COMMISSIONER BRIEFING

The Layered Care Model

A four-pillar framework for re-commissioning services for people with co-existing mental health and substance use needs.

30–50%
of mental health service users have co-occurring substance use

70%+
of substance use service users have a mental health diagnosis

Both
systems were designed to treat one or the other — not both

THE STRUCTURAL FAILURE

People are referred and re-referred, dropped for missing appointments, or turned away in crisis because they are **"too high" for mental health care or "too distressed" for substance use services**. This is not a resourcing accident. It is what the system was built to do — separate, sequence, and sort.

Re-commissioning that adds capacity to the same architecture will reproduce the same outcomes. The fix is structural: **commission for co-existence as the norm, not the exception.**

THE LAYERED CARE MODEL — FOUR PILLARS

#	PILLAR — what to commission for
1	**Structural Flexibility** Modular teams, shared eligibility thresholds, no single-condition gatekeeping. Data used for feedback, not surveillance. Services bend around the person, not the other way round.
2	**Integrated Social Determinants** Housing, money, immigration status, stigma and community embedded in core care plans — not bolted on as "signposting". One cross-disciplinary table, not seven separate referrals.
3	**Enhanced Agency** Goals co-created, peer support funded as core (not pilot), real choices within real constraints. People are partners in their care, not problems to be processed.
4	**Contextualised Care** Care matches setting — prison, hostel, ED, rural primary care, perinatal — rather than forcing one delivery model everywhere. Variation is a feature, not a failure of fidelity.

"The four pillars are an architecture, not a staircase. They work together, all the time — or the system reverts to sorting people by their most legible problem."

WHAT CHANGES OPERATIONALLY

- No exclusion on grounds of substance use (or distress) at the front door of either service.
- Joint care plans are the default for anyone presenting with co-existing needs — not a separate "complex case" pathway.
- Outcomes measured in stability, contact retention, and self-defined progress — not abstinence milestones or appointment compliance alone.
- Peer-led roles funded as core establishment, with parity of pay and supervision.
- Workforce development includes phenomenological and trauma-informed training across mental health, substance use, and primary care.
- A named accountable lead per locality for co-existence outcomes, reporting on system-level (not service-level) performance.

THE ASK

Write the four LCM pillars into the next re-commissioning round — as specification requirements, not aspirational language. Use the clauses below as a starting draft, adapted to local context.

SAMPLE SPECIFICATION LANGUAGE

ELIGIBILITY The Provider shall not exclude any person from assessment or care on the basis of co-occurring substance use or mental distress, regardless of intoxication at point of contact.

JOINT PLANNING A single, jointly-authored care plan shall be the default for any person identified as having co-existing needs, with one named lead practitioner accountable across services.

SOCIAL DETERMINANTS Housing, financial, legal and community-connection needs shall be assessed and addressed as part of core care — evidenced through plan content, not signposting alone.

AGENCY Service users shall co-author their goals and shall have access to funded peer support delivered by people with lived experience, on parity terms with other roles.

CONTEXT Delivery models shall be adapted to local settings (e.g. justice, perinatal, rural, hostel, ED) rather than imposing a single citywide model. Variation shall be reported as adaptive, not non-compliant.

OUTCOMES Provider performance shall be assessed on retention in contact, self-defined stability, and inter-service handover quality — alongside, not subordinate to, single-domain clinical metrics.

SOURCE

Bratt, S. (2026). *A Philosophical Critique of Co-Existing Mental Health and Substance Use Challenges: Pain Comes First — Drugs Come Later*. Palgrave Macmillan. ISBN 978-3-032-13179-9.

CONTACT

paincomesfirstdrugscomelater.com
bratts1@hope.ac.uk