



special articles

Psychiatric Bulletin (2003), 27, 183–186

H. L. GRAHAM, A. COPELLO, M. BIRCHWOOD, J. ORFORD, D. McGOVERN, G. GEORGIU
AND E. GODFREY

Service innovations

Coexisting severe mental health and substance use problems: developing integrated services in the UK

One of the challenges for services in the UK has been how best to meet the needs of those people who experience severe mental health problems and use drugs and alcohol problematically. It is now well-documented in the international literature that the coexistence of severe mental health and substance misuse problems are common (e.g. Regier *et al*, 1990; Krausz *et al*, 1996; Menezes *et al*, 1996; Fowler *et al*, 1998; Mueser *et al*, 2000; Graham *et al*, 2001) and often correlated with a number of adverse outcomes (Smith & Hucker, 1994; Johnson, 1997; Mueser *et al*, 2000). Integrated treatment approaches developed in the USA for this client group (e.g. Drake & Wallach, 2000; Drake *et al*, 2001), and although they offer much food for thought and some direction, they could not be wholly imported and implemented in the UK because of significant differences in the contextual factors that guide service provision in the two countries. The challenge in the UK has been to develop effective services that fit with the unique community-based treatment approaches for substance misuse problems and mental health that have developed and historically offered separately and in parallel.

We have been working since 1997 within Northern Birmingham Mental Health Services towards developing integrated treatment services for this client group. Our aim has been to work towards a situation where clients with coexisting severe mental health and substance misuse problems remain engaged and case-managed within mainstream mental health services. If necessary, the client's care can be shared with substance misuse services.

The service context

Northern Birmingham Mental Health NHS Trust provides mental health and substance misuse services to a catchment population of approximately 570 000 in an urban area of the UK. The area is multicultural and inner city, and has been classified as one of high social deprivation. The Trust has evolved into a provider of 'functionalised' community mental health teams, i.e. teams that are

specialised in function and tailored to the needs of particular client groups (e.g. assertive outreach, home treatment, rehabilitation and recovery), as outlined in the National Health Service Plan (Department of Health, 2000). The Trust is also a provider of community-based treatment services for those who use drugs and alcohol problematically. These services delivered care in parallel to the 'functionalised' mental health services, although historically, some level of liaison existed.

In common with the situation elsewhere, it became apparent that the needs of those with severe mental health problems who use drugs/alcohol problematically were not being met by the existing separate service provision (Drake *et al*, 2001). Bearing in mind that the 1-year prevalence rate of substance misuse among our clients with severe mental health problems was found to be 24% (Graham *et al*, 2001), the need was therefore significant. Among clients within assertive outreach mental health teams, rates were even higher. The major unmet need for integrated substance misuse treatment for people with severe mental health problems was the backdrop for a fundamental shift in service provision. The Trust's attempt to address this shortfall of services was to develop a new initiative, spearheaded by the Combined Psychosis and Substance Use (COMPASS) Programme aimed at integrating current service provision for this client group. Long-term funding for the initiative was secured from specific monies from the Mental Health Challenge Fund. A multi-agency steering group, incorporating key stakeholders, and a number of other groups involving key managers and clinicians from substance misuse and mental health services within the Trust were put in place to direct and facilitate the development and evaluation of this initiative.

The COMPASS Programme: an integrated 'shared-care' treatment approach

An 'integrated shared care' model was developed to complement the existing service provision within the



Northern Birmingham Mental Health Trust. The model aimed to achieve integration of treatment both at the level of the clinician and service. The key principle underlying this integration is that both mental health and substance misuse problems and the relationship between the two are addressed simultaneously by the mainstream mental health clinician. However, in some cases, more specialist input might be required, and this can be achieved through shared care between mental health and addiction services. Sharing care between service levels means that agreed protocols need to be in place for closer and/or joint working between mental health and substance misuse services.

Thus, the COMPASS Programme evolved as a specialist multi-disciplinary team that aims to train and support existing mental health and substance misuse services in order to provide integrated treatment, where appropriate, to their client group. This was in opposition to creating an additional specialist third service that took on a separate case-load. This service model of supporting 'mainstream' mental health services to deliver interventions is well supported by the recent Department of Health dual diagnosis policy guidelines, over separate and isolated 'dual diagnosis' teams/specialists (Department of Health, 2002). The team comprises a service director/clinical psychologist, research psychologist, three senior community psychiatric nurses, a senior occupational therapist and sessional input from a consultant psychiatrist in addictions. Annual costs are approximately £240 000.

Overall, the focus of the COMPASS Programme is on training and co-working with staff in the teams supporting those with severe mental health problems. As such, the primary focus has been in the assertive outreach mental health teams, where there is higher prevalence and greater need for more intensive input because of the clinical nature of the client group. In the other teams/services, the focus is on providing a consultancy service and facilitating closer working between the two services. Each of these two components is described further below.

