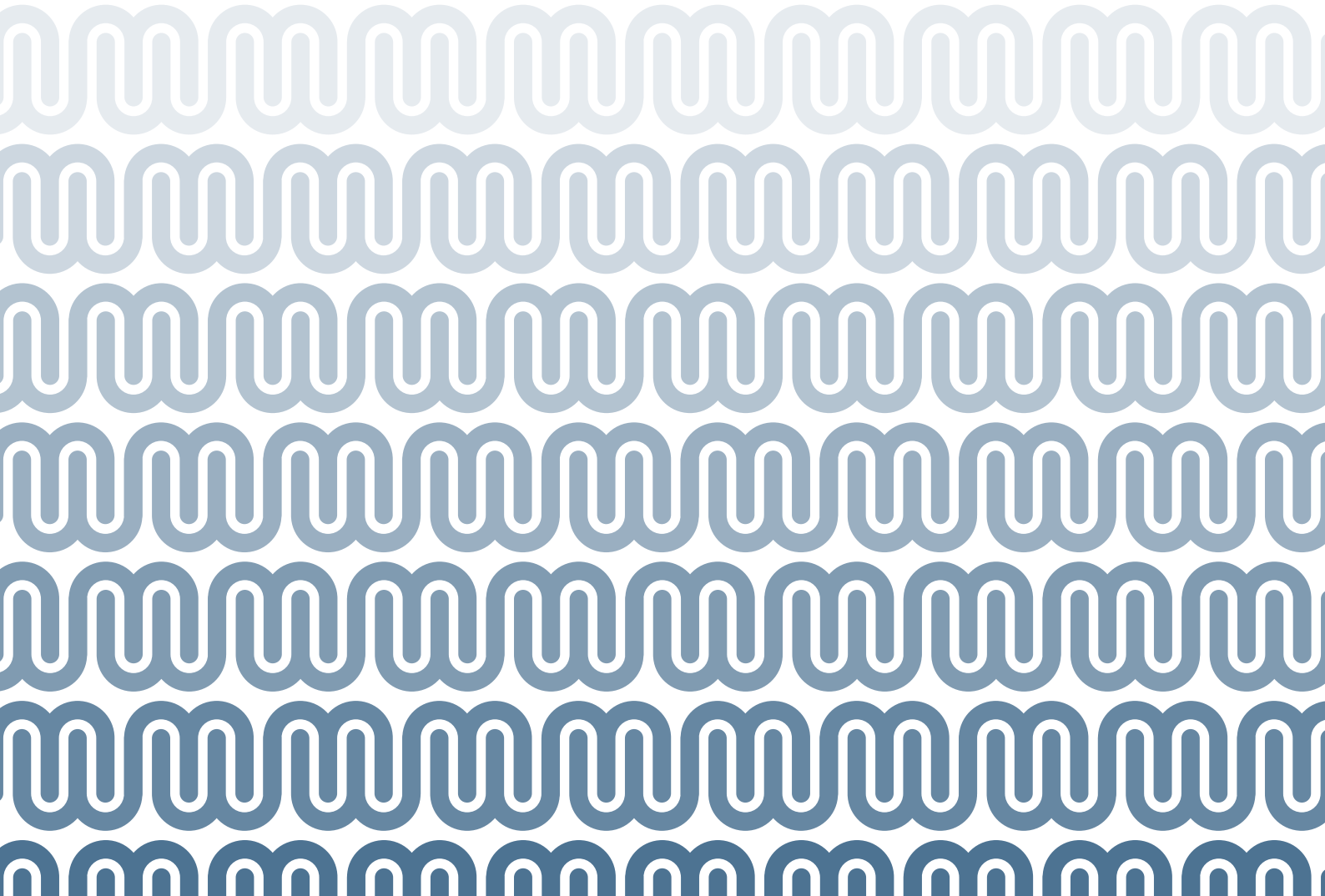
mental welfare commission for scotland

Ending the exclusion:

Care, treatment and support for people with mental ill health and problem substance use in Scotland

Themed visit report

September 2022



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

What people told us: a selection of quotes

People living with mental ill health and addiction issues:

> *"I just want to see change. I've lived more than half of my life with this condition...and all I see is people dying or being forgotten about."*

> *"When I asked for sleeping tablets my GP said, 'I'm not your drug dealer'."*

Voices of relatives:

> *"…addiction services and mental health services are complex and outdated. They need reform, they are understaffed and underfunded and very, very neglected."*

> *"I don't have the knowledge or confidence or back up to get help for him."*

> *"Exhausting. Our own mental health has suffered due to the stress of dealing alone with my relative's addiction and mental health problems. We feel totally abandoned by a broken system which refuses to help those most in need. ….The only way out seems through suicide."*

Police officers:

> *"Little/no out of hours support for people, police/ambulance are constant fall back for other services, when neither are the appropriate services to offer meaningful assistance beyond an assessment at A&E."*

GPs:

> *"If the patient has any substance abuse then mainstream psychiatry services will automatically reject any referrals and tell us to refer to the addiction services. Even when the main problem at that time is the mental illness".*

> *"Psychiatry locally give the impression that they do not accept the concept of dual diagnosis- it is common to see substance or alcohol misuse listed as the principle issue and a plan for care by the addictions team, who are distinctly separate from the mental health team, with no mental health team input if substance or alcohol misuse is apparent."*

A housing support worker:

> *"The biggest obstacles we find are from the actual agencies / services themselves, not the clients."*

Foreword – Julie Paterson, chief executive

More people lose their lives to drug misuse in Scotland than in any other European country. Scotland has the highest rate of death due to alcohol in the UK, with the numbers climbing during the pandemic.

It is estimated that alcohol or drug misuse was a factor in something between 48% and 56% of all suicides between 2008 and 2018 in Scotland. These statistics are shocking.

Our report looks at the experience of people who are living with both mental ill health and problematic drug or/and alcohol use. Whether people use alcohol and or drugs to alleviate their mental ill health, or whether mental illness becomes a consequence of alcohol and or drug use, varies. In either situation, lives are devastated. Deprivation has a clear tie to each of these issues.

Our aim

We set out to look across Scotland to determine how we are dealing with this crisis, and whether the measures currently in place for people with both mental ill-health and a substance use problem are effective.

We heard from many individuals and from their families.

We heard from GPs – a critical point of contact – and from secondary health and care professionals. We listened to the experience of third sector organisations, who are often embedded in communities and know the challenges faced by individuals very well.

Failure to follow guidance

What we found was that a huge amount of work has been done to create strategies that should make a difference. Perhaps, given that the problem is so significant, this should not be a surprise.

But we also found that the guidance and standards set out by government are not being followed at a local level. There was a clear failure to implement guidance in most areas of the country. And that failure is having a direct impact on the lives of very vulnerable people and their families, who need joined-up support.

Ninety per cent of the GPs who responded to us said they had experienced difficulties in referring patients to both mental health services and addictions services, including when the person presented in crisis.

We heard about stigma from the very services that should be supporting people.

Individuals and professionals alike all highlighted the issue of staff shortages, and the impact this is having at every stage.

Call for action

Most of our recommendations are for health and social care partnerships (and their respective health boards and local authorities), who must take the lead in ensuring that the guidance already in place is enacted locally. This is absolutely critical.

We also call on NHS Education Scotland to take a key role, and we ask Scottish Government to monitor the delivery of our recommendations and address any barriers to delivery within 12 months.

We ask that all of those organisations read this report closely and work together to reinvigorate Scotland's approach to tackling this pressing issue.

Executive summary

This report looks at the experience of people who are living with both mental ill health and problematic drug or/and alcohol use. It considers how effective and joined-up their care and treatment is; both from the point of view of individuals and from those who work within health and care services in Scotland.

In total, 426 people engaged with us as part of this work through consultations, focus groups and questionnaires. We were keen to focus on their direct experience of services and working within them. We are grateful for their insight and expertise.

Whilst we found pockets of good practice, and a real desire to improve care and treatment we were concerned to find that national guidance and standards that emphasise the need for services to work closely together to meet all the needs of a person have not been realised.

People with lived experience and families/carers describe a system in which they feel discriminated and are often 'bounced' between mental health services and addictions services. The policy ideal that there should be 'No Wrong Door' has not necessarily led to every door being open.

People who are working in services echoed those with lived experience, highlighting a lack of protocols that ensure that needs are met holistically, that people should have care co-ordinators and care plans, are not 'bounced' between services, or excluded from services due to their problem substance use.

Despite guidance on the importance of clear care plans, 77% of professionals said documented care planning did not happen or that they were unware of it.

Despite the Medication-Assisted Treatment (MAT) Standards introduced following the report of the Drugs Death Task Force, we found little awareness of the standards particularly relevant to our report, on engagement and joined-up working so that people with a substance (drug or alcohol) use problem can access mental health care at the point of treatment.

We are concerned that the term 'dual diagnosis' that emphasises the presence of a mental health condition and co-occurring problem substance use may inadvertently reduce the focus on the social and physical health care needs of this already vulnerable group of people. Only 16% of GPs and 13% of other NHS professionals indicated that there is an agreed local protocol for physical healthcare monitoring that they were aware of.

