Home Office, 2007, The Arrestee Survey 2003 – 2006, Boreham et al, http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/virtuallibrary/110385.pdf

84. Home Office, 2014, The heroin epidemic of the 1980s and 1990s and its effect on crime trends - then and now https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332952/horr79.pdf

85. HM Inspectorate of Prisons (2014) Annual Report 2013-14 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf

86. http://www.howardleague.org/suicide-in-prison/

87. See http://www.theguardian.com/society/2014/sep/16/chris-grayling-mental-health-prisons - the commitment is contingent upon the general election.

88. For a summary of the current response, including information about seizures of NPS in prisons, see https://www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison

89. HM Chief Inspector of Prisons for England and Wales (2014) Annual Report 2013–14 http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-14.pdf

90. House of Commons Justice Committee (2015) Prisons: planning and policies http://www.parliament.uk/business/committees/committees-a-z/commons-select/justice-committee/news/report-prisons-planning-and-policies/

91. I.e. Incidents of prison disorder

92. HM Chief Inspector of Prisons for England and Wales (2014) Annual Report 2013–14 http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-14.pdf

93. Home Office (2007) The Corston Report http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf

94. Ministry of Justice (2013) Gender differences in substance misuse and mental health amongst prisoners. Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf

95. http://www.spectrumhealth.org.uk/

96. http://www.cqc.org.uk/location/1-226813064?referer=widget4

97. http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/new-hall/new-hall-2013.pdf

98. http://www.togetherwomen.org/

99. http://england.shelter.org.uk/?_ga=1.127125517.1201614119.1422885577

100. http://www.theyworkforyou.com/wrans/?id=2014-12-16.218865.h&s=mental+health#g218865.r0)

101. http://www.cypmhc.org.uk/about_us/

102. https://www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

103. http://www.independent.co.uk/news/uk/home-news/girl-16-with-mental-health-problems-held-by-police-for-nearly-48-hours-as-no-nhs-beds-free-9892833.html

104. http://www.westernmorningnews.co.uk/8203-Devon-Cornwall-Police-halts-mentally-ill/story-26111002-detail/story.html

105. Department of Health (2015) Report of the work of the Children and Young People's Mental Health Taskforce https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

106. House of Commons Health Committee (2014) Children's and adolescents' mental health and CAMHS http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf

107. http://www.skillsforhealth.org.uk/news/latest-news/item/174-children-young-people-s-health-services-national-occupational-standards-launched

108. DrugScope & UKDPC (2012) Domino Effects http://www.ukdpc.org.uk/publication/domino-effects/

109. To be published in mid-2015

110. For an overview of the lifetime scarring effects of youth unemployment, see Bell & Blanchflower, Oxf Rev Econ Policy (Summer 2011) 27 (2): 241-267. doi: 10.1093/oxrep/grr011 http://oxrep.oxfordjournals.org/content/27/2/241.full.pdf+html

111. Marcus Roberts Andy Bell, (2013),"Recovery in mental health and substance misuse services: a commentary on recent policy development in the United Kingdom", Advances in Dual Diagnosis, Vol. 6 Iss 2 pp. 76 – 83 http://www.emeraldinsight.com/doi/pdfplus/10.1108/ADD-03-2013-0007

112. Home Office (2010) Reducing Demand, Restricting Supply, Building Recovery https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

113. UKDPC (2008) A vision of recovery: UKDPC recovery consensus group http://www.ukdpc.org.uk/publication/recovery-consensus-group/

114. The various 'stars' in use in sectors such as mental health, substance misuse and homelessness adopt a similar 'whole person' approach. See http://www.outcomesstar.org.uk/

115. Bell & Roberts (2013)

116. http://www.mentalhealth.org.uk/help-information/mental-health-a-z/r/recovery/

117. http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/february-2015/statistical-bulletin.html

118. Approximate figure. This will vary considerably depending on terms used.

119. Currently unavailable but usually retrievable at https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health

120. Waddell & Burton (2006) Is Work Good for Your Health and Wellbeing? https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf

121. DrugScope (2014) http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/PathwaystoEmployment2014.pdf

122. The Marmot Review (2010) Fair Society, Healthy Lives: Executive Summary

123. HM Government (2012) Social Justice: transforming lives https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49515/social-justice-transforming-lives.pdf

124. Joseph Rowntree Foundation (2015) The Cost of the Cuts: The Impact on Local Government and Poorer Communities http://www.jrf.org.uk/sites/files/jrf/CostofCuts-Full.pdf

