NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Coexisting severe mental illness and substance misuse

Date of quality standards advisory committee post-consultation meeting:
21 May 2019

2 Introduction

The draft quality standard for coexisting severe mental illness and substance misuse was made available on the NICE website for a 4-week public consultation period between 13 March and 10 April 2019. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 15 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Strong support for the content of the quality standard
- Suggestions to extend the definition of severe mental illness to include broader mental health problems
- Suggestion to include more information on communication difficulties, including identifying people with communication needs, throughout the equalities sections
- Include inadequate housing and homelessness, which are often experienced by this population, as they are barriers to optimal clinical care and accessing benefits

Consultation comments on data collection

- Systems are not in place in general practice so it is difficult to get exact population numbers as diagnosis in this group is difficult
- Measures relevant to each quality statement can be found within Addaction's substance misuse database, Nebula

Consultation comments on resource impact

- A stakeholder felt that service provision is patchy

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Support for this quality statement
- Specific approaches are needed for people aged 14-25 so include a section on their additional vulnerability
- Note that GPs, CAMHS and early intervention teams have a significant role to play. Professionals need to be trained to identify substance misuse early
- Some confusion around the focus of the statement – comprehensive assessment or initial identification
- Add that information about alcohol and drug misuse will be shared between services with the person's consent
- Asking about substance misuse at every contact could be intrusive, especially if the person is well
- Equality and diversity considerations:
  - include consideration of possible intellectual disability, autism or brain injury
  - staff should be trained to work with people with communication difficulties who will struggle to communicate, listen and remember information accurately
- Definition of asking about use of alcohol and drugs:
  - refer to new psychoactive substances and include exploring relationships between the quantity, frequency and patterns of use of different substances
  - seeking corroborative evidence should not happen this early for people aged over 25 years and may affect the relationship with the provider
  - corroborating evidence should be sought as often as possible and not only by mental health services

- comment that the expertise for the assessment of substance misuse is within the substance misuse service, not mental health

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- Difficulties in identifying exact numbers for this population
- Using an agreed tool and modifying IT systems may simplify the process of identifying the population but will need additional resources
- Local systems should prompt for all varieties of substance use including psychoactive substances

5.2 Draft statement 2

People aged 14 and over are not excluded from mental health or substance misuse services because of coexisting severe mental illness and substance misuse.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Support for this quality statement
- It is important to have pathways in place to prevent people aged 14 - 18 from being excluded and to establish effective care for this group
- The first point of contact may be a practitioner or administrator who isn't familiar with good practice relating to inclusion
- A lot of this happens at the initial phone call so this may be hard to measure
- Serious physical health conditions may be misattributed to intoxication. Intoxication lasts a few hours so reassessment afterwards is recommended

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- In some areas providers have systems and structures in place within adult and children's services with integrated planning so data collection should be feasible
- Many services aren't set up to collect this data in a consistent way and reasons for rejecting referrals aren't always clear so difficult to identify

Consultation question 3 – resource impact

Stakeholders made the following comments in relation to consultation question 3:

- This may not currently be achievable by local services given the resources required to deliver it
- This will be difficult to achieve as substance misuse services for people aged under 17 are not widely available

5.3 Draft statement 3

People aged 14 and over with coexisting severe mental illness and substance misuse have a care coordinator working in community mental health services if they are receiving care from secondary care mental health services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Support for this quality statement
- This population experience barriers in accessing mental health or alcohol services so support through a care coordinator can help maintain contact with services
- People with severe mental illness should have care coordination in place so this could cause confusion
- The role of the care coordinator should not be diluted for example when cost savings have to be made
- Suggestion to include the skills and training level as this role can involve assertive outreach which is a very skilled job

Consultation question 3 – resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Achievement depends on the systems in place. In areas with more advanced systems resource implications will be reduced
- Resource implications include specialists in both services, development of a multi-disciplinary approach in both services, training and data collection and analysis
- Provision of services is not consistent. People may have a care coordinator already but what they do, and their training and skills, will be variable

5.4 Draft statement 4

People aged 14 and over with coexisting severe mental illness and substance misuse are followed-up if they miss an appointment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Support for this statement
- Mental health services should always refer formally rather than expect people to self-refer. Suggestion to measure formal referral with relevant clinical information
- Mental health services should accept direct referrals from substance misuse services rather than having to refer via the GP
- Include sharing details of missed appointments between services so there is a safety net to ensure people agree with monitoring and review plans
- People do not attend for various reasons, for example they may have to prioritise organising benefits over attending, so they may need skilled support to attend
- Statements 1-3 include engaging with the person and statement 4 should use this assertive and wider approach, follow-up seems too narrow
- Definition of follow-up:
  - include contact with family and friends
  - when an appointment is missed the referrer, GP or health and social worker should be notified and follow-up is by the whole team
  - describe the follow-up actions that will take place. Systems must be in place to ensure that people who do not attend do not struggle as a result
  - follow-up needs to be prompt, assertive and sustained, involving relevant others where appropriate
- People with communication problems can lack understanding of time and can be hard to engage so different ways of accessing help and support should be offered
- Verbal information should be supported by written accessible information for people, in line with the person's communication preferences

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- It will be difficult to generate meaningful data. A potential unintended consequence of this measure is GPs not referring people who are likely to miss appointments

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Statement to complement statement 1 around asking people with substance misuse problems about mental health problems
- Joint working agreements and training using an agreed set of local policies and procedures that is regularly reviewed by key strategic partners
- Physical health care
- Carer involvement

