# Evidence Briefing 4: At-risk groups and vulnerabilities

## Need to know

- Socioeconomically deprived groups often report lower levels of average alcohol use but experience greater or similar levels of alcohol-related harm.
- Alcohol and drug-related deaths are much higher in the most deprived areas, compared to the least
- Alcohol and drug use issues are more common amongst homeless people than the general population
- All LGBT+ populations experience some form of health inequality, including an increased risk of alcohol and drug use issues
- Alcohol and drug use issues are more common for those with *pre-existing* mental health issues or behavioural disorders, but equally alcohol and drug use can increase the risk of *developing* certain mental health issues
- The prevalence of alcohol and drug use issues is much greater in the prison population than in the general population
- At-risk groups are not mutually exclusive, and often an individual will face multiple risks, and thus multiple barriers to services

## Key findings

- Integrated services and care pathways are important for all at-risk groups to tackle multiple and complex needs effectively. This includes multi-agency working, continuity of care and considerable wraparound support eg housing, finance and employment services
- At-risk groups face barriers to accessing services. For LGBT+ groups, health staff training and awareness can be effective in mitigating this, as well as capturing data on sexual orientation and gender identity to inform service design and delivery
- Specific services, workers and spaces can be effective for supporting protected characteristic groups.
- Those with coexisting mental health and alcohol or drug use issues (dual diagnosis) can benefit from tailored interventions which are non-confrontational, simultaneously address mental health and alcohol or drug use, and are delivered by trained staff
- For homeless populations, assertive, long-term outreach services and Housing First approaches have demonstrated effectiveness in increasing engagement and reducing alcohol and drug related harms
- Rapid, easy and timely access to services is particularly important for homeless populations, and those involved with Criminal Justice services

## Good practice

- Pride in Practice
- Leeds Dual Diagnosis Project
- Housing First Glasgow
- Turning Point Scotland218 Centre
- The High Impact & Complex Drinkers project
- Tomorrow's Women

## Potential Stakeholders

- Homelessness services and housing providers
- LGBT+ services
- All health professionals
- Scottish Prison Service
- Third sector
- Alcohol and drug services
- Mental health services
- Police Scotland
- Service users/peer involvement
- Social work

# Introduction

This briefing covers populations that are at greater risk of alcohol and drug related harms. It provides information on each population, as well as evidence relating to what specific interventions are recommended for each. The four main at-risk groups that have been identified are:

- People experiencing or at risk of deprivation, poverty and homelessness
- LGBT+ people (lesbian, women who have sex with women, gay, men who have sex with men (MSM), bisexual, transgender, non-binary and other minority sexual orientation and gender identity groups)
- People with mental health issues and / or behavioural disorders
- People involved with Criminal Justice services

This list should not be taken to be exhaustive, and other at-risk groups should be considered, such as older adults (Briefing 8), and vulnerable young people such as those who are care experienced ( Briefing 6) . What works for at-risk populations is likely to overlap considerably with what works for the general population in reducing alcohol and drug-related harms and this briefing should be read in conjunction with the life-stage briefings where appropriate. Any intervention for at-risk groups should also be based on the key themes detailed in Evidence Briefing 2, including whole systems; person-centred approaches and trauma informed practice.

While there are a number of good practice examples as to what works for different at-risk groups there is still a considerable need and opportunity to further grow the evidence base and to add to the case study databank for each at-risk group.

# Context

It should be noted that these at-risk groups are not mutually exclusive, and often an individual will face multiple risks, and thus multiple barriers to accessing services. For example, involvement with the criminal justice system and severe mental health issues are both more common amongst the homeless population; poverty is a main driver of homelessness; mental health issues are more prevalent in the LGBT+ community; and LGBT+ young people are at greater risk of becoming homeless than the general population[1].

Multiple and complex needs have been recognised in the literature. ‘Dual diagnosis’ refers to coexisting alcohol or drug use issues alongside a mental health problem. Dual diagnosis requires more intensive, long-term support and can increase barriers in access to services, as well as discontinuity of care as a result of service fragmentation. For example, mental health services and alcohol and drug services are often placed in “separate budget pools”, and can have different approaches and ways of working. This can impact on their effectiveness for people with dual diagnoses. There can also be other barriers such as psychiatric services requiring abstinence as a prerequisite to assessment[2].

