The Cognitive Behaviour Therapist (2025), vol. 18, e14, page 1 of 12
doi:10.1017/S1754470X2400031X

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ORIGINAL RESEARCH

What leads clinicians to exclude drug and alcohol users from NHS Talking Therapies services? An audit of decision making within clinical records

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(Received 10 March 2024; revised 28 October 2024; accepted 22 November 2024)

Abstract

Drug and alcohol users have been suggested to face disproportionate exclusion from mental health services, but data on any such exclusion are not readily available. This study examined the clinical records of those excluded from an NHS Talking Therapies service due to drug or alcohol use, focusing on (1) quantitative levels of alcohol consumption, and (2) the rationales documented by clinicians for excluding these individuals. Our results suggest that over half (57%) of those excluded due to alcohol use were consuming below the 15-unit daily threshold recommended for signposting to specialist alcohol assessment. Clinicians cited various rationales for exclusion, including the potential for poor treatment outcomes and health risks associated with concurrent use. Due to being based on a single service, these findings may be limited in their generalisability, but they offer an initial signal that there is potential over-exclusion of some alcohol users from NHS Talking Therapies, and that rationales for exclusion may not consistently align with best practice principles. We discuss implications for NHS Talking Therapies clinicians, and for the development of future clinical guidance.

Key learning aims

(1) To understand how different levels of drug or alcohol use may affect the outcomes of psychological therapy.
(2) To learn why individuals with drug or alcohol use experience exclusion from mental health services.
(3) To examine how clinical practice within an NHS Talking Therapies service aligns with best practice principles.
(4) To explore skills and clinical principles that can lead to optimal treatment planning for these individuals.
(5) To explore how integrated working between NHS Talking Therapies and local drug and alcohol services can enhance service-user experiences.

Keywords: barriers to treatment; clinician attitudes; comorbidity; Improving Access to Psychological Therapies Programme (IAPT); NHS Talking Therapies; substance misuse

Introduction

The UK Department of Health has previously described concurrent mental health problems and drug or alcohol use as 'the most challenging clinical problem that we face' in frontline services (Department of Health, 2002; p. 1). Concurrent drug or alcohol use is associated with a spectrum

of negative outcomes, including homelessness, suicide, poor physical health, criminal justice system contact, relapse after treatment for substance use, and greater severity and persistence of both disorders (Compton *et al.*, 2007; Kessler, 2004; Najt *et al.*, 2011; University of Manchester, 2022). UK prevalence studies suggest rates within secondary care mental health settings of around a quarter for co-occurring harmful alcohol use, and almost a third for problem drug use (Weaver *et al.*, 2003), while the available data for NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies, IAPT) services are similar (Buckman *et al.*, 2018).

Concurrent drug or alcohol use and psychological therapy outcomes

This trend for poorer outcomes has been suggested to extend to psychological therapy for common mental health problems, which some studies have found to be negatively associated with concurrent drug or alcohol use (e.g. Boschloo *et al.*, 2012; Gajecki *et al.*, 2014; Giebel *et al.*, 2014). Elsewhere, however, psychological therapy has been found to be effective in spite of co-occurring drug or alcohol use (Buckman *et al.*, 2018; Gajecki *et al.*, 2014; Hunt and Delgadillo, 2022). One possible explanation for this discrepancy is that any negative impact on therapy outcomes will depend on the level of substance use: it is only in cases where the substance use is of a level where it interferes with the core tasks of therapy, or where it requires treatment in its own right, that psychological therapy outcomes will suffer. Consistent with this interpretation, Buckman *et al.* (2018) note that in the NHS Talking Therapies service they studied, those with very severe levels of alcohol use had likely already been signposted to drug and alcohol services and so would not have been included in their sample, and in the study by Boschloo *et al.* (2012) poorer outcomes were predicted by *severe* alcohol use only.

Barriers to accessing mental health services

Effective clinical decision making, in which those with concurrent drug or alcohol use are neither inappropriately excluded from nor inappropriately accepted for treatment within mental health services, is therefore essential to ensuring good outcomes for these service-users. This is especially important in cases where mental health problems 'lie at the heart of' individuals' drug or alcohol problems, and where early intervention for mental health issues may play a significant role in preventing the onset of drug or alcohol misuse (Home Office, 2021). Yet a pattern of these individuals 'falling through the gaps' between services, due to not meeting either service's inclusion criteria, has frequently been highlighted in both drug and alcohol and mental health policy (e.g. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017; Department of Health, 2002; Home Office, 2021; Mental Health Taskforce, 2016; Public Health England, 2017). One explanation suggested for such exclusion is that it results from negative assumptions about concurrent drug or alcohol use amongst clinicians in mental health services, for example that 'mental health treatment cannot be effective when there is *any* level of concurrent substance use', or that 'the substance misuse problem should *always* be treated first by drug and alcohol services' (e.g. Adams, 2008; Lawrence-Jones, 2010; Todd *et al.*, 2002). The empirical data on the scale of any such exclusion from mental health services, however, are limited. Although there exist UK data that up to a third of patients within drug and alcohol services have not received treatment for a co-occurring mental health problem (Office for Health Improvement and Disparities, 2023; Shahriyarmolki and Meynen, 2014; Weaver *et al.*, 2003), empirical data showing that these individuals have been actively excluded from mental health services are not readily available, and appear to be limited to anecdotal data from surveys of the perceptions of drug and alcohol treatment providers (e.g. Recovery Partnership, 2016, as cited by Public Health England, 2017).