Working with the assertive outreach teams

Because of the clinical needs of the client group within the assertive outreach teams, the bulk of our resources have been aimed at these. These teams are being trained intensively to provide integrated treatment for problematic substance use in tandem with other needs that are met routinely (Table 1). In addition, to achieve the required level of competence in delivering this integrated treatment, members of the COMPASS Programme team work alongside members of the assertive outreach teams on a weekly basis (typically 2 days per week), and in the majority of instances work jointly on specific cases. The treatment approach used, cognitive-behavioural integrated treatment (C-BIT), is specifically designed to change the teams' approach to working with this client group and enable clinicians to engage and work with clients who have severe mental health problems and use drugs/alcohol problematically, particularly those who do not initially perceive substance misuse as problematic.

Table 1. The total number of staff who have received training from the COMPASS Programme in Northern Birmingham Mental Health NHS Trust

Team type	Type of training	Number of attendants
Assertive outreach	Full C-BIT training	71
Primary care liaison		
Full team	Awareness raising	57
Two staff	Brief C-BIT training	15
In-patient wards		
Full team	Awareness raising	71
Two staff	Brief C-BIT training	22
Rehabilitation and recovery		
Full team	Awareness raising	17
Substance misuse		
Full team	Awareness raising	40
Total number receiving training		293

C-BIT, cognitive-behavioural integrated treatment;
COMPASS, Combined Psychosis and Substance Use.

This intervention within the assertive outreach teams is being evaluated using a quasi-experimental research design using teams as clusters over a 3-year period (Copello *et al*, 2001).

Consultation-liaison service

It was clear from consultations with the other community mental health and addiction teams and services within the Trust that they did not all require the intensive input given to assertive outreach teams. However, they often experienced difficulties in accessing services and felt they lacked particular skills and knowledge to assess and intervene (Maslin *et al*, 2001). As a result two additional interventions are offered as part of a consultation-liaison service: a brief intervention and training.

From developments in the area of brief interventions for substance misuse treatment a number of principles were incorporated into this service (Miller *et al*, 1995). The brief intervention is carried out over a 12-week period and consists of two sessions of a motivational enhancement intervention, with a focus on reasons that maintain problematic substance use, and two follow-up sessions. The treatment sessions are preceded by an in-depth assessment. The aim of the brief intervention is to engage clients in discussing their drug and/or alcohol use and its impact on mental health and to mobilise motivation so they are then able to make changes appropriate to their stage of change. 'Significant others' (if possible and appropriate) and keyworkers are included in the process.

Staff can contact the COMPASS Programme team to access this brief intervention service. However, keyworkers are involved in the intervention from the outset to ensure that there is joint ownership and that they feel able to continue the work once the COMPASS Programme is no longer involved. The inclusion of significant others is



to promote social support for change through the client's social network. The two follow-up sessions focus on monitoring and encouraging progress. A method based on a time series design is being utilised to evaluate the effectiveness of the pilot consultation–liaison service. The main sources of requests for this service come from the in-patient facilities, primary care mental health teams and community drug teams. On average, 75 requests are made for this intervention each year.

As part of the consultation–liaison service, a two-stage training package is offered to the in-patient facilities and primary care mental health teams (Table 1). The first stage of training involves the whole team/service and focuses on raising awareness of the reasons for problematic substance use among those with severe mental health problems and its impact on mental health and functioning. The second stage of training requires team/in-patient managers to identify two members of staff who would take a specialist interest/lead in this area and serve as designated liaison persons for other services, especially substance misuse services. The identified staff receive the second stage of specialist training to support their in-patient facility/team. The focus of this skills-based training is to help staff learn how to engage clients in discussing problematic substance use, build motivation to change and screen and assess for problematic substance use and its relationship with mental health. Similarly, mental health awareness-raising sessions are offered to substance misuse services. The aim of having trained, designated liaison people in both mental health and substance misuse services is to have a point of contact within each service and a formalised link. The aim is to improve access to services, and movement between services where appropriate, for this client group.

Future directions

A number of developments have taken place within the COMPASS Programme since its inception. The programme is still in its early days, but a number of important lessons have been learned. The essence of the COMPASS Programme team is the enhancement of integration and hence the development of skills and systems necessary to achieve severe mental health and substance misuse treatment integration within an array of service components that already operate within the Trust. It is important to emphasise that the specifics of this particular service model were based on an assessment of local need and tailored to fit the service structures already in place in the Trust. Developments across the country will need to identify and address the specific needs of the local area.

