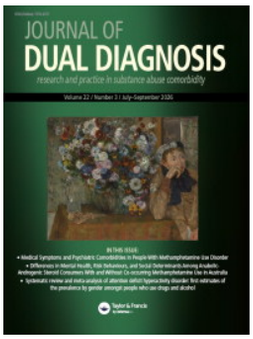

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The Implementation of Current UK Guidance for the Treatment of Co-Occurring Mental Health and Substance Use Conditions: A Mixed Methods Systematic Review and Thematic Synthesis

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ABSTRACT

Background: Clinical guidance exists on the provision of care for co-occurring mental health and substance use conditions in the UK. This systematic review aimed to identify the extent to which the guidance has been applied, including barriers and facilitators to delivery, and to examine use of strategies to support implementation of the guidance. **Methods:** We searched PsychINFO, MEDLINE, CINAHL, Embase, and Web of Science for articles published between 1st January 2017 (when the guidance was published) to 28th January 2025. Studies were eligible if they focused on service use and/or treatment provision for adults in the UK with co-occurring substance use and mental health conditions. The findings were analyzed using a thematic synthesis, through line-by-line coding of study findings to develop analytical themes. **Results:** Three themes were identified from 17 eligible studies. Theme one reflects "challenges to care for co-occurring conditions", which describes how service users face 'wrong doors'; issues surrounding the recognition of co-occurring conditions; and access to care when and where it is needed, despite guidance recommending the 'no wrong doors' approach. Theme two reflects approaches for the "integration of care" as recommended in the guidance, such as communication across services and ensuring that support for people with co-occurring conditions is 'everyone's job'. The third theme highlights barriers (e.g., stigma) and facilitators (e.g., therapeutic optimism) to applying the guidance. **Conclusion:** This review identified an implementation gap between best practice guidance and the provision of care for co-occurring conditions in the UK setting, which needs to be explored across a global context. There were positive examples of strategies to implement the guidance, particularly from small-scale intervention evaluations, yet studies of larger scale real-world intervention implementation are needed.

KEYWORDS
Systematic review; substance use; mental health; implementation

Mental health and substance use conditions often co-occur (Jané-Llopis & Matytsina, 2006; Lai et al., 2015; Puddephatt et al., 2021a; Puddephatt et al., 2021b). A bidirectional relationship exists whereby poor mental health may lead to increased substance use to alleviate symptoms (Bell & Britton, 2014) and substance use can worsen mental health (Boden & Fergusson, 2011). Both mental health and substance use conditions individually are associated with adverse physical health consequences, however, this risk is greater for people with co-occurring conditions (Onyeka et al., 2019; Rees et al., 2022; Ujhelyi-Gomez et al., 2023). Despite the existence of national clinical guidance for people with co-occurring conditions (NICE, 2016; Public Health England, 2017), a wide treatment gap exists in the United Kingdom (UK), with evidence suggesting that this population are less likely to receive a good standard of coordinated support than people experiencing poor mental health without substance use conditions (O'Donnell et al., 2025; Priester et al., 2016). People with co-occurring conditions report multiple barriers to accessing care, for example, being ineligible for mental health support due to their substance use and insufficient

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integration of care (O'Donnell et al., 2025; Priester et al., 2016).

The challenge of implementing clinical guidelines is a broader issue across healthcare, with several reviews outlining implementation barriers across the micro (individual behavior, e.g., clinicians' awareness of guidance), meso (organizational, e.g., lack of time), and macro (context and system, e.g., funding cuts, reduced staff) levels (Correa et al., 2020; Fischer et al., 2016; Francke et al., 2008). Clinical guidelines are not mandatory and despite the Health and Social Care Act 2012 promoting the consideration of National Institute for Health and Care Excellence (NICE) guidelines, recommendations may be ignored with few consequences (Morriss, 2015). This review focuses on two key existing clinical guidance documents: "Better care for people with co-occurring mental health, and alcohol and drug use conditions" from Public Health England (PHE, 2017) and NICE's "Coexisting severe mental illness and substance misuse: community health and social care services" (NICE, 2016). Both NICE and PHE (now part of the Office for Health Improvement and Disparities) are/were governmental bodies who produce guidance documents, primarily for health and social care professionals. PHE guidance was specifically designed for NHS England, and does not apply to all of the UK, with Wales and Scotland producing their own guidelines.

Several core principles of care are recommended in both documents: 'No wrong door', whereby people should not be excluded from services due to co-occurring conditions; treatment for either conditions should be available at every contact point; and 'everyone's job', meaning commissioners and providers have joint responsibility to work together to meet service users' needs (PHE, 2017). NICE guidance also recognizes the importance of identifying co-occurring conditions and the co-ordination of care (NICE, 2016).

Alongside the guidance, NICE outlines different treatment models (NICE, 2016); serial, parallel and integrated care with evidence from randomized controlled trials and aspects of the guidance advocating for an integrated treatment model (Barrowclough et al., 2001). However, there is still considerable uncertainty regarding what is meant by "good" integrated care for this population. One review suggests that good integrated care can happen across micro, meso, and macro levels, discussed above (Savic et al., 2017). A realist synthesis examined the mechanisms through which treatment models for co-occurring mental health and substance use conditions work, for whom, and in what circumstances (Harris et al., 2023). The findings highlighted the ongoing challenges of implementing current guidelines, including structural barriers (e.g., austerity and competitive commissioning) and barriers at the provider level (e.g., willingness to treat, lack of training and supervision). To improve practice, programme theories were developed and grouped into three contextual themes: committed leadership; clear expectations for the treatment across services; and explicit processes relating to the co-ordination of care (Harris et al., 2023).

This review builds on previous evidence syntheses (e.g., Harris et al., 2023), with a specific focus on the implementation of UK guidance to understand, from the academic literature, whether and how the PHE and NICE guidance (PHE, 2017; NICE, 2016) have been applied. We aimed to systematically synthesize quantitative, qualitative, and mixed methods studies of service users and professionals involved in the provision of care for co-occurring substance use and mental health conditions, to explore the extent to which the guidance is being implemented, including barriers and facilitators to implementation, and to examine use of strategies to support implementation.

Methods

The systematic review was pre-registered on Prospero (CRD42023438787) and is reported in accordance with the PRISMA statement (Page et al., 2021).

Eligibility criteria

Studies focusing on psychosocial or psychological service use and/or treatment provision (with or without pharmacotherapy) for people with co-occurring substance use and mental health conditions were eligible for inclusion. Any type of substance use (including alcohol), except for tobacco, and any mental health condition (formally diagnosed or self-reported), were eligible. Eligible populations included people accessing treatment (adults aged ≤ 18, no upper age limit, with co-occurring mental health and substance use conditions, i.e., 100% of the sample, or samples selected based on having co-occurring conditions) and/or professionals or volunteers involved in treatment provision (mental health services which treat substance use, or substance use services which treat mental health, or integrated services). There were no other inclusion or exclusion criteria for study participants, and we did not exclude any studies based on additional co-morbidities.

Only studies which were conducted wholly or in part in the UK (if the UK sample could be extracted separately) were included. Only studies including data collected since 2016 were included (and published after

1st January 2017), as the review aimed to explore the NICE and PHE guidance implementation, published in 2016 and 2017, respectively. Empirical research of any design was included, whether qualitative, quantitative, or mixed methods, and including observational or experimental study designs. Opinion pieces and editorials were not included, but case studies and government or third sector reports were included.