People with lived experience, families/carers, and professionals noted a common theme was the impact of staff shortages on delivering care and treatment and in the continuity of care. People with lived experience and their relatives/carers told us how this is resulting in people having to re-tell their stories to multiple professionals. Many people have experienced past trauma or adverse childhood experiences and it is upsetting to have to recount these experiences repeatedly. This is not trauma-informed psychological care.

The final report of the Drugs Death Taskforce called for an end to stigma as an essential element in Scotland's fight against its high rate of drug-deaths. Our work also confirms that

stigma is preventing these issues being seen as the health problems that they are and is compounding the suffering for individuals and their families and carers.

In summary, current service provision is not good enough. This was confirmed by people who use services, their relatives and 84% of GPs, 77% of NHS secondary care staff and 93% of staff working in non NHS services who engaged with us.

Strategies, policies, standards and guidelines are not being translated into practice to the benefit of individuals and their families. However, like one of our respondents Mr A below, they still retain hope of change. We must listen and we must deliver.

> *"People with dual addictions or coexisting mental health conditions and substance misuse problems can and do recover, I have seen broken people with mental health issues and addiction's achieve this who are now in full time employment, living life, and are out there helping others. With the right care, support, empathy and encouragement people's lives can be transformed or even made easier to live a more fulfilling Life. I have a way to go still, but I have made positive progress, not always easy, but I'm getting there."* (Mr A)

Recommendations

To health and social care partnerships (supported by health boards and local authorities) by October 2023:

1. There should be a clear written policy/service delivery model reflecting national standards and guidance, outlining the expectations for the holistic, joined up care of people with a co-occurring mental health condition and problem substance use (if one does not already exist)*.
2. Audits should be undertaken to ensure that every person with a co-occurring mental health condition and problem substance use has a documented care plan with a care-coordinator identified.
3. Protocols should be in place detailing agreed approaches for people who disengage with services and this includes people with co-occurring mental ill health and problem substance use.
4. Psychiatric Emergency Plans should be reviewed to ensure that sections that set protocols for the care and treatment of those individuals presenting intoxicated provide a mechanism for contemporaneous and subsequent engagement.

To NHS Education for Scotland (NES)

5. NES to consider with relevant stakeholders, and report on how educational and improvement programmes for professionals working in mental health, addiction services and social care might:
    a. Embed a trauma-informed approach to care and treatment of people with mental health conditions and problem substance use;
    b. Address stigmatising attitudes within professionals towards people with mental health conditions and problem substance us.

To The Scottish Government

6. The Scottish Government should monitor the delivery of the above recommendations and work with health and social care partnerships (and associated health boards/local authorities) and NES to support consistency and address any barriers to delivery over the next 12 months.

** In the **absence** of or pending such a written policy/service delivery model for integrated care for this group**, to avoid any inadvertent exclusion now**, the Commission considers that the lead service for this group that require secondary care mental health services and addictions services**, should be secondary care mental health services (with support from addictions services as needed).*

Chapter 1: Introduction & methodology

Background

It is common for people to experience problems with both their mental health and their use of drugs/alcohol.

The relationship between mental health conditions and problem substance use is complex. For some people, problem substance use might lead to the emergence of a mental health condition. For others, the mental health condition might lead to the problem substance use as people use alcohol or drugs as a way of trying to cope with the distress of a mental health condition. For some people, a traumatic event or period or an adverse childhood experience can lead to these difficulties.

It is difficult however to know exactly how many people are affected by both. One reason is a lack of clarity on definitions.

In this report, the term problem substance use is used to mean the use of alcohol, illegal drugs or prescription drugs that leads to harmful consequences for the individual and their relationships with friends, carers and family.

Some services, professionals and groups representing people who have a diagnosed mental health condition (for example, depression or schizophrenia) and problem substance use refer to the existence of both these conditions at the same time as a 'dual diagnosis'. However we consider this term potentially unhelpful as many people with these difficulties also have multiple needs around their physical healthcare and their social needs. A narrow focus by using certain terms can inadvertently lead to exclusion or a lack of holistic care.

Another reason which makes it difficult to know how many people have both a mental health condition and problem substance use is the double layer of stigma, that is, stigma associated with mental health and stigma associated with substance use:

The Scottish Drugs Forum states that "stigma marginalises people with a substance use problem and makes them more vulnerable". And Scotland's See Me programme confirms 'research we carried out across Scotland found that 56% of people with a mental health condition have experienced stigma and discrimination'.

There is therefore a significant group of people in Scotland being treated unfairly and less likely to reach out for support and more likely to die.

Estimates suggest that between 20-37% of people using mental health services have a difficulty with drugs and alcohol.[1]

[1] Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. A systematic review - PubMed (nih.gov) (accessed 23 June 2022)

It is estimated that alcohol or drug misuse was a factor in between 48% - 56% of all suicides between 2008 and 2018 in Scotland.[2]

Strategies, Policies, Standards and Guidelines

The Scottish Government's current Mental Health Strategy (2017-2027) has actions that aim to develop better mechanisms for the assessment and referral for people with dual diagnosis and to offer opportunities to pilot improved arrangements for their care (Actions 27& 28).[3]

In 2021, the Scottish Government, following the work of the Drugs Death Taskforce, published ten standards for medication-assisted treatment (MAT) for people with addictions. The standards are to help reduce deaths, promote recovery and ensure a patient-centred approach to the delivery of safe, effective and accessible treatments.[4]

Standard 9 of the MAT standards sets out that all people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery. This standard aims to ensure that those receiving treatment for drug use have access to mental health care and do not fall between gaps in service provision. The MAT standards document states that the standards are a guide for service improvement and should be overseen by local improvement teams and that they are not intended for local or national performance management.

In June 2022 a report from Public Health Scotland[5] (PHS) on the implementation of MAT Standards 1-5 across all of Scotland's 29 Alcohol and Drug Partnerships shows that there is unwarranted variation in the implementation of the standards. It identifies risks that partial implementation will not realise the reduction in drug-related deaths. However, perhaps in cognisance of the identified risks of uncertainties around funding, and the concerns it raises about systems being unable to collect the evidence required for intelligence led quality improvement work, whilst PHS recommends full implementation of MAT standards 1-5, it only recommends partial implementation of MAT standards 6-10 by April 2023. The criteria around this standard emphasises the need for local substance use services and mental health services to be able to refer effectively between themselves, for staff working in these services to be competent in assessing problem substance use needs and mental health needs and the need for local protocols around information sharing and joint working arrangements.[6]

---

[2] NCISH report 2021 display.aspx (manchester.ac.uk) (accessed 23 June 2022)[3] Scottish Government, *"Mental Health Strategy: 2017-2027"* *https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf*

[3] Scottish Government, *"Mental Health Strategy: 2017-2027"* *https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf*

[4] Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot) (accessed 19 June 2022)

[5] National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards - National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards - Publications - Public Health Scotland

[6] Standard 9 Mental Health - Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)

In recognition that many people who have problem substance use often have experienced trauma or adverse childhood experiences, Scottish Government published guidance for Commissioners of these services that presented a model of trauma-informed matched care.[7]

This guidance highlights that to engage with psychological work, there must be some degree of stabilisation in substance use although abstinence does not have to have been achieved.

Finally, the "Drug misuse and dependence: UK guidelines on clinical management" (often referred to as the 'Orange Book') from 2017 sets out guidance to health and social care staff who provide drug treatment and support.[8]

This guidance states that for people with 'co-existing mental health and substance use problems':

> *"It is important that individuals are not turned away from either drug and alcohol treatment services or mental health services due to their coexisting illness but rather that such services should aim to be perceived by service users and their carers as supportive with 'no wrong door' through which to enter services."* (p232)

The principles in this 'Orange Book' guidance include strategic collaboration between mental health and addiction services to provide adequate expertise and treatment, identification of patient needs and communication between services, ensuring people can access support and treatment for both conditions and to support the individual in a person centred manner. Where possible, it is suggested that an integrated model of care may be most appropriate, however it is recognised that this model may not always be feasible. The guidance also describes how professionals in addictions services and mental health services should be able to undertake basic assessments about mental health and alcohol and drug use respectively. It states that people with mild to moderate mental health needs in an addictions service can be supported without need for referral to secondary mental health care, however for those with severe mental illness, mental health services should be the lead service.

The National Institute of Health and Care Excellence (NICE) guidelines for people with coexisting severe mental illness and problem substance use set out that services should not exclude people due to their drug use. The guidelines recommend that individuals have care coordinators, that their carers and families join them in setting care plans and that care plans should be holistic, meeting mental health and physical health needs and social supports. Like the 'Orange Book', and the Scottish Government MAT 9 standard they recommend local joint care planning for service delivery.[9],[10]

Although the NICE guidelines refer to people with more severe mental illness and the UK wide 'Orange Book' guidance refers to people with a wider range of mental health conditions, both

[7] The delivery of psychological interventions in substance misuse services in Scotland: A guide for commissioners, managers, trainers and practitioners
[8] Drug misuse and dependence: UK guidelines on clinical management - GOV.UK (www.gov.uk)
[9] https://www.nice.org.uk/guidance/cg120/resources/coexisting-severe-mental-illness-psychosis-and-substance-misuse-assessment-and-management-in-healthcare-settings-pdf-35109443184325
[10] https://www.nice.org.uk/guidance/ng58/resources/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services-pdf-1837520014021

emphasise joint working between services, care coordination, care planning, and meeting holistic needs in a person-centred way.

