Why you should read this article:

- To read about the challenges experienced by people with co-occurring mental health issues, alcohol and drug use in accessing appropriate services
- To enhance your assessment skills when working with people with co-occurring mental health issues, alcohol and drug use
- To contribute towards revalidation as part of your 35 hours of CPD (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

Supporting people with co-occurring mental health issues, alcohol and drug use

Ben Metcalfe

Citation
Metcalfe B (2024) Supporting people with co-occurring mental health issues, alcohol and drug use. Mental Health Practice. doi: 10.7748/mhp.2024.e1675

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

Correspondence
ben.metcalfe@gmmh.nhs.uk
𝕏@metcalfing

Conflict of interest
None declared

Accepted
1 August 2023

Published online
January 2024

Abstract

It is common for people with co-occurring mental health issues, alcohol and drug use to 'fall between' substance use and mental health services, leading to suboptimal health outcomes. There has been an acknowledgement in UK governments' policies that more integrated services for this group are required. This article identifies why such people can be missed by healthcare services and the barriers that maintain this longstanding issue. The article discusses the need for effective assessment and intervention and how approaches such as motivational interviewing can provide support across services. The author also emphasises the benefits of joint working across agencies and the complexities involved in caring for this group of people.

Author details

Ben Metcalfe, Manchester Dual Diagnosis Liaison Service (MDDLS) lead, Greater Manchester Mental Health NHS Foundation Trust, Manchester, England

Keywords

addiction, dual diagnosis, mental health, mental health service users, substance misuse

Aims and intended learning outcomes

The aim of this article is to assist nurses to anticipate the complex challenges of delivering care to patients with a range of needs relating to co-occurring mental health issues and alcohol or drug use. After reading this article and completing the time out activities you should be able to:

- Understand the effects of co-occurring mental health issues, alcohol and drug use.
- Recognise the challenges for people with co-occurring mental health issues, alcohol and drug use in accessing appropriate services.
- Identify the principles of working practice that should be applied during assessment of people with co-occurring mental health issues, alcohol and drug use.
- Outline the challenges in ensuring that care for people with co-occurring mental health issues, alcohol and drug use is coordinated more effectively in the future.

The governments of England and Wales, Scotland and Northern Ireland have recently published drug strategies (Department of Health 2021, HM Government 2021, Scottish Government 2022) in which a common theme is the need to reduce the numbers of deaths attributed to drugs and to improve the lives of those affected by drugs. Within these policies is an acknowledgement that more integrated services are required to support people with co-occurring mental health issues, alcohol and drug use.

The terminology for people with mental health issues that occur concurrently with alcohol and drug use is evolving. Previous terminology such as 'dual diagnosis' has come to be regarded as unhelpful, partly because it implies that the person already has a medical diagnosis and partly because people labelled as dual diagnosis often have multiple needs (Hamilton 2014). While dual diagnosis is still used as a working definition in many UK services, for the purpose of this article the author uses the

acronym COMHAD (co-occurring mental health and alcohol and/or drug use conditions) (Public Health England (PHE) 2017).

One of the reasons the interface between mental health issues and alcohol and drug use is important is the prevalence of these conditions. For example, the National Institute for Health and Care Excellence (NICE) (2011) detailed that 40% of people with psychosis will use substances at some point in their life, while PHE (2017) emphasised that mental health issues are experienced by most drug (70%) and alcohol (86%) users in substance use treatment settings.

The interactions between mental health issues and alcohol and drug use are diverse, with each condition fluctuating in severity throughout an individual's life. However, the prevailing diagnostic perspective often means that people accessing mental health services are required to have a mental health diagnosis, which acts as a gatekeeper to care provision across different services (Rao 2022). This means that staff in drug and alcohol and mental health services assess people through their specialist 'lens', which risks underemphasising or even neglecting a concomitant issue. Additionally, a person's age, gender, ethnicity and previous experiences of seeking help will affect their experiences of care, treatment and service inclusion. The interaction between mental health and substance use is, therefore, described accurately as complex (NICE 2016).