Search strategy

We searched the PsychINFO, MEDLINE, CINAHL, Embase, and Web of Science from 1st January 2017 to 28th January 2025 for publications available in English. Grey literature was searched using ProQuest, British Library via Ethos, International Clinical Trials Registry Platform, Overton.io and Bielefeld Academic Search Engine. The search strategy, including relevant MeSH terms, was developed in consultation with an academic librarian (Supplementary Material 1). Search terms related to substance use, mental health conditions, treatment, and the geographical location. Studies included in relevant systematic reviews or citing the NICE or PHE guidance were also screened, as well as reference lists of eligible studies. Authors were contacted to obtain any studies that could not be located.

Study selection

Following de-duplication of the search results in EndNote, titles and abstracts were screened through Rayyan by one researcher (ZS), with 10% being independently screened by a second researcher (PI). These were a random sample of the entire dataset, not based on AI recommendations. It should be noted that Rayyan is an AI-assisted tool, but all studies were manually screened by the researchers. Any uncertainties or disagreements between researchers were discussed with the team and agreement reached on all studies. Full texts of potentially eligible papers were then reviewed by one researcher (ZS), with the second independently screening 10% of the results (PI). These were a random sample of the entire dataset, not based on AI recommendations. Again, any discrepancies were resolved though discussion and, if necessary, consulting with a third researcher (LH). LH screened reference lists of eligible studies and 'cited by' lists of guidance documents.

Data extraction

A data extraction form was adapted from the JBI Mixed Methods Data Extraction template (Joanna Briggs Institute, 2024). The following data were extracted: study identifiers; study design; participant characteristics; treatment or intervention details (setting, treatment type); outcomes. One researcher (ZS) extracted data from all studies, and two additional researchers (PI and LH) independently checked 50% of the extracted data each. Any discrepancies were discussed, and agreement reached between the research team.

Quality appraisal

Three researchers (ZS, PI, LH) independently assessed the included studies using the relevant CASP Critical Appraisal Checklists (2022). ZS appraised all studies and PI and LH appraised half of the studies each. Inter-rater reliability was calculated at 95.3%, and any discrepancies rectified after discussion.

Data synthesis

Meta-analysis was not performed due to the small number of included quantitative studies and therefore statistical heterogeneity was not explored. Data from qualitative and quantitative studies was integrated using thematic synthesis (Thomas & Harden, 2008). We followed a convergent integrated method, suggested by the Joanna Briggs Institute Handbook, whereby the quantitative data were 'qualitised', extracting and translating textual descriptions of study findings through a narrative interpretation to allow integration with the qualitative data (Sandelowski, 2000). Original authors' narrative summaries of quantitative findings were also extracted to guarantee accuracy of the qualitised findings. Across qualitative findings, both the author interpretations and participant quotes were extracted and analyzed. ZS, PI, and LH completed line-by-line coding of findings in NVIVO-12 to develop a coding framework (Supplementary Material 2), and each study was coded by two researchers. Deductive codes were developed from the guidance (Figure 1) and inductive codes were generated from the data. Following this, the review team collaboratively explored similarities and differences between the codes via extensive discussions, and hierarchically grouped them, resulting in 'descriptive' themes that described patterns across the included papers. Finally, the review team discussed the descriptive themes in relation to the research questions and developed 'analytical' themes, synthesizing the findings across all studies to generate new interpretive constructs.

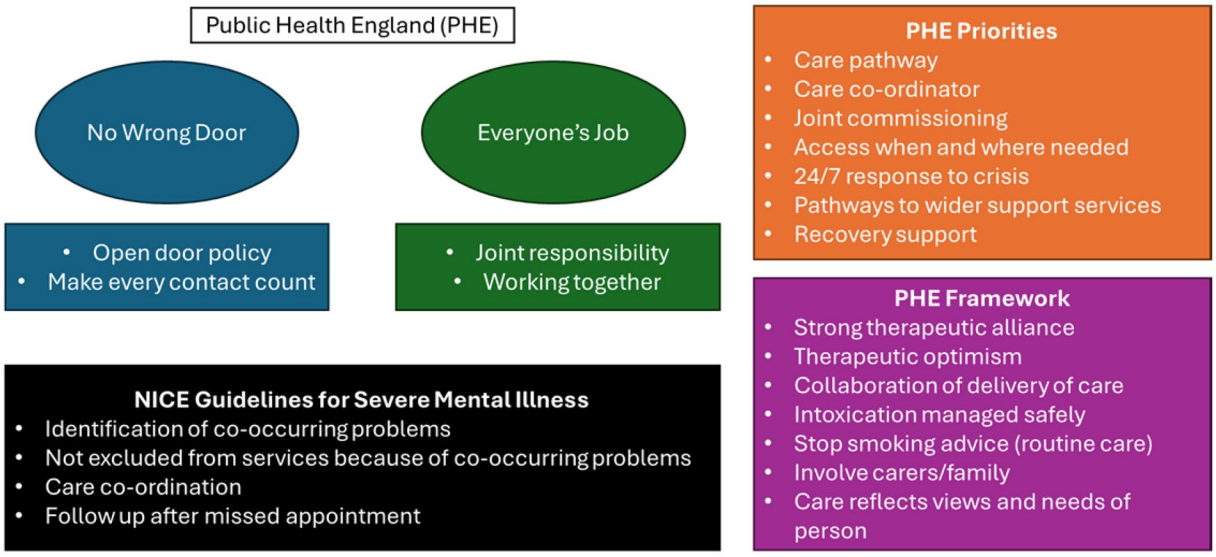

Figure 1. Overview of PHE and NICE guidelines for the provision of care for people with co-occurring substance use and mental health problems, that were used to inform deductive coding.

PPI & stakeholder involvement

This review forms part of a wider project on treatment pathways for people with co-occurring alcohol and mental health conditions (NIHR204587), which includes a coauthor with lived experience on this manuscript (and as a co-investigator on the wider project), and an advisory group of five people with lived experience. Their input was gathered throughout the project to ensure that the research questions and methods were appropriate and relevant to their experiences (e.g., initial discussions highlighted that aspects of the guidance are not being implemented). The group were also invited to review and offer feedback on the manuscript to ensure that content reflected their lived experience.

Results

The initial search identified 16,319 records. After duplicate removal, 15,247 titles and abstracts were screened, then 410 were retrieved for full text screening (see Supplementary Material 3), with 17 studies included (Figure 2). Table 1 summarizes the included quantitative studies (N = 2), with one single-arm pre-post intervention study exploring the effectiveness of a psychoeducational group therapy (Chilton et al., 2018) and one randomized controlled trial of a digital intervention to reduce alcohol use in mental health treatment seeking veterans (Trompeter et al., 2024). Table 2 summarizes the mixed methods studies (N = 4). They include an evaluation of an integrated post-traumatic stress disorder and substance use treatment (Airdrie et al., 2022), a quality improvement project which integrates substance use workers into mental health services (Dugmore & Bauweraerts, 2021), an exploration of the impact of substance use in psychiatric intensive care units (Moyes et al., 2021), and an evaluation of a positive psychology intervention with practitioners (Ujhelyi Gomez et al., 2020). Table 3 outlines the qualitative studies (N = 11). There are 7 studies of interviews with service users (exploring experiences of specific treatment/intervention approaches (Allen et al., 2024; Chilton et al., 2020; Johnson et al., 2019; Milani et al., 2020), or more general experiences of seeking treatment (Puddephatt et al., 2024; Sims, 2022; Stott & Priest, 2018), two case studies of the treatment of an individual (Johann Willmann, 2021; Sims, 2022), one realist evaluation including service users, carers, and service providers (Hughes et al., 2024), and one feasibility study of a cannabis reduction intervention for adults with psychosis (interviews with service providers) (Middleton Curran et al., 2023).