# People experiencing or at risk of deprivation, poverty and homelessness

Lower income households and people living in the most deprived neighbourhoods experience significant health inequalities. This is most striking in relation to alcohol and drug-related harm[3]. Individuals from deprived communities are more likely to have experienced psychological trauma and mental health issues. This has been linked to the use of drugs as a coping mechanism. Low employment opportunities and few community resources also appear to be associated with greater risk of drug use issues. In Scotland, when the most deprived decile is compared to the least deprived decile, it has been found that:

- Alcohol related deaths are nearly 7 times higher[4]
- Hospital admissions due to alcohol are nearly 9 times higher[5]
- Alcohol use issues are more than 8 times higher[6]
- Chronic liver disease is 7 times higher[7]
- Drug use issues are 17 times higher[8]

**The alcohol harm paradox**: Socioeconomically deprived groups often report lower levels of average alcohol use but experience greater or similar levels of alcohol-related harm. This is particularly true for mortality from chronic liver disease.[9]

**Alcohol and drug use issues are more common amongst homeless people**[10]. The relationship between alcohol and drug use and homelessness is complex but has been linked to several intersecting issues, including living an unhealthy lifestyle, experiencing trauma[11], offending and coping with severe mental health issues, which are all more prevalent amongst this group[12]. Reduced access to support, including not being registered with a GP, compounds health inequalities for homeless people. New Psychoactive Substance use also appears to be more common in homeless populations.

- A 2018 Scottish Government study found that, of those that had experienced homelessness at some point in their life, 19% had evidence of alcohol and / or drug interactions, compared to 5% of the control group[13]
- This study also found that 30% had evidence of a mental health problem, compared to 21% of the control group, and that 6% of those who had experienced homelessness had a mental health problem combined with alcohol and drug use issues, compared to 1% of the control group[14]
- Early evidence from Glasgow Alcohol and Drug Recovery Services suggests that the rise in the use of “Street Valium” was partly responsible for a 43% increase in drug related deaths in the city between 2017 and 2018[15]. Increased use of this drug has been particularly pronounced among homeless populations

Suicide has also been linked to financial problems, demonstrating the need for holistic support, and the links between the different vulnerable groups[16].

# LGBT+ populations

LGBT+ is an umbrella term representing many sub-populations, including lesbian, gay, bisexual, non-binary, transgender and intersex people. While it should be acknowledged that each sub-population has distinct health and wellbeing needs, in general all LGBT+ populations experience some form of health inequality, including an increased risk of alcohol and drug use issues[17] [18].

- In 2018, 14% of LGBT people in Scotland drank alcohol almost every day over the last year, compared to 9% of the general population[19]
- 62% of participants in the Trans Mental Health Study reported drinking outside government guidelines, compared to 40% of the general population. This higher prevalence has been attributed to coping with gender dysphoria, experiences of transphobia and with mental health issues[20]
- According to LGBT Youth Scotland, 24% of young homeless people in Scotland are LGBT and 77% of those stated that their LGBT+ identity was "a causal factor in them becoming homeless"[21]
- Around half of LGBT+ people in Britain have experienced depression in the last year. This is much higher than in the general population[22]
- 25% of LGBT+ people had experienced discrimination when accessing services, including 21% in healthcare services[23]
- One in five LGBT people "aren't out" to any healthcare professional about their sexual orientation when seeking general medical care. This number rises to 40% bi men and 29% of bi women[24]
- In Britain, one in seven LGBT+ people have avoided treatment for fear of discrimination[25]
- LGBT people who disclosed their sexual orientation to their GP were 21% more likely to feel their GP met their health needs as an LGBT person than patients who did not disclose[26]
- The rise of "chemsex" (engaging in sex while under the influence of drugs such as GHB, mephedrone and crystal methamphetamine) amongst men who have sex with men (MSM) is increasing the risk of New Psychoactive Substance (NPS) use for gay and bisexual men[27] [28]
- A Public Health England study found that men who have sex with men (MSM) and who are in treatment for use of non-opiate drugs were more likely to inject (16%) compared to heterosexual men (3%), which may reflect the practice of slamming (injecting mephedrone or crystal methamphetamine)[29].

It has been suggested that the increased risk of alcohol use issues in the LGBT+ community could be in part due to heavy drinking norms in the commercial gay scene, with "habitual promotion of drinks such as alcopops, spirits and shots"[30], as well as "strong peer pressure to drink across the life course"[31]. Drinking alcohol has also been found to be an important part of "identity construction"[32] for this group, particularly in relation to gender.