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	Institute of Alcohol Studies	All quality statements	As alcohol use disorders have been associated with a broader range of mental health problems than those included in the definition of severe mental illness included in the quality standard (e.g. antisocial personality disorder has been associated with alcohol use disorders (Moeller, F.G., Dougherty, D.M., Antisocial Personality Disorder, Alcohol, and Aggression. National Institute on Alcohol Abuse and Alcoholism (NIAAA)), we would support extending this quality standard to apply to a broader range of mental health problems.
2	Opportunity Nottingham	Quality statements 2,3,4	We support these statements in their entirety
3	Royal College of Speech & Language Therapists	Equalities paper	The RCSLT was surprised at the lack of reference to communication difficulties in the equalities paper. Speech, language and communication difficulties are common in psychiatric conditions. They may be an intrinsic part of the disorder (as in schizophrenia), a side effect of treatment (as in drug-induced dysarthria) or a pre-existing disorder such as a stammer or social language difficulties associated with autistic spectrum disorder. • 81% of children with emotional and behavioural disorders have significant unidentified language deficits. • 84% attendees at area psychiatric services had language impairment and 74% had communication difficulties • People with communication problems are at a greater risk of having mental health problems than their peers We recommend that a reference is added to the importance of identifying people with communication needs. References • BRYAN, K., 2013, Psychiatric Disorders and Communication. In: L. Cummings, (2013) Cambridge Handbook of Communication Disorders (Cambridge: CUP), pp. 300-317Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. • Botting N, Durkin K, Toseeb U, Pickles A, Conti-Ramsden G. Emotional health, support, and selfefficacy in young adults with a history of language impairment. British Journal of Developmental Psychology 2016; 34, 538–554.
4	Royal College of Speech & Language Therapists	Equalities paper	We recommend that more information is added to the Equalities paper on the needs of people with communication difficulties.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

			People with communication problems will struggle to understand and articulate their needs, which can result in inappropriate referrals and inaccurate assessments. Interventions are less likely to fail if someone has been appropriately assessed and supported to make decisions in the first place.
5	Change Grow Live	Oversight of quality standards	Many services to local population appear to lack oversight of DD quality standards The CQC NHS Patient Survey Programme (2018) https://www.cqc.org.uk/sites/default/files/20181122_cmh18_statisticalrelease.pdf Indicates high levels of conformance in relation to Cluster 16 (DD). This accords with the findings in this QS document. The CQC, informed by the comments and findings from the National Confidential Inquiry into Suicide and Safety in Mental Health regarding excess risk, morbidity and mortality in relation mental disorder and substance misuse, may wish to extend its remit beyond Closter 16 given the comments in 1-5 above (defn) and issues of diagnostic plasticity and uncertainty. PHE and NHS local commissioning may wish to ensure that there is extant joined up commissioning regarding DD and that there are mutually agreed pathways and protocols in place. There is scope for including primary care in the pathways and protocols (GP, ambulance, A&E).
	Question 1		
6	Addaction	Question 1 (reflect quality) Statement 1,2,3 and 4	The standard focusses on severe mental illness (SMI) and the clear role of secondary mental health care. Therefore it is less clear how needs can be optimally met for those whose mental health needs do not meet the threshold for secondary mental health care but exceed the threshold for IAPT services and have difficulties with substance use.
7	Royal College of General Practitioners	Question 1	Partly. The quality standard does not address challenges related to the inadequate housing (e.g. lack of social housing, accommodation in hostels) and homelessness often experienced by this group of patients, which is often a barrier to optimal clinical care and to accessing benefits
8	Royal College of General Practitioners	General	The committee should consider an additional statement to complement Statement 1 around asking people with substance misuse problems about mental health problems. For example, 'People aged 14 and over with substance misuse are asked about their mental health'
9	Royal College of Speech & Language Therapists	Question 1	Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? We believe that there is a lack of focus on improving support by identifying and accommodating individuals' communication needs. People accessing mental health services are at an increased risk of communication needs. This risk is compounded by the fact that communication needs present a barrier to accessing psychological therapies, which are verbally delivered. Communication needs which have not been identified also prevent accurate assessments of a person's mental health needs being undertaken.
10	South London and Maudsley NHS Foundation trust	Question 1	Does this draft quality standard accurately reflect the key areas for quality improvement? Given the significant involvement of the third sector in substance misuse treatment provision, joint working agreements and training become crucially important factors in the delivery of high quality dual diagnosis care.