Quality appraisal

All studies were assessed using the relevant method CASP quality appraisal checklist. Figure 3 shows the aggregated results from the qualitative and mixed methods studies (quantitative studies were not included in the figure due to differences in quantitative CASP items), whilst Tables 1–3 report each study's overall quality ratings. Figures 4 and 5 show the CASP

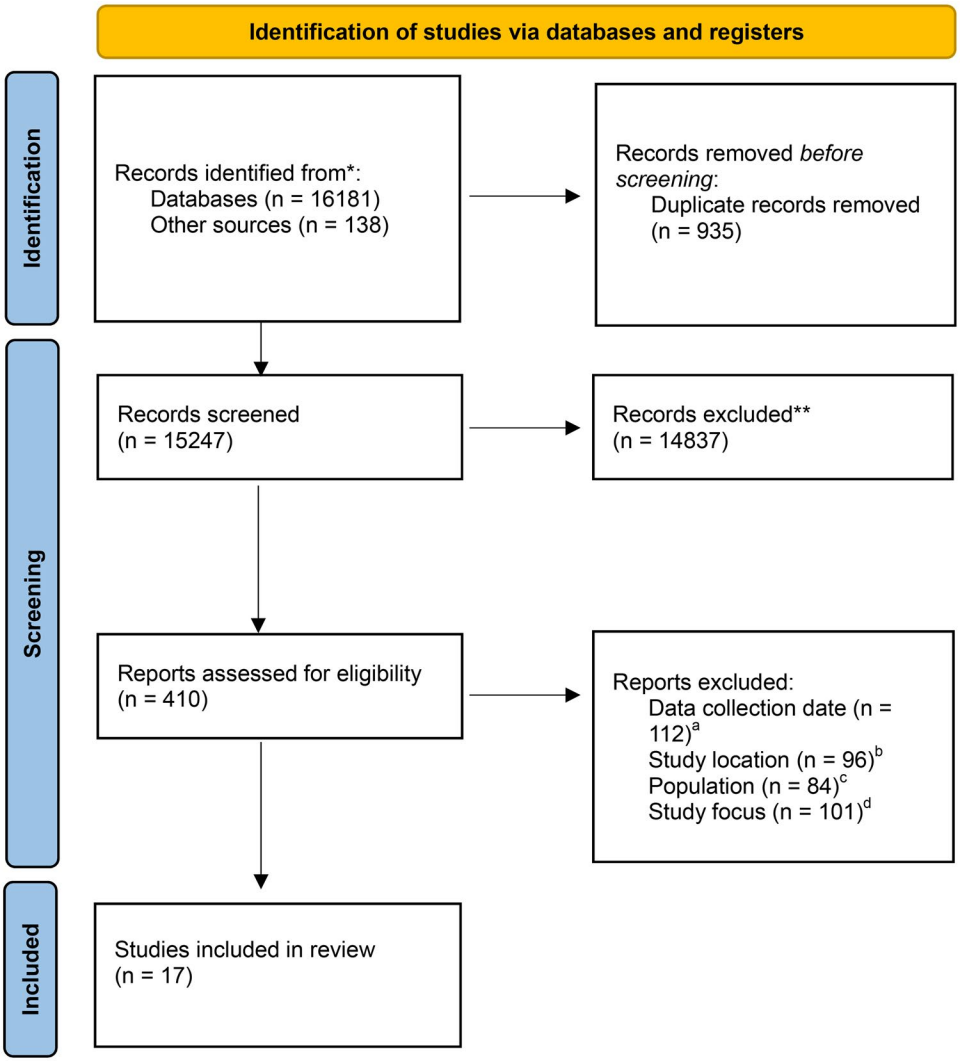

Figure 2. PRISMA flow diagram.

Note. Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

[a]Data collection was conducted prior to 2016 (when the first of the guidance documents was published).

[b]Study location was outside of the UK.

[c]Population was either under 18 years of age, or the whole sample did not have both a mental health condition and a substance use problem.

[d]Study focus was not on treatment for co-occurring conditions, such as drug efficacy studies, studies on prevalence of conditions or related outcomes.

summaries for the two quantitative studies, randomized controlled trials and cohort studies respectively. Studies were not excluded on the basis of quality rating, though all studies were rated as high (n = 11) or moderate (n = 6) quality. Funding information for studies in included where available, although there was no industry funded research that may suggest a risk of bias.

Thematic synthesis

Three themes were identified from the literature, each with three sub-themes, reflecting challenges to care for co-occurring conditions, integration of care, and barriers and facilitators to applying the guidance.

Theme 1: Challenges to care for co-occurring conditions

People with co-occurring substance use and mental health conditions report experiencing challenges to accessing guidance-based care, such as encountering "wrong doors" and conflicting eligibility criteria; healthcare providers failing to identify co-occurring conditions; and delays to timely and flexible support. However, there were examples of good practice, demonstrating that aspects of the guidance can be applied.

Theme 1.1: Wrong doors. Despite PHE and NICE guidance stating that people with co-occurring conditions should not be excluded from services,

Table 1. Characteristics of quantitative studies included in the review.

Authors (year)	Aims	Study design	Setting	Wider context	N	Sample details	Mean age (SD)	Gender M:F	Funding Source	Key sections of guidance extracted	CASP Rating
Chilton et al. (2018)	To determine the effectiveness of a psychoeducational group therapy for dual diagnosis	Single-arm pre-post intervention study.	Outreach treatment program	Group psychoeducational therapy delivered as a partnership outreach project between statutory and non-statutory services who work with patients with co-occurring mental health and substance use problems	51	Working age adults (aged 18–65) who met DSM-5 criteria SMI and current substance misuse (alcohol was the most frequently used substance).	34.5 (8.8)	28:23	This research did not receive any specific grant funding.		High[a]
Trompeter et al. (2024)	To investigate changes in quality of life following a digital smartphone application (DrinksRation) for veterans who had previously sought clinical mental health support	Randomised controlled trial.	Not service-specific	Digital smartphone application (DrinksRation) that involved techniques such as self-monitoring, goal setting, and personalized feedback, to help modify alcohol consumption (control group received guidance about alcohol consumption and a unit calculator)	123 (intervention n = 62; control n = 61)	Veterans consuming at least 14 units/ week of alcohol who have previously sought clinical mental health support.	47.6 (NR)	117:6	Forces in Mind Trust		Moderate[b]

Note. SMI = severe mental illness, DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, NR = not reported, NICE = National Institute for Health and Care Excellence, PHE = Public Health England, ▲ = key section of the guidance followed, ▼ = key section of the guidance not followed, [a] = assessed using the CASP cohort checklist; [b] = assessed using the CASP Randomized Controlled Trial (RCT) Checklist.