Effects of co-occurring mental health issues, alcohol and drug use

Rarely do two conditions, such as mental health issues and substance use, combine to cause such elevated risks to health. The perceived 'collision of complexity' between mental health issues, alcohol and drug use and the related services means it is unsurprising that people with COMHAD, particularly severe and enduring mental illness, experience suboptimal health outcomes.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH 2022) reported that there were high proportions of people with alcohol (47%) and drug (37%) use issues and comorbidity, for example more than one mental health diagnosis (53%) appearing in figures for those dying by suicide between 2009 and 2019. Similarly, a review of national data and population surveys identified the following (PHE 2017):

- Significant health risks among young people, including high levels of self-harm, domestic violence and sexual exploitation, with low referral rates from mental health services into drug and alcohol services.
- The use of substances by women to manage the psychological and physical harm resulting from their experiences of violence.
- COMHAD as a common factor in mental health crisis admissions to acute hospitals via emergency departments (EDs) in 2012-13, with 20% due to alcohol use.
- A high prevalence of COMHAD among the prison population, where COMHAD is the norm rather than the exception. More than 55% of people in the criminal justice system who experienced mental health issues also had substance use issues.
- In 2012, more than half (55%) of 58,000 people nationally who experienced the most severe disadvantages, for example substance use and homelessness and involvement with the criminal justice system, had a diagnosed mental health condition and nearly all (92%) had a self-reported mental health issue (Bramley et al 2015).
- People with mental health issues were more likely to smoke, leading to a 10-20-year reduced life expectancy.
- Men and women living with schizophrenia in the community had a 20.5 and 16.4-year reduced life expectancy respectively, while people with psychosis and who also used substances were more likely to be non-adherent to prescribed medicines, demonstrate poor engagement with treatment programmes and have more and longer inpatient stays (NICE 2011).

The Department of Health and Social Care (DHSC) (2023) has reported a 25% fall in rates of suicide by patients in NHS mental health trusts that have implemented a specific policy on the management of COMHAD (DHSC 2023). Other clinical measures that can reduce suicide risk in this group include ensuring that frontline healthcare staff have the skills required to assess the needs of people with COMHAD and placement of specialist alcohol and drug use clinicians within mental health services (NCISH 2022).

TIME OUT 1

Consider the services in your local area and identify the following:

- Who delivers mental health services?
- Who delivers substance use services?
- How are these integrated or aligned and what are the strengths and challenges of this arrangement?
- What local services or expertise in co-occurring mental health issues and alcohol and drug use are available?

Challenges in accessing services

Access to services for people experiencing COMHAD is complex and dynamic. Historically, the configuration of mainstream mental health and substance use services means that they each develop their own organisational rules and philosophies of care, which can make navigating the system and starting to develop relationships with staff challenging for service users. Other challenges include lack of knowledge of COMHAD among staff and negative attitudes of staff towards, and stigma associated with, substance use.

Organisational issues

Organisational barriers to accessing services for people experiencing COMHAD may include remote locations, lack of flexible opening times, discharge policies for nonattendance, minimal adaptation to provide outreach or afterwork services and high diagnostic entry thresholds. Historically, most mental health services in England have been commissioned by NHS England, while substance use services are usually commissioned by local authorities. This creates multiple access points across services within a geographical region (Hamilton 2014, Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017). As an example, at the time of writing there were two mental health providers and five different substance use providers in the ten local boroughs across one of England's largest cities. For service users with COMHAD who may move around a region due to being homeless, it can be daunting to achieve timely access to services.

In addition, communication between services can vary. For example, some areas have shared IT systems which can benefit inter-service communication, others may only have information-sharing agreements, and some may have no formal arrangements. Similarly, staff taking up roles in another region or service can take time to learn how local services work. Overall, there is no 'one system model' for people experiencing COMHAD, which can adversely affect care pathways and the way service users navigate services (Hamilton 2014).

Philosophy of care

The philosophy of care in some services can present a challenge for service users experiencing COMHAD. For example, historically it is the responsibility of the individual service user to seek out substance use services (unless mandated by a court). This means that, in general, the person is required to recognise that they have an alcohol and/or drug use issue and show a desire to address it. The same applies in primary care level mental health services such as NHS Talking Therapies (NHS 2022), whereas staff in tier two mental health services, such as community mental health teams or social care, can explore a person's mental capacity and, if necessary, use legislation such as the Mental Capacity Act 2005 or the Mental Health Act 1983 (as amended 2007) to safeguard them.