			There is a need for more clarity and seamlessness at the interface between MH and SM services, with regards to referrals, joint working and transfer of care The fact that it hasn't been possible to set standards in these areas is disappointing and this could be a missed opportunity. Some of the recommendations in NICE 2011 and 2016 relate to this. e.g NICE (2016 1.4.1) Work together to encourage people with coexisting severe mental illness and substance misuse to use services. Consider: using an agreed set of local policies and procedures that is regularly reviewed by key strategic partners Two other areas of care requiring quality improvement are physical health care and carers involvement; both minimally featured in this draft QS.
	Question 2 – data collection		
11	Royal College of General Practitioners	Question 2	No, the systems are not in place in general practice. As mentioned above, it will be difficult to attain exact numbers of the people with severe mental illness and coexisting substance misuse as diagnosis in this group is difficult. Also some of the data will be hidden, such as patients not being seen in mental health services due to intoxication.
	Question 3 – resource impact		
12	Royal College of General Practitioners	Question 3	Provision of services is patchy, some parts of the country will have existing service models which will be delivering.
	Statement 1		
13	Addaction	Question 1 (reflect quality) Statement 1	The quality of the detail attached to this statement could be enhanced by including a reference to the use of New Psychoactive Substances
14	Addaction	Question 1 (reflect quality) Statement 1	The quality of the detail attached to this statement could be enhanced by including a reference to poly substance use and the importance of exploring any relationships between the quantity, frequency and patterns in the use of the different substances (illicit, prescription only medication, over the counter medications, and New Psychoactive Substances). This would help give a more accurate picture of any risks/substance interactions and help to optimally target interventions e.g. harm reduction advice
15	Addaction	Question 2 (systems and structures to collect data) Statement 1	This statement could be measured using Addaction's substance misuse database (Nebula). However it appears that this statement would primarily (but not exclusively) sit within other service providers and health care practitioners including secondary mental health services rather than substance misuse services, and therefore would be recorded using the those services' /practitioners' databases rather than the substance misuse database. If this *were* to be recorded in Nebula, it would simply require the addition of one or more new Event tick boxes to record that the service user has been asked about Substance Misuse (and their response), and a Crystal report could be written to examine responses and accompanying case notes. The event tick boxes could also be used to calculate the proportion of service users who have been asked the question (and how many responded in the affirmative. Under our organisation's current arrangements, this would be unlikely to involve additional significant financial cost.

16	Change Grow Live	Definition of SMI (p6)	Severe mental illness includes a clinical diagnosis of schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, or severe depressive episodes with or without psychosis Consideration should be given to the burden of harm and disability associated with severe eating disorder (F50), body dysmorphic disorder (F45.22) and anxiety disorders (F40 & 41). Also, ADH (F90).
17	Change Grow Live	Exclusion from definition of SMI (p6)	Disorders in the puerperium not mentioned Mental and behavioural disorders associated with the puerperium may not initially meet the defn of SMI, but require specialist assessment and, in many cases, treatment. Child and parental safety are paramount and subject to escalated risk.
18	Change Grow Live	Exclusion from definition of SMI (p6)	Need to cross reference to Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder (DH, 2003) Cross reference to supporting document Personality disorders and substance misuse - Dr Sarah Welch. People with personality disorders (typically but not exclusively DSM-V Cluster B subtypes), in keeping with hierarchical typology) should not have their SMI disorders discounted).
19	Change Grow Live	Exclusion from definition of SMI (p6)	SMI and learning disability Learning disability and SMI are often treated within adult psychiatric services (acute on chronic episodes) and any associated substance misuse requires careful assessment and thoughtful treatment.
20	Change Grow Live	Exclusion from definition of SMI (p6)	Diagnostic plasticity and uncertainty To reduce the risks associated with falling though the gap of services based on diagnosis which may be plastic and/or uncertain, and not based on the harm and/or disability of the mental illness. For a variety of reasons, diagnoses of SMI made be “unmade”. It is suggested that the “dual diagnosis” approach is maintained putatively for six months after the dSMI diagnosis is “unmade”.
21	Change Grow Live	Asking about alcohol, and drugs (p8)	Local systems (eg Patient Information Systems such as Rio, Jade, bespoke, manual/paper-based) Local systems should prompt for all varieties of substance use, including ne psychoactive substances (Neptune http://neptune-clinical-guidance.co.uk/) and Internet sources (Psychonaut project http://www.psychonautproject.eu/).
22	Change Grow Live	Statement 1	I think this a very relevant statement and GPs, CAMHS, schools, universities, parents, early Intervention teams etc have a significant role to play. In my opinion there is lack of training and skills among the above services to discuss or identify substance misuse issues especially when the types of substances used by children and young people is changing all the time. The focus therefore need to be on education and training among the relevant staff and professionals first so that any substance misuse issues are identified early and treatment is started for both mental health and substance misuse problems.
23	Institute of Alcohol Studies	Statement 1	Asking those with suspected or confirmed severe mental illness about their use of alcohol represents a key area of quality improvement. There is evidence to suggest alcohol use is not currently considered in mental health services. Through a survey and seminar session with mental health and alcohol treatment service workers undertaken in 2018, our research (Institute of Alcohol Studies and Centre for Mental Health. 2018. Alcohol and Mental Health: Policy and