Despite the existence of multiple guidelines that emphasise not allowing people to fall between services, our initial consultation, as part of this work, suggested that the guidance is not followed; the aspirations are not realised in practice.

Methodology

In early 2020/2021, we met with representatives from twenty organisations and we held a focus group with 15 people with lived experience (through Scottish Families Affected by Alcohol and Drugs) and had meetings with 4 carers.

During these meetings we gathered information about what was perceived to be working well and the issues that we should gather more information about to understand the gaps.

We then created bespoke surveys for people with lived experience, their relatives and carers and for professionals who work with them. We distributed our surveys online through the Commission's twitter account, website and also through a number of collaborating stakeholders. We also visited individuals face to face (when safe and possible) and through online meetings to complete the surveys.

In total, 426 people engaged with us as part of this work. Appendix 1 provides details of those who responded and informed our work.

Our consultation with people with lived experience and other research indicates that there was no common understanding of the commonly used term, 'dual diagnosis' to describe the group of people with a mental health condition with problem substance use. We were aware that many people used this term and so we accepted this as the term we used for our consultation (although during the course of this project we became aware of the term's propensity to exclude). We adopted the definition used by NICE for people with co-existing severe mental illness and substance misuse to clarify what we meant by the term.

> *"Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage)."* NICE[11]

However, it was clear that the people with lived experience who engaged with us determined what the term 'dual diagnosis' meant to them and they often included mental health conditions that would not meet the level of severity that we had defined. In turn, we did not exclude information gathered from and about people who did not meet the NICE definition.

> *"I think we need to take a step back and ask why we are talking about dual diagnosis. It is not about diagnosis. We need services that recognise and work with the complexity of people's lives including the trauma and difficulties they have been through."* (relative/carer)

[11] Overview | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE (Accessed 23 June 2022)

Chapter 2: Learning from people with lived experience

Accessing the right supports at the right time, in the right place and provided by the right person is an essential part of recovery. We wanted to know, from those who have experience, who was providing support and whether these supports were holistic and coordinated: meeting mental health, physical health, problem substance use and social support needs as guidelines and policies indicate.

What we expected to find

We expected to find individuals seeking and receiving support from a range of different sources including primary health services (GP), secondary health services (community mental health team, addictions service, psychiatry), local authority, third sector (charity and voluntary organisations), family and friends.

We expected to hear of individuals seeking and receiving a range of types of support including practical (housing, employment, financial, childcare) emotional (counselling, peer support, self-help) and health based (physical and mental health).

We expected to hear about clear, supportive crisis planning for particularly difficult times in a person's life. We also expected to find evidence of clear coordination given the complexities faced by this particularly vulnerable group of individuals.

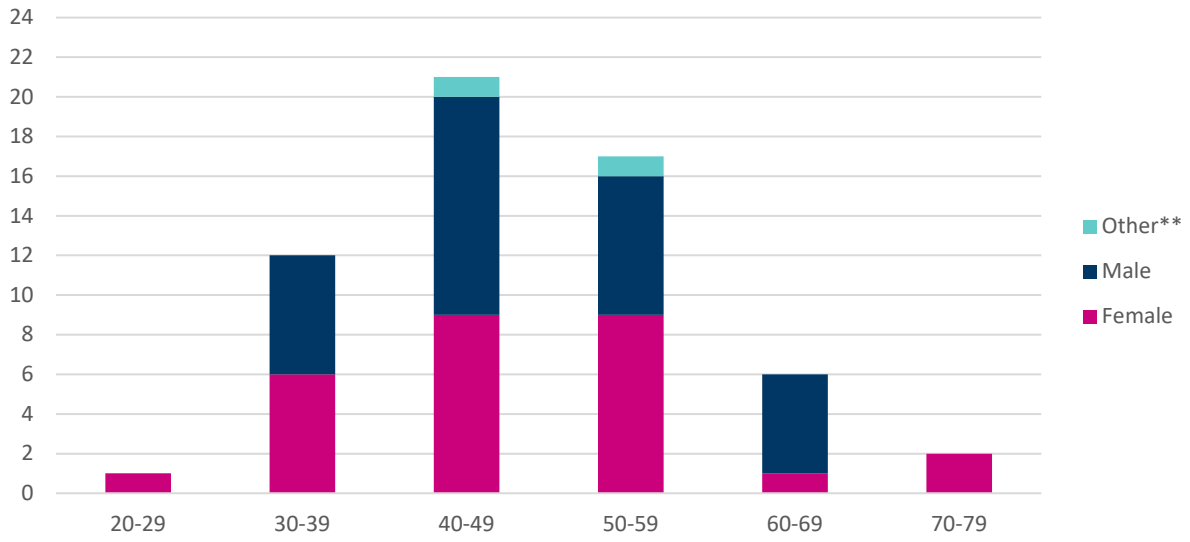
What we heard

People with lived experience

Sixty five people, who identified themselves as living with both mental health and problem substance use issues, responded to our request for information. They came from 11 different health board areas. Figure 1 shows the breakdown of respondents into age and gender groups.

People described where they lived as a city (26%), town (34%), small town (22%) or rural area (9%) and others did not respond to this question. Ninety percent of respondents felt the area they lived in was accessible, a 30 minute drive from the nearest town.

Figure 1. Age and gender categories of respondents*

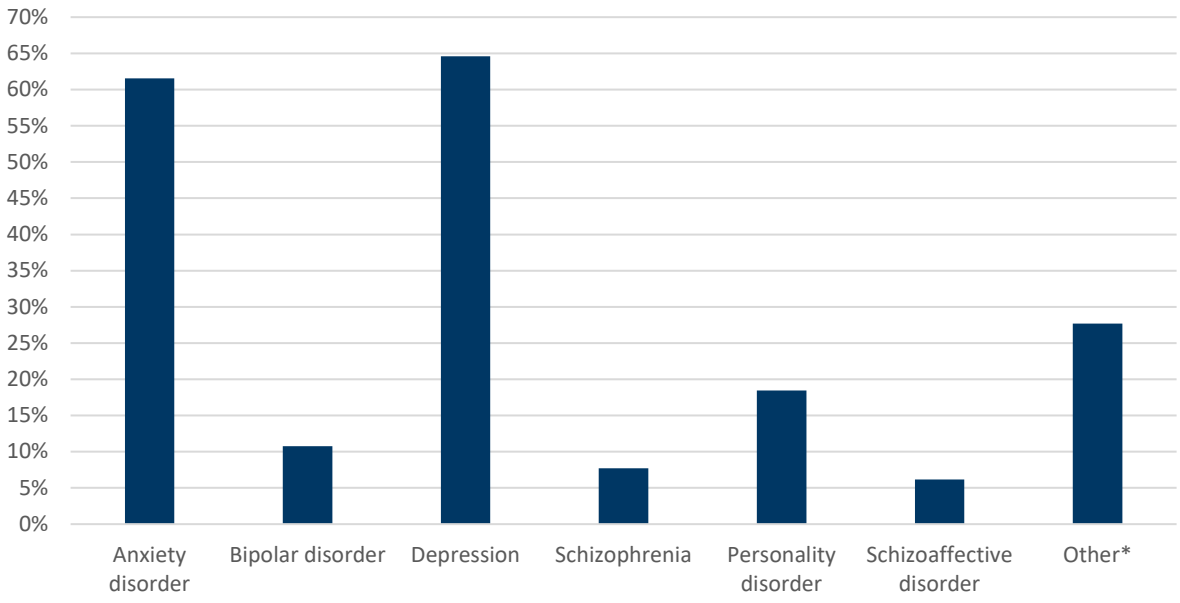


** (n= 65), 6 responses missing; **Other included as gender fluid and non-binary.*

The majority of individuals (90%) had received an assessment by an NHS mental health practitioner or psychiatrist. 90% of respondents reported that they had been diagnosed with a mental illness and 85% reported that they had been diagnosed with a dual diagnosis. 10% (n=7) respondents reported that they did not have a diagnosis but felt they should have one.