# Mental health issues and behavioural disorders

**Alcohol and drug use issues appear to be more common for those with pre-existing mental health issues or behavioural disorders[33], but equally to increase the risk of developing certain mental health issues[34].**

- Research shows that mental health issues are experienced by 70% of people with drug use issues and 86% of people with alcohol use issues in community alcohol and drug use treatment[35]
- A review of bipolar disorder and alcohol use disorder showed that that the two conditions commonly occur in the same individual[36]
- A 2006 NICE review found evidence of associations between certain personality characteristics, including attention deficit disorders and impulsiveness, and the increased likelihood that experimentation with drugs will lead to harmful use[37]
- The prevalence of alcohol use issues among people with psychiatric disorders is almost twice as high as in the general population and people with mental health issues such as schizophrenia are at least three times as likely to have alcohol use issues than the general population[38]

**Alcohol and drug use and mental health issues are both risk factors for suicide attempts and ideation[39].**

- The restriction of alcohol is one of the WHO's recommendations for preventing suicide[40]
- Alcohol and drug use disorders have been found in "25–50% of all suicides", and "suicide risk is further increased if alcohol or substance use is comorbid with other psychiatric disorders" [41]
- "Of all deaths from suicide, 22% can be attributed to the use of alcohol, which means that every fifth suicide would not occur if alcohol were not consumed in the population" [42]
- People have "approximately seven times increased risk for a suicide attempt soon after drinking alcohol, and this risk further increases to 37 times after heavy use of alcohol"[43]

# People Involved with Criminal Justice Services

**The prevalence of alcohol and drug use issues is greater in the prison population, and people involved with criminal justice services, than in the general population. Socioeconomic deprivation, homelessness, mental health issues and Adverse Childhood Experiences are all more common people involved with criminal justice services, which should be considered when designing services and delivering interventions for this group.**

- One study in Scotland found that nearly three quarters (73%) of people in custody had an alcohol use disorder, with a third (36%) likely to be alcohol dependent[44]
- Of the 960 tests carried out 2017/18 in Scotland when entering prison, 78% were positive for illegal drugs[45]. The drugs most commonly detected when entering prison in 2017/18 were cannabis, cocaine and opiates[46]
- Of the 562 tests carried out in 2017/18 in Scotland when leaving prison, 31% were positive for illegal drugs. This percentage has gradually increased since 2009/10[47]
- The percentage of prisoners who stated that they were under the influence of drugs at the time of their offence was 40% in 2015[48]
- Two in five (41%) of prisoners, and 60% of young prisoners, reported being drunk at the time of their offence in 2015[49]
- Young adults (18-24) are the most likely age group to come into contact with the police[50]
- 70% of women in prison require “clinical detoxification”, and “over half have engaged in crime to support someone else’s drug use” [51]
- “Black people are more likely to experience stop and search, more likely to be taken to court and are more likely to be fined or imprisoned for drug offences” [52]

**Key to evidence briefing**

## 3 Detailed analysis of what works

High quality and multiple source evidence to support this approach (1)

Some evidence or emerging evidence to support this approach (2)

Limited evidence for this approach or potential development area for further investigation (3)

| People experiencing or at risk of deprivation, poverty and homelessness | Mental Health / Behavioural Disorders | LGBT+ | Prisoners and persons with convictions |
|---|---|---|---|
| Integrated services and care pathways (1) | Integrated services and care pathways (1) | Health professional training and awareness raising (1) | Specific services, workers and spaces (1) |
| Assertive, long-term outreach services (2) | Holistic assessment (2) | Capturing and using data (2) | Integrated services and care pathways (1) |
| Rapid, easy and timely access to services (1) | Named care coordinators (2) | Specific services, workers and spaces (1) | Rapid, easy and timely access to services (1) |
| Accessible mental health services (2) | Accessible mental health services (2) | Integrated services and care pathways (1) | Positive social identity; increasing 'recovery capital' (2) |
| Holistic assessment (2) | Dual diagnosis training and awareness (2) | Holistic assessment (2) | Holistic assessment (2) |
| Dual diagnosis training and awareness (2) | Motivational techniques and cognitive behavioural therapy (2) | | |
| Wet Housing / Day Centres (3) | | | |
| Housing First approaches (1) | | | |