			practice in England) found that less than a 1/5 of respondents felt alcohol use was adequately considered or understood within mental health treatment services. There are three reasons this statement should be included in this quality standard. Firstly, evidence suggests that co-occurring alcohol use disorders and mental health difficulties are common. Secondly, asking those with suspected or confirmed severe mental illness about their use of alcohol might inform their care. Finally, the presence of alcohol use disorders and mental health difficulties is associated with worse outcomes for these individuals. Firstly, evidence suggests that co-occurring alcohol use disorders and mental health difficulties are common. Public Health England report that 86% of those accessing alcohol treatment services also have a co-occurring mental health difficulty (Public Health England. 2017. Better care for people with co-occurring mental health and alcohol/drug use conditions), while "an estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year" (Public Health England. 2016. Health matters: harmful drinking and alcohol dependence). Further to this, English hospitals saw more than 200,000 admissions in 2014/15 "for mental and behavioural disorders due to alcohol use, accounting for almost 19% of all alcohol-related hospital admissions" (Public Health England. 2016. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. p. 49). Secondly, understanding a person's alcohol use might inform their care. For example, it has been demonstrated that experiencing an alcohol use disorders could delay recovery from mental health difficulties (Greenfield, T.K. Individual Risk of Alcohol-Related Disease and Problems, Chapter 21 in Heather N., Peter T.J., Stockwell T. (eds) (2001), International Handbook Alcohol Dependence and Problems, John Wiley & Sons Ltd, pp. 413–439). This is an important consideration given the suggestion that alcohol use is a common response for those experiencing such conditions (University of Stirling. 2013. Health First: an evidence-based alcohol strategy for the UK). Finally, as noted in the rationale for this quality statement, the presence of alcohol use disorders and mental health difficulties is associated with worse outcomes; problem drinking has been found to be associated with suicide amongst those accessing mental health services (Public Health England. 2016. Health matters: harmful drinking and alcohol dependence).
24	London Borough of Havering	Guideline Access to substance misuse and MH services service NG58, 1.1.1	The NICE definition of severe mental illness excludes personality disorder but this is included in the Care Programme Approach https://webarchive.nationalarchives.gov.uk/20130105012529/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647 and the PHE "Better Care for people with co-occurring MH and alcohol and drug use conditions. The inconsistency leads to those who present with a personality disorder/substance misuse being excluded from a Care programme Approach and being marginalized
25	London Borough of Havering	Guideline As above NG58, 1.1.3	The definition needs to include rough sleepers
26	NHS England	Statement 1	This statement could be improved by adding that information about alcohol and drug misuse will be shared between services with the patient's consent.

27	Opportunity Nottingham	Statement 1	We support statement 1 but would also point out the possible presence intellectual disability, autism or brain injury should also be considered. These may be masked by either substance misuse or severe mental illness and a combination of both. We have evidence from our Clinical Psychologist of individuals where it is highly likely that had mental health / ASD been recognised sooner, outcomes would be different for people with one or more of these conditions. There is growing evidence that this is a common issue people facing Severe Multiple Disadvantage for instance https://liverpoolwavesofhope.org.uk/everything/liverpool-waves-of-hope-launches-ground-breaking-brain-injury-screening-pilot/
28	Oxfordshire County Council	Statement 1	The expertise for the assessment of substance misuse is within the SM service, for the mental health service to carry out the assessment would involve input from drug and alcohol services as follows: 1) Clarification of what constitutes an issue (from SM services) 2) Training for MH staff on undertaking the assessment 3) A clear set of criteria to measure against (this would need to be devised by the SM service) A specialist within each service may be a more beneficial approach to completing assessments and help in developing a formal protocol, to ensure ongoing collaboration as well as quickly resolving barriers to individual joint service users.
29	Oxfordshire County Council	Statement 1	The quality statement is quite broad from age 14+. It would be worth considering either two quality statements, one covering adults and one covering the needs of people 14-25.
30	Oxfordshire County Council	Statement 1	If the preference is to keep this as one quality statement, then it would be helpful to include a section covering the additional vulnerability of the young. Whilst our young people service works closely with CAMHS workers, within mental health and substance misuse services, providers need specific approaches to this age group that are different from those 25+. We should be considering the needs of people 25 and under as a special group because of their age being a vulnerability whether they have mental health issues or not
31	Oxfordshire County Council	Statement 1	In addition, the statement around mental health services seeking corroborative evidence from families, carers or significant others, we consider is too much at this initial stage, and feel this sits later in the care journey. Asking this initially could also affect the relationship that the provider is trying to develop with the patient. However, regarding 14-25-year olds, this may be more appropriate at the early stages and further corroborates our assertion that those 14-25-year olds need a separate quality statement or a section within this one.
32	Public Health England	Statement 1	Public Health England (PHE) is supportive of this statement of the quality standard as it is in line with the relevant National Institute for Health and Care Excellence (NICE) guidelines and PHE's 2017 guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions, available to view here: https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services. Professionals routinely asking about drug and alcohol misuse is an essential area for quality improvement for identifying and assessing co-existing substance misuse and mental health conditions.
33	Royal College of General Practitioners	Statement 1	We support this statement regarding the importance of asking about substance/alcohol misuse in patients with suspected or diagnosed severe mental illness, as so many patients with substance misuse disorders have mental

			health problems and vice versa. This advice is echoed in Drug misuse and Dependence UK guidelines https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management. However, the measurement calls for the patient to be questioned regarding their drug/alcohol use at 'every contact'. This could become intrusive and potentially stigmatising, especially if the patient is well or consulting about another matter, for example, going on holiday. The focus needs to be on asking this at a time which could benefit the patient (e.g. through offering support/treatment), rather than on data collection.
34	Royal College of General Practitioners	Statement 1 - outcome	It is difficult to have exact numbers of the people with severe mental illness and coexisting substance misuse. In practice, it is often very difficult to say, other than with the benefit of hindsight, and even then, it can be difficult, that a patient has a severe mental health problem independent of substance misuse. These numbers will be therefore inexact.
35	Royal College of Speech & Language Therapists	Page 4	The Standard emphasises asking people about their experiences and previous services. People with communication problems will have difficulty: • Expressing themselves through verbal communication • Understanding and using language to communicate • Listening to what is being said to them • Remembering and recalling information accurately It is essential that those gathering the views of people have the necessary skills and knowledge to communicate effectively with them and to support their communication.
36	Royal College of Speech & Language Therapists	Page 5 and 6	Speech and language problems have been described as one of the most important clinical diagnostic features of severe mental health problems. It is therefore essential that all staff are trained to have the skills to engage with people with communication difficulties. References: • Thomas, P. 1995. 'Thought disorder or communication disorder: linguistic science provides a new approach', *British Journal of Psychiatry* 166:3, 287-90. McKenna, P. and Tomasina, O.H. 2005. *Schizophrenic speech*, Cambridge: Cambridge University Press.
37	Royal College of Speech & Language Therapists	Page 7	The RCSLT recommends that all assessors need to be trained to identify and understand communication difficulties and how to adapt their own communication to be able to engage with the person. This will result in better involvement of the person in decision making and more accurate assessments,
38	Royal College of Speech & Language Therapists	Page 7	People with communication difficulties will struggle to communicate their wishes. People with communication problems have difficulty: • Expressing themselves through verbal communication • Understanding and using language to communicate • Listening to what is being said to them • Remembering and recalling information accurately

