Mental health and substance misuse

Summary

DrugScope

On behalf of the Recovery Partnership

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

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Structure of the summary

We would like to thank all the individuals and organisations who attended the summit held in November 2014, particularly those who presented or led discussions around specific service or policy areas and especially Andy Bell of the Centre for Mental Health and Dr Mike Kelleher or South London and the Maudsley NHS Trust/Public Health England for their advice in scoping the agenda. The discussions at the summit have provided a significant contribution to this briefing.

The briefing provides an overview of the intersection between substance misuse and mental ill health. In a more ideal world, it would have been possible to take a holistic view of a highly integrated system of commissioning, service design and service delivery. However, and despite the publication in 2002 of the first guidelines specifically aimed at addressing multiple needs and dual diagnosis, the progress made in integration at every level has been patchy.

Current developments may start to pull this in the other direction. The announcement in the 2015 Budget (and previously in the 2014 Autumn Statement) that the government intends to explore the potential savings, efficiencies and improved outcomes that might be gained through the pooling of budgets and local coordination of activity around people with multiple needs may bring about improvements. For the time being, however, the picture is one of a frequently fragmented system of commissioning and provision with a number of potential points of failure and some obvious tensions.

We have approached the development of this briefing in a consultative and collaborative way. Much of the agenda was set by a summit event held in November 2014 which engaged a number of experts and stakeholders from the voluntary sector, the National Health Service and from academia, including senior clinicians, service providers and mental health, drug and alcohol policy leads.

Informed by the discussions at the summit and through separate consultation with stakeholders, the report is structured around the following themes:

- The national policy context and environment;
- Use of the Mental Health Act: crisis provision and places of safety;
- Prison and offender health care;
- Services for young people;
- Building a better life for yourself.

In a sector that is the subject of considerable and fast-paced activity, the briefing cannot do more than provide a snapshot of the intersection between mental health and substance misuse at a particular point in time.

This summary report presents some of the key findings from discussions with stakeholders and services and a selection of the key recommendations.

The national policy context and external environment

Since 2010 there has been considerable political interest and policy activity around mental health. Much of this has been encouraging. For example, the establishment of parity of esteem in the Health and Social Care Act 2012 could – potentially – contribute to redefining the way that mental health care and services are thought about, the activities of the Crisis Care Concordat and the Mental Health Intelligence Network can contribute much to the improvement of the way that mental health and complex needs are met, and that the 2002 dual diagnosis guidelines are to be reviewed is most welcome. The willingness of the coalition government, late in its term, to commit to a structural review of young people's services in particular is welcome.

However, while there is much to be welcomed, there are several and substantial causes for concern. Like many public services, there are signs that mental health services, along with substance misuse services, are under financial pressure. In the current environment this may be inevitable, but despite the drive towards parity of esteem, there are some signs that spending on mental health is going down as a proportion of all health spending, despite a continuing and consistent increase in demand for services.

The health and public health reforms of April 2013 have had the effect of splitting the funding and commissioning arrangements of mental health and substance misuse services. Nobody would claim that the prior arrangement, under which the responsibilities sat much more closely together, had delivered the type of change that the clinical evidence for comorbidity of

substance misuse and mental ill health appears to call for. It also seems likely that, so soon after very substantial changes to the arrangement of health and public health, there is likely to be limited appetite for any further reform, but at the least, the connections between the services will need to work effectively.

Recommendations

- Policy makers and commissioners should examine what needs to be done to align the funding and commissioning of services for people with complex needs. As a minimum, this could include strengthening the statutory guidance for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies 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 services and that the needs of people with coexisting substance misuse and mental ill health are assessed and met;
- The government has committed to exploring how pooling budgets and/or sharing incentives could offer a solution to better serving those with complex and multiple needs. 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. With a general election this year, this commitment should be honoured irrespective of the composition of the next government;
- All services and stakeholders engaged emphasised that the key to effective partnership working and integration

lies in people and professional relationships as much as policy and systems. 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;

- 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-wide level, parity of esteem is close to being achieved. Ongoing, active assessment of where and how resources are being allocated is essential.