Table 2. Characteristics of mixed methods studies included in the review.

Authors (year)	Aims	Study design	Setting	Wider context	N	Sample details	Mean age (SD)	Gender M:F	Key sections of guidance extracted	CASP Rating[a]
Airdrie et al (2021)	To explore experiences of attending 'seeking safety' group-based treatment and evaluate its impact on mental health symptoms and substance use.	Convergent parallel mixed methods: individual semi-structured interviews & observational data (routinely collected service data on mental health and substance use before, during, and after treatment).	Drug and alcohol services	Seeking safety intervention (integrated treatment of PTSD and substance use - 25 weekly sessions involving psychoeducation, skill teaching, practice) ran within a drug and alcohol service.	7	Service users attending a Seeking Safety group within the substance use service, who met criteria for co-occurring substance use problems (alcohol was the most frequently used substance) and PSTD.	NR	5:2	PHE: ▲Strong therapeutic alliance. ▲Care reflects the views and needs of person.	High
Dugmore et al (2021)	To integrate substance use services into mental health, to enable the service user group to access both services and continue to engage with substance use services on discharge to improve outcomes.	Quality improvement project and evaluation. Quantitative outcomes included changes in patients being discharged without transfer of prescribing, engagement with substance use services, and referrals. Qualitative outcomes included staff feedback and a patient case study.	Joint working across mental health and a local substance use service	A quality improvement initiative with secondary mental health services and a drug and alcohol service, which included setting up a jointly-led dual diagnosis clinic and employing two substance use workers on acute mental health wards	NR	Service users in Leicestershire Partnership NHS Trust. Staff working in secondary mental health services and drug and alcohol services. Case study: A substance use service user with history of polysubstance use and anxiety, depression, and trauma.	NR	NR	NICE: ▲▼Not excluded from services because of co-occurring problems. ▲Identification of co-occurring problems. PHE: ▲No wrong door. ▲Everyone's job. ▲Collaboration in the delivery of care. ▲Recovery support.	Moderate
Moyes et al (2021)	To determine the extent of substance misuse within PICUs and understand the impact of substance use on PICU wards, staff and patients.	Literature review, online survey (closed and open-ended questions) with staff working in PICUs, and a workshop and roundtable with clinicians, patients and carers.	Psychiatric Intensive Care Units (PICUs)	The survey was distributed to key contacts who work in PICU wards across the UK. The workshop was organised by the Quality Network for PICU members, including staff, patients and carers.	15 & 50	15 PICU wards responded to the survey and 50 people attended the workshop (including staff from a range of roles, patients and carers).	NR	NR	NICE: ▲Identification of co-occurring problems. PHE: ▲▼Everyone's job.	Moderate
Ujhelyi Gomez et al (2020)	To investigate practitioners' views of the wellbeing of their clients; how positive psychology could be integrated with current approaches; how practitioners benefitted from the intervention; and how the intervention could be further improved.	Single-arm pre-post intervention to assess changes in practitioners following the intervention. Focus groups with practitioners who completed the intervention.	Drug and alcohol services	Positive psychology intervention for dual diagnoses, that was delivered to psychosocial intervention workers who work in a substance use service.	17	Psychosocial intervention workers in a substance use service.	43.1 (NR)	8:9	PHE: ▲Strong therapeutic alliance. ▲▼Therapeutic optimism.	Moderate

Note. NR = not reported, PICU = psychiatric intensive care units, NICE = National Institute for Health and Care Excellence, PHE = Public Health England, ▲ = key section of the guidance followed, ▼ = key section of the guidance not followed, [a] = assessed using the CASP Qualitative Studies Checklist.

Table 3. Characteristics of qualitative studies included in the review.

Authors (year)	Aims	Study design	Setting	Wider context	n	Sample details	Mean age (SD)	Gender M:F	Key sections of guidance extracted	CASP Rating[a]
Allen et al. (2024)	To develop an understanding of whether, and how, current service provision within a UK Early Help (EH) system supports families experiencing multiple problems including parental domestic violence and abuse, mental health, and substance use.	Semi-structured interviews with service users and focus groups with service providers and commissioners.	UK Early Help System which brings together service support for families where there are multiple problems.	UK Early Help is an approach implemented by service localities across the UK. Practitioners can refer families with multiple needs (e.g., domestic violence, mental health substance, use) and families can self-refer.	16	Service users with co-occurring mental health and substance use, service providers, and senior leaders/ commissioners (in Southern England).	NR	NR	NICE: ▼Follow-up after missed appointments. ▼Not excluded from services because of co-occurring problems. PHE: ▲▼Access when and where needed. ▲▼Care reflects the views and needs of the person. ▲▼Collaboration in the delivery of care. ▲▼Everyone's job. ▲▼Involve carers/ families. ▼No wrong door. ▲Pathways to wider support services. ▲Recovery support. ▲▼Strong therapeutic alliance.	High
Chilton et al. (2020)	To investigate the experiences of individuals with a range of complex mental health needs and coexisting substance misuse problems who took part in a psychoeducational group program.	Semi-structured interviews.	NHS mental health services and drug and alcohol services	Group psychoeducational therapy developed as a partnership outreach program between local NHS mental health services and substance use services to enhance service delivery for dual diagnosis service users.	15	Community NHS mental health service users with DSM-5 SMI and current substance misuse.	44.6 (11.0)	9:6	PHE: ▲▼Care reflects the views and needs of the person. ▲Collaboration in the delivery of care.	Moderate
Curran et al. (2023)	To explore staff views on the feasibility and acceptability of using contingency management plus psychoeducation intervention to reduce cannabis use in the context of specialist mental health services for young adults with psychosis, to inform wider learning about implementation of such approaches in mental health services.	Semi-structured interviews and focus groups.	Mental health services	Individuals involved in the delivery of contingency management (in early intervention for psychosis teams across 23 NHS trusts in England), as well as early intervention staff and managers who did not deliver the intervention, and academic experts on contingency management interventions were recruited.	47	40 managers and staff working in mental health services where contingency management had been delivered, 4 staff who delivered contingency management, and 3 key informants (academic experts in relevant fields).	NR	NR	PHE: ▲▼Strong therapeutic alliance. ▲Therapeutic optimism.	High

(*Continued*)

Table 3. Continued.