Diagnoses reported

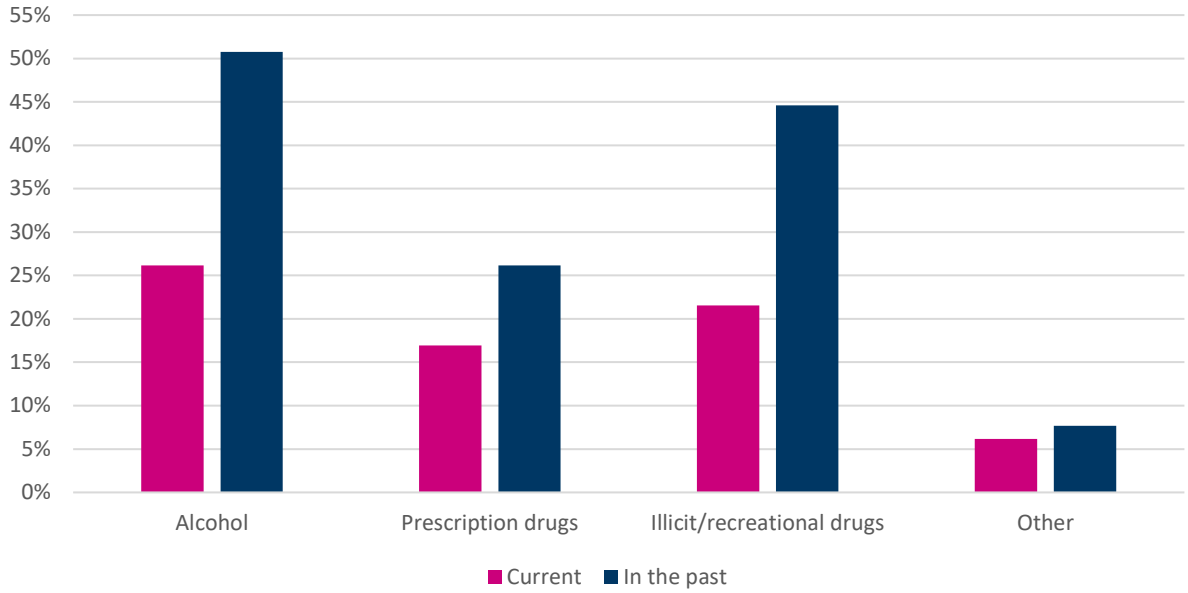
Figure 2 Mental Illness diagnosis from individuals with lived experience



Other diagnoses individuals reported included: obsessional compulsive disorder, foetal alcohol syndrome, post-traumatic stress disorder, autism, post-natal depression, attention deficit hyperactivity disorder and psychosis.

We asked individuals what substances they were currently using or had used in the past.

Figure 3 Substance used by individuals with lived experience



The provision of treatment, as reported by our 65 respondents, is presented in the table below.

Table 1: Provision of treatment for individuals with lived experience

Provision of treatment	**%**	**Number** (n=65)
Community addictions team	22%	14
Inpatient services	2%	1
Community mental health team	14%	9
GP	28%	18
Inpatient services	8%	5
Specialist integrated teams supporting people with both mental health and problem substance use issues	5%	5
Other	3%	2
No treatment provided	8%	3
Missing data		8

We asked about sources of support and what type of support was being received. (Table 2). People often described more than one source of support. Most individuals reported that the main type of support they received was emotional support. (See Table 3).

Table 2: Source of support provided for individuals

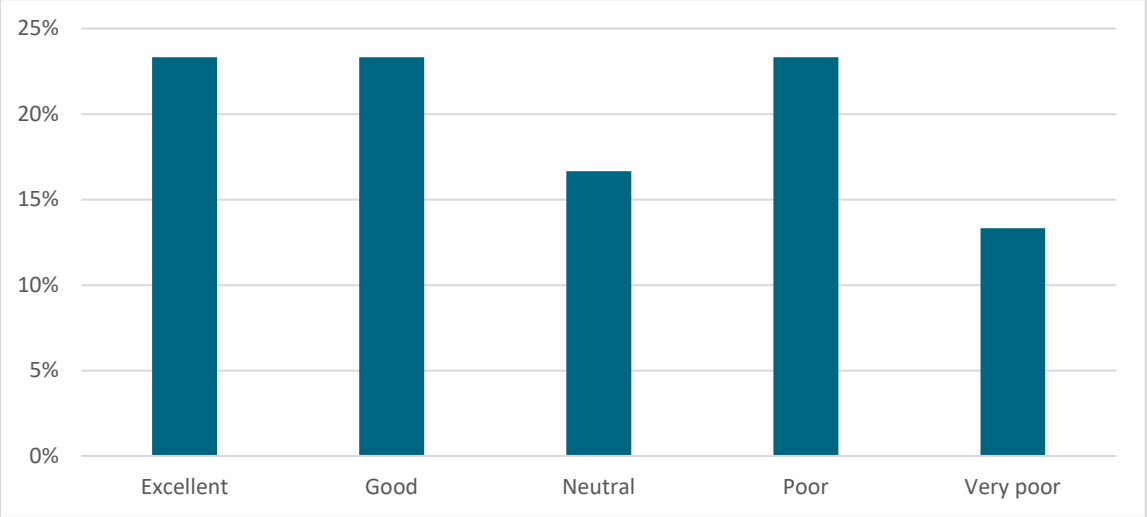
Support provider	**%**	**Number** (n=65)
Local council	12%	8
Social work department	11%	7
NHS	51%	33
Charity or voluntary	34%	22
Private care	2%	1
Volunteers	11%	7
Peer support worker	25%	16
Counsellor	15%	10
Family	40%	26
Friends	25%	16
Other	9%	6
None	8%	5
Not sure	2%	1

Table 3: Type of support provided
**Other support included mutual aid and friendship*

Types of support provided	**%**	**Number** (n=65)
Housing	28%	18
Employment	5%	3
Physical health	32%	21
Self-care	23%	15
Finances	8%	5
Social support	23%	15
Emotional support	58%	38
Counselling	22%	14
Childcare	0%	0
Education	3%	2
Other*	15%	10

We asked if more than one service was providing their care, treatment and support, how they experienced information sharing between these services. Of those who answered this question (n=30) 23% (n=7) stated communication was excellent, 23% stated it was good, and 23% (n=7) stated it was poor (see Figure 4).

Figure 4: Individuals view on communication between services



We were keen to understand what worked well. Our respondents told us about various factors that were important to them. We list them below.

Box 1: Common themes of what worked well with current support

- A clear diagnosis
- Medication
- Individual qualities in staff including: trusting, kind, empowering, realistic, caring, helpful, encouraging, non-judgemental, validating problems, good listening skills, honest, empathetic, respectful, approachable
- Staff consistency
- Support available 24/7
- One to one support alongside group therapy
- Support providers keeping in regular contact both over the phone and face to face
- Recovery focused
- Groups to meet others & on-line support groups
- Support to develop self-help strategies
- Peer led support by those with lived experience
- Support providers working well together and communicating with one another
- Self-help, helping others, mutual aid
- Counselling
- Understanding root cause of addiction
- In-patient rehabilitation along with follow up in the community
- Meaningful activity
- Ensuring individuals have the basics like food, heating, financial support
- One person to help with everything
- Phased exit when support has to come to an end
- 12-step recovery programme

Crisis support

In terms of where individuals would go if they were in crisis; the most common responses were their GP and addictions team (see Table 4).

Table 4: Services that individuals might access if in a crisis

Where to go in a crisis	%	Number (n=89)
Community Mental Health Team	25%	16
Addictions team	37%	24
Local psych hospital	3%	2
Crisis centre	6%	4
Charity	9%	6
GP	38%	25
999/111	25%	16
A and E	15%	10
Police	8%	5
Samaritans	12%	8
Breathing space	9%	6
Local council/social work department	8%	5
Friends/family	28%	18
Other (including support workers and recovery groups)	20%	13

Relatives and carers are key supports however 77% of families (60 families) felt they did not know what to do in a crisis.

> *"I don't have the knowledge or confidence or back up to get help for him."*
>
> *"No one is interested. He will probably die before he gets any help."*
>
> *"Only A&E and that scares us due to stigma, reluctant to go."*

The impact of the Covid-19 Pandemic

Over half of our respondents 57% (n=37) reported significant impacts on their treatment since the start of the pandemic. We were informed of delays in initial assessments, long waiting lists to start treatment or for consideration of inpatient / residential detox before treatment could be contemplated. We were also made aware of how staff shortages resulted in individuals having to re-tell traumatic stories.

Individuals described the difficulties they experienced getting a face-to-face appointment. There was a recognition from respondents that a 'therapeutic alliance' between the person with living experience and the people who support them is fundamental for recovery or

stabilisation. Some individuals were left with no support or telephone support only. Individuals also told us about support groups being cancelled and feeling socially isolated, depressed and anxious as a result. Individuals missed the support from others with a shared experience. However, we also heard that some individuals preferred support being delivered remotely due to it being more accessible.

Families also felt that the pandemic had had a significant impact on the support available for their relative.

> *"Made it non-existent. Waiting lists are so long seeking help is almost pointless."*

Lockdown often separated people from their families and this, in addition to the reduced support, increased the isolation many individuals experienced. The subsequent deterioration in mental health and increased substance use meant many individuals became increasingly unwell during Covid-19.

> *"Lockdown had a very detrimental effect which led ultimately to his drink/drive charges/losing his job/house and not being able to see his children for a time."*

> *"Disastrous - he has ended up in prison due to poor follow up and service provision".*

What we learned

Beyond the pandemic lockdown experience, we learned from those with experience and their relatives that the current standards and guidelines are not being translated into practice for them.

In many cases, mental health teams and substance misuse teams appear to be working exclusively rather than in tandem.

> *"Each service blames the other and you get poor treatment from both. Require integrated mental/physical/addiction care staff located together and allocated to appropriate staff."*

Accessing these services in order to receive an assessment can often prove challenging. We heard about the difficulties of being assessed (assessment refused) by mental health services when under the influence of drugs/alcohol. There appears to be a widespread expectation of individuals being substance free before their mental health issues can be treated. This is not in keeping with guidelines.