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

The Mental Health Act 1983 is almost uniquely powerful legislation. The Centre for Mental Health described it as

> *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.*

As such, it is perhaps unsurprising that use of the powers within the Act and how provision can best be shaped to meet need

has been the subject of interest recently just as it has been in the past. There have been notable policy developments, including refreshed Mental Health Act Code of Practice and reviews of the powers under S.135 and S.136 of the Mental Health Act, but one of the most notable shifts of focus is onto the use of cells in police stations as places where people detained under the act can be taken to – known as places of safety.

There have been multiple drivers for this. The coalition government has prioritised the improvement of mental health services (although it should be noted that this new and welcome emphasis on the role of mental health care has not yet fed through in the form of significant additional resources) and the appropriateness of using police cells as places of safety has formed part of the discourse. Public interest has been stimulated by a number of high-profile problems in accessing a place of safety, and the relatively recent prioritisation of improving services for children and young people has thrown a spotlight on the use of police cells and adult facilities for children and young people in crisis.

Overall, the use of all powers of detention continues to rise, increasing by around 30% over the last 10 years. This inevitably places strains on services with a role in meeting crisis and acute need, and the increase has taken place at a time of slowly but consistently shrinking capacity in parts of the system. For example, the availability of NHS overnight mental health beds has declined 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.

Following a survey conducted in 2014, the Care Quality Commission postulated that the use of health-based places of safety may be little more than supply and demand, and that use of them is higher where there is more availability. They also noted, however, that many health-based places of safety operate with policies that effectively exclude anyone intoxicated or suspected of being intoxicated through alcohol or drugs, regardless of the quantities or substances consumed and any observed risk factors.

Recommendations

- The recommendations of the Independent Commission on Mental Health and Policing conducted at the request of the Metropolitan Police Service should be considered for implementation across 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;
- 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 exclusion criteria.

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

For many people in crisis, their first contact with support and/ 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 data for the prevalence of substance misuse, mental ill health and comorbidity affecting individuals within the prison system is limited and fragmented. However, there is undoubtedly a high incidence of individuals being affected by one or the other or both within the prison population.

Summit attendees were broadly unanimous that while new commissioning arrangements have, to an extent, brought treatment for substance misuse and mental ill health closer together, the legacy of the way these services have developed had resulted in lasting effects. Not least, substance misuse treatment in prisons has, over a period stretching back a decade or so, been the focus of constant political interest and consequent investment. This has been less the case with mental health treatment, although that may now be changing.

This is not to suggest, of course, that everything is well with regard to substance misuse and treatment in prisons. The number and amount of substances apparently available in prisons continued to be troubling, and service providers working across substance misuse and mental ill health spoke about the detrimental impact of substantial reductions in prison officer head count.

All offenders, including short sentence offenders, will be required to receive support via the new Transforming Rehabilitation scheme. This will oversee the support of all former prisoners assessed as low to medium risk, with the National Probation Service overseeing high risk ex-offenders. Summit participants and other stakeholders were very cautiously optimistic about the prospects of this improving support for people who would have previously been entitled to none. It must be stressed that there was unanimity that for this to be successful and safe, Transforming Rehabilitation will have to work as intended and that the delivery model and payment model are both untested as yet.

As Lord Bradley noted in his landmark 2009 report, for all but the most serious offenders there are numerous points along the 'offender pathway' at which an individual might be diverted from offending, or into a more appropriate type of service if their offending behaviour is connected to substance misuse, mental ill health or a related social or health factor. The roll-out of the Liaison and Diversion Pilots proposed by Bradley appears, on early evaluation, to be paying dividends across multiple dimensions, including in cash terms, reduced offending and through disrupting patterns that often lead to reoffending.

By April 2015, 50% of the population of England will be covered by liaison and diversion schemes operating within a standardised framework, although the authors of a recent 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.

Recommendations

- 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 novel psychoactive substances in general and synthetic cannabinoids in particular;
- The proposals for mental health units within 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.

Services for young people

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 also 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 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.

Recommendations

- 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 work 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 risks, 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 however, this development has taken place separately and largely in isolation. In their paper, Bell and Roberts look for areas of common ground, and find many. Not least among the similarities is the congruence between recovery capital as conceptualised in the context of substance misuse and the elements that support recovery considered from the perspective of mental ill health. This should provide a prompt for commissioners and service providers – that the same attributes and interventions that tend to support recovery in one area appear likely to support it in others.