Interactions between staff from different services, who must attempt to determine which person should be in receipt of which service and for which risks, can increase the challenge of accessing services for people experiencing COMHAD. Similarly, discrepancies between staff members' perceptions of who should be involved in a service user's case can at best create delays to treatment and at worst create exclusionary factors; for example, where an individual without a defined mental health diagnosis might not be accepted into mental health services because of their substance use (NCISH 2022).

Staff knowledge, negative attitudes and stigma

Mental health nurses may encounter a significant number of people who use drugs or alcohol during their career, yet their undergraduate nursing degree programme may only have included a limited amount of study on substance use. Similarly, frontline staff in substance use services, for example recovery coordinators, may not be trained in caring for people with mental health issues. This lack of knowledge, alongside limited access to training and inadequate resources, can result in staff in drug and alcohol services developing negative attitudes towards people experiencing COMHAD (Hamilton 2014).

People with COMHAD are also known to experience stigma in a number of ways (Lloyd 2010, Krausz et al 2014). For example, Alcohol Change UK (2019) emphasised how frontline practitioners' perceptions of alcohol consumption as a 'lifestyle choice' negatively affected their readiness to explore service users' issues fully. This reluctance on the part of practitioners could negatively affect service users' attitude towards attending or accessing services.

Additionally, service users may experience 'othering', which can be described as the act of treating someone as though they are not part of a recognised group or as 'different' in some way. This can apply to people with COMHAD, with some healthcare staff regarding alcohol-related issues as 'self-

inflicted' and beyond their remit of care delivery. Any assumption that alcohol use is an example of a person exercising 'free choice' is unhelpful and should be challenged by nurses who encounter it in their colleagues (Alcohol Change UK 2019).

TIME OUT 2

You are working as a mental health liaison psychiatric nurse and are called to your hospital's ED to undertake a mental health assessment with John, a middle-aged man, who has been brought in by his wife. This is John's first ED presentation. His wife says he has been drinking alcohol and expressing suicidal ideas; she also says that he is dependent on alcohol and has been 'talking to people who aren't there'. She explains that he experienced trauma as a child and he drinks more heavily at certain times of the year. John also struggles with extreme mood swings and often seems to be 'up and down'. John's wife feels that he self-medicates with alcohol.

During your assessment with John, what factors might you consider? Think about the following:

- What clinical issues might you need to consider in someone presenting to the ED when intoxicated?
- What clinical issues might be encountered with someone who presents with alcohol withdrawal symptoms?
- What other health issues may be complicated by a person who presents to the ED while intoxicated?
- What factors may influence John's willingness to stay in the ED?
- Is there an enhanced risk in John's case?

Assessment

An understanding of the service user's past and present experience of COMHAD should form part of the holistic assessment. A thorough holistic assessment enables the nurse to develop a broader understanding of a person's needs, especially when they are entering treatment, and is essential to providing optimal care (NICE 2011, PHE 2017). As well as adopting an empathic, non-judgemental approach, any nurse attempting to assess the needs of a person experiencing COMHAD should:

- Attempt to identify the person's use of alcohol and/or drugs, for example using a recognised screening tool such as ASSIST-Lite (a shortened version of the Alcohol, Smoking and Substance Involvement Screening Tool), which helps healthcare professionals to identify risky drug and alcohol use and respond in an evidence-based manner (PHE 2021). The ASSIST-Lite tool uses a series of questions about the person's use of alcohol, stimulants, cannabis and opioids, among other substances; for example, their use of illicit drugs or non-prescribed medicines within the last three months.
- Attempt to identify if the person is experiencing withdrawal and, if so, assess the severity by using a tool such as the Severity of Alcohol Dependence Questionnaire (SADQ) (Stockwell et al 1979), the revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar) (Sullivan et al 1989) or the Clinical Opiate Withdrawal Scale (COWS) (Wesson and Ling 2003).
- In the case of substance use, assess the types of drugs used, including: the quantity and frequency of use; how the drugs were obtained; any evidence of harmful use; pattern of use; and risks of withdrawal (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017).