			It is essential that staff gathering the views of people have the necessary skills and knowledge to communicate effectively with them and to support their communication during this process, including support from speech and language therapists.
39	South London and Maudsley NHS Foundation trust	Statement 1 (robustness)	People aged 14 and over with suspected or confirmed severe mental illness are asked about their use of alcohol and drugs. *Suggested modification: People aged 14 and over with suspected or confirmed severe mental illness are thoroughly assessed for drug and alcohol use by suitably skilled staff and offered appropriate interventions* This statement does not sufficiently convey the crucial need for assessments to be as comprehensive and as thorough as possible and conducted by suitably skilled professionals. Only *asking* people about their use may create a barrier to gaining sufficient information to inform decision making with regards to providing the appropriate intervention. Also, given the skills shortages among staff, a screening or assessment tool (or proforma) should be encouraged to improve robustness and consistency. Some of this information is buried deeper in the background text but it may be helpful to bring it more to the fore in the actual statement. Most people will quickly look through the quality standards and not read the background information.
40	South London and Maudsley NHS Foundation trust	Statement 1 (measure)	Depending on how this information is recorded, harvesting and analysing the data can be challenging. Using an agreed tool and modifying IT systems may simplify the process. Modifying IT systems will require additional resources including time and training to embed any changes into practice.
41	South London and Maudsley NHS Foundation trust	Statement 1 (page 7)	For example, in some settings such as emergency departments, it may be considered appropriate only to obtain confirmation from the person that they use a substance and then pass this information on to the mental health service caring for them for further assessment. This example appears to diminish the relevance of thoroughly assessing drug and alcohol use in an A&E. setting. Only seeking to confirm whether the person uses or not can create difficulties in cases where more information is required to ensure patients' safety in an emergency situation. For example knowing what, how much, how administered, how often used and when last used are key questions for establishing effectively management plans for substance related overdose/withdrawal presentations page 7 (Lines 19-21) - Corroborating information with relevant others should be sought (with permission) as often as possible; and not only by MH services as appears to be suggested here.
	Statement 2		
42	Addaction	Question 1 (reflect quality) Statement 2	The quality of this statement could be enhanced by the ensuring evidence of written and agreed joint working arrangements between mental health and substance misuse services (also including joint agreements with other provision within a persons' care). Also include an aim to go beyond joint working arrangements - to joint commissioning and co accountability for jointly agreed outcomes in work with people with co existing mental health difficulties and substance misuse.
43	Addaction	Question 2 (systems and	Measures relevant to this statement could be found within Addaction's substance misuse database Nebula. From a substance misuse service perspective and within the current Nebula set-up there are a least two options:

		structures to collect data) Statement 2	1. For declined referrals, workers are most likely to use discharge reasons of “Client Unable to Engage” or “Inappropriate Referral”. When selecting one of these options, workers could be instructed to use the “Discharge Notes” field to record the specific reason(s) for declining treatment i.e. mental health difficulties. This could then be monitored/numbers involved calculated via Crystal reports (at no anticipated significant additional cost). 2. For those already in treatment, based on the response to the tick box (es) above (Statement 1, Question 2), service users with co-existing substance misuse and severe mental illness could be given a “tag” on the system and a report created/run to monitor the attendance pattern of this cohort (at no anticipated significant additional cost), and follow-ups arranged with individuals as required.
44	Change Grow Live	Statement 2	People aged 14 and over are not excluded from mental health or substance misuse services because of coexisting severe mental illness and substance misuse. Currently there are no dual diagnosis pathways in place for people aged 14-18 years. It is therefore very important we have such pathways in place with CAMHS, EI teams etc. which will prevent these patients from being excluded and will help to establish proper and effective care for this patient group. In my opinion because of lack of any such policies currently, it is going to be hard to measure this standard. Also, are very limited inpatient facilities to deal with 14-18 years who have got substance misuse issues and need a detox or a rehab. Lots of young people are presenting with Xanax and Spice addiction. It is too risky to deal or manage these patients in the community. We therefore need to look into establishing enough inpatient services for this patient group so that they are not excluded.
45	Change Grow Live	Exclusion from services (p14) Experience of patchy response at first point of contact. Or within local teams	First point of contact may be practitioner or administrative and may or may not be familiar with good practice relating to inclusion. Is the first point of contact trained to triage according to the quality standards?
46	Change Grow Live	Intoxication (p11)	Mental health and substance misuse practitioners do not exclude people from the service because of severe mental illness or substance misuse, even if they are severely intoxicated on presentation This difficult issue is poorly addressed in the standards. 1) Serious physical health conditions (especially neurological, infective and metabolic disorders) may be misattributed to intoxication (eg due to smell of alcohol, past history). “Intoxication” lasts a few hours (without further substance use), so reassessment afterwards is recommended (as in MHA assessments where triggered via the AMHP service.
47	Institute of Alcohol Studies	Statement 2	The Institute of Alcohol Studies welcomes the inclusion of this quality statement as our own research suggests this represents a key area of quality improvement. Through a survey and seminar session with mental health and alcohol treatment service workers undertaken in 2018, our research (Institute of Alcohol Studies and Centre for Mental Health. 2018. Alcohol and Mental Health: Policy and practice in England) confirmed what has often been suspected:

			that those experiencing co-occurring mental health difficulties and alcohol use disorders face difficulties in accessing adequate treatment. More that 4 in 5 (84%) respondents agreed that alcohol use disorders represented a barrier to mental health support for individuals, and when asked to comment on the quality and appropriateness of the care available for those experiencing this co-morbidity, most respondents characterised this as 'poor'. However, this research also suggested that this quality standard may not currently be achievable by local services given the resources required to deliver it. More than 90% of respondents suggested funding shortages were a barrier to improving access to treatment services for those experiencing co-morbid alcohol use and mental health difficulties (Institute of Alcohol Studies and Centre for Mental Health. 2018. Alcohol and Mental Health: Policy and practice in England). Alcohol treatment services have suffered substantial disinvestment in recent years. Currently, the commissioning of alcohol treatment services is "overseen by local authority Public Health teams, with support from Public Health England…[funded] through a ring-fenced local authority public health grant" (Alcohol Concern / Alcohol Research UK. 2018. The Hardest Hit: Addressing the crisis in alcohol treatment services. p. 6). However, there is no protection of funds for alcohol treatment services under this grant. This has meant that many local authorities suffering cuts have chosen to defund these services, with some areas reporting cuts to funds for alcohol services as high as 58% (Alcohol Concern / Alcohol Research UK. 2018. The Hardest Hit: Addressing the crisis in alcohol treatment services. p. 7). More concerning, the ring-fencing of funds for public health altogether will be removed next year, leaving these services more vulnerable still (Alcohol Concern / Alcohol Research UK. 2018. The Hardest Hit: Addressing the crisis in alcohol treatment services. p. 6). These cuts have an additional impact on individuals with co-occurring mental health and alcohol use difficulties; these funding reductions have seen some local authorities adopt a "payment by results" model which has the unintended consequence of disincentivising services to support patients with complex needs that might represent greater investment (Drummond, C. 2017. Cuts to addiction services are a false economy).
48	Oxfordshire County Council	Statement 2	Within Oxfordshire our providers do have systems and structures in place within both adult and children's services, using a collaborative and proactive approach to enhance our ability to meet the needs of service users with co-existing substance misuse and mental health needs. Dual Diagnosis is a complex cohort within Oxfordshire Services and closer partnership working has delivered greater understanding across organizations, improved integrated planning and enhanced continuity of care. Therefore, we consider that it should be feasible to collect data
49	Public Health England	Statement 2	PHE is supportive of this statement of the quality standard as it is in line with the relevant NICE guidelines and PHE's guidance on commissioning and delivering services for people with co-occurring conditions. PHE's guidance was produced to encourage commissioners and service providers to work together to improve access to services, respond effectively and flexibly to presenting needs and prevent exclusion. The principle of 'no wrong door' is one of the two key principles that this guidance proposes, and it should guide commissioning and delivery.
50	Royal College of General Practitioners	Statement 2	This statement will be difficult to achieve as currently substance misuse services for those under 17 are not widely available in all local areas. To meet this standard, substance misuse services for people aged 14-17 need to be commissioned and to be in operation in all local areas across England.

			Also, it is important to ensure that services have strong medical expertise in the diagnosis, management and treatment of mental health and substance misuse, in addition to psychosocial interventions.
51	Royal College of General Practitioners	Statement 2	We support this statement and recognise that this can be a source of considerable difficulty when looking after patients with mental health and substance misuse services. It should not matter if a patient presents to substance misuse or mental health services, they should have a quality assessment, and only after that be cared for in the setting most appropriate to their needs, with the services (mental health and substance misuse) working together for the patient. The Drug misuse and Dependence UK guidelines also promote a 'no wrong door' policy https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management It might be difficult to measure these incidence as, in practice, a lot of this in my experience happens at the stage of the initial phone call and may be hard to capture in practice. There are some cases where services will simply make it clear that they will not see patients, for example, mental health services not seeing patients with substance misuse problems may simply decline to see patients who are intoxicated. Some patients are intoxicated a lot of the time, e.g. with alcohol or a patient with a heroin habit who is not on a script.
52	Royal College of Speech & Language Therapists	Page 9	We are pleased to see a Standard on ensuring that people are not excluded from services. Our members have many examples of where people fall can between the gaps in service provision. We have received illustrations of where young adults with autism and mental health needs are not seen by the learning disability team as they do not have a registered learning disability, there is no autism service and they do not meet the criteria to access mainstream mental health services either.
53	South London and Maudsley NHS Foundation trust	Statement 2 (Measure)- Structure	(Page 9) Evidence of local arrangements to ensure that…… This measure could more clearly state the importance of joint working agreements between MH and SM services. The requirement of such referrals and joint working protocols would facilitate measurement of the standard.
54	South London and Maudsley NHS Foundation trust	Statement 2 (Measure)- Structure	This standard will be hard to measure because many services aren't currently set up to collect this data in a consistent way in this area. The reasons offered for rejecting referrals are often less clear. When people are refused access to a service, the reasons put forward aren't usually "….*because of coexisting severe mental illness (or substance misuse)".* These may well be the underlying reasons but often not clearly stated. Reasons cited for declining referrals often include non-engagement, non- attendance and mental health (in the case of referrals from substance misuse services) or substance misuse (in the case of referral from MH services) not being the 'primary' problem at that time. This usually reflects the fact that services aren't set up or adequately resourced for working with dual diagnosis.
	Statement 3		
55	Addaction	Question 2 (systems and structures to collect data) Statement 3	Measures relevant to this statement could be found within Addaction's substance misuse database Nebula, for example: 1. Adding new Event tick boxes (as described for statement 1, Question 2), or by adding the question to the existing Young Person and Adult Assessment wizards. There would likely be a cost involved to add questions to the Assessment Wizards (ca £500 - £1,000 + VAT), but not a cost to add Event tick boxes.