| Intervention Type | Description | Relevant groups | Effectiveness | Enablers and inhibitors to impact | Good Practice |
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| **Health professional training and awareness raising** | "LGBT people often receive inappropriate treatment and advice from primary care services due to a lack of knowledge about the ways in which health needs of LGBT+ patients differ from the needs of heterosexual and cisgender patients"[53].<br><br>Training and awareness raising for health professionals involves designing best practice guides for staff, embedding LGBT+ inclusive training within standard NHS Scotland training[54], creating a culture of tolerance and positivity around LGBT+ patients, and ensuring LGBT+ patients are given full and correct health and wellbeing information. | **LGBT+** | | ✓ Identify best practice for LGBT+ inclusive staff training and share this learning[55] for example through best practice guides[56]<br>✓ Celebrate primary care services who are providing a high standard of care to LGBT+ communities[57]<br>✓ Positive response when a patient discloses that they are LGBT+[58]<br>✓ Use of correct pronouns for trans and non-binary groups[59]<br>✓ "Develop and prominently display bullying and harassment policies which communicate a zero-tolerance approach to homophobic, biphobic and transphobic discrimination" [60]<br>✓ "Publicise clear complaints procedures to encourage reporting" [61]<br>✓ Make LGBT+ inclusive information and resources readily available for patients[62], including signposting to other services[63]<br>✓ "Visibly represent LGBT+ communities in local campaigns and health initiatives"[64] for example wearing rainbow lanyards[65], adding an LGBT+ logo to a health website[66]<br>✓ Engage with local LGBT+ communities[67] through community networks and venues[68]<br><br>× Refusing trans specific healthcare due to addiction status[71]<br>× Using traditional definitions of families[72] | Pride in Practice, Greater Manchester[69]<br><br>LGBT Charter for organisations and schools[70] – this programme enables LGBT people to be proactively included in every aspect of an organisation's work, protecting staff and providing high quality services to customers or programme participants |

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| **Capturing and using data** | The label 'LGBT+' represents a broad cross-section of society, encompassing a huge range of needs and intersections.<br><br>Capturing data and best practice on specific subgroups within the LGBT+ umbrella is needed to inform service development[73], and could help inform service design and delivery, as well as identifying inequalities in outcomes . However, such data is rarely recorded, even at the level of the LGBT+ umbrella | **LGBT+** | No / limited evidence on effectiveness as not regularly done | ✓ Datasets on alcohol and drug use should be broken down by sexual orientation and gender identity[74]<br><br>✓ Implement sexual orientation and trans status monitoring to ensure LGBT+ patients are included in health promotion activities and to identify differences in treatment outcomes[75]<br><br>✓ Use national and local data to inform service design and delivery for example by identifying hotspots of need[76] | |

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| **Specific services, workers and spaces** | Research has demonstrated a need for bespoke services for particular marginalised groups. Such services may be entirely separate from mainstream services, or embedded within a wider service, but require dedicated workers and spaces, as well as tailored approaches, in order to be effective. | **LGBT+** | Strong evidence of effectiveness for MSM, evidence gaps exist for other LBGT+ sub-groups | ✓ Specific LGBT+ counselling or alcohol and drug services[77]<br>✓ A separate confidential room to discuss LGBT+ specific needs in pharmacies[78]<br>✓ Sub-group specific services including:<br>• Transgender support services[79] including interventions delivered by "transgender peers"[80]<br>• Lesbian and bisexual women's health services<br>• Dedicated drug services for men who have sex with men (MSM) acknowledging the rise of 'chemsex', 'slamming' and associated risks of blood-borne viruses[81]<br>✓ Tailored women-only services and interventions for women prisoners and women with convictions[82] for example women's attendance centres[83]<br>✓ Specific services for black people with drug use issues who are prisoners or have convictions[84]<br>• | SX Scot Services[85] – provide specific health and wellbeing services for men who have sex with men<br>Guy's and St Thomas' NHS Foundation Trust (Burrell Street Clinic) 'Slamming Kits' for MSM[86] for LGBT+<br>Avon and Wiltshire NHS Trust[87] for women prisoners and women with convictions<br>218 Centre, Turning Point Scotland[88] for women prisoners and diversion from prison |
| | | **Prisoners and persons with convictions** | Strong evidence for the need for tailored gender specific interventions for women prisoners and persons with convictions, particularly sex workers | | |