https://doi.org/10.1017/S1754470X2400031X Published online by Cambridge University Press

Purpose of the present study

The purpose of the present study was to take some initial soundings as to what leads NHS Talking Therapies clinicians to exclude individuals with concurrent drug or alcohol use. Guidance from both NICE (2011) and NHS Talking Therapies (National Treatment Agency, 2012) recommends that those drinking over 15 units of alcohol per day should be considered for medically assisted detoxification, within general practice or specialist alcohol services. Through a retrospective review of existing clinical records, our first aim was therefore to establish what proportion of those excluded from an NHS Talking Therapies service due to alcohol use were drinking amounts in excess of this threshold. Our second aim was to explore qualitatively the rationales clinicians documented for excluding service-users due to use of either drugs or alcohol, and to explore the degree to which these rationales appear to align with good practice principles.

Method

Setting

The study was undertaken in an NHS Talking Therapies service in south London. The service's care pathway was typical of NHS Talking Therapies services in that new referrals into the service first underwent an approximately 20-minute initial triage assessment by telephone, with the aim of determining suitability for the service. At this point the referral would either be excluded and potentially signposted to other services, or put forward for a more comprehensive face-to-face assessment within the service. Although NHS Talking Therapies guidelines recommend that only qualified clinicians complete initial triages (National Collaborating Centre for Mental Health, 2024), the majority of initial triages in this service were conducted by a combination of qualified psychological wellbeing practitioners (PWPs) and other staff without formal qualifications (e.g., Assistant Psychologists), who typically had an undergraduate degree in psychology and received in-house training and supervision. A smaller number of triages were completed by trainee PWPs and both qualified and trainee high-intensity CBT therapists. All triage assessments were then discussed with a qualified staff member (usually a PWP) before making final service suitability decisions. Exact data on the breakdown of clinician roles in completing initial triages are unavailable.

Sample

Our sample consisted of referrals to the service that were declined due to co-occurring drug or alcohol use in the first half of 2018 (1 January to 3 July). During this period there were 5273 referrals to the service in total, 678 of which were excluded; 50 (7%) of those were excluded due to drug or alcohol use, or 0.9% of the total referral intake. Due to missing data, $n = 47$ were included in our final sample. Nine of our sample were not offered treatment based on information contained within the referral alone, while 38 were excluded after the initial triage; no individuals were excluded after undergoing more comprehensive post-triage assessment, or after having already started treatment.

Procedure

Data were extracted from service-users' electronic clinical records, covering information related to demographics, mental health diagnosis, amount and frequency of substance use, and the rationale for not offering treatment. For those using alcohol, the typical weekly intake was converted into units of alcohol based on the NHS Alcohol Units guidance (National Health Service, 2022). In cases where the information within the clinical records was not sufficiently clear as to the type, volume or frequency of drink, we adopted the following rules of thumb in order to standardise our

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conversions: references to a bottle of spirits were counted as 700 ml, and a 'mini bottle' as 50 ml; a 'small bottle' of wine was counted as 375 ml, and a glass as 250 ml; references to 'a beer' or 'a lager' were counted as 440 ml high-strength cans; references to 'binges' were counted as 8 units in a single session for men, or 6 units for women, consistent with the UK Government definition (Office for National Statistics, 2018). In cases where the typical intake was given as a range (e.g. 'X currently drinks between two and three glasses of wine per evening'), the upper-bound figure was used. Two authors (K.S. and R.H.) jointly reviewed the rationale for why each service-user was not offered treatment, and coded for categories. Data were analysed using IBM SPSS version 27.

Results

Sample characteristics

The sample was 59.6% male ($n = 28$) with a median age of 40.0 ($SD = 11.5$). Ethnicity categories in order of frequency were white British ($n = 25$, 53%), black British ($n = 11$, 23%), any other white background ($n = 5$, 11%), white and black Caribbean ($n = 2$, 4%), Asian British ($n = 1$, 2%), and British unspecified ($n = 1$, 2%). Ethnicity data were missing for $n = 2$ (4%) of the sample. The most common recorded mental health diagnosis was depression ($n = 33$, 70%), followed by generalised anxiety disorder ($n = 3$, 6%), social anxiety disorder ($n = 1$, 2%), and agoraphobia ($n = 1$, 2%). Data on mental health diagnosis were missing for $n = 9$ (19%).