			2. If required/desired, workers can record contact details of the Care-Coordinator using the existing “Professional Worker” module (so no additional cost involved). 3. To monitor those who “*are satisfied with the support they receive*”, the existing NHS “Friends and Family” test can be completed at the end of each TOP+ wizard.
56	Change Grow Live	Care coordination (p14) Lack of training is often cited as a reason for suboptimal care coordination	Care coordinators may not be trained or feel competent in good practice in order to apply the quality standards. Need to have evidence of training needs analysis and gap training with updates.
57	Institute of Alcohol Studies	Statements 3 & 4	As has been suggested by the responses to the previous items, evidence suggests that those individuals with coexisting substance misuse and mental health conditions experience barriers in accessing mental health or alcohol treatment services. Considering this, it becomes essential contact is maintained with those which do reach services. Research from Alcohol Change UK has noted how "GPs struggled to deal with complex or chaotic clients effectively" (Alcohol Concern / Alcohol Research UK. 2018. The Hardest Hit: Addressing the crisis in alcohol treatment services. p. 14). Additional support for these individuals through a care coordinator or through follow up on missed appointments might help maintain contact with services for these individuals.
58	Oxfordshire County Council	Statement 3	Achievement of this would be dependent on what systems are in place within localities, which would determine the resources required. Where areas are more advanced the resource implications will be reduced.
59	Oxfordshire County Council	Statement 3	Resource requirements would include: • At least one specialist in mental health service that is an expert in substance misuse • At least one specialist within the substance misuse service that is a specialist in mental health • If there are not specialists in each service, then there would need to be resource requirement around the development of a clear set of guidelines for the assessment process in respect of substance misuse criteria • Development of a multi-disciplinary approach in both services will involve time and resource • Mutual training in understanding the subtleties of presentation for both issues especially in young people Collection and analysis of data
60	Public Health England	Statement 3	PHE is supportive of this statement of the quality standard as it is in line with the relevant NICE guidelines and PHE guidance on co-occurring conditions, which highlights that every person with co-occurring conditions should have a named care coordinator to help coordinate the multi-agency care plan and that for people with severe mental illness, this should come under the care programme approach.
61	Royal College of General Practitioners	Question 3	Provision of services is patchy, some parts of the country will have existing service models which will be delivering. Patients are very likely to have a care coordinator already but what they do, and their training and skills, will be variable.

62	Royal College of General Practitioners	Statement 3	Patients with severe mental illness should already have a lot of care coordination in place so this could be a source of confusion. It is important that the role of the care coordinator is not diluted, for example when cost savings have to be made this sort of post is very vulnerable. To ensure the care coordinator has the high level of skills and training needed for the role, the committee should consider incorporating the skills and training level needed into the quality statement. It is important that this role does not degenerate into a simply pastoral role operated by an inexperienced worker. This sort of role can involve an assertive outreach approach, which is a very skilled job. The professional development of care coordinators is referenced in NG58 recommendation 1.5.10 “Ensure the care coordinator in secondary care mental health services is supervised and receives professional development to provide or coordinate flexible, personalised care.”
	Statement 4		
63	Addaction	Question 1 (reflect quality) Statement 4	The quality statements 1-3 rely on a degree of engagement with the service user – assertive engagement by those involved with the service user and working with the networks around the person. The quality of statement 4 could be enhanced by using a term that reflects this assertive and wider approach - ‘follow up’ would seem to be too narrow?
64	Addaction	Question 2 (systems and structures to collect data) Statement 4	Measures relevant to this statement could be found within Addaction’s substance misuse database Nebula, for example: 1. As per Question 2 statement 2 point 2 above, attendance (or otherwise) could be monitored via a Crystal report, and a new event tick box could be added to record “follow-up subsequent to missed appointment” (or similar) if/when this has taken place. Note: Nebula does not automatically discharge clients and so there is no automatic process, for example, after missed appointments – this always needs to be done manually by a worker.
65	Change Grow Live	Follow-up after a missed appointment (p18)	Missed appointments are a herald sign for excess and/or escalating risk. This is particularly important during transition in treatment modality (eg inpatient to community) and when discharge is precipitous. Some services derogate from offering follow up. MH services should always refer formally: the self-referral “test of motivation” route is inappropriate and easily allows patients to fall into the gap between services. Need to see evidence of formal referral with relevant clinical information (ie not just “please see and treat” with little else. Some substance misuse services still have to refer via the patient’s GP. This is an unnecessary hurdle for patients and places extra, inappropriate burden on the GP. All MH services should accept direct, formal referrals from substance misuse services.
66	Change Grow Live	Follow-up after a missed appointment (p18)	The National Confidential Inquiry into Suicide and Safety in Mental Health (note new title to reflect greater scope) cites lack of appropriate contact with family and friends in case of missed appointments https://sites.manchester.ac.uk/ncish/ 1) Missed appointments in both substance misuse and MH services should always record a risk and action based Review in Absence, including a degree of assertive follow up. Review in Absence should appropriate contact with family and friends, as well as professionals, in case of missed appointments.