Authors (year)	Aims	Study design	Setting	Wider context	n	Sample details	Mean age (SD)	Gender M:F	Key sections of guidance extracted	CASP Rating[a]
Hughes et al. (2024)	To use a realist approach to test and refine service model programme theories of what works under what context for people with severe mental illness and co-occurring substance use.	Case study evaluation of realist programme theories.	Mental health services and relevant partnering agencies.	Six sites across the UK providing care for co-occurring SMI and substance use, with varying service models.	96	25 service users with co-occurring SMI and substance use; 13 carers of service users with co-occurring SMI and substance use; 58 service providers.	NR	NR	NICE: ▲▼Care co-ordination. ▲▼Not excluded from services because of co-occurring problems. PHE: ▲Care coordinator. ▲▼Care reflects the views and needs of the person. ▲▼Collaboration in the delivery of care. ▲▼Everyone's job. ▲▼No wrong door. ▲Recovery support. ▲Pathways to wider support services. ▲▼Strong therapeutic alliance. ▼24/7 response to crisis.	High
Jackson et al. (2024)	To explore experiences of the formal health and social care system for co-occurring heavy alcohol use and depression through the lens of relational autonomy.	Semi-structured interviews.	Not service-specific	North-East of England and North Cumbria.	39	Individuals with self-identified current or recent hazardous or harmful alcohol use and mild to moderate depression were recruited through voluntary organizations (e.g., mental health charities, community alcohol services, and social housing providers).	NR	21:18	NICE: ▼Follow-up after missed appointments. ▼Identification of co-occurring problems. ▲▼Not excluded from services because of co-occurring problems. PHE: ▲▼Access when and where needed. ▲▼Care reflects the views and needs of the person. ▼Collaboration in the delivery of care. ▼Everyone's job. ▲▼No wrong door. ▲Pathways to wider support services. ▲Recovery support. ▼24/7 response to crisis.	High
Johnson et al. (2019)	To explore experiences of a new ACT-based substance misuse program.	Semi-structured interviews.	Secure NHS mental health service	ACT intervention delivered in a secure NHS mental health service.	6	Service users in a secure mental health hospital detained under the mental health act, with a history of substance misuse.	31.3 (7.0)	2:4		High

(*Continued*)

Table 3. Continued.

Authors (year)	Aims	Study design	Setting	Wider context	n	Sample details	Mean age (SD)	Gender M:F	Key sections of guidance extracted	CASP Rating[a]
Milani et al. (2020)	To explore the impact and mechanisms of change of the dual diagnosis anonymous (DDA) program.	Longitudinal qualitative trajectory analysis: members of DDA were interviewed 3 times over a period of 12 months and facilitators were interviewed twice and commissioner was interviewed once.	Third sector services	Dual Diagnosis Anonymous (DDA), a peer support group similar to 12 steps of Alcoholics Anonymous (AA), with an additional 5 steps for mental health problems.	9	6 DDA members, 2 DDA facilitators with a history of mental health disorders and/or substance use disorders, and the 1 drug and alcohol service commissioner.	NR	7:2	PHE: ▲Joint commissioning. ▲Care reflects views and needs of the person. ▲Therapeutic optimism. ▲Strong therapeutic alliance. ▲Recovery support. ▲Pathways to wider support.	High
Puddephatt et al. (2024)	To explore experiences with alcohol and how drinking has changed over time among minority ethnic groups with a diagnosed mental health problem.	Semi-structured interviews.	Not service-specific.	People of minoritized ethnic backgrounds accessing online or community mental health support or recruited through social media.	25	People from minoritised ethnic groups with a diagnosed mental health disorder (mostly depression and anxiety) and either currently drinking at hazardous or above levels, or former drinkers.	NR	16:6	NICE: ▲Identification of co-occurring problems PHE: ▲Involve carers and family ▲No wrong door	High
Sims et al. (2022)	To illustrate the use of trauma-based CBT in an individual engaging with substance use services.	Case study.	Drug and alcohol services	Trauma-based CBT delivered within a substance use service.	1	Substance use service users with PTSD.	26	0:1	PHE: ▲Recovery support.	Moderate
Stott et al. (2018)	To use a narrative approach to explore the process of mental health recovery as an individual journey in a social context (i.e., the social nature of recovery) and toto explore the impact of alcohol's specific cultural meanings.	Unstructured interviews.	Drug and alcohol services	Community-based substance misuse service.	10	Individuals with co-occurring mental health and alcohol misuse difficulties who had engaged with both the substance misuse service and a specialized mental health service in the previous two years.	NR	6:4	NICE: ▲Identification of co-occurring problems. PHE: ▼Care reflects the views and needs of the person. ▲▼No wrong door. ▲Strong therapeutic alliance. ▲Therapeutic optimism. ▲Recovery support. ▲Pathways to wider support.	High

(*Continued*)

Table 3. Continued.

Authors (year)	Aims	Study design	Setting	Wider context	n	Sample details	Mean age (SD)	Gender M:F	Key sections of guidance extracted	CASP Rating[a]
Willmann et al. (2024)	To explore the care of a patient presenting at the emergency department with symptoms arising from a combination of severe mental illness and substance misuse.	Case study	Not service-specific	An emergency department in the South of England.	1	An individual with AUD and schizophrenia, who had previously engaged with the psychiatric liaison team.	NR	1:0	PHE: ▼Collaboration in the delivery of care. Pathways to wider support. ▼Intoxication managed safely.	High

Note. ACT = acceptance and commitment therapy, CBT = cognitive behavioral therapy, NR = not reported, NICE = National Institute for Health and Care Excellence, PHE = Public Health England, AUD = alcohol use disorder, ▲ = key section of the guidance followed, ▼ = key section of the guidance not followed, [a] = assessed using the CASP Qualitative Studies Checklist.

studies demonstrated that this does not always happen. People with co-occurring conditions were turned away from services, typically mental health support (due to eligibility criteria), until they reduced their alcohol use (Hughes et al., 2024; Jackson et al., 2024; Sims, 2022).

> "In my clinical experience, as soon as a person mentions any substance-use issues, the stock response from mainstream mental health services is: "once you have 'sorted' out your substance use, re-refer yourself back to us"." (author interpretation, Sims, 2022).

Other evidence highlighted that being turned away from services can have adverse consequences, such as suicidal ideation (Puddephatt et al., 2024) and unplanned emergency alcohol-related hospital admissions (Johann Willmann, 2021).

Nevertheless, there were positive examples, such as integrating substance use workers into inpatient mental health services to enable referrals into substance use services prior to discharge (Dugmore & Bauweraerts, 2021). The studies emphasize the importance of a responsive and flexible first contact with services, to build trust and optimize engagement (Hughes et al., 2024).

Theme 1.2: Recognition of co-occurring conditions. Guidance emphasizes the importance of recognizing when conditions co-occur, including screening for co-occurring conditions, rather than only focusing on what is perceived to be the primary need. Studies reported that healthcare professionals may not ask people with mental health conditions about alcohol use, and vice versa, preventing the identification of co-occurring conditions and acting as a barrier to care.

> "No-one asked me why I drank, until a particular nurse recognised that (I) was suffering from PTSD." (quote from service user participant, Stott & Priest, 2018)

One study found that frontline care providers recognized the high prevalence of co-occurring substance use conditions within mental health services, yet issues tended to arise with management who do not understanding co-occurring needs. The authors recommended additional training within mental health services to ensure everyone has a basic skillset to address both mental health and substance use (Hughes et al., 2024). Another study highlighted the importance of addressing underlying anxiety-based problems (though trauma-based cognitive therapy), which untreated, can reduce an individual's ability to sustain recovery (Sims, 2022).