We equally heard that addiction services often refuse to get involved if an individual has mental health difficulties and the individual will be re-directed back to mental health services. In some cases, individuals appear to have to navigate services who respond with 'not my problem' rather than accepting individuals 'whatever their problem'.

We were told that the attitude of service providers can be a problem. People reported being 'labelled' and individuals being made to feel that their problems were a 'life choice' or having 'self-inflicted' their problems.

Stigma associated with the conditions still appears to influence how professionals view people with a difficulty that is a health problem.

> *"When I asked for sleeping tablets my GP said 'I'm not your drug dealer'."*

> *"People look down on me, I've been to a couple of chemists where I get my prescription for methadone. They made me take it in front of other customers, it was humiliating. They have a private room for this type of thing but they don't use it, they keep you waiting and serve other customers before you. It's cruel."*

We also heard about the lack of consistency of staff providing support leading to significant challenges in building a trusting relationship.

We were concerned that despite all the strong arguments for people to have care plans and a care coordinator our sample of respondents reported that they did not have clear care and support plans.

Again, despite Scottish Government guidance around trauma-informed psychological matched care support, our respondents described that staff were not trauma-informed. We were concerned to learn that the staff shortages are resulting in people having to retell their traumas.

We heard about the particular difficulties for certain groups of individuals. These comments were not so frequent that we have included them in the list of common themes above however from an equalities perspective we were made aware of particular difficulties around the additional complexities around care settings when young people have a mental health condition and problem substance use.

Some women reported that they were often asked about whether they were engaged in sex work in order to fund their addiction. They experienced the way in which this was asked as pejorative. Women reported that they are more likely to lose their children to alternative care arrangements.

Finally, in terms of access, services that are based on a Monday-Friday, 9am -5pm model do not work for all and it was suggested there should be a move away from this traditional model of timings of service delivery.

Our respondents told us what was important to them. The list is noted in the box above. Some of what they describe goes beyond the deficit models they are experiencing and speaks to a model of service delivery that seeks to extend a person's capabilities. They have a right to expect this.

> *"I just want to see change, I've lived more than half of my life with this condition...and all I see is people dying or being forgotten about."*

Chapter 3: The voice of relatives/carers of people with mental health conditions and problem substance use

The Carers (Scotland) Act 2016 came into force on the 1 April 2018**.** The Act provides rights to carers including rights of involvement and a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria.

One of the identified outcomes of the Rights, Respect Recovery report from Scottish Government in 2018[12] was that children and families affected by alcohol and drug use would be safe, included and supported. It stated that "families" includes anyone who is concerned with another person's drug use.

The document acknowledged the far-reaching consequences for families including family breakdown, financial worries, social isolation, stigma and the increased risk of adverse childhood experiences (ACE's) affecting children in later life. Support from friends and family can be a key component of recovery as outlined by people with lived experience in the previous chapter but carers need support in their own right.

The Family Recovery Initiative Fund (FRIF) was set up in 2018 to enable the development of support groups to help families by offering small grants and the government has committed to continuing this.

What we expected to find

In light of the above legislation and policy initiatives we expected to find that families were included in all conversations about an individual's care, where appropriate, and that their input was encouraged and supported. We also expected that they would have access to support and education in their own right and that systems and services are in place to allow this.

What we heard

We received 65 completed online questionnaires and spoke to 12 friends and family face to face or on Zoom. Of the 77 family members/people we had contact with, 67 were female and 9 were men (87/12%), with the majority (60% n=46) being in the 45-64 age group. 40% (n=30) of those supporting someone were parents of the individuals (with 28 of those being mothers (93%)) and 30% (n=20) were children, some of whom, were young carers. We had replies from people who lived across 12 different health board areas with the highest numbers coming from Greater Glasgow and Clyde =19 (25%), Lothian = 11(14%), Grampian = 10(13%), and Forth Valley = 9(12%) .

About half of the families we spoke to said their relative had been diagnosed with both a mental illness and problematic substance use by a doctor.

78% of them said that they felt their relative's substance use was a way of dealing with their mental illness.

[12] Rights, respect and recovery: alcohol and drug treatment strategy - gov.scot (www.gov.scot)

74% were aware of mental health assessments being carried out but most reported they had had no part in them.

> *"NO NEVER!"*

> *"Yes. Have been in appointments with him in tears and begging for help to no avail."*

The impact of having a parent with a mental health condition and substance use problem was highlighted in the responses too. Young people commented on the overwhelming responsibility they had taking care of their parent, other siblings, running the house and juggling school or college.

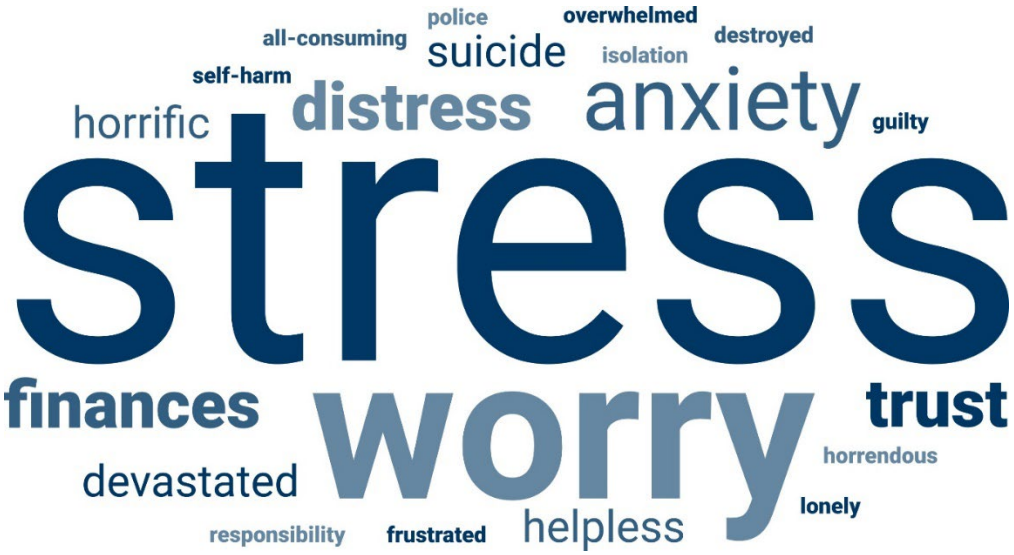
> *"My younger siblings have been in and out of the care system, on at risk registers. I was forced to leave home at 16 with little to no support system and I left school at 14 due to not wanting to leave my mum alone and with my younger siblings which has affected our mental health and future prospects."*

The effect on younger children and extended family was also immense.

> *"My relative has three children under 10 whom she has been unable to care for. The children now live with other family members."*

Impact on the family

The impact of supporting a family member with a mental health condition and substance use problem is far-reaching and devastating. We asked families about this and some of their responses are illustrated in the word cloud below.



The mental and emotional stress on families was evident.

> "W*e are done in! We love him, support him but it's been such a struggle to get him any support. When we do it's awful, judgemental, inconsistent and minimal. No support for us. Scottish families only found by ourselves eventually and helped for 8 weeks with CRAFT*[13] *training".*

> *"This is a cruel destructive illness. I am grieving for my loved one that I have lost although physically he is not dead yet."*

We were keen to find out what support families had to help them cope while also helping their family member. One of the overriding positives in the responses was the support families had had from family support groups. The many glowing reports regarding Scottish Families Affected by Alcohol and Drugs (SFAD) were testament to that; they were described as "fantastic", "amazing", "brilliant"," great support" and "couldn't do without them." Families Campaign for Change were called "a lifeline".

Several local carer centres were also said to have provided excellent support for the families

In terms of family support from services, 39 respondents of 77 stated they had been offered no support at all and many were finding it increasingly difficult to cope.

> *"No connection with family in same household to support plan and aid open communication Too quick to discharge if struggling with engaging NO HELP WHEN IN CRISIS!!!"*

> *"I feel very alone and scared".*

Others acknowledged that lack of resources and training made the situation worse

> *"…addiction services and mental health services are complex and outdated. They need reform, they are understaffed and underfunded and very, very neglected."*

Adult support plans

Under the Carers (Scotland) Act 2016 act local authorities have a statutory duty to offer an adult support plan to adult carers or a young carer statement. This is to assess the support needed to allow the carer to continue caring and separate from support provided to the individual. Only six (8%) families had been offered an adult support plan or young carer statement. Eleven (14%) commented that it did not apply to them but did not explain why. Forty eight (62%) said they not been offered one. Thirty one people (40%) said that they had been informed of support but of those, 20 (65%) did not feel they had enough support to help their relative.

Attitudes

The civil rights activist Maya Angelou famously said that 'people will forget what you said, people will forget what you did but people will never forget how you made them feel'. When

[13] CRAFT is an organisation that offers training in all aspects of managing and strengthening relationships in families. The Commission cannot comment on the training. We have added this footnote to clarify the meaning as presented in this quote only.

we asked families about their experiences of attitudes towards them from services the term "judgemental" was mentioned 25 times in the responses.

Support from friends and family is invaluable but many families faced difficulties maintaining that support. Forty per cent (n=30) commented that even those close to them struggled to understand, and those that did often withdrew as time went on without any resolution.