67	NHS England	Statement 4	This statement could be improved by adding that information regarding missed appointments will be shared between services so that there is appropriate safety netting to make sure patients are concordant with monitoring and review plans.
68	Public Health England	Statement 4	PHE is supportive of this statement of the quality standard as it is in line with the relevant NICE guidelines. We are aware of recent research findings that supports focus on missed appointments as an opportunity to intervene, support engagement and prevent deaths. A recent national retrospective data linkage study found that missed primary care appointments represent a significant risk marker for all-cause mortality, particularly in patients with mental health conditions (1). Patients with long-term mental health conditions who missed more than two appointments per year had a greater than eight-fold increase in risk of all-cause mortality compared with those who missed no appointments. These patients died prematurely, commonly from non-natural external factors such as suicide. (1) McQueenie, Ross, David A. Ellis, Alex McConnachie, Philip Wilson & Andrea E. Williamson, (2019) Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study, BMC Medicine 17:2 https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1234-0
69	Royal College of General Practitioners	Statement 4	We support this statement. Multiple agencies may already be involved with the care of the patient, both medically and issues such as housing, sometimes probation, supervised methadone/subutex consumption etc. There are many calls on the patient's time and reasons for them not getting to an appointment. The patient may have to prioritise organising benefits over an appointment. The patient may be of no fixed abode, unstably housed or sleeping on friends' floors and simply not get the appointment. It is not enough to simply remind the patient of the appointment, they will often need skilled support to get to an appointment, so simple interventions, like text message reminders are unlikely to be sufficient. It will be difficult to generate meaningful data around this standard. A GP could engage with the key worker, keep trying to get the patient to their outpatient appointment - and risk the patient not going and yet another DNA. The easy thing would be to not re-refer (on the grounds the patient is at risk of not going) – the numbers would look a lot better, but the care of the patient is worse.
70	Royal College of Speech & Language Therapists	Page 18	The RCSLT welcomes the Standard on following up appointments. This was a recommendation from *The Bercow: Ten Years On* Report which highlight that some of the most vulnerable people never receive support due to non-attendance at an appointment. We recommend that information must be added to describe what follow up actions will take place. Clear systems must be in place to ensure that people who do not attend an appointment do not struggle as a result. We recommend that when someone does not attend an appointment the referrer, GP or health and social worker should be notified and there should be follow-up by the team working with the individual.
71	Royal College of Speech & Language Therapists	Page 20	People with communication problems can lack understanding of time and as a result they may miss an appointment. We recommend that all verbal information is supported by written accessible information for people. People should be asked for their communication preferences to ensure that all information is accessible.

72	Royal College of Speech & Language Therapists	Page 21	The RCSLT supports better joint working. All professionals involved in the care of the person with mental health needs should be involved in decision-making. There also needs to be the recognition that people with communication needs can be harder to engage and that alternative ways of accessing help and support must be offered based on the individual's needs.
73	Royal College of Speech & Language Therapists	Page 22	In the follow up activity section we recommend adding: When someone does not attend an appointment the referrer, GP or health and social worker must be notified and there should be follow-up by the whole team working with the individual.
74	South London and Maudsley NHS Foundation trust	Statement 4 clarity	People aged 14 and over with coexisting severe mental illness and substance misuse are followed-up if they miss an appointment. This standard highlighting the issues of follow up (FU) is much welcomed. The potential impact of the quality statement however could be enhanced. As it stands, it is unclear what appropriate and good quality follow up looks like. This statement could be strengthened by highlighting that FU needs to be prompt, assertive/sustained (prolonged) involving relevant others where appropriate.
	No comments		
75	Department of Health and Social care		Thank you for the opportunity to comment on the above quality standard. I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation
76	Royal College of Nursing		This is just to inform you that the feedback I have received from nurses working in this area of health suggests that there are no comments to submit on behalf of the Royal College of Nursing to inform on this consultation.
77	Royal College of Paediatric and Child Health		Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft quality standard for Coexisting severe mental illness and substance misuse. We have not received any responses for this consultation.
78	Royal College of Psychiatrists		The College has no comments to make.
	Other comments		
79	Change Grow Live	Briefing paper Joint working / Multi agency approach 4.5.1	Multi agency working should also include colocation of mental health and substance misuse services
80	Change Grow Live	Briefing paper Joint working / Multi agency approach 4.5.1	When it comes to commissioning – along with acknowledging the importance of joint commissioning of mental health and substances services there needs to be an increase in commissioning of dual diagnosis services.

Registered stakeholders who submitted comments at consultation

- Addaction
- Change Grow Live
- Department of Health and Social Care
- Institute of Alcohol Studies
- London Borough of Havering, Public Health
- NHS England
- Opportunity Nottingham
- Oxfordshire County Council
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Psychiatrists
- Royal College of Speech and Language Therapists
- South London and Maudsley NHS Foundation Trust