Substances used

Twenty-nine per cent ($n = 14$) of the sample was recorded as using alcohol only; 43% ($n = 20$) as using drugs only; 25% ($n = 12$) as using alcohol combined with at least one non-alcohol substance; while one service-user (2%) was recorded as being abstinent at the time of assessment, but as previously using drugs. The substances most frequently recorded as being used were alcohol ($n = 26$, 55%), cannabis ($n = 19$, 40%), cocaine powder ($n = 8$, 17%), heroin ($n = 6$, 13%), crack cocaine ($n = 5$, 11%), 'chem sex' drugs (e.g. gamma butyrolactone (GBL), gamma hydroxybutyrate (GHB); $n = 5$, 11%), 3,4-methylenedioxymethamphetamine (MDMA)/ecstasy ($n = 3$, 6%), ketamine ($n = 1$, 2%), non-prescribed benzodiazepines ($n = 1$, 2%), and unspecified 'class A' drugs ($n = 1$, 2%).

Levels of alcohol consumption

Table 1 presents data on average daily alcohol consumption, and the proportion consuming ≥15 units per day. Due to insufficient information within the clinical record to be able to calculate alcohol units for one service-user, results are presented for $n = 25$.

Thirty-six per cent of the sample of alcohol users were documented as drinking ≥15 units per day. However, because we had no way to determine accurately how many of these individuals were discharged primarily due to their use of alcohol or due to their concurrent use of drugs, we performed the same calculation for a smaller sub-sample of $n = 14$ who were recorded as using alcohol *only*. Amongst this sub-sample the proportion consuming ≥15 units per day increased to 50.0%. The true proportion of service-users excluded due to alcohol use consuming ≥15 units per day is therefore assumed to fall between 36.0 and 50.0%, and for ease of interpretation we report the average of these figures, which is 43.0%. Figure 1 presents the spread of these data relative to the 15-units-per-day threshold.

Clinicians' rationales for excluding from NHS Talking Therapies

Table 2 presents clinicians' rationales for excluding from NHS Talking Therapies that we extracted from the clinical records, which we categorised by the following themes: (1) the level or type of

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Table 1. Excluded service-users' average daily alcohol use and proportion drinking ≥15 units

		Average daily alcohol use (alcohol units)			Proportion drinking ≥15 alcohol units daily	
Sub-sample of excluded service-users	*n*	*M*	*SD*	Range	*n*	%
Using drugs and alcohol	25	12.4	7.3	1.7–30.0	9	36.0
Using alcohol only	14	15.7	6.9	6.9–30.0	7	50.0

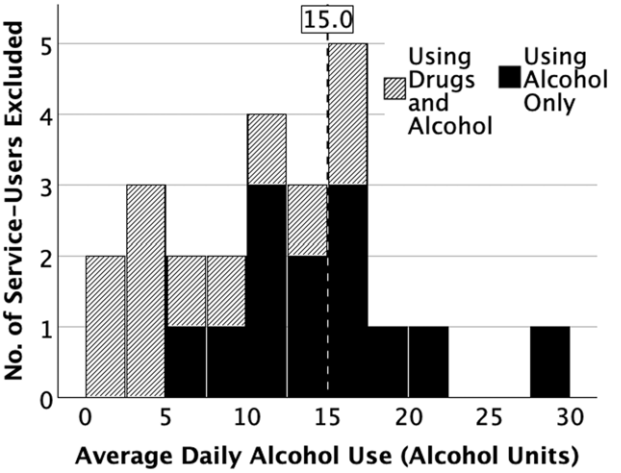

Figure 1. Levels of alcohol consumption amongst excluded service-users, relative to the 15-unit daily threshold.

drug or alcohol use is unsuitable; (2) drug or alcohol use could cause negative outcomes; (3) drug or alcohol use is the main difficulty; (4) drug and alcohol services would be more suitable; (5) the drug or alcohol use and mental health problems are interlinked.

Discussion

Main findings

We found that over half (57%) of service-users excluded from this NHS Talking Therapies service due to alcohol use consumed less than the 15-units-per-day threshold recommended by both NICE and NHS Talking Therapies guidelines for alcohol detoxification referral. Additionally, we categorised clinicians' documented rationales for excluding service-users due to drug or alcohol use, which predominantly highlighted concerns about the suitability of the substance use level, potential negative health or treatment outcomes, and the interplay between substance use and mental health symptoms.