> *"The general attitude is that they do not matter, they are a drug addict and therefore, in their minds and attitude, a waste of time, effort and energy."*

The impact of this led to families feeling guilty and inadequate. Many admitted to negative feelings about themselves and blamed themselves unnecessarily.

Twenty six per cent (n=20) of our respondents told us about their experience caring for a parent. They were also aware, even as children, of the impact of other people's opinions.

> *"When I was a child this impacted me… as I grew older I became more educated and aware of my mum's condition and became more defensive for her rather than embarrassed."*

Family involvement

Some of the stress on families comes from their exclusion from any plans to help their relative. Services are frequently short sighted when it comes to the valuable information families have on an individual's past history and the support they can provide.

> *"He tells me no one has called him, no letters are received and they won't speak to me due to GDPR[14] even though my son wants me to deal with everything as he can't cope."*

> *"Services must listen to what the families have to say - they know the person before illness, during illness, and on recovery. We have the full picture of the full person - we see them as a whole; not just a list of symptoms and behaviours."*

The daily reality for some families cannot and should not be underestimated.

> "*Exhausting. Our own mental health has suffered due to the stress of dealing alone with my relative's addiction and mental health problems. We feel totally abandoned by a broken system which refuses to help those most in need. ….The only way out seems through suicide".*

What we learned

The overriding message from speaking to families is the lack of support, care and treatment they feel is available to their relative and themselves. They describe patchy, inconsistent services who fail to properly engage. Their own input is frequently dismissed and they are often excluded from any care and treatment plan. The lack of crisis support, advocacy and rehabilitation services were also highlighted.

[14] GDPR is the General Data Protection Regulation and refers to regulations around how personal data is gathered, used and managed.

Both the NICE guidelines and the 'Orange Book' guidelines specifically mention the involvement of carers and families in the development of care plans. This often starts from the assessment process. Our sample showed that three-quarters of families were not involved. The lack of involvement and the lack of carer support are not due to a lack of policies around this but due to a failure of implementation.

We were also concerned at the way in which families feel judged with regards their relatives developing these conditions, this is in keeping with the stigma that people with lived experience described in the previous chapter.

The final report of the Drugs Death Taskforce called for an end to stigma as an essential element in Scotland's fight against its high rate of drug-deaths. Our work confirms that stigma is preventing these issues being seen as the health problems that they are and is compounding the suffering for individuals and their families and carers.

Chapter 4: The views of professionals

What we expected to find

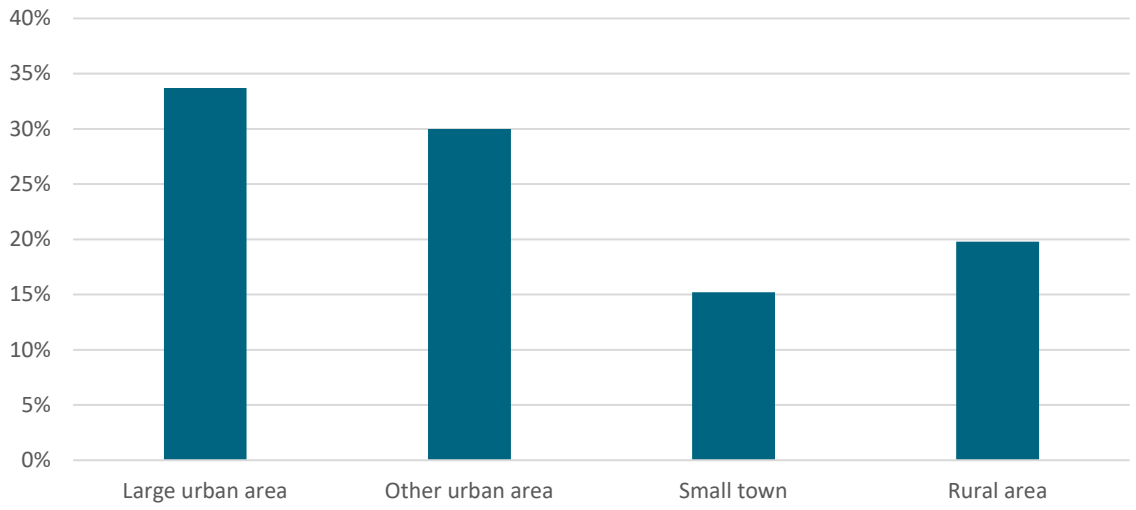
We expected professionals in primary and secondary care and in non-NHS settings to describe approaches informed by the policies and standards described in our first chapter. That is, services which ensure that individuals are never turned away, or passed from service to service, or told that their treatment is conditional on another treatment.

What we heard

Primary care

Eighty nine GPs from 10 different health boards completed our questionnaire. They worked in a mixture of urban and rural areas as shown in the graph below. 68 of these GPs (77%) worked in areas that were more readily accessible to patients (about 30 minute to drive to an area with a population of 10,000 or more) and a further 10 worked very remotely (more than a 60 minute drive to an area with a population of 10,000 or more).

Figure 5 Areas GPs work in by percentage



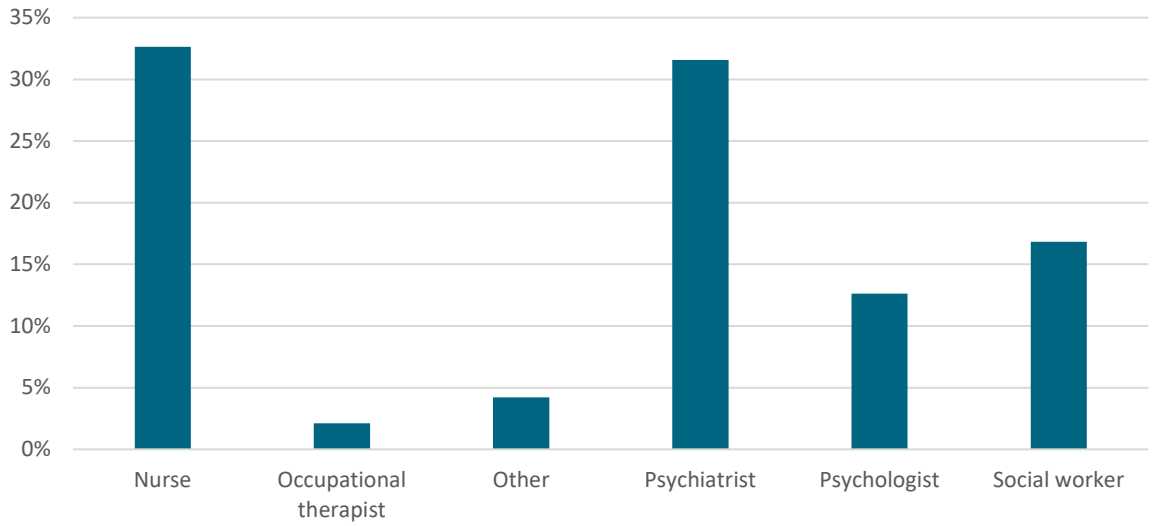
A large urban area was considered as populations of 125,000 or more; other urban area was considered as populations of 10,000 to 124,999; a small town was considered as populations of 3,000 to 9,999; and a rural area was considered as populations less than 3,000.

65 GPs stated that they worked with individuals who experienced both mental health and problem substance use on a weekly basis (75%) with others saying it was less than weekly. Only 1% (n=1) of GPs stated they did not currently work with people with the two conditions diagnosed.

Secondary care professionals

Ninety five secondary care professionals from a variety of disciplines from 12 health board areas completed our questionnaires as below.

Figure 6: Secondary care respondent disciplines by percentage



36% (n=34) worked within a community mental health team (CMHT) and 36% (n=34) worked within addiction services. Others worked within inpatient mental health or addiction services and social work, pharmacy, homeless services, liaison psychiatry or forensic services.

52% (n=49) worked within a large urban area (population of 125,000 or more), whilst 28% (n=26) were within other urban area (population of 10,000 to 124,999), 15% (n=14) small town (population of 3,000 to 9,999) and 5% (n=5) in rural areas (population less than 3,000).

77% (n=73) of secondary care staff respondents worked with patients with a mental health condition and problem substance use on a weekly basis,17% (n=16) work with individuals with both mental health conditions and substance use problems less than weekly and 5% (n=5) don't currently work with this group of people.

Non-NHS professionals

There were a total of 61 respondents from 9 different health board areas. 30% worked in a large urban area, 36% in another urban area, 31% in a small town and 23% in rural areas.

Of the 61 respondents, 46% of respondents worked in a local authority, 28% from Police Scotland, 15% were from the third sector,10% were from the voluntary sector and 3% were described as independent. 11% reported that they worked in the NHS (somewhat confusingly, but this may relate to NHS staff working within or being seconded to non-NHS services).

84% of non-NHS respondents stated that they worked with individuals with a coexisting mental health condition and problem substance use on a weekly basis, whilst 10% stated it was less than weekly. The majority of respondents 72% told us they work with those who use drugs and alcohol. 63% work with those with mental illness such as anxiety and depressive disorders and 49% work with those with severe mental illness such as psychosis. They work

in services that include: home care/housing support service/those who are homeless, all adults (including those with a learning disability, physical disability and mental health difficulties), and adults with a forensic background/offending behaviour, young carers, and those with acquired brain injury. They provide advocacy, counselling, practical support with daily living, welfare, housing, and in the case of the police, immediate emergency response and protection of life.

