Care models for coexisting serious mental health and alcohol/drug conditions: the RECO realist evidence synthesis and case study evaluation

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Scientific summary

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Background

Approximately 30–50% of people with serious mental health illness (SMI) have a coexisting alcohol/drug condition, leading to significant negative health and social outcomes. Despite the scale of these co-occurring conditions, there is limited evidence to inform treatment, with the evidence that is available failing to provide a definitive answer as to how services and treatments should be best delivered to improve health and other outcomes for this diverse group.

Objectives

The aim of this project was to use a realist approach to understand what works, how, for whom and in what circumstances by synthesising data from published and grey literature, mapping and describing the characteristics of UK services and service provision, and undertaking in-depth focus groups and interviews in locations picked to be representative of the range of provision identified in the mapping and review of the literature. The outcome was a set of refined programme theories (PTs), which underpin an explanatory framework that can be used to inform future research, policy and practice.

Methods

We conducted a series of distinct, yet interrelated work packages (WPs) to achieve our research objectives.

Work package 1: development of programme theories

The aim of WP1 was to (1) map the literature to provide a systematic overview of the nature of the published and grey literature on types of service provision for people with co-occurring severe mental health and alcohol/drug conditions (COSMHAD) and (2) develop realist PTs for interventions and service models for COSMHAD. An a priori protocol was registered with PROSPERO. In phase 1, in consultation with stakeholders (including clinical experts in COSMHAD and those with lived experience), we elicited a set of initial PTs in a workshop and analysed policy documents and articles describing COSHMAD services in practice in the UK. In phase 2, we followed the five stages for realist synthesis. A total of 172 papers were included in the synthesis.

Work package 2: service mapping

Work package 2a: mapping of United Kingdom co-occurring severe mental health and alcohol/drug conditions services

The aim of WP2 was to gather information on the availability of COSMHAD treatment across the UK. To achieve this, information was gathered by direct requests to relevant health and social care organisations, either as speculative e-mails or as Freedom of Information requests. In addition, internet searches for relevant services were also conducted. The initial information requests were sent by e-mail in March 2020 and had to be halted due to the start of the coronavirus disease 2019 (COVID-19) pandemic. A second wave of requests was sent in October 2020 to organisations that had not responded. The information requested included the details of the approach/treatment pathway for COSMHAD that each organisation commissioned/provided, and whether treatment was commissioned/

provided specifically for COSMHAD, knowledge of any other COSMHAD service being provided in the same location, and name and contact details of the organisation's COSMHAD lead (if there was one).

Work package 2b: service audit/survey

Using the information gathered during the national mapping, 16 organisations were identified as providing COSMHAD services. This was on the basis that their response indicated that there was some form of dedicated resource (typically in the form of specifically funded staff roles) to deliver the COSMHAD model. The 16 services were asked to provide more detail using an online audit form. This included items on the approach to treatment, the range of treatments offered, staff training/supervision, commissioning and funding of COSMHAD services, and health economic data. This survey was sent to a key member of staff in each of the organisations to complete, with the option of a follow-up telephone call to aid response rates. The data were used to identify models of service delivery.

Work package 3: refining programme theories

The purpose of WP3 was to test and refine the PTs developed in WP1 in real-world settings. Six case study sites were selected that represented examples from the three types of service models identified in WP2. Staff were recruited and consented to participate in online focus groups. Service users and carers were approached by clinical staff in the service to inform them of the study and to pass on contact details to the realist evaluation co-occurring (RECO) researcher. The RECO researcher would then contact and discuss the project, and if they were interested, they would give informed consent. Service users and carers participated in online focus groups and individual interviews. One carer focus group was face to face. Topic guides were developed from the 11 PTs that were developed in the realist synthesis, and all the interviews and focus groups were conducted using realist interviewing style. All interviews were recorded using Microsoft Teams and the auto-transcription facility. The transcripts were anonymised and analysed in NVivo.

Results

Work package 1: realist synthesis
A set of 11 refined PTs were identified from the literature and these broadly fell into three interconnecting categories: committed leadership; clear expectations regarding COSMHAD from mental health and substance use workforces; and clear processes to co-ordinate care.

Work package 2: service mapping
The initial mapping identified that most areas of the UK offer some form of integrated care or treatment pathway for people with COSMHAD. However, only 16 services indicated that they offered more than an agreed pathway and offered something more tangible. The information provided from the audit of the services was used to broadly divide into three main models of delivery:

1. Network – this is a broad collection of staff from a range of local services that share agreed care pathways and come together for network meetings and shared training.
2. Consultancy – a specialist team that provides consultancy to the mainstream mental health services, including joint assessment, advice on care planning and clinical management and continuous professional development (CPD) training.
3. Lead and link – this model is led by a clinical expert leader (often a consultant nurse or equivalent) with 'link workers' or 'champions' based across the mental health service to support this role.

However, there was significant variation in the level of investment in terms of dedicated staff. Six sites were selected to be case studies.

Work package 3: case studies

A total of 58 staff, 25 service users and 12 carers participated in the focus groups and interviews. Data were obtained that supported 10 out of 11 PTs. There were limited data regarding pre-registration/ undergraduate training (despite prompts) because the participants had no connection to the curriculum development and delivery for nursing, allied health, social care or medical training. Some of the PTs had more supporting evidence than others.