However, from the literature (e.g. Drake et al, 2001) and national policy guidance (Department of Health, 2002), a number of critical components need to be implemented within service models.

It is the case that internationally, a number of 'integrated' service models exist, some of which are being or have already been evaluated (Drake et al, 2001). However, there is a need for the development of service models in the UK that fit within the National Service

Framework (Department of Health, 1999) and NHS Plan (Department of Health, 2000), and are evaluated for effectiveness and tailored to local need (Copello et al, 2001). It is essential that developments within this area, particularly within the UK, are evaluated for effectiveness and lead to improvements in the pathways of care for people who experience severe mental health problems and use substances problematically, and integration of treatment and continuity of care between substance misuse and mental health services.

Acknowledgements

We thank Professor Kim Mueser (Dartmouth, NH, USA), who has served as an external consultant in the development of this service model, Sarah Badger, Mike Preece, Derek Tobin and Jo Wall for their role in these developments, as part of the COMPASS Programme Team and staff and clients in the North Birmingham Mental Health Trust for their continued support during the developmental process.

Declaration of interest

None.

References

- COPELLO, A., GRAHAM, H. L. & BIRCHWOOD, M. (2001) Evaluating substance misuse interventions in psychosis: the limitations of the RCT with 'patient' as the unit of analysis. Editorial. *Journal of Mental Health*, **10**, 585–587.
- DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health.
- (2000) *NHS Plan: A Plan for Investment, a Plan for Reform*. London: Department of Health.
- (2002) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*. London: Department of Health.
- DRAKE, R. E. & WALLACH, M. A. (2000) Dual diagnosis: 15 years of progress. *Psychiatric Services*, **51**, 1126–1129.
- , ESSOCK, S. M., SHANER, A., et al (2001) Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, **52**, 469–476.
- FOWLER, I. L., CARR, W. J., CARR, N. T., et al (1998) Patterns of current and lifetime substance use in schizophrenia. *Schizophrenia Bulletin*, **24**, 443–455.
- GRAHAM, H. L., MASLIN, J., COPELLO, C., et al (2001) Drug and alcohol problems amongst individuals with severe mental health problems in an inner city area of the UK. *Journal of Social Psychiatry and Psychiatric Epidemiology*, **36**, 448–455.
- JOHNSON, S. (1997) Dual diagnosis of severe mental illness and substance misuse: a case for specialist services? *British Journal of Psychiatry*, **171**, 205–208.
- KRAUSZ, M., HAASEN, C., MASS, R., et al (1996) Harmful use of psychotropic substances by schizophrenics: Coincidence, patterns of use and motivation. *European Addiction Research*, **2**, 11–16.
- MASLIN, J., GRAHAM, H., CAWLEY, M., et al (2001) Combined severe mental health and substance use problems: what are the training and support needs of staff working with this client group? *Journal of Mental Health*, **10**, 131–140.
- MENEZES, P. O., JOHNSON, S., THORNICROFT, G., et al (1996) Drug and alcohol problems among individuals with severe mental illness in south London. *British Journal of Psychiatry*, **168**, 612–619.
- MILLER, W. R., ZWEBEN, A., DICLEMENTE, C. C., et al (1995) *Motivational enhancement therapy manual: a clinical research guide for therapists treating individuals with alcohol dependence*. NIAA, Project MATCH Monograph Series, 2. Rockville, MA: US Department of Health and Human Services.



special
articles

MUESER, K. T., YARNOLD, P. R., ROSENBERG, S. D., et al (2000) Substance use disorder in hospitalized severely mentally ill psychiatric patients: prevalence, correlates and subgroups. *Schizophrenia Bulletin*, **26**, 179–192.

REGIER, D. A., FARMER, M. E., RAE, D. S., et al (1990) Co-morbidity of mental

disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association*, **264**, 2511–2518.

SMITH, J. & HUCKER, S. (1994) Schizophrenia and substance abuse. *British Journal of Psychiatry*, **165**, 13–21.

***Hermine L. Graham** Consultant Clinical Psychologist and Head of COMPASS Programme, NBMHT, 12–13 Greenfield Crescent, Edgbaston, Birmingham B15 3AU, **Alex Copello** Consultant Clinical Psychologist and Senior Lecturer, School of Psychology, University of Birmingham, **Max Birchwood** Director, Early Intervention Service, Harry Watton House, Birmingham, **Jim Orford** Professor of Clinical and Community Psychology, School of Psychology, University of Birmingham, **Dermot McGovern** Consultant Psychiatrist, Early Intervention Service, Harry Watton House, Birmingham, **George Georgiou** Consultant Psychiatrist, Addictive Behaviour Centre, Birmingham, **Emma Godfrey** Research Psychologist, COMPASS Programme, Birmingham