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| **Integrated services and care pathways for multiple and complex needs** | As noted in the context section of this briefing, it is common for people to present with multiple, complex issues and for these to interact and overlap with one another. In order to be able to tackle multiple issues effectively, meet unmet needs, and enable people to engage with support, services need to work together to ensure equity of access and continuity of care.<br><br>Where possible, services should aim to provide several elements of support eg mental health, housing, alcohol and drug use services, under one roof. | **People experiencing or at risk of deprivation, poverty and homeless-ness**<br><br>**Mental Health / Behavioural Disorders**<br><br>**LGBT+**<br><br>**Prisoners and persons with convictions** | Strong evidence of the need for integrated services and multi-agency working for these vulnerable groups | ✓ Joint commissioning arrangements in place between the local authority and clinical commissioning groups[89]<br><br>✓ Personalised needs assessment to identify the barriers which may be impacting on people's ability to engage with services[90]<br><br>✓ Where appropriate, link people into financial services and support, as well as housing and employment services[91]<br><br>✓ Integrated services for trans people[92]<br><br>✓ Multi-disciplinary team approach[93]<br><br>✓ As vulnerable groups may present with multiple alcohol and drug use issues, integrated substance use specialisms may be needed[94]<br><br>✓ Alcohol use issues and violent offences have been linked, thus interventions that tackle alcohol and violence should be considered[95]<br><br>✓ Multi-agency care is particularly important for those with schizophrenia and alcohol and drug use issues[96]<br><br>✓ Access to "accommodation, employment support, specialist substance use treatment and related services" has been identified as crucial to positive outcomes for prisoners upon release[97]<br><br>✓ | Ipswich-Suffolk's multi-agency strategy to support women to exit prostitution[98]<br><br>The High Impact & Complex Drinkers project[99] |

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| **Assertive, long-term outreach services** | Assertive outreach involves "persistent and long-term engagement with individuals"[100] which is pro-active and assertive "even in the face of challenging" behaviour or disengagement[101].<br><br>It requires highly skilled workers, who are able to detect and prevent issues early on and build productive relationships with people experiencing homelessness. | **People experiencing or at risk of deprivation, poverty and homeless-ness** | Limited evidence on impacts of assertive outreach, particularly in the longer term, but some evidence to suggest that it reduces the number of people sleeping rough, and on the characteristics of more effective services[102] | ✓ Intensive and open-ended support where needed, rather than time-limited[103]<br>✓ "Founded on consistent client identification and referral"[104]<br>✓ Based on one-to-one relationships between a client and a specific worker, "who sticks with the client" [105]<br>✓ Delivery is in "community settings where appropriate, rather than in offices or institutions, to promote ordinary living"[106]<br>✓ Mobile outreach[107]<br>✓ "Where outreach leads to permanent, rather than temporary, accommodation tenancy sustainment outcomes are better"[108]<br>✓ "Accommodating rough sleepers in shared or congregate housing appears to be less effective and less desirable than self-contained options"[109]<br><br>× Only placing an assertive outreach worker into the system, rather than focussing on joint solutions that meet multiple complex needs[113]<br>× Using assertive outreach to 'move people on'[114]<br>× Absence of suitable permanent housing[115] | Simon Community outreach and drop-in services[110]<br><br>No Second Night Out[111] – combination of assertive outreach, public engagement, support to access temporary accommodation and/or reconnection. Small-scale evaluations suggest some success[112] |

| Intervention Type | Description | Relevant groups | Effectiveness | Enablers and inhibitors to impact | Good Practice |
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| **Rapid, easy and timely access to services** | As vulnerable groups often face additional barriers to engaging with services, it is important that all opportunities for access to support are taken, particularly at vulnerable transition points, such as re-entry into the community after a period of incarceration. | **People experiencing or at risk of deprivation, poverty and homeless-ness**<br><br>**Prisoners and persons with convictions** | Research evidences a need for a focus on making services accessible and available at critical points | ✓ Place mental health nurses and social workers within police stations, particularly for women prisoners or women with convictions[116]<br>✓ Utilise prison as an opportunity to engage people in alcohol and drug treatment[117]<br>✓ Effective care planning is needed to continue support from community to prison re-entry into the community[118] particularly for those who are homeless[119]<br>✓ Referral pathways should be clear to both staff and prisoners and take account of the high levels of literacy problems among prisoners[120]<br>✓ Accessible services for those who have no recourse to public funds for example homeless migrant populations[121]<br>✓ Ensure services are designed to welcoming and non-judgemental<br><br>× Complex referral pathways<br>× Delay between referral and access to support[124] | The “Effective Practice Model” for adults with convictions[122]<br><br>a reconnections-based approach to homeless migrants[123] |