Our finding that 57% of service-users excluded due to alcohol use were drinking below the recommended threshold can be subjected to different interpretations. In particular, we cannot be sure that the decisions to exclude these individuals truly represent deviations from the clinical guidelines and from good practice, or whether some of these service-users may have been excluded on the basis of *binge*-pattern drinking. Binge drinking (as opposed to alcohol *dependence*) could conceivably result in drinking less than an average of 15 units per day but still constitute a valid reason for exclusion from NHS Talking Therapies. While there exists a UK Government definition of binge drinking (>8 units in a single session for males, or >6 units for females; Home Office, 2012), there is currently no available guidance as to what frequency or other associated

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Table 2. Clinicians' documented rationales for excluding from NHS Talking Therapies

Rationale for excluding from NHS Talking Therapies	*n* coded with this rationale	%
1. Level or type of drug or alcohol use is unsuitable		
(1.1) Drug or alcohol use is too high	10	21.3
(1.2) Needs to reduce/stabilise drug or alcohol use prior to NHS Talking Therapies treatment	24	51.1
(1.3) Needs to abstain from drugs and alcohol prior to NHS Talking Therapies treatment	3	6.4
(1.4) Using Class A drugs	1	2.1
(1.5) Using heroin 'on top of' opiate substitute treatment	1	2.1
2. Drug or alcohol use could cause negative outcomes		
(2.1) Drug or alcohol use could limit effectiveness of NHS Talking Therapies treatment	9	19.1
(2.2) NHS Talking Therapies treatment could make drug or alcohol use worse	3	6.4
(2.3) Currently under drug and alcohol services but not engaging, unlikely to engage with NHS Talking Therapies	1	2.1
(2.4) Would be unable to abstain around NHS Talking Therapies appointments	1	2.1
3. Drug or alcohol use is the main difficulty		
(3.1) Clinician has determined the main problem to be drug or alcohol use	15	31.9
(3.2) Service-user goals relate to drug or alcohol use	7	14.9
(3.3) Drug or alcohol use may be associated with physical health risks	1	2.1
4. Service-user's needs are better met by drug and alcohol services		
(4.1) Unlikely that a short-term drug and alcohol intervention in NHS Talking Therapies would reduce drug or alcohol use	1	2.1
(4.2) More likely to benefit from drug and alcohol input rather than NHS Talking Therapies	1	2.1
(4.3) Currently engaged with drug and alcohol services	1	2.1
(4.4) Currently abstinent but previously using drugs or alcohol, signpost to drug and alcohol services for 'counselling and abstinence support'	1	2.1
5. Drug or alcohol and mental health problems are 'interlinked'		
(5.1) Mental health symptoms are 'interlinked with' drug or alcohol use	1	2.1
(5.2) Drug or alcohol use may be causing mental health symptoms	6	12.8
(5.3) Drug or alcohol may be 'masking' mental health symptoms	4	8.5
(5.4) Service-user is using drugs or alcohol to manage their emotions	1	2.1

features of binge drinking might constitute an exclusion criterion for NHS Talking Therapies. Although we consider it unlikely that our below-threshold 57% figure is fully attributable to exclusions based on problematic binge drinking, we cannot investigate this using our data, and in any event lack an agreed-upon threshold for comparison. Towards a balanced interpretation, we suggest that this finding may signal that some individuals are being declined treatment within NHS Talking Therapies despite drinking below the recommended threshold for signposting to alcohol intervention. However, as the 15-unit daily threshold identifies likely alcohol dependence rather than problematic binge drinking, the actual proportion excluded without clinical justification is likely lower than 57%.

Based on our findings regarding clinicians' rationales for exclusion from NHS Talking Therapies, we propose the following discussion points. Firstly, we suggest that when NHS Talking Therapies clinicians are considering excluding due the level of the drug/alcohol use (see Table 2; rationales 1.1–1.3) or due to concluding that drug/alcohol use is the main problem (rationale 3.1) or that it cannot be treated within NHS Talking Therapies (rationales 4.1, 4.2), their decision making should be based on specific and quantifiable information about an individual service-user's pattern and amount of use. This may be easier with alcohol, which in contrast to non-alcohol substances can more readily be converted to a standardised unit of measurement and compared against an agreed-upon threshold for suitability. Clinicians may therefore need guidance for assessing the level of non-alcohol substances objectively. Likewise, judgements that the drug or alcohol use is the main difficulty (rationale 3.1) or that it cannot be treated within NHS Talking Therapies (rationales 4.1,

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4.2) will be strengthened with reference to specific and quantifiable clinical information in support of such conclusions, although this may be less ambiguous in cases where the service-user's own treatment goals clearly relate to addressing drug or alcohol use (rationale 3.2).