Following the above, a discussion may be held as to what weighs most heavily (severity of mental health, or severity of substance use). A decision-making tool, such as the quadrant model (McDonell et al 2012) can be used to support decision making. The quadrant model in this context can be used to determine the most appropriate approach to treatment and care (Findings 2020). For example, using the model can assist the nurse to make a reasonable clinical case for why the person may not be eligible for a mental health service assessment at this point, but instead requires an assessment by a drug and alcohol service. However, such is the dynamic nature of a person's mental health or substance use, a reliance on this model as a decision-making tool can also lead to unresolved disputes or delays and tensions between services who hold an equally valid reasonable case for why the person may not be suitable for a drug and alcohol service, but actually require mental health support in the first instance (Findings 2020). It can be unclear at times where severity lies, and it is unlikely to be on a two-dimensional continuum (McGovern et al 2007), and it oversimplifies conditions that co-occur. The case study detailed in Time out 2 could fall into any of the four sections of the quadrant model over a short period of time.

With the multiple reasons people use alcohol or drugs – which may result in poor mental health, or be a response to poor mental health, trauma, societal norms, or somewhere in between – assessments need to explore the 'why and how' it is developed as opposed to simply exploring 'what'. Standardised forms that do not support conversations, curiosity and compassion risk not only excluding patients but also de-skilling a workforce. Therefore, assessment and development of a shared formulation between services around

Key points

- The perceived 'collision of complexity' between mental health issues, alcohol and drug use and related services can result in suboptimal health outcomes for service users
- Access to services for people with co-occurring mental health issues and alcohol and drug use (COMHAD) is challenging, in part due to service-related issues, a lack of knowledge among staff and negative staff attitudes
- An effective assessment should explore 'why' and 'how' the person has COMHAD
- Joint working across multiple agencies in supporting people experiencing COMHAD is essential to improve patient outcomes

the interaction of substance use and mental health is vital (NICE 2011, PHE 2017). In the case study, the case could be explained by several hypotheses such as stress, vulnerability or self-medication, but can only be determined by a deeper, shared understanding of the case. The understanding of the past and present relationship between mental health and substance use work towards the understanding of a desired future and factor into the holistic assessment.

TIME OUT 3

Thinking about John's situation in time out 2, review the standardised assessment tools you use in routine practice and reflect on whether they take account of COMHAD. What elements, if any, may be missing?

Navigating change

In health and social care settings people experience turbulence in their life because of change. This may be a change in their mental health (often relapse and remitting conditions), or changes in substance use. Where both conditions co-occur, a person may have found equilibrium. At the same time a person's life situation is dynamic. One way of understanding change is to explore a person's feelings, thoughts and attitudes about it. This is a shift away (but not a complete divergence) from a medical perspective, one which can be understood by Prochaska and DiClemente's (1984) transtheoretical model of change. Whether a person is pre-contemplative towards change (unaware of a problem and/or not wishing to change), contemplative to change (in 'two minds'), determined (taking steps) or maintaining a change, rather than passing through these stages sequentially, any change experienced by a person with COMHAD is likely to be non-linear because of the multifaceted determinants. Therefore, the nurse should seek to engage with the person on their terms, or in other words 'where they are' in terms of change.

A common trope in services is that staff should meet people 'where they are at'. Attempting to understand the thoughts, feelings and values of a person experiencing COMHAD through compassion and empathy can guide the nurse's clinical practice, which may include the use of techniques such as motivational interviewing (NICE 2011, Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017). Ahn and Wampold (2001) reported that the effectiveness of any specific psychological intervention is probably due to general factors, such as the therapeutic alliance, rather than treatment specificity. To draw on motivational interviewing, Miller and Rollnick (2013) explained that this is a style and set of skills for tackling diverse challenges through the development of a partnership or alliance with a person.

TIME OUT 4

Following your mental health assessment, John is admitted to one of the hospital wards and treated for alcohol-related withdrawal symptoms for 48 hours. When you visit John on the ward to undertake a risk assessment before his potential discharge you do not observe any signs or symptoms of psychosis and John does not recall talking to himself in the ED. He explains that he had 'overdone it' and he 'won't drink to excess' again. He also says he is not experiencing any suicidal ideation. John is eager to leave hospital and return home, however his wife is worried, particularly because he states that he does not want to stop drinking completely. Before you complete your risk assessment, consider the following:

- Do you have any concerns about John's capacity to make decisions about his care and support on discharge?
- How could John's wife be supported in her role as main carer?
- How might a technique such as motivational interviewing assist you to gain an understanding of John's risk status?