Current service provision

In relation to current service provision, only 16% (n=14) of GPs and 23% (n=21) of NHS professionals agreed that adequate care and treatment is currently provided. Only 4 of 61 non-NHS professionals agreed that adequate care and treatment is currently provided.

Police officers told us there is:

> *"Little/no out of hours support for people, police/ambulance are constant fall back for other services, when neither are the appropriate services to offer meaningful assistance beyond an assessment at A&E."*

19% of secondary care staff (n=15) were aware of agreed care arrangements and responsibilities between primary and secondary care. 16% (n=12) were aware of policies outlining how services should work together.

90% (n=79) of GPs felt there were gaps in service provision and had experienced difficulties in referring patients to both mental health services and addictions services, including when the patient presented in crisis.

GPs reported that referrals can be declined from community mental health services due to the person's substance use, without any further assessment or signposting, leaving the GP to re-refer to other supports. A number of GPs felt unsupported in managing substance use, stating that the local addictions team would only see patients for opiate replacement therapy. GPs reported that they were left to manage people who were dependent on benzodiazepines or gabapentinoids.

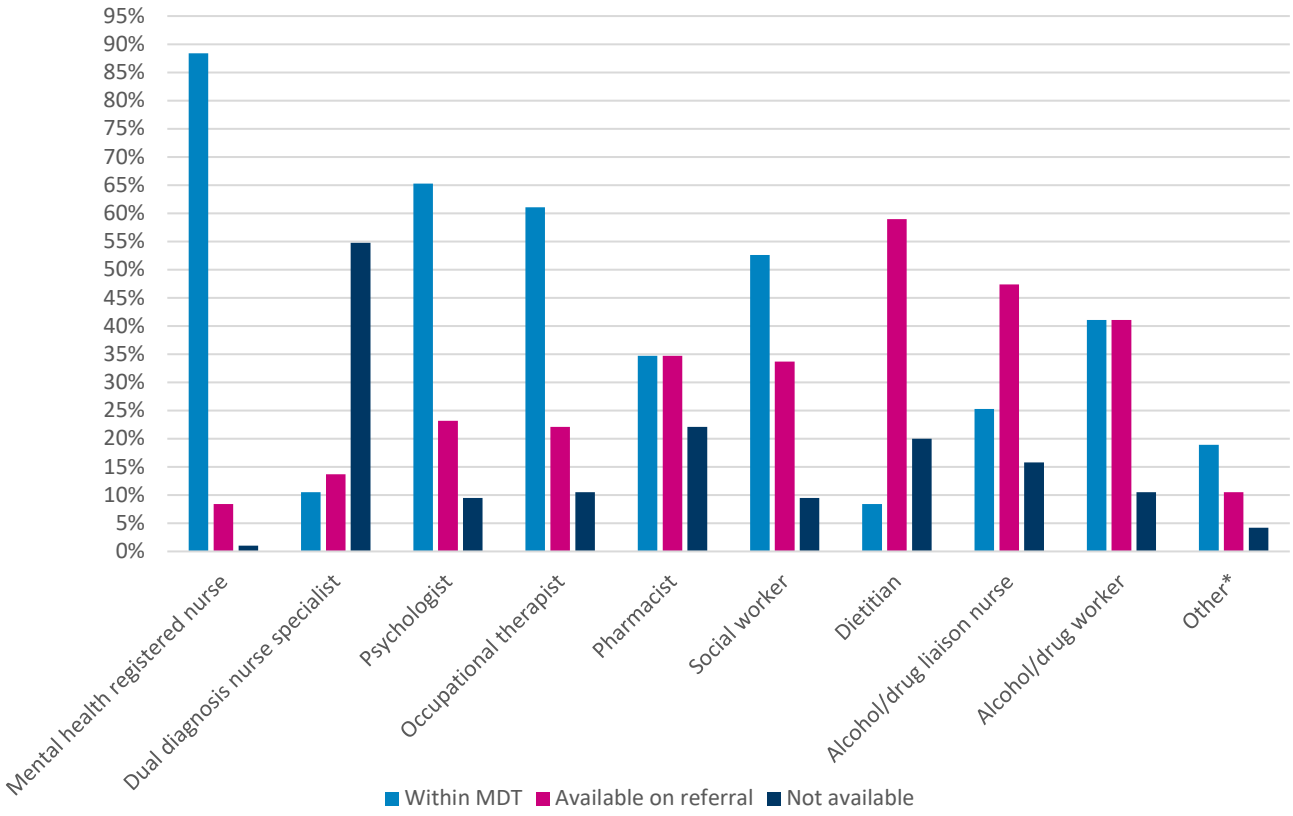
> *"If the patient has any substance abuse then mainstream psychiatry services will automatically reject any referrals and tell us to refer to the addiction services. Even when the main problem at that time is the mental illness".*

> *"Psychiatry locally give the impression that they do not accept the concept of dual diagnosis- it is common to see substance or alcohol misuse listed as the principle issue and a plan for care by the addictions team, who are distinctly separate from the mental health team, with no mental health team input if substance or alcohol misuse is apparent."*

80% (n=79) of GPs identified barriers to referring patients to mental health and/or addition services. In particular primary care reported long waiting times for assessment, difficultly accessing mental health assessments due to patients' ongoing substance use, lack of resource in secondary care services to offer appointments due to staffing levels, patients discharged due to non-attendance at secondary care appointments and under-resourced services using complexity as a reason to decline referral.

Secondary care staff identified that in the majority of areas, people can access support from community addiction services (this is a service primarily designed to meet the needs of people with addictions) and/or the local community mental health team (CMHT). Most respondents (61%) reported that there was no separate 'dual diagnosis' team, 24% did not know if such a team existed and 13% said that there was a 'dual diagnosis' team. Other services/professionals that they were able to access through their own multi-disciplinary team (MDT) or through referral are shown in Figure 7 below.

Figure 7 Teams/professionals secondary care can access.



**Other included: Support worker, peer support worker, Psychiatrist, CAAP, Counsellors, Recovery Development workers, and GPs.*

Inpatient Services

Sometimes people with mental health conditions and problem substance use will require inpatient admissions. Fifty seven per cent of secondary care professionals (n=53) identified that adult acute mental health wards (these are wards that admit people with mental health conditions) are available for this. 12% (n=12) identified the availability of specialist in-patient addiction service provision and 3% (n=3) stated there was access to a specialist dual diagnosis inpatient service. A quarter reported that there was no in-patient provision or that they were not aware of this. The most common reason for admission was a deterioration in mental health that led to a risk to self or others. The need for inpatient detoxification was

another common reason for inpatient treatment as was failure to respond to community treatment for either condition with consequent risks.

42% of respondents (n=39) were aware that there was a waiting list to be admitted for hospital treatment. This waiting list was mostly for elective inpatient detoxes, as most patients requiring hospital admission for their mental health were admitted on an emergency basis.

Although most professionals reported that pre-discharge planning with community services occurs regularly, only 19% (n=18) report CPA (Care Programme Approach) with its named care coordinator role, being used routinely as part of discharge planning. Although 46% (n=43) of secondary care professionals report responsibilities for ongoing monitoring are made clear, 67% (n=59) of GPs felt that the responsibilities for ongoing monitoring from primary care was not made clear at discharge.

45% (n=40) of GPs indicated that patients are offered physical health monitoring annually, whilst 37% (n=33) said it was not offered and 18% (n=16) were unsure. Only 16% (n=14) of GPs indicated that there is an agreed local protocol for physical health monitoring. 81% (n=66) of GPs noted that the responsibility lies with primary care. In responses to the survey, professionals reported that the lack of agreed local protocols meant that there was often variation in what services people received. At the time of the survey, responses indicated that routine physical health monitoring had stopped in many practices or become a low priority (this was as a consequence of the pandemic).

Only 13% (n=12) of secondary care professionals stated that an agreed local protocol for the medical monitoring of patients with both mental health conditions and substance use issues exists, whilst 36% (n=34) reported there was no such protocol with 51% (n=47) being unsure.

Care plans

Despite guidance that every person should have a documented care plan, 77% (n=72) of secondary care professionals reported that this did not happen or they were unaware of it. Although guidance recommends the use of CPA, only 26% of professionals (n=24) reported the use of CPA, on a discretionary basis in relation to complexity and risk and not as standard practice. In some cases, it was stated that CPA was not thought to be clinically necessary and other professional meetings were held under local shared care arrangements instead.

Medical monitoring

Individuals with mental health conditions and substance use problems often have physical health co-morbidities requiring monitoring. In addition, medications prescribed for the treatment of their mental health and substance use often require monitoring. Only 13% (n=12) of secondary care staff stated that an agreed local protocol for the medical monitoring of patients with coexisting mental health conditions and problematic substance use exists, whilst 36% (n=34) reported there wasn't with 51% (n=47) being unsure.

14% (n=13) of GPs indicated that all patients with known or suspected mental health conditions together with substance use problems receive an assessment of their mental, physical and social care needs in primary care with 56% (n=48) highlighting that they did not and 30 % (n=27) indicating they were unsure if this occurred. 95% (n=84) of GPs were unaware of an Integrated Care Pathway for this group of patients in their local area and equally 95%

(n=77) of secondary care professionals were unaware of any established local protocols for the assessment and management of patients with both diagnoses.