Some clinicians' rationales for exclusion may reflect misconceptions about concurrent drug or alcohol use. For example, some decisions appeared to be linked with the use of specific *types* of drug (rationales 1.4, 1.5), possibly indicating a misconception that certain substances are inherently contraindicated for treatment within NHS Talking Therapies, irrespective of the level or impact of use. Similarly, some clinicians documented that NHS Talking Therapies treatment alongside concurrent drug or alcohol use would be ineffective (rationale 2.1), or could result in exacerbated drug or alcohol use (rationale 2.2). These may be valid clinical judgements when made case-by-case and based on information derived from an individualised assessment, but clinicians should be advised against arriving at such conclusions based on blanket assumptions. Examples of clinicians using individualised and specific clinical information to support their judgements that NHS Talking Therapies treatment would be ineffective included identifying whether service-users would be able to refrain from drug or alcohol use around treatment appointments (rationale 2.3), and whether they were engaging meaningfully with drug and alcohol services (rationale 2.4). Similarly, we highlight that current engagement with drug and alcohol services (rationale 4.3), or having a history of problematic substance use despite being abstinent currently (rationale 4.4), should not inherently constitute criteria to be excluded from NHS Talking Therapies, so long as there is a common mental health problem present, and any ongoing drug or alcohol use is unlikely to interfere.

In some instances clinicians' decisions to exclude appeared to be linked with physical health risks associated with drug/alcohol use (rationale 3.3). This is important as the existing NHS Talking Therapies guidelines do not offer specific guidance on how to assess health risks associated with drug or alcohol use, and when these might constitute a reason to prioritise intervention from drug and alcohol services. The physical health risks associated with problematic substance use include the risk of overdose, risks associated with injecting (e.g. bloodborne viruses, vein damage and infection), toxicological risks from either chronic or acute use, and risks associated with unsafe sexual practices linked particularly with so-called 'chem sex' drugs (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017). While the mere presence of such risks might not constitute an automatic rationale for exclusion, they should be identified as part of any risk assessment within NHS Talking Therapies, and may require the advice or input of specialist drug and alcohol services in order to be managed safely.

Finally, clinicians referred to mental health and drug or alcohol problems as being variously 'interlinked' (rationales 5.1–5.4). The NHS Talking Therapies positive practice guide recognises that the effects of problematic drug or alcohol use can resemble the appearance of mood or anxiety disorders, and conversely that some individuals use drugs or alcohol as a coping strategy for an underlying mental health problem (National Treatment Agency, 2012). However, it is unclear why the mere existence of any such reciprocal effects should constitute a reason for exclusion from NHS Talking Therapies services. Instead, clinicians might consider whether the drug or alcohol use can be conceptualised and treated similarly to any other behavioural strategy within a cognitive behavioural framework. After all, a key feature of cognitive models across disorders is that behavioural strategies play critical roles in maintaining the problem and its symptoms (Clark, 1999; Salkovskis, 1991). The usual approach to such reciprocity is to account for it within the clinical formulation, and to use this understanding to devise ways of disrupting the cycle. Why should drug or alcohol use as a behavioural strategy be treated any differently?

Implications for practice

Positive outcomes for drug and alcohol users will depend on NHS Talking Therapies clinicians being supported to engage in sound clinical decision making and treatment planning for this

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population. This can be promoted at the local level, through service design, local policy, supervision and training programmes; and nationally, through policy guidance and defining competency standards. Locally, services should emphasise the importance of grounding clinical decisions in individualised assessment and tangible clinical information, and proactively challenge unhelpful assumptions about concurrent use. These efforts might be supported through routine incorporation of standardised screening tools, such as the AUDIT-10 (Saunders *et al.*, 1993) and ASSIST-Lite (Ali *et al.*, 2013), into NHS Talking Therapies assessments or minimum datasets, which would provide clinicians with an essential level of information across all contacts, as well as yielding high-quality data to support audit and service evaluation. The AUDIT-10 and ASSIST-Lite are intended to be used as screening instruments, however, and there is a risk of over-reliance on these for decision making rather than treating them as components of a broader assessment that is individualised, involves the service-user as an active participant, and leads to treatment planning based on a shared clinical formulation. Such instruments may therefore need to be supplemented with clinician-administered interview schedules and/or decision-making algorithms, such as that presented by Buckman *et al.* (2018), in order to support nuanced decision-making processes. The need for individualised decision making is further reinforced by the fact that people may vary in their tolerance for a given substance, based on factors including chronicity of use and neurobiological variation (Elvig *et al.*, 2021), such that two individuals using the same amount of a substance may experience very different psychoactive effects, with potentially different implications for their suitability for NHS Talking Therapies. Although quantitative thresholds may provide a useful starting point for suitability decisions therefore, they should not be the sole input source, and a 'one-size-fits-all' criterion will not work. Indeed, as discussed earlier, one of the methodological challenges in this study was that even individuals drinking *below* the threshold of 15 daily units may still potentially be considered unsuitable for NHS Talking Therapies, if their pattern of alcohol use is consistent with problematic binge drinking.