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| **Positive social identity; increasing 'recovery capital'** | Research suggests an important role for social networks in creating a 'pro-social identity', such as friends, family and groups that promote non-alcohol and drug related activities, or provide opposition to use[125], can provide support and encouragement for recovery, and can link people to positive opportunities such as employment and training.<br><br>'Social identity mapping' has been proposed as a potentially effective way to understand the 'recovery capital' that an individual may have upon release from prison[126]for example colour coding networks to indicate whether a person is in recovery, currently has alcohol or drug use issues etc. "This then creates a visualisation of the recovery capital available to the individual through their social networks" | **People involved with Criminal Justice Services** | There is evidence to suggest that positive social networks impact on ability to maintain recovery from alcohol or drug use issues.<br><br>Less is known about how these networks can be developed and / or strengthened | ✓ Engagement with groups who "have access to more pro-social resources in the community and who are able to provide structures and support to the recovery pathway" [127]<br><br>✓ Undertake a social identity mapping exercise with prisoners before their return into the community<br><br>✓ Link people being released from prison to community resources<br><br>✓ Engage persons involved in Criminal Justice in meaningful activities<br><br>✓ Enable visits and input from family or friends while in custody.[128] (provided relationships are not abusive)<br><br>✓ Recovery-oriented social networks[129] eg access to peer-led positive alcohol and drug free environments[130]<br><br>× Stigma and social exclusion[131] | |

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| **Holistic assessment** | As many individuals have multiple and complex needs, initial service assessments need to be cognisant of this and able to capture wider issues. This links to integrated services and care pathways. | **People experiencing or at risk of deprivation, poverty and homeless-ness**<br>**Mental Health / Behavioural Disorders**<br>**LGBT+**<br>**Prisoners and persons with convictions** | Evidence suggests a need for assessments that are able to account for multiple, intersecting issues<br><br>Limited evidence on best practice tools | ✓ Use several different tools, for example screen separately for alcohol use, and assess wider issues[132]<br>✓ Or use a holistic tool to assess all needs for example for homeless people the Homeless Health Assessment Tool[133]<br>✓ "Use of common assessment, screening tools and care plan templates can support a more co-ordinated care planning process"[134]<br><br>× Multiple assessments for example to access different services | Homeless Health Assessment Tool[135]<br><br>Single Shared Assessment? |
| **Named care coordinator** | Named care coordinators can assist individuals in navigating often complex systems of services. They can act as a main point of contact for individuals with dual diagnosis, and convene meetings with relevant professionals[136] | **Mental health / behavioural disorders** | Effective for complex needs | ✓ Care coordinators being informed about various types of local support and services<br>✓ Effective relationships between organisations/services and commitment to joint care<br>✓ Assigning one health or social care professional to everyone with a dual diagnosis<br><br>× Lack of communication between services<br>× Individuals being referred from service to service without receiving care | Leeds Dual Diagnosis Project[137] |

| Intervention Type | Description | Relevant groups | Effectiveness | Enablers and inhibitors to impact | Good Practice |
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| **Accessible mental health services for those with alcohol or drug use issues** | Mental health services which are accessible for those with problem alcohol or drug use. Services recognise that individuals have multiple intersecting needs that cannot be adequately addressed by one service alone. | **People experiencing or at risk of deprivation, poverty and homeless-ness** | Effective for those with dual diagnosis | ✓ Awareness of stigma and inequity of access to services that people may face[138]<br>✓ Looking out for multiple needs eg physical health problems, homelessness or unstable housing[139]<br>✓ Building confidence, self-esteem, social networks and life skills[140]<br>✓ Solving "real-life problems" including housing, debts and benefit issues | Turning Point Hertfordshire Complex Needs Service[141] |
| | | **Mental health / behavioural disorders** | | × Exclusion of people with severe mental illness who are experiencing alcohol and/or drug use issues[142] | |
| **Dual diagnosis training and awareness** | The coexistence of alcohol and drug use and mental ill-health is referred to as "dual diagnosis"[143].<br>While specialised services for those with a dual diagnosis are ideal, practitioners working across health and social care can also benefit from introductory training on the impacts of mental health and alcohol or drug use on one another. | **People experiencing or at risk of deprivation, poverty and homeless-ness** | Effective for introductory training | ✓ Free to access<br>✓ Increases awareness of mental health and how it impacts on alcohol and drug use<br>✓ Increases awareness of alcohol and drug use and how they impact on mental health<br>✓ Provides information about skills and interventions with a focus on what helps[144] | E-learning content on dual diagnosis (developed by Coventry University and PROGRESS)[145] |
| | | **Mental health / behavioural disorders** | | × Use of jargon<br>× Need for more in-depth training to create dual diagnosis specialists[146] | |