Motivational interviewing

Motivational interviewing is a way to have a conversation about change which seeks to strengthen a person's own motivation and commitment to change. Motivational interviewing is an intentional move away from a 'righting style', or well-meaning advice, deliberate correction, or judgement of a person's choices and subsequent behaviours. It relies on partnership through collaboration, acceptance through empathic listening and a demonstration of non-judgemental attitudes. It is an active process of compassion and empowerment through 'calling forward' the wisdom and best advice from a person a nurse is supporting. It is the belief that resources to change lie with the person. The nurse's desire to help, reflexivity to fix and 'make people better' though well intended can remove a sense of autonomy from a person seeking support (Miller and Rollnick 2013).

Meeting people where they are at requires a responsiveness to the changes observed. To draw on a metaphor of guiding or walking alongside a person is to reflect – does this person even wish to walk with us? Where are we going? Why are we going there and how may we get there? The first question here fits with the model of change. Until there is

a desire, ability, reason or need to change, how can we know the direction of care to provide. A person may not be 'lacking in motivation' to stop using substances, rather they are more motivated to use substances than stop. There is tremendous value in understanding what this motivation is. To reduce this to a simple dichotomy of 'motivation' or 'unwise decisions' and 'lifestyle choice' does not meet people where they are at, or account for the complexity of a person's ambivalence. There are a multitude of interventions that nurses can adopt for those who may not be considering change and at any stage. 'They didn't want to engage' cannot effectively be stated unless a trauma-informed approach considering harm reduction, pre-engagement style development of trust, outreach, brief advice, longitudinal assessment of capacity, safeguarding and consistency in approach has been explored in the first instance.

Motivational interviewing provides not only the approach and attitudes essential in developing an alliance with people, but also a way to put this into practice. It is common to hear staff talk in an empathic manner about people they have supported. It is the active communication to the person being supported of these thoughts and considerations that shows there is a willingness to 'meet them where they are'. This takes a degree of curiosity which emerges from an ability to see the world from that person's perspective (empathy). This is demonstrated through open questions; enquiry that draws on a narrative, an exploration of strengths, challenges, resources, barriers ('Help me understand what this has been like for you?'). By responding to the strengths the nurse hears, a person's resources are affirmed, which can help identify strengths as a positive attribute that can now be used to help them on their journey ('You've overcome challenges in the past'). The nurse can develop their active listening skills to be reflective to what they are hearing. A desire to understand a person's meaning from what they communicate is a demonstration of compassion and empathy ('You're frustrated you find yourself in hospital again') and often a deeper meaning can be found as a result. Reflective listening is a skill that takes a short time to understand but lots of practice to feel at ease with. Motivational interviewing supports listeners to summarise where a person is – their hopes, fears, challenges, strengths and a richer understanding of their experience. It is only then nurses can start to claim to have met someone where they are at (Miller and Rollnick 2013).

The nurse can then move forward (and sometimes step backwards) together with people, with permission, with agreement, with a sense of trust and collaboration. Through neutral and non-judgemental enquiry, the nurse can evoke reasons and hopes and resources for change and weigh these against fears and concerns of not changing. The nurse can provide options or choices and explain what the next turns may look like at a person's own pace. Training models for all staff should focus on the importance of interviewing skills, establishment of a therapeutic relationship and common factors as the bedrock of skills to become an effective practitioner (Ahn and Wampold 2001).

A capability framework for working effectively with people experiencing COMHAD describes the values, knowledge and skills required and may be useful for nurses as a skills development tool (Hughes et al 2019). The capability framework includes a reflective self-assessment for healthcare professionals in areas such as (Hughes et al 2019):

- Values – the healthcare professional's ability to communicate compassionate care verbally.
- Effective management – skills in developing relationships in a helpful atmosphere.
- 'Right care, right time' – the ability to provide a comprehensive, strengths-based assessment.
- Effective working with multiple agencies – knowledge of local services, communication between services, local agreements and how to share information about service-users' risk.
- Families – ability to work with service-users' families and carers.
- Physical health and health promotion – awareness of the physical health risks associated with COMHAD, such as chronic obstructive pulmonary disease or liver disease, and the skills required to support service users to access healthcare and to offer brief advice on a range of health issues.