Greater integration and collaboration across services was highlighted in the recent Home Office-commissioned 'Dame Black report' as essential for effective treatment of this population (Home Office, 2021). NHS Talking Therapies and local drug and alcohol services need to ensure that patients do not 'fall between the cracks', through clarity of treatment pathways, joined-up care planning, and two-way consultation on cases. These services can also upskill each other's workforces locally through reciprocal provision of training. The Dame Black report also emphasised that, nationally, professional competency standards must encompass the knowledge and skills for effectively responding to co-occurring problems. While the current edition of the national curriculum for UK high-intensity CBT courses includes competencies related to substance misuse (Health Education England, 2022), these may benefit from specific knowledge and competency requirements around issues that have been highlighted by this study, such as the assessment of treatment suitability, fostering positive clinician attitudes, and shifting the focus from exclusion to finding ways to meet the needs of individuals with co-occurring substance use.

Finally, what actually constitutes best practice in this area is clearly a complex question; greater clarity will likely evolve through an interplay of existing guidance and practice-based research assessing that guidance's implementation, and identifying gaps (NICE, 2002). Areas identified by the present study that might be addressed in future guidelines include the need for clear suitability criteria around binge drinking and non-alcohol substances, the impact of substance-related risks, and common clinical dilemmas such as service-users using 'on top of' opiate substitute treatment.

Comparison with existing literature

To the best of our knowledge, no previous study has examined levels of drug or alcohol use amongst individuals excluded from NHS Talking Therapies services, or from mental health services more broadly. Our finding that only 0.9% of referrals to this NHS Talking Therapies

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service were excluded due to concurrent drug or alcohol use does not appear to be consistent with the suggestion of widespread exclusion of drug and alcohol users from mental health services (although it would only be by knowing the *relative* rates of exclusion and inclusion of these referrals that this figure can be interpreted meaningfully). On the other hand, our result that 57% of those excluded with below-threshold alcohol use suggests that at least *some* individuals were being excluded from this NHS Talking Therapies service with relatively low levels of alcohol use. A possible explanation for the perception amongst drug and alcohol treatment providers that unfair exclusion is widespread (e.g. Recovery Partnership, 2016) is that they may be generalising from a relatively small number of cases that are inappropriately excluded, perceiving these as the norm rather than the exception. Alternatively it may be that these perceptions are based on experiences of individuals with more severe substance misuse, or on experiences of exclusion from secondary care mental health services, which may exhibit a different culture towards drug and alcohol use compared with primary care NHS Talking Therapies services.

Limitations

Because this study was conducted at a single NHS Talking Therapies site, the generalisability of our findings to other sites across the country is limited, particularly given previous research highlighting significant variability in service delivery across services (Gyani *et al*., 2013). A key limitation in this regard is that triage assessments in this service were conducted by both qualified and unqualified staff, contrasting with national guidance that assessments be conducted by qualified clinicians only. Although unqualified staff received in-house training and suitability decisions were reviewed with a qualified clinician, this practice still deviates from national standards and may have influenced exclusion decisions. The extent to which such practices occur in other services, particularly in response to service pressures and operational targets, is unknown, and may significantly impact the generalisability of our findings. This issue only became apparent after data collection, and should be considered when interpreting the results.

Additional limitations include the lack of a standardised drug and alcohol measure, which likely introduces measurement error into our data. As it was not feasible for us to collect data on referrals that *were* taken on for treatment despite reporting drug or alcohol use at triage, we are unable to report on the relative rates of exclusion/acceptance into the service, even if an overall exclusion rate of 0.9% appears low. Additionally, presenting data only on excluded individuals may create a biased picture in which suggestions of potential divergence from best practice are overly magnified, overstating the scale of any problem. Finally, by focusing on extracting overall themes and average daily alcohol intake rather than conducting granular level, case-by-case evaluations, our methodological approach ignores the clinical nuances and context of each individual exclusion decision needed to make a well-founded judgement about its clinical justification. Therefore, while our results highlight some overall patterns, these should not be interpreted as definitively reflecting deviations from good practice.

Future research

Our finding that some alcohol users are being excluded from treatment with below-threshold levels of alcohol consumption needs replication across other NHS Talking Therapies services. The methodological limitations of the present study could be overcome with improved study designs, such as a prospective design in which all new assessments are administered a standardised measure of drug or alcohol use (cf. Buckman *et al*., 2018), combined with more standardised collection of clinicians' rationales for exclusion/acceptance into the service. This would allow for more reliable analyses of who is declined treatment and why, as well as a picture of the relative scale of exclusion. Future research should also examine the long-term outcomes for excluded individuals, which is critical for evaluating whether exclusionary practices contribute to adverse outcomes, such as worsening mental health or

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substance use, poorer treatment outcomes when excluded service-users are eventually treated, or whether these individuals even re-present to services at all.

Conclusions

This study sheds light on the complexities of exclusion practices within an NHS Talking Therapies service for individuals with concurrent drug or alcohol use. Our analysis reveals some potential over-exclusion, where individuals who could benefit from NHS Talking Therapies are turned away due to alcohol use. Clinicians' decisions sometimes appeared to diverge from what should be best practice principles, suggesting a need for clear guidelines and training for clinicians. Future research should broaden the scope to other NHS Talking Therapies sites to validate these findings, and also examine long-term outcomes for excluded individuals.