As part of building a better life for yourself, we have considered employment, housing, the health impacts of homelessness and the role of social security. This omits several important aspects of recovery capital, and space permits only a brief consideration of each. The vital contribution each can make is clear.

Employment has the potential to provide people with autonomy, personal and financial independence, self-esteem, motivation and positive social networks. However, employment in and of itself should not be seen as a panacea; the quality of work is important and there is evidence that low-status, low-paid, insecure and unpleasant work with limited opportunities for progression is not favourable for health and wellbeing. Furthermore, there is evidence that these poor jobs are often the type of work most readily accessible to those on the periphery of the labour market.

Overcoming this can present challenges to individuals and the services that support them. Research by the UK Drug Policy Commission and others has illustrated the extent of stigma and discrimination displayed by employers. It is inevitable that, aside from companies who have taken positive action to recruit from non-standard sources, jobseekers with histories of substance misuse face significant disadvantage in the job market. Unlike individuals with almost any other health problem, there is no protection under the Equality Act 2010 for people affected by substance use (other than when dependent on originally prescribed medication). Mental ill health on the other hand is protected.

This is not to say that a legislative change would, on its own, produce a sea change in enabling access to the job market (and to goods and services); discrimination comes in many forms but rarely overtly and explicitly. The difficulty people with mental health problems often find in securing employment is an indicator of the limited possibilities offered by merely extending protection. It could however serve as a statement of intent: that as a government and as a country, there is a commitment to the principle that people should be given every opportunity to make positive changes in their lives. The Americans with Disabilities Act, by providing limited protection for people affected by drug and alcohol misuse, may provide a useful template for sending the signal that discrimination against people in recovery and in treatment is not condoned.

A reform with the potential to make a significant change would be to ensure that the Individual Placement and Support (IPS)

model of employment support is made more widely available. Ensuring that IPS is made available to more people affected by mental ill health has been a long-standing government commitment and was confirmed in the 2015 Budget, but more can be done. IPS originated within the mental health sector, but there are extremely promising signs that the approach can also be highly effective for people with primary barriers to employment relating to substance use, or to co-existing mental ill health and substance misuse.

Housing is less equivocally a recovery asset. In providing a means of meeting immediate safety needs, it is one of the foundations on which progress can be built. However, many people accessing substance misuse treatment face housing problems, with 10% of people accessing treatment in 2013-14 having no fixed abode and 14% having some other level of housing need.

For people who are actually homeless, and particularly those who are street homeless, the consequences are serious. Homeless people have a very seriously reduced life expectancy and face multiple and significant barriers to accessing services, acquiring accommodation. Various components of welfare reform appear to be detrimental both for housing and homelessness; services working with people with complex and coexisting needs will need to be responsive to client needs.

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 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, which in many circumstances is not the case.

Recommendations

- 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 Individual Placement and Support 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. Despite the increasing prominence of the recovery agenda with all its positive connotations, nothing of a similar scale or nature has been attempted 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.

Further reading

2015 Budget Red Book: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413949/47881_Budget_2015_Web_Accessible.pdf

The Crisis Care Concordat: http://www.crisiscareconcordat.org.uk/

Mental Health Intelligence Network: http://www.yhpho.org.uk/default.aspx?RID=198138

Centre for Mental Health review of Sections 135 & 136 of the Mental Health Act: http://www.centreformentalhealth.org.uk/pdfs/Centre_for_MH_review_of_sections_135_136.pdf

The Bradley Report: http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf

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

The report of the CAMHS Taskforce: https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

Marcus Roberts & Andy Bell, Recovery in mental health and substance misuse services: a commentary on recent policy development in the United Kingdom: http://www.emeraldinsight.com/doi/pdfplus/10.1108/ADD-03-2013-0007

Adult Drug Statistics from the National Drug Treatment Monitoring System: http://www.nta.nhs.uk/uploads/adult-drug-statistics-from-the-national-drug-treatment-monitoring-system-2013-14.pdf

For current guidance on workplace adjustments required under the Equality Act 2010: http://www.equalityhumanrights.com/your-rights/employment/work-place-adjustments