TIME OUT 5

You are about to refer John for treatment in the community. Remember that he may have an underlying mental health issue masked by a number of years of using alcohol and that this may require multiagency meetings to develop a shared plan of support.

Consider the following:

- What type of care and follow-up support might you recommend for John, for example counselling?
- Which service(s) in your area would you consider referring John to?
- How confident are you that these services will accept your referral?

What would be the best and worst-case scenarios for John's onward referral?

Future challenges

The importance of joint working across multiple agencies in supporting people experiencing COMHAD cannot be overstated; the nurse may need to involve housing, homeless agencies, advocate services, physical health, social care and criminal justice systems. PHE (2017) emphasised this joint working as 'everyone's job', while guidance from NICE (2011) emphasises a requirement for COMHAD needs to be addressed at the same time as part of an integrated package of care. Commissioners and providers of mental health and alcohol and drug services have a joint responsibility to meet the needs of people with co-occurring conditions by working together to reach shared solutions. The UK-wide Drug Misuse and Dependence Guidelines on Clinical Management (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017) suggested a framework for services to ensure:

- Effective strategic collaboration between commissioners and providers to provide adequate treatment.
- Assessment information is used to inform care planning and not to exclude individuals from a service.
- Assessment of individuals leads to appropriate treatment even if the required specialised support is provided elsewhere; for example, the assessing professional might refer the person with COMHAD to a more appropriate drug and alcohol or mental health service.
- Services support people with COMHAD using person-centred care to enable them to better manage their own lives.
- All relevant services deliver timely, compassionate and clinically appropriate responses to individuals in crisis.

Positive attitudes towards people experiencing COMHAD can be maintained with regular co-designed training delivered by mental health and social care services (Foster 2020). In addition, multiagency approaches, inter-service staff placements and enhanced assessment skills can contribute to best practice for people experiencing COMHAD.

Research is expected to be published via a Realist Evaluation of Co-Occurring (RECO) service model to enhance an understanding of what works well, where and why (University of Leeds 2020).

Collision of complexity

At the beginning of this article, the author referred to a collision of complexity between people experiencing COMHAD and service provision. To begin to address this, the author would argue that nurses and other health and social care staff should challenge the idea that service users' COMHAD issues are incomprehensible; additionally, the author would suggest that these services should 'hold' cases until agreement is reached on the most appropriate service for that person at that point in their care journey. In the author's view, the real complexities lie not with individual service users but with health and social care services' collective inability to respond accordingly. Understanding this complexity may involve these services reflecting on the challenges they have experienced in the past in delivering effective, multiservice, person-centred care and support to this patient group.

TIME OUT 6

Access the capability framework for working effectively with people with co-occurring mental health and alcohol/drug use conditions (Hughes at al 2019) using the QR code shown (which you can scan with your mobile device) or by visiting: **www.clinks.org/sites/default/files/2019-06/Capability%20Framework%20FINAL.PDF** Review the framework and complete the self-assessment section.

How might this self-assessment be incorporated into your appraisal or continuing professional development?

Conclusion

Despite the existence of UK-wide national guidance on clinical management of people experiencing COMHAD, gaps in service provision remain. This may be due to a perceived collision of complexity between individuals' needs and service provision. It is important, therefore, that nurses challenge the perception that a service user's issues are incomprehensible and/or untreatable. Additionally, health and social care providers should reflect on the complexities of the systems that are intended to deliver care for people with COMHAD and consider ways in which to address these. An effective assessment should explore 'why' and 'how' the person has developed COMHAD rather than focusing only on 'what' type of issue they have, and nurses can use a range of skills to achieve this. Furthermore, development of a shared assessment procedure between services that manage substance use and those that manage mental health is essential to improve care for this patient group. Healthcare professionals such as nurses should be able to work alongside other services to understand and attempt to meet the needs of people experiencing COMHAD.

CPD CONTINUING PROFESSIONAL DEVELOPMENT

TIME OUT 7

Identify how supporting people with COMHAD applies to your practice and the requirements of your regulatory body

TIME OUT 8

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: **rcni.com/reflective-account**

References

Ahn H-N, Wampold BE (2001) Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. Journal of Counseling Psychology. 48, 3, 251-257. doi: 10.1037/0022-0167.48.3.251

Alcohol Change UK (2019) Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017. alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017 (Last accessed: 22 September 2023.)