125. http://www.cnwl.nhs.uk/employment-services/individual-placement-and-support-ips-service/

126. http://www.centreformentalhealth.org.uk/employment/ips.aspx

127. Department for Work and Pensions (2013) The disability and health employment strategy: the discussion so far https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

128. House of Commons Work and Pensions Committee (2009) DWP's Commissioning Strategy and the Flexible New Deal http://www.publications.parliament.uk/pa/cm200809/cmselect/cmworpen/59/9780215526656.pdf

129. For information about the Public Sector Equality Duty, see http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty

130. http://83.244.183.180/WorkProg/wp_cuml_jo/tabtool_wp_cuml_jo.html

131. DWP records ill health by ICD classification

132. Mind (2014) Fulfilling Potential? ESA and the fate of the Work-Related Activity Group http://www.mind.org.uk/media/933438/2014-support-not-sanctions-report.pdf

133. DWP (2014) Work Programme Official Statistics to June 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/355896/Work_Programme_Statistical_Release_Sep14_Final.pdf

134. https://www.gov.uk/government/news/12-million-to-help-people-with-mental-health-problems-get-back-into-work

135. http://www.socialfinance.org.uk/

136. http://blogs.cabinetoffice.gov.uk/socialimpactbonds/outcomes-fund/

137. https://www.biglotteryfund.org.uk/sioutcomesfunds

138. http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Getting%20problem%20drug%20users%20(back)%20into%20employment_%20employer,%20provider%20and%20service%20user%20perspectives.pdf

139. http://www.kaleidoscopeproject.org.uk/our_services_partnership_working.asp

140. http://support.fitforwork.org/app/answers/detail/a_id/277

141. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138118/Equality_Act_2010_-_Duty_on_employers_to_make_reasonable_adjustments_for....pdf

142. DrugScope (2013) Work Programme pilots aimed for people affected by drug and / or alcohol dependency. http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/WorkProgrammePilots.pdf

143. https://www.gov.uk/government/speeches/kids-company

144. Office for Disability Issues (2010) Equality Act 2010 Guidance http://www.equalityhumanrights.com/sites/default/files/documents/EqualityAct/odi_equality_act_guidance_may.pdf

145. For an overview of the provisions in the Americans With Disabilities Act, see http://www.dol.gov/elaws/asp/drugfree/drugs/ada.asp

146. https://www.gov.uk/government/news/help-to-work-nationwide-drive-to-help-the-long-term-unemployed-into-work

147. Department for Work and Pensions (2015) DWP's Welfare Reform agenda explained https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410726/dwp-reform-agenda-explained-1-feb-2015.pdf

148. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295384/foi-79-2014.pdf

149. Joseph Rowntree Foundation (2014) Welfare Sanctions and Conditionality in the UK http://www.jrf.org.uk/sites/files/jrf/Welfare-conditionality-UK-Summary.pdf

150. Beatty, Foden et al (2015) Benefit sanctions and homelessness: a scoping report http://www.crisis.org.uk/data/files/publications/Sanctions%20Report%202015_FINAL.pdf

151. https://www.gov.uk/government/publications/universal-support-delivered-locally-information-for-local-authorities

152. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399782/personal-budgeting-support-guidance.pdf

153. Centre for Regional Economic and Social Research (2015) Direct Payment of Housing Benefit: Are Social Landlords Ready? http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/dp-hb-social-landlords-ready.pdf

154. Shelter (2008) Good practice briefing: Housing First http://england.shelter.org.uk/__data/assets/pdf_file/0008/145853/GP_Briefing_Housing_First.pdf

155. https://www.gov.uk/government/policies/providing-housing-support-for-older-and-vulnerable-people

156. Homeless Link (2015) Support for single homeless people in England http://www.homeless.org.uk/sites/default/files/site-attachments/Full%20report%20-%20Single%20homelessness%20support%20in%20England%202015.pdf

157. For an overview of homelessness in London, see LDAN (2013) Making connections to build recovery http://www.ldan.org.uk/PDFs/HomelessnessReport.pdf

158. http://www.pathway.org.uk/news/articles/about-the-faculty-for-homeless-and-inclusion-health/

159. The Faculty for Homeless and Inclusion Health (2013) Service Standards for Commissioners and Service Providers http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf

160. http://www.pathway.org.uk/

161. https://www.gov.uk/government/news/ten-million-pound-cash-boost-to-improve-the-health-of-homeless-people