Our findings reinforce the importance of nuanced assessment and decision-making processes that lead to informed decisions about substance use, without prematurely excluding individuals from much-needed psychological therapy. Integrated working between NHS Talking Therapies and substance misuse services may help support this and prevent service-users getting lost between systems. Policymakers and service providers must collaborate to ensure that exclusion criteria do not inadvertently deprive individuals of necessary mental health care, ultimately working towards more inclusive and supportive treatment frameworks. Ultimately, improving access and ensuring fair treatment pathways for all, including those with substance use issues, is critical for improving public health outcomes, in line with the founding aims of the NHS Talking Therapies programme.

Key practice points

(1) Clinicians should follow available guidelines and best practice principles when considering excluding drug and alcohol users from NHS Talking Therapies.
(2) Gathering specific and quantifiable information about service-users' use, including by utilising standardised assessment tools, can inform suitability decisions more accurately.
(3) Clinicians should avoid making decisions based on blanket assumptions about concurrent substance use, or based on a single clinical data source (e.g. alcohol units).
(4) Treatment planning for these individuals should involve the service-user as active participant, and be based on an individualised clinical formulation of both the mental health and substance use problem.
(5) Ongoing training for NHS Talking Therapies clinicians and integrated working with local drug and alcohol services can help promote optimal practices and minimise unnecessary exclusions.

Further reading

National Treatment Agency (2012). *IAPT Positive Practice Guide for Working with People Who Use Drugs and Alcohol*. London, UK: National Treatment Agency for Substance Misuse.

Data availability statement. The data that support the findings of this study are available from the corresponding author upon reasonable request.

Acknowledgements. The authors extend their sincere gratitude to the two anonymous reviewers for their invaluable comments on an earlier version of this manuscript.

Author contributions. **Khodayar Shahriyarmolki:** Conceptualization (equal), Formal analysis (equal), Investigation (equal), Methodology (equal), Project administration (equal), Supervision (equal), Writing - original draft (equal); **Rachael Hemingway:** Conceptualization (equal), Data curation (equal), Formal analysis (equal), Investigation (equal), Methodology (equal), Project administration (equal), Writing - original draft (equal); **Hannah Strang:** Conceptualization (equal), Data curation (equal), Formal analysis (equal), Investigation (equal), Methodology (equal), Project administration (equal), Writing - original draft (equal).

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Competing interests. The authors report no competing interests.

Ethical standards. Ethical approval was obtained from the local NHS clinical governance committee. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

References

Adams, M. W. (2008). Comorbidity of mental health and substance misuse problems: a review of workers' reported attitudes and perceptions. *Journal of Psychiatric and Mental Health Nursing*, *15*, 101–108.

Ali, R., Meena, S., Eastwood, B., Richards, I., & Marsden, J. (2013). Ultra-rapid screening for substance-use disorders: the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST-Lite). *Drug and Alcohol Dependence*, *132*, 352–361.

Boschloo, L., Vogelzangs, N., van den Brink, W., Smit, J. H., Veltman, D. J., Beekman, A. T. F., & Penninx, B. W. J. H. (2012). Alcohol use disorders and the course of depressive and anxiety disorders. *British Journal of Psychiatry*, *200*, 476–484.

Buckman, J. E. J., Naismith, I., Saunders, R., Morrison, T., Linke, S., Leibowitz, J., & Pilling, S. (2018). The impact of alcohol use on drop-out and psychological treatment outcomes in Improving Access to Psychological Therapies Services: an audit. *Behavioural and Cognitive Psychotherapy*, *46*, 513–527.

Clark, D. M. (1999). Anxiety disorders: why they persist and how to treat them. *Behaviour Research and Therapy*, *37*, S5.

Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017). *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (p. 317). London, UK: Department of Health.

Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry*, *64*, 566–576.

Department of Health (2002). *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*. London, UK.

Elvig, S. K., McGinn, M. A., Smith, C., Arends, M. A., Koob, G. F., & Vendruscolo, L. F. (2021). Tolerance to alcohol: a critical yet understudied factor in alcohol addiction. *Pharmacology Biochemistry and Behavior*, *204*, 173155.

Gajecki, M., Berman, A. H., Sinadinovic, K., Andersson, C., Ljótsson, B., Hedman, E., Rück, C., & Lindefors, N. (2014). Effects of baseline problematic alcohol and drug use on internet-based cognitive behavioral therapy outcomes for depression, panic disorder and social anxiety disorder. *PLOS One*, *9*, e104615.

Giebel, C. M., Clarkson, P., & Challis, D. (2014). Demographic and clinical characteristics of UK military veterans attending a psychological therapies service. *The Psychiatric Bulletin*, *38*, 270–275.

Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013). Enhancing recovery rates: lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*, 597–606.