The main findings were that positive attitudes including empathy and compassion were seen as a critical context for engaging people in services. Positive attitudes were influenced by access to CPD training, and also ongoing support and supervision in practice. It was important that people could see that the clinical skills taught in CPD worked effectively in practice. This was also promoted by working alongside (shadowing) a clinical expert in COSMHAD. The role of a clinical expert (most commonly a consultant nurse in COSMHAD) was rated highly by the staff for a number of reasons, including keeping COSMHAD on the agenda both clinically and strategically; having an oversight of the whole care pathway; and fostering relationships between key agencies (such as substance use, housing, etc.). The expert lead also offered a training and supervision programme within the organisation, and in some cases facilitated local special interest networks which included peer support, sharing expertise across disciplines, and building interagency and interdisciplinary relationships. The quality of these inter-agency relationships was seen to be critical for integrating care for COSMHAD. Clear and collaborative care pathways that were needs led, person-centred and holistic were important. The service users and carers reported that fragmented local services were really difficult to navigate, and therefore service users often ended up falling through the gaps, increasing the need for crisis care including the police, ambulance service and emergency rooms, none of which is satisfactory in helping people to move forward with their recovery. For effective integrated care to occur, there was a clear need for organisational commitment to this agenda at a senior strategic level (including local commissioning) as well as commitment in operational managers. This commitment ensures investment in posts (such as the expert leaders); protected time for staff to access training, supervision and network meetings; and mandating standards of care for people with COSMHAD. In addition, there needs to be a commitment to recruiting and retaining the workforce that have the requisite knowledge, skills and values. This also links to the need to ensure that pre-registration education for nurses and allied health professionals as well as psychiatry and psychology includes content in working with COSMHAD, as well as offering placements where health and social care students get positive experience of assessing and planning care for people with COSMHAD.

Carers felt that they carried a lot of the burden of caring for their loved one, and often felt excluded from the care team. They found that peer support was very helpful, but they too would benefit from more clarity in the care pathways and consistency of approach.

Discussion

Despite over two decades of attention and policy guidance to improve responses to people with COSMHAD, the mapping revealed a lack of investment in specific roles to support care pathways, workforce development and quality of care. Most of the services we identified had been in existence in some form or another for many years and were driven by enthusiastic champions with fragile funding, and often limited strategic or organisational support.

Models of care were generally based on an expert lead role plus link workers (dedicated roles) or local champions (not dedicated roles, but supplemental to their role) to support the work within the service as well as co-ordinating services across several agencies. In addition to leadership and supporting care pathways, all of the case studies offered in-house training and consultation. One of the case studies involved a dedicated team of clinicians who offered consultation and training only, as opposed to

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carrying out any direct clinical work. One model operated as a network of link workers but was missing the strategic lead as that post had not been filled following the departure of the previous lead. The RECO study has been able to identify the important contexts under which integrated care can be provided (mechanism) which produces positive outcomes for service users (and their carers). It is clear that COSMHAD needs to be prioritised as a service development issue and this requires drivers from national and local policy-makers and commissioners. NHS mental health providers should be the main provider with key responsibilities for people with serious and enduring mental health problems irrespective of other comorbidities (in this case alcohol and or drugs). Staff in mental health services should have a minimum level of knowledge and skills regarding the interface between mental health and substance use. Training alone, without clinical supervision and/or other practice-based learning opportunities, is likely to be insufficient. The RECO study demonstrates how valued and multifaceted the role of the clinical expert is in promoting good practice for COSMHAD. They need senior organisational level support for this work.

Strengths

This is the first study to use realist methods to identify the contexts under which mechanisms work and identify the types of outcomes that are meaningful for staff, service users and carers. The PTs were generated from a number of sources (stakeholder consultation, literature and document synthesis and primary data) using robust methodology. This is also one of the first studies to include the lived experience of being a service user and carer and triangulate with the staff data. We sampled case studies across three types identified from mapping the broader UK service provision.

Limitations

The study was impacted by COVID-19. The national response to COVID-19 in health and social care impacted on responses to requests for information in the UK mapping exercise. Therefore, there may have been additional services in existence that we did not identify. Due to social distancing and various national and regional lockdowns, the data collection was almost entirely conducted online. While we collected our target sample of staff, we did not recruit to target for the service user and carer focus groups and interviews. Online methods were a barrier to some people. However, the data from the service user and carers were obtained across most of the sites and were sufficient to answer the research questions.

Conclusion

Co-occurring serious mental illness and substance use is a common phenomenon in mental health care, yet the mental health, substance use and related services remain ill-equipped to meet the needs of people with COSMHAD. The RECO study provides details on how and in what circumstances integrated care can work better for people with COSMHAD. This requires joined-up policy at government level and local integration of services. We have also identified the value of expert clinicians who can support the workforce in sustaining this programme of work. People with COSMHAD have complex and multifaceted needs which require a comprehensive and long-term integrated approach. The shift to integrated health and social care is promising but will require local support (local expert leaders, network opportunities and clarity of roles). Future research should focus on evaluating whole system approaches as opposed to reductionist individual interventions. This includes establishing the cost-effectiveness of key components of the COSMHAD models.

Study registration

This study is registered as PROSPERO CRD42020168667.

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