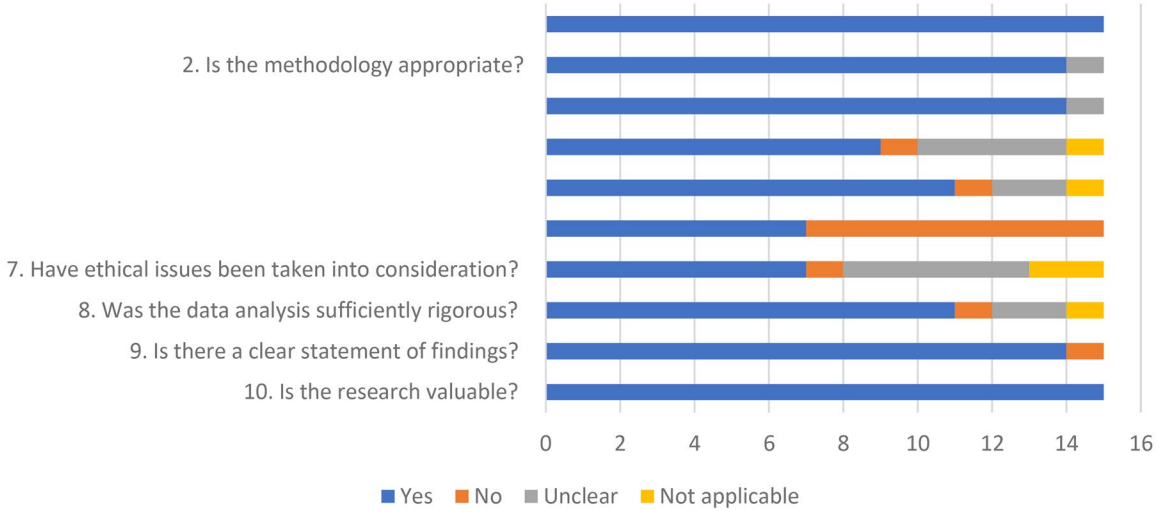

Figure 3. Critical appraisal summary for qualitative and mixed methods studies using the CASP Qualitative Studies Checklist (CASP 2024a).

Some service users recognized the link between their substance use and mental health (Chilton et al., 2020), whereas others did not; resulting in delays in accessing care for both conditions (Puddephatt et al., 2024). Engaging with healthcare services (or interventions) can improve service users' understanding of the impact of substance use on mental health (Airdrie et al., 2022; Johnson et al., 2019; Puddephatt et al., 2024; Stott & Priest, 2018). However, culturally appropriate care is needed when raising discussions about substance use with people from minoritised ethnic/religious groups (Puddephatt et al., 2024) to account for intersecting experiences which can impact substance use disclosure and the acceptability of existing approaches.

Theme 1.3: Access to care when and where needed. PHE guidance regarding timely and flexible access to care (PHE, 2017) is not often applied in practice. Often, services have long waitlists, and the lack of early support allows co-occurring problems to become more entrenched (Allen et al., 2024). Both long waiting times and difficulty of access for mental health services were emphasized in comparison to substance use services which were perceived as less difficult to access. However, staff in substance use services do not always have the expertise required to adequately address mental health needs (Hughes et al., 2024).

Narratives of recovery highlighted the importance of flexible and practical support (Stott & Priest, 2018), yet lack of flexibility was a frequently cited barrier to access, e.g., being expected to attend appointments during work hours (Jackson et al., 2024). The inability to access care when and where needed can lead to crisis presentations:

> "Service users and carers suggested that first response services (e.g., A&E or the police) were often the only way to receive any kind of support in a crisis… service users described being caught in a cycle of presenting at times of crisis in an attempt to get support for their mental health with discharge often resulting in further suicide attempts of relapse of substance use problems." (author interpretation, Hughes et al., 2024)

Whilst not suitable for all populations nor all contexts, evidence from a randomized control trial suggested that digital interventions can be beneficial for people with co-occurring problems (26), and these interventions may offer greater flexibility.

Theme 2: Integration of care

Although disagreement about what good integrated care looks like, NICE and PHE guidance recommend the provision of integrated care, outlining the importance of coordinating care across services for mental health, substance use and wider needs, ideally through an assigned care coordinator, and incorporating partnership working and communication across services. However, across the included literature, good integration of care was not always evident.

Theme 2.1: Partnership working. Many studies highlighted the importance of services working in partnership, with benefits to service users' experiences, staff relationships and treatment outcomes. For example, an initiative across a secondary mental health service and a substance use service included establishing a jointly-led dual diagnosis clinic and employing two substance use workers on inpatient mental health wards (Dugmore & Bauweraerts, 2021), which improved partnership working and communication as well as service user outcomes and safety.

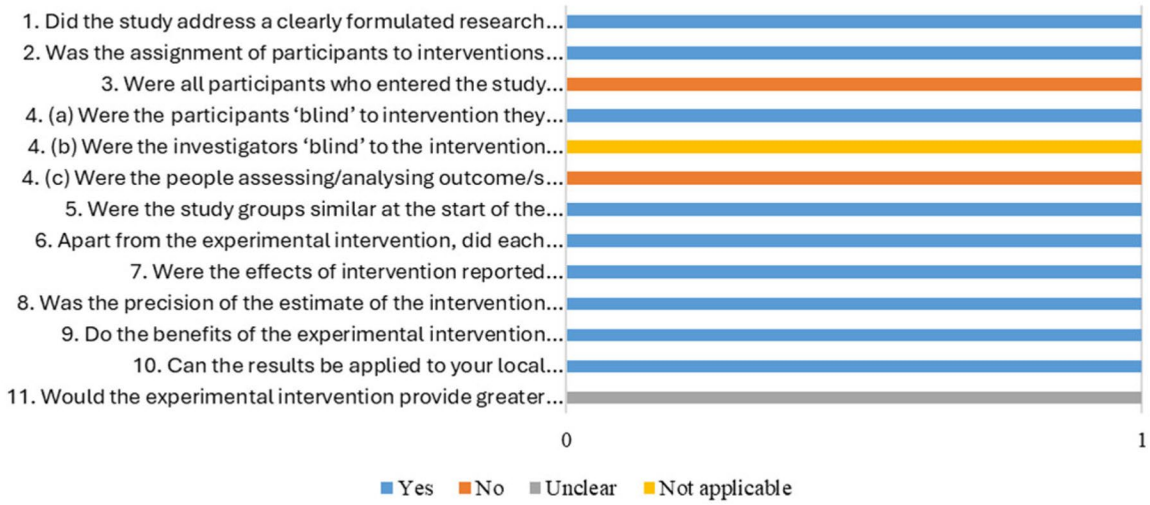

Figure 4. Critical appraisal summary for randomized controlled trials using the CASP Randomized Controlled Trials Checklist (CASP, 2024b)