Health Education England (2022). *National Curriculum for High Intensity Cognitive Behavioural Therapy Courses* (4th edn). https://www.hee.nhs.uk/sites/default/files/documents/HIT%20CBT%20Curriculum%204th%20Edition%202022_10%20Nov%202022.pdf (accessed 21 June 2024).

Home Office (2012). *The Government's Alcohol Strategy*. London, UK. https://www.gov.uk/government/publications/alcohol-strategy (accessed 1 August 2023).

Home Office (2021). *Review of Drugs Part Two: Prevention, Treatment, and Recovery*. London, UK: Department of Health and Social Care. https://www.gov.uk/government/publications/review-of-drugs-phase-two-report (accessed 21 June 2024).

Hunt, V. J., & Delgadillo, J. (2022). Is alcohol use associated with psychological treatment attendance and clinical outcomes? *British Journal of Clinical Psychology*, *61*, 527–540.

Kessler, R. C. (2004). The epidemiology of dual diagnosis. *Biological Psychiatry*, *56*, 730–737.

Lawrence-Jones, J. (2010). Dual diagnosis (drug/alcohol and mental health): service user experiences. *Practice*, *22*, 115–131.

Mental Health Taskforce (2016). *The Five Year Forward View for Mental Health*. London, UK: Mental Health Taskforce to the NHS in England. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (accessed 1 August 2023).

Najt, P., Fusar-Poli, P., & Brambilla, P. (2011). Co-occurring mental and substance abuse disorders: a review on the potential predictors and clinical outcomes. *Psychiatry Research*, *186*, 159–164.

National Collaborating Centre for Mental Health (2024). *NHS Talking Therapies for Anxiety and Depression Manual (Version 7)*. London, UK: NHS England.

National Health Service (2022). Alcohol units. https://www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units/ (accessed 1 August 2023).

National Treatment Agency (2012). *IAPT Positive Practice Guide for Working With People Who Use Drugs and Alcohol*. London, UK: National Treatment Agency for Substance Misuse. https://www.drugwise.org.uk/wp-content/uploads/iapt-drug-and-alcohol-positive-practice-guide.pdf (accessed 1 August 2023).

https://doi.org/10.1017/S1754470X2400031X Published online by Cambridge University Press

NICE (2002). *Principles for Best Practice in Clinical Audit*. Abingdon, UK: Radcliffe Medical Press Ltd. https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf (accessed 21 June 2024).

NICE (2011). *Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking (High-Risk Drinking) and Alcohol Dependence*. London, UK: National Institute for Health and Clinical Excellence. https://www.nice.org.uk/guidance/cg115 (accessed 1 August 2023).

Office for Health Improvement and Disparities (2023). *Adult Substance Misuse Treatment Statistics 2021 to 2022: Report*. London, UK: Department of Health and Social Care. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022/adult-substance-misuse-treatment-statistics-2021-to-2022-report (accessed 1 August 2023).

Office for National Statistics (2018). *Adult Drinking Habits in Great Britain: 2017*. London, UK. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/opinionsandlifestylesurveyadultdrinkinghabitsingreatbritain/2017 (accessed 1 August 2023).

Public Health England (2017). *Better Care for People With Co-Occurring Mental Health and Alcohol/Drug Use Conditions: A Guide for Commissioners and Service Providers*. London, UK: PHE Publications. https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services (accessed 1 August 2023).

Recovery Partnership (2016). *State of the Sector 2015*. London, UK: Adfam. https://www.basw.co.uk/resources/recovery-partnership-state-sector-2015 (accessed 1 August 2023).

Salkovskis, P. M. (1991). The importance of behaviour in the maintenance of anxiety and panic: a cognitive account. *Behavioural and Cognitive Psychotherapy*, *19*, 6–19.

Saunders, J. B., Aasland, O. G., Babor, T. F., De La Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction*, *88*, 791–804.

Shahriyarmolki, K., & Meynen, T. (2014). Needs assessment of dual diagnosis: a cross-sectional survey using routine clinical data. *Drugs: Education, Prevention and Policy*, *21*, 43–49.

Todd, F. C., Douglas Sellman, J., & Robertson, P. J. (2002). Barriers to optimal care for patients with coexisting substance use and mental health disorders. *Australian & New Zealand Journal of Psychiatry*, *36*, 792–799.

University of Manchester (2022). *The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK Patient and General Population Data, 2009–2019, and Real Time Surveillance Data*. Manchester, UK: Healthcare Quality Improvement Partnership. https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/ (accessed 1 August 2023).

Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., … & **Comorbidity of Substance Misuse and Mental Illness Collaborative study team** (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, *183*, 304.

Cite this article: Shahriyarmolki K, Hemingway RL, and Strang HJ (2025). What leads clinicians to exclude drug and alcohol users from NHS Talking Therapies services? An audit of decision making within clinical records. *The Cognitive Behaviour Therapist*. https://doi.org/10.1017/S1754470X2400031X