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| **Motivational techniques and cognitive behavioural therapy** | Motivation building concerns "engaging the patient, then exploring and resolving ambivalence for change in [alcohol or drug] use"[147]<br><br>Cognitive behavioural therapy is used to help individuals to challenge and change negative thought patterns and actions[148]. (See adults briefing for more detail). | **Mental health/ behavioural disorders** | Effective for reducing the amount of substance used for 12 months after intervention[149]<br><br>Effective in impacting on readiness to change use at 12 months that was not maintained at 24 months<br><br>Limited evidence of effectiveness in reducing hospitalisation[150] | ✓ Need for sustained delivery<br><br>✓ Those with dual diagnosis taking an "active role in goal-setting and accomplishments during the course of treatment"[151]<br><br>✓ Simultaneous treatment of problem alcohol or drug use and mental health issues[152]<br><br>✓ Treatments which are tailored to individual needs[153]<br><br>✓ Use of specialist trained personnel[154]<br><br>✓ Engagement should be non-confrontational and respectful of the client's subjective experience of substance use[155] | Dual diagnosis toolkit: A practical guide for professionals and practitioners[156] |

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| **Housing First approaches** | Stable housing has been shown to be important for improving mental and physical health and wellbeing. As mental ill-health and homelessness increase the risk of alcohol and drug use issues, approaches such as Housing First may reduce alcohol and drug related harms.<br><br>In contrast to more traditional housing approaches, "Housing First does not require sobriety or treatment/service compliance as a condition for program entry or service continuation."[157] | **People experiencing or at risk of deprivation, poverty and homeless-ness** | Mixed evidence emerging around effectiveness, but this is likely to reflect a group with complex and persistent needs.<br><br>A number of studies suggest reductions in alcohol use[158] [159]and illicit drug use[160161]<br><br>More effective than 'treatment first' approaches[162] | ✓ Adequate resources should be allocated to recruiting and retaining a highly skilled and experienced staff team[163]<br>✓ Provide continuity of support and consistency of support workers[164]<br>✓ Develop the necessary statutory and operational partnerships before implementation[165], including "strong links and formalised service level agreements between the housing and support provider"[166]<br>✓ Provide considerable wraparound support for those with alcohol and drug use issues[167]<br>✓ Evaluate specific harm reduction outcomes relating to alcohol and drug use within Housing First programmes[168]<br>✓ Flexible, non-time-limited support in their homes and communities."[169]<br>✓ Engage frontline staff at an early stage[170]<br>✓ Liaison with the police to "alleviate housing providers' concerns about the legalities of housing active drug users"[171]<br>✓ Supportive community of tenants[172]<br>✓ Reduce social isolation and encourage participation in activities[173]<br><br>× Expectation of 'linear' progression and recovery<br>× Requiring demonstration of housing readiness[175]<br>× Requiring "absolute sobriety" to keep housing[176] | Housing First Glasgow, Turning Point Scotland[174] |

| Intervention Type | Description | Relevant groups | Effectiveness | Enablers and inhibitors to impact | Good Practice |
|---|---|---|---|---|---|
| **Wet housing / day centres** | Wet housing or wet centres are spaces in which drinking is permitted. They are designed to reduce "harm from drinking in public spaces"[177], particularly for homeless populations, and to provide support and treatment to otherwise excluded populations[178]. | **People experiencing or at risk of deprivation, poverty and homeless-ness** | Limited evidence of effectiveness, particularly recent studies<br><br>May help to reduce alcohol harm inequalities in some instances[179] | ✓ Adjust service delivery and specifications to suit local need and context[180]<br><br>✓ Keep the objective of helping clients to control drinking central[181]<br><br>✓ Maintain good local community relations[182] | Kiel safe drinking room, Germany[183]<br><br>REST centre, Liverpool[184]<br><br>Guidance manual for operating wet day centres in British towns[185] |

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