162. http://data.london.gov.uk/dataset/chain-quarterly-reports/resource/23240a34-22c0-489a-80a7-3ede548dc470

163. For a very brief overview of current entitlements see http://www.ldan.org.uk/PDFs/Paul%20Anderson%20Homeless%20Link%20Jan%202015.pdf

164. For example the Olallo Project http://www.saintjohnofgod.org/servicedetail.php?passedid=37

165. For example http://www.thamesreach.org.uk/what-we-do/international-reconnection/london-reconnection-project/

166. Michal P. Garapich (2010) The Unwanted: Social and cultural determinants of homelessness and alcohol abuse among Eastern European migrants in London – research report http://www.migrantsrights.org.uk/files/news/CRONEM_report.pdf

167. http://www.time-to-change.org.uk/

168. Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–13: an analysis of survey data Evans-Lacko, Sara et al. The Lancet Psychiatry , Volume 1 , Issue 2 , 121 – 128 http://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(14)70243-3.pdf

169. McGinty E.E., Goldman H.H., Pescosolido B. et al. Social Science and Medicine: 2015, 126, p. 73–85. http://www.sciencedirect.com/science/article/pii/S0277953614007990b

170. http://meam.org.uk/voices/

171. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407030/Rough_Sleeping_Statistics_England_-_Autumn_2014.pdf

172. "For examples of the current guidance provided for employers, see: http://www.equalityhumanrights.com/private-and-public-sector-guidance/employing-people/work-place-adjustments "

173. Annual Report from MHMDS Returns 2013-14, HSCIC: http://www.hscic.gov.uk/catalogue/PUB15990/mhb-1314-ann-rep.pdf

174. Office for National Statistics, 2014, Suicides in the United Kingdom, 2012 Registrations: http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2012/stb-uk-suicides-2012.html

175. Office for National Statistics, 2014, Suicides in the United Kingdom, 2012 Registrations: http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2012/stb-uk-suicides-2012.html

176. Coid J, Yang M, Tyrer P, Roberts A, Ullrich S., 2006, Prevalence and correlates of personality disorder in Great Britain. British Journal of Psychiatry, 188: 423-431

177. [3] Perala et al (2007) Lifetime prevalence of psychotic and bipolar I disorders in a general population Archives of general psychiatry, 64:19-28

178. Annual report on children and young people's health from the Chief Medical Officer (CMO), Professor Dame Sally C Davies, 2013 https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

179. Drug Misuse: Findings from the 2013/14 Crime Survey for England and Wales, Home Office, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335989/drug_misuse_201314.pdf

180. UK Focal Point on Drugs, 2014 http://www.nta.nhs.uk/uploads/uk-focal-point-report-2014.pdf

181. http://www.emcdda.europa.eu/countries/prevalence-maps

182. For examples , see Hamilton, I., Lloyd, C., Hewitt, C., & Godfrey, C. (2014). Effect of reclassification of cannabis on hospital admissions for cannabis psychosis: A time series analysis. International Journal of Drug Policy, 25(1), 151-156. 10.1016/j.drugpo.2013.05.016 and Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study Di Forti, Marta et al. The Lancet Psychiatry , Volume 2 , Issue 3 , 233 - 238

183. Drinking Habits Amongst Adults, Office of National Statistics, 2012 http://www.ons.gov.uk/ons/dcp171778_338863.pdf

184. Institute for Alcohol Studies: Alcohol, Health Inequalities and the Harm Paradox: Why some groups face greater problems despite consuming less alcohol, http://www.ias.org.uk/uploads/pdf/IAS%20reports/IAS%20report%20Alcohol%20and%20health%20inequalities%20FULL.pdf

185. Health and Social Care Information Centre (2014) Smoking, drinking and drug use among young people in England in 2013 http://www.hscic.gov.uk/catalogue/PUB14579/smok-drin-drug-youn-peop-eng-2013-rep.pdf

186. Institute of Health Equity (2010) Fair Society Healthy Lives http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

187. Department of Health (2012) The Public Health Outcomes Framework for England, 2013-2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

188. Institute of Health Equity (2014) Social Determinants of Mental Health http://www.instituteofhealthequity.org/projects/social-determinants-of-mental-health

189. Institute for Health Equality (2014) The impact of the economic downturn and policy changes on health inequalities in London http://www.instituteofhealthequity.org/media/press-releases/the-impact-of-the-economic-downturn-and-policy-changes-on-health-inequalities-in-london