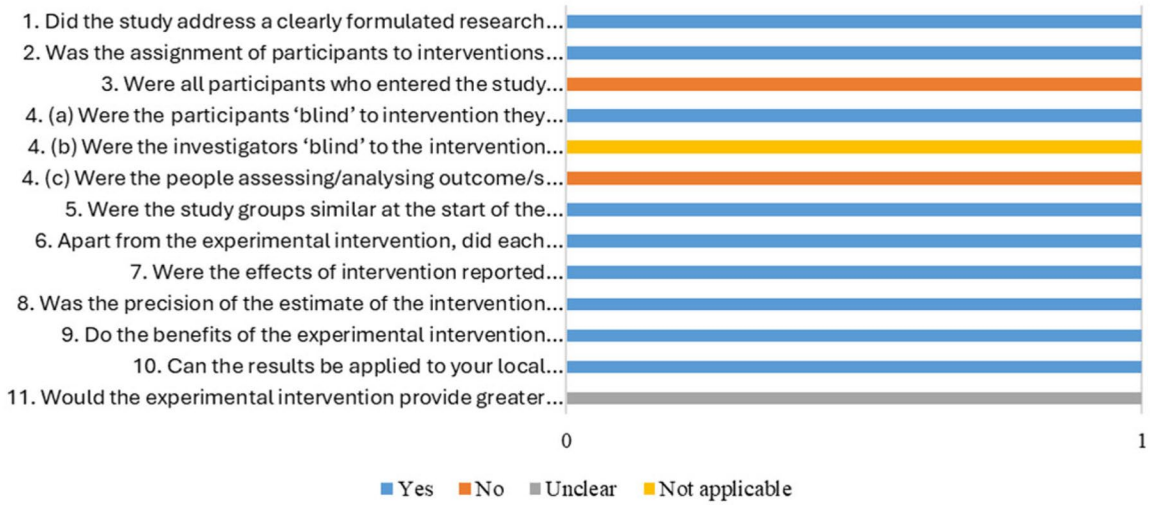

Figure 5. Critical appraisal summary for cohort studies using the CASP Cohort Studies Checklist (CASP 2024c).

Closer partnership working can result in better identification and more demand for support from service users who have co-occurring conditions (Dugmore & Bauweraerts, 2021). Whilst collaboration appeared to improve care, research suggested that this was not typical practice. One audit of psychiatric intensive care units found that 60% of wards reviewed did not offer psychological interventions for substance use (Moyes et al., 2021). Moreover, staff on two of the wards offering such interventions reported not receiving training in substance use, raising questions about their quality.

Many studies identified that a lack of partnership working resulted in service users seeking out services which took a more integrated approach, for example, through Dual Diagnosis Anonymous (DDA; a mutual aid 12-steps fellowship for people with co-occurring problems).

> "The most important thing about the DDA is that it fills a gap where other [mutual aid] fellowships are lacking. It's a reassuring place where you can talk about your addiction issues but also your mental health." (direct quote from service user participant, Milani et al., 2020).

Theme 2.2: Communication and information sharing. An important feature of good integrated care is communication across services both at organizational and service delivery levels (Savic et al., 2017). Yet, most of the included papers identified poor communication, with service user accounts describing how this resulted in adverse consequences and gaps in care (Jackson et al., 2024).

The lack of communication even within a service, made things difficult, with service users having to repeat information multiple times to different

practitioners, deterring them from wanting to access services.

> "They don't have seemed to speak to each other. You know you hear so many times the communication breaks down between people and between services, between the mental health people between the police between the drug worker…." (direct quote from carer participant, Hughes et al., 2024).

Staff also described challenges in contacting mental health providers, including for service users experiencing multiple disadvantage, or who were currently in crisis, with providers from other organizations sometimes trying to fill in the gaps in care and support someone with their mental health (Allen et al., 2024).

Theme 2.3: Everyone's job. The guidance outlines that responsibility for care for people with co-occurring conditions, should be 'everyone's job'. In the same ethos as 'no wrong doors', this concept relates to the need for services to take shared responsibility for this population. However, service providers reported that the responsibility was often passed on, with many services particularly reluctant to take on care for those with more complex needs.

Service users may be passed on due to concern about potential risk that may not be within the remit of a service, which could also result in someone not being seen at all.

> "People start to get passed around … it's that idea. Oh, here's some risk that I can't deal with. I don't know what to do with that or I can't deal with that. So, what I'm gonna do is send you to someone else now," (direct quote from staff participant, Hughes et al., 2024).

Furthermore, service users indicated that they were balancing a tightrope of whether their needs were too great for services to manage, or not serious enough, meaning that they didn't always know where to go, or they need to report being in crisis to get seen.

Theme 3: Barriers and facilitators

The final theme summarizes the barriers and facilitators to implementation of the guidance, which can be interpreted as micro (stigma and therapeutic optimism) and meso (organizational and system-level) barriers and facilitators.

Theme 3.1: Stigma. Stigma can operate at individual or structural levels to consciously or unconsciously prevent service providers from implementing the guidance, such as excluding someone with co-occurring conditions from services due to judgements about entitlement or the likelihood of someone accepting support.

> "Some believed that most clients would not recover and only so much can be done for them." (author interpretation, Ujhelyi Gomez et al., 2020).

There were also examples of self-stigma affecting service users' actions, for example in delaying them from seeking support (Milani et al., 2020) or preventing them from disclosing their alcohol use.

> "Many people's accounts suggested that stigma around alcohol use had delayed or prevented them from disclosing their heavy alcohol use." (author interpretation, Jackson et al., 2024).

Nevertheless, there were examples of approaches which helped to challenge stigma, such as a person-centred group psychoeducational therapy that was delivered in a partnership between local NHS mental health services and substance use services:

> "Participants stated they valued the experience of social inclusion and participation in the decision-making process … which contrasted with their pervading sense of social exclusion and perceived stigma from mental health services and society at large, which they had endured over many years." (author interpretation, Chilton et al., 2020).

Theme 3.2: Therapeutic optimism. Within the included studies, there was evidence for therapeutic optimism as a micro level factor which facilitated guidance implementation (Airdrie et al., 2022; Allen et al., 2024; Hughes et al., 2024; Jackson et al., 2024; Middleton Curran et al., 2023; Milani et al., 2020; Stott & Priest, 2018; Ujhelyi Gomez et al., 2020), with examples showing the importance of the therapist understanding the wide ranging needs of the service user. Compassion and acceptance were also highlighted as crucial elements of an integrated care and in supporting the service user's longer-term recovery journey, which is outlined in the PHE guidance:

> "a therapeutic relationship with a particular professional was a key part of recovery" (author interpretation, Stott & Priest, 2018).

Theme 3.3: Organizational and system-level. Studies focusing on the service provider perspectives at the meso level described organizational and systemic barriers, including lack of time and training, lack of organizational commitment, and the need for joined up working, as barriers to delivering co-ordinated

care, with siloed commissioning contributing to fragmented services which results in many service users falling through the gaps (Dugmore & Bauweraerts, 2021; Hughes et al., 2024; Moyes et al., 2021; Middleton Curran et al., 2023; Ujhelyi Gomez et al., 2020). Studies of service providers noted this as a barrier, stating that there are:

> "…bureaucratic barriers to collaboration, not knowing whom to speak to in order to facilitate collaboration, and service level differences in commitment to collaborative working" (author interpretation, Allen et al., 2024).

Some studies identified approaches that need to be implemented at the meso level to support the application of the guidance. For example, one study within a hospital setting called for more efficient use of resources and staff; reduction in service user numbers; increased effectiveness of the A&E department; quicker turnover (Johann Willmann, 2021).