Bramley G, Fitzpatrick S, Edwards J et al (2015) Hard Edges: Mapping Severe and Multiple Disadvantage in England. lankellychase.org.uk/publication/hard-edges (Last accessed: 22 September 2023.)

Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug Misuse and Dependence: UK Guidelines on Clinical Management. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf (Last accessed: 26 September 2023.)

Department of Health (2021) Preventing Harm, Empowering Recovery – Substance Use Strategy: A Strategic Framework to Tackle the Harm from Substance Use (2021-31). www.health-ni.gov.uk/publications/substance-use-strategy-2021-31 (Last accessed: 22 September 2023.)

Department of Health and Social Care (2023) Policy Paper. Suicide Prevention in England: 5-year Cross-Sector Strategy. www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy (Last accessed: 25 September 2023.)

Findings (2020) The Complexity and Challenge of 'Dual Diagnosis.' findings.org.uk/PHP/dl.php?file=dual.hot#quadrant_dual_diagnosis (Last accessed: 26 September 2023.)

Foster G (2020) 'The dual diagnosis attitudes survey': understanding the attitudinal impact of training across mental health and alcohol and drug service systems. Advances in Dual Diagnosis. 13, 4, 137-149. doi: 10.1108/ADD-05-2020-0004

Hamilton I (2014) The 10 most important debates surrounding dual diagnosis. Advances in Dual Diagnosis. 7, 3, 118-128. doi: 10.1108/ADD-05-2014-0013

HM Government (2021) From Harm to Hope: A 10-Year Drugs Plan to Cut Crime and Save Lives. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079147/From_harm_to_hope_PDF.pdf (Last accessed: 22 September 2023.)

Hughes L, Trippier J, Kipping C et al (2019) Capability Framework: Working Effectively with People with Co-occurring Mental Health and Alcohol/Drug Use Conditions. www.clinks.org/sites/default/files/2019-06/Capability%20Framework%20FINAL.PDF (Last accessed: 22 September 2023.)

Krausz RM, Werker GR, Strehlau V et al (2014) Applying addictions harm reduction lessons to mental health settings. Advances in Dual Diagnosis. 7, 2, 73-79. doi: 10.1108/ADD-01-2014-0003

Lloyd C (2010) Sinning and Sinned Against: The Stigmatisation of Problem Drug Users. UK Drug Policy Commission, London.

McDonell MG, Kerbrat AH, Comtois KA et al (2012) Validation of the co-occurring disorder quadrant model. Journal of Psychoactive Drugs. 44, 3, 266-73. doi: 10.1080/02791072.2012.705065

McGovern MP, Clark RE, Samnaliev M (2007) Co-occurring psychiatric and substance use disorders: a multistate feasibility study of the quadrant model. Psychiatric Services. 58, 7, 949-954. doi: 10.1176/ps.2007.58.7.949

Miller WR, Rollnick S (2013) Motivational Interviewing Helping People Change. Third edition. The Guilford Press, New York NY.

National Confidential Inquiry into Suicide and Safety in Mental Health (2022) Annual Report 2022: UK Patient and General Population Data 2009-2019, and Real-Time Surveillance Data. https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/ (Last accessed: 22 September 2023.)

NHS (2022) NHS Talking Therapies. www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies (Last accessed 22 September 2023.)

National Institute for Health and Care Excellence (2011) Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings. Clinical guideline No. 120. NICE, London.

National Institute for Health and Care Excellence (2016) Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Community Health and Social Care Services. NICE guideline No. 58. NICE, London.

Prochaska JO, DiClemente CC (1984) The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy. Dow Jones-Irwin, Homewood IL.

Public Health England (2017) Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use Conditions: A Guide for Commissioners and Service Providers. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf (Last accessed: 22 September 2023.)

Public Health England (2021) How to Use the ASSIST-Lite Screening Tool to Identify Alcohol and Drug Use and Tobacco Smoking. www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use/how-to-use-the-assist-lite-screening-tool-to-identify-alcohol-and-drug-use-and-tobacco-smoking (Last accessed: 22 September 2023.)

Rao T (2022) Dual diagnosis – what's in a name? Advances in Dual Diagnosis. 15, 3, 149-151. doi: 10.1108/ADD-08-2022-048

Scottish Government (2022) National Drugs Mission Plan: 2022-2026. www.gov.scot/publications/national-drugs-mission-plan-2022-2026/ (Last accessed: 22 September 2023.)