Discussion

This review sought to understand the extent to which UK guidance for the provision of care for co-occurring substance use and mental health conditions is being implemented, including barriers and facilitators to implementation, and to identify examples of changes in practice which enabled implementation of aspects of the guidance. From the 17 included articles, it was clear that several key principles of the guidance are not being implemented, particularly "no wrong doors", "everyone's job", and integrated care. Evidence shows that service users are still being excluded from mental health services because of ongoing substance use, and that some services are reluctant to provide care to those with complex needs, preventing provision of well-integrated or co-ordinated care. There are barriers across micro, meso, and macro levels, which prevent the guidance from being implemented, such as stigma from service providers; lack of time, training, and organizational support; and differences in commissioning approaches resulting in fragmented services. Despite this, there were positive examples of care provision that aligned with current guidance, such as therapeutic optimism and skilled staff, flexible and practical support, multi-agency working, and committed and supportive working. We also found instances of integrated intervention approaches that could be delivered in localized areas, including one example of an initiative that successfully integrated substance use nurses within mental health services (Airdrie et al., 2022; Allen et al., 2024; Chilton et al., 2018; Dugmore & Bauweraerts, 2021; Milani et al., 2020). However, these required joint working and commissioning, and wider implementation of scaled-up approaches would require specific financing.

This review highlights the clear implementation gap that exists in the UK and globally in the delivery of best practice guidance. This gap is common in mental healthcare treatment (Correa et al., 2020; Fischer et al., 2016; Francke et al., 2008; McGinty & Eisenberg, 2022) but compounded for this population who are highly stigmatized and experience additional complications due to the complexity of their treatment needs. Additionally, there were differences in experiences within populations with co-occurring conditions, with evidence that certain marginalized groups (e.g., minoritised ethnic and religious groups) may be even less likely to receive best practice care (Puddephatt et al., 2024). Some of the barriers to implementation related to the beliefs of staff about the benefits of following the guidance, as many viewed this group of service users as difficult to treat and unlikely to recover (Ujhelyi Gomez et al., 2020), suggesting that they may be less motivated to change their practice. One of the short-term outcomes of delivering an integrated care approach was an increase in workload and referrals, due to better identification of co-occurring conditions (Dugmore & Bauweraerts, 2021). As such, and in the context of stretched services, staff may be concerned about the consequences of increasing workloads. These issues may be further accentuated within a marginalized group of service users who may not be seen when they fall between services, until they reach crisis point or experience physical health consequences and require emergency care (Jackson et al., 2024; Johann Willmann, 2021).

This review has shown that provision of guidance alone may be insufficient to deliver a good standard of care to a service user group with more complex needs and there is a need to understand the implementation approaches required to support guidance delivery. Approaches could include strategies outlined in both the present and previous reviews, focusing on committed leadership, staff training and expectations, and collaborative service delivery (Harris et al., 2023). For example, leaders who are committed to collaborative working and integrated care, and support continuous staff development and recruitment of skilled staff, may improve therapeutic relationships. Staff understanding of trauma and how best to support this is an important element of the therapeutic relationship, but requires additional training and development, as well as time. Additionally, staff in both mental health and substance use services must

accept that the provision of care for people with co-occurring conditions is "everyone's job", which can be facilitated through staff training to reduce stigma and integrating staff across services to learn through practice. It is also important to note that within the UK context, mental health services are usually delivered by the NHS, whereas substance use treatment falls under local authority governance and is often delivered by charities or voluntary sector organizations, presenting additional barriers to integrating care, and complicating the reach of the guidance.

Wider approaches such as financial payments for screening and brief alcohol interventions have been found to be effective but are typically implemented at a single service level (e.g. in primary care) (Department for Health and Social Care, 2025; O'Donnell et al., 2016) and on a time-limited and relatively low level. Given the complexity of the treatment landscape for this population, there is a need for a solution to be coordinated through a pan-system and multi-agency approach, requiring funding to be used more flexibly over a longer-term period.

To our knowledge, this is the only review that has explored empirical data to identify the extent to which NICE and PHE guidance are being implemented in the UK. The aims of this review were developed through collaboration with people with lived experience, who outlined that aspects of the guidance were not implemented in their experiences of seeking support for co-occurring conditions. We also included a wide range of studies and study settings, beyond experimental designs, including quantitative and qualitative data obtained from primary and secondary care NHS services and third sector organizations. This enabled us to capture staff and service user experiences of care for co-occurring conditions, as well as evaluations of small-scale intervention approaches. However, the variation across studies and study settings limits our ability to understand exactly what is happening in practice. Additionally, this review only included studies which were conducted in the UK, since 2017, to align with the date of publication of PHE and NICE guidance. Earlier and more international research may provide relevant evidence of effective approaches to improve the delivery of care for people with co-occurring conditions or identify potential barriers and facilitators to good co-ordinated care which may be applicable to the UK-context. The period over which some studies were conducted also included the COVID-19 pandemic, which had significant implications for both treatment and research, and may have influenced what treatment options were available and the ways in which they were accessed. This was not discussed in detail in many of the included studies but may have influenced findings.

The findings of this review have implications for clinical practice and research. With the recent publication of new guidance for the care of people with co-occurring conditions (Department for Health and Social Care, 2025), which echoes many of the points from the previous guidance, this review identifies actions that may be required in parallel to this publication, to ensure that they are implemented. Challenges experienced by people with co-occurring conditions relate to barriers to implementing the guidance across micro (e.g., stigma, lack of recognition of co-occurring conditions), meso (e.g., lack of communication or partnership working across services and differences in organizational commitment to collaborative working), and macro levels (e.g., siloed commissioning of services), with these findings outlining that a multi-systems approach is needed to address these barriers. Many studies included in this review identified effective intervention approaches, such as integrating substance use workers within mental health services and staff training to reduce stigma and improve therapeutic optimism, yet delivering these approaches at scale can be difficult. There is a need for further implementation research to overcome barriers to scaling these interventions in real-world settings, and on how these can be implemented into existing systems

Conclusion

This review identified an implementation gap between the PHE and NICE best practice guidance and the provision of care for co-occurring substance use and mental health conditions. This review highlights barriers faced by service users when trying to access co-ordinated care to address their needs and challenges experienced by service providers involved in the delivery of care, demonstrating that key principles of the guidance, such as "no wrong doors", "everyone's job" and co-ordinated care, are not being implemented. Nevertheless, there were positive examples of how the implementation of the guidance can be facilitated, particularly from small-scale intervention evaluations. However, scaling these interventions to real-world service delivery is challenging, and requires funding, support, and commitment across all levels and services.

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Author contributions

CRediT: **Zoe Swithenbank**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – original draft, Writing – review & editing; **Patricia Irizar**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – original draft, Writing – review & editing; **Lauren Halsall**: Data curation, Formal analysis, Investigation, Writing – original draft, Writing – review & editing; **Jo-Anne Puddephatt**: Supervision, Writing – review & editing; **Phil Parkes**: Validation, Writing – review & editing; **Amy O'Donnell**: Conceptualization, Supervision, Validation, Writing – review & editing; **Colin Angus**: Conceptualization, Supervision, Validation, Writing – review & editing; **Colin Drummond**: Conceptualization, Methodology, Supervision, Validation, Writing – review & editing; **Kat Jackson**: Investigation, Validation, Writing – review & editing; **Laura Goodwin**: Conceptualization, Funding acquisition, Investigation, Methodology, Supervision, Validation, Writing – original draft, Writing – review & editing.

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