Stockwell T, Hodgson R, Edwards G et al (1979) The development of a questionnaire to measure severity of alcohol dependence. British Journal of Addiction to Alcohol and Other Drugs. 74, 1, 79-87. doi: 10.1111/j.1360-0443.1979.tb02415.x

Sullivan JT, Sykora K, Schneiderman J et al (1989) Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). British Journal of Addiction. 84, 11, 1353-1357. doi: 10.1111/j.1360-0443.1989.tb00737.x

University of Leeds (2020) The RECO Study: Realist Evaluation of Service Models and Systems for CO-Existing Serious Mental Health and Substance Use Conditions. medicinehealth.leeds.ac.uk/faculty-/dir-record/research-projects/1296/the-reco-study-realist-evaluation-of-service-models-and-systems-for-co-existing-serious-mental-health-and-substance-use-conditions (Last accessed: 22 September 2023.)

Wesson DR, Ling W (2003) The Clinical Opiate Withdrawal Scale (COWS). Journal of Psychoactive Drugs. 35, 2, 253-259. doi: 10.1080/02791072.2003.10400007

Co-occurring mental health issues, alcohol and drug use

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. The term 'dual diagnosis' in the context of people with mental health issues that occur concurrently with alcohol and drug use is now regarded as:

a) Unhelpful ☐
b) Influential ☐
c) Accurate ☐
d) Insulting ☐

2. Which of the following describes accurately the interaction between mental health and substance use?

a) Contradictory ☐
b) Mutually exclusive ☐
c) Symbiotic ☐
d) Complex ☐

3. A high proportion of people experiencing co-occurring mental health and alcohol and/or drug use (COMHAD) can be found in:

a) Urban areas ☐
b) The prison population ☐
c) Wales ☐
d) Private hospitals ☐

4. Which of the following may impede access to services for people experiencing COMHAD?

a) Remote locations ☐
b) Lack of flexible opening times ☐
c) Discharge policies for non-attendance ☐
d) All of the above ☐

5. Discrepancies between staff members' perceptions of who should be involved in a particular service user's case can create:

a) Delays to treatment ☐
b) Enhanced integrated care ☐
c) An effective shared care pathway ☐
d) A multi-agency care package ☐

6. What factor might cause staff in drug and alcohol services to develop negative attitudes towards people experiencing COMHAD?

a) Excess paperwork ☐
b) Cognitive dissonance ☐
c) Limited access to training ☐
d) Inadequate IT infrastructure ☐

7. Which of the following is accurate? Othering can be described as:

a) An alternative term for differential diagnosis ☐
b) The act of treating someone as though they are not part of a recognised group or as 'different' in some way ☐
c) Dividing patients into specific cohorts according to their social status ☐
d) A research term for discarding subjects due to a lack of variation in a study population ☐

8. The purpose of the ASSIST-Lite screening tool is:

a) To decide if service users may be eligible for self-help groups ☐
b) To ascertain the drug or alcohol content of a blood sample ☐
c) To assess if an individual has underlying mental health issues ☐
d) To help healthcare professionals to identify risky drug and alcohol use ☐

9. According to the transtheoretical model of change, the contemplative stage involves:

a) Being 'in two minds' regarding any change ☐
b) Not wishing to change ☐
c) Already taking steps to change ☐
d) Being committed to a change that has already taken place. ☐

10. Which of the following is inaccurate? Motivational interviewing:

a) Is a technique that seeks to strengthen the individual's motivation to change ☐
b) Represents an intentional move away from a 'righting style', which involves well-meaning advice ☐
c) Is a technique that seeks to weaken the individual's motivation to change ☐
d) Relies on partnership through collaboration, acceptance through empathic listening and a demonstration of non-judgemental attitudes ☐

How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

You may want to write a reflective account. Visit rcni.com/reflective-account

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to **rcni.com/cpd/test-your-knowledge**

This multiple-choice quiz was compiled by Jason Beckford-Ball

The answers to this quiz are:

1. a, 2. d, 3. b, 4. d, 5. a, 6. c, 7. b, 8. d, 9. a, 10. c

This activity has taken me ___ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor ☐

As a result of this I intend to: _____

_____

_____