The families we spoke to echoed these opinions with 67% of the 77 families saying the physical health of their relative was not a priority for health services.

Severity of Illness

Guidance directs that severe mental illness should be managed within secondary care mental health services. 75% (n=67) of GPs indicated that all patients with psychosis were referred to secondary mental health care. In the free text responses to our questionnaires, there was a general theme that GPs feel it is difficult to obtain support for patients, regardless of the severity of their mental health diagnosis, when there is a history of problem substance use.

Awareness of MAT 9 and service readiness/response

Following the introduction of the Medication Assisted Treatment (MAT) standards we were interested to explore how these had been implemented in clinical practice, particularly MAT standard 9 that requires that all people with co-occurring drug use and mental health difficulties receive mental health care at the point of MAT delivery.

39% (n=35) of secondary care professionals respondents indicated that it had been implemented, 66% of whom worked in addiction services. 25% (n=23) of respondents indicated that the standard had not been adopted (the majority of whom worked in mental health services). The remaining 36% (n=33) indicated that they were unsure or left this question blank (with the majority being in mental health services).

Retaining patients in treatment

45% (n=41) of secondary care professionals stated that patients are discharged from follow up when they do not 'engage' i.e., miss a defined number of appointments (this is not nationally set). However, this appears to be dependent on the patient's presentation- if there are concerns about risk, then further attempts to engage the patient will be trialled.

Non-NHS based professionals agreed with the sense of current difficulties. Their responses suggested a lack of joined-up working across the sector and they were similarly concerned about the exclusion of people from individual services.

Homelessness was cited as a particular exclusion criterion by non-NHS professionals (working in the third sector) who reported that they had experienced community mental health teams rejecting referrals for individuals who were not living in stable accommodation. For services who support individuals with co-occurring mental health conditions and problem substance use who are without stable or secure accommodation this exclusion criteria felt discriminatory and stigmatising.

> *"The biggest obstacles we find are from the actual agencies/services themselves, not the clients"* (housing support worker)

For individuals and those who support people who are regarded as homeless they challenged the view of people being hard to reach; instead they shifted the focus to services and the need for them to 'reach out'. For staff who support people who are homeless it seemed a rather

uncomplicated endeavour to 'reach out' and engage with individuals. They further extend this view by suggesting homeless people are in full view of the public and can be located at various predictable places in towns and cities across Scotland.

Lack of accommodation, frequent moves and lack of consistent care poses an increased risk of exploitation; deterioration in mental health, propensity to move towards substance use as a form of self-medicating and concerns that people, young and old, may become 'lost' or 'abandoned' by statutory and non-statutory services were noted. The 'No Wrong Door' approach tells us that it is the responsibility of services to join up and flex support, not the individual to develop and navigate the complexities of their own care plan.

What we learned

Work from the National Confidential Inquiry, the Safer Services Toolkit (updated 1 July 2022) shows that in England, there was a 25% fall in rates of suicide by patients in those NHS Trusts which had put in place a policy on the joint management of patients with co-morbid alcohol and drug misuse.[15]

We didn't find these policies here. Instead we learned that, despite the guidance in Scotland that emphasises the need for clear written protocols on joint working, the absence of, or lack of awareness of protocols for joint working is striking and somewhat hard to believe.

Our work further highlighted that there is even a lack of recognition of the need to address substance use and mental illness concurrently, whilst the substance use may be perpetuating the problem, without treatment of their mental state, it is likely that the person will struggle to stop using substances.

> *"It's the chicken and the egg. They use drugs to help with mental health however this isn't treated as they are using drugs. Mental health support in this team doesn't appear to be taking place and predominately is about the drugs/alcohol issues."*

Supporting individuals through crises

NICE guidance [NG58] states that it is important to:

> "*Ensure practitioners have the resilience and tolerance to help people with coexisting severe mental illness and substance misuse through a relapse or crisis, so they are not discharged before they are fully equipped to cope or excluded from services."*

The 'Orange Book' highlights the need to act when a patient presents in crisis due to the high risk associated with a deterioration in their mental health, physical health or substance use. This guidance further highlights that most addiction services are designed for the planned management of drug use and are not appropriately resourced to respond to crisis situations. The staffing issues that have been highlighted by individuals, carers and professionals we engaged with prevent the development of the resilience required to make good on the aspirations of the NICE guidance.

There were isolated comments that indicated that there was a shared care protocol in some services that appears to operate in crisis situations. This may be through the Psychiatric

[15] display.aspx (manchester.ac.uk) (accessed 03 August 2022)

Emergency Plans that Boards are required to maintain although this was not specifically mentioned in responses to our questionnaire.

The implementation of the MAT standards

Standard 9 highlights the expectation and need for mental health services, substance use services and social services to work jointly in a holistic manner to improve access to care for those with co-occurring mental health conditions and problem substance use. The standard further sets out the expectations of each service in delivering this standard. In our reading of the extant policy documents and guidance, MAT 9 is a restatement of what should already be taking place. It is suggested that delivery of this MAT standard centres around a 'no wrong door' approach, as mentioned in the 'Orange Book' and quoted in the introductory chapter. The Royal College of Psychiatrists in Scotland, in setting out its priorities for Scottish parliament in 2021-26, refers to a 'No Wrong Door' approach and describes a public health-led approach to addressing drug and alcohol addictions, including access to care and treatment for those with a dual diagnosis.

Our data shows that professionals in addictions services are more aware of the MAT standards than those in mental health services. The recent (June 2022) Public Health Scotland Benchmarking report[16] that provides detail on the extent to which the first five standards have been implemented shows that there is a real challenge ahead. Whilst we welcome the clarity in the report, that as the Minister for Drugs Policy aptly describes 'pulls no punches' (p5), we look forward to seeing in future updates, the evidence around the implementation of MAT 9, that will ensure that we have a measure of the extent to which services are working together for the individual.

For the moment, we are disappointed that our data shows that only 26% of professionals report the use of the care programme approach (CPA) as a mechanism to ensure shared care, clear care-planning, and a named care-coordinator. This is recommended in the 'Orange Book' and is set out as an example of meeting the criteria in MAT 9.

> *"I do try to do that in practice, suggesting that a drug problem is not a mental health problem is a false dichotomy. Designing services that propagate that dichotomy seems likely to lead to failure."*

> *"Never heard of this and I would be surprised if people engaging in substance use get good access to mental health treatment because most of the specialist services (such as the psychological trauma service) won't see people with substance use problems."*

Similarly, on MAT standard 3 that aims to ensure that people at high risk of drug-death are assertively followed-up and references the need for a multi-service approach to engaging and maintaining people in care and treatment, we note the Public Health Scotland (PHS) report that shows partial implementation of this standard in 69% of the alcohol and drug partnerships.

Our data noted that in some areas, more assertive outreach is carried out than in others and that community mental health teams are more likely to discharge patients due to non-

[16] National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards. 2021/22 (publichealthscotland.scot)

engagement than addiction services are. It was noted that unless there is significant risk or the patient requires community supports or use of mental health legislation, then they are likely to be discharged due to non-engagement. There is rarely a co-ordinated approach to non-attendance by all relevant services with decisions based on individual presentation and associated risks.

Given that only 16% (n=14) of GPs and 23% (n=21) of NHS secondary care staff agreed that adequate care and treatment is currently provided, there is much work to be done to implement the existing guidelines. There were suggestions in comments from professionals about creating specialist 'dual diagnosis' teams however we felt that this would set up further barriers rather than reduce them. We were also mindful of recommendations made in NICE guidance NG58 that suggests that services should '*Adapt existing specialist services to meet both a person's coexisting severe mental illness and substance misuse needs and their wider health and social care needs. Do not create a specialist 'dual diagnosis' service." (1.5.6)*

From people with lived experience we had heard about the impact re-telling their story has on reliving past trauma. We had heard of the difficulties around staffing that has compounded this issue as continuity of care is lost. It was therefore very encouraging to hear of the model in North Angus, that has broadened the workforce to include peer-workers and by being a 'one-stop-shop' is consciously trying to avoid people having to re-tell their trauma.

Box 2

North Angus 'Hub': an inclusive model of acceptance into support, treatment and recovery.

This model included mental health nurses, medical staff, social workers, occupational therapists, psychology, third sector staff along with local authority colleagues from housing services. There was also a primary care pathway.

Important to the success of this model was the employment of peer support staff. People with living experience (peers) not only provided support to individuals but due to their specialist background knowledge helped break down barriers to services such as psychological therapies. As a collective service it was recognised peer support workers were in a unique position to really understand the daily challenges individuals' experience with their mental health and the complex nature of substance use and navigate the complexities of the mental health system. They could make referrals to other parts of the service.

From the outset it was agreed that 'no referral would be refused'. While referrals would be 'triaged' this was not undertaken as an inclusion or exclusion criteria only to determine who within the Hub would be the best fit for the individual. To ensure individuals referred into the Hub were met with the right staff, each person would be invited to meet with two members of the team. For example the first appointment may be with a mental health nurse and staff from local housing department. The individual is given a choice, consider their immediate needs and who is best placed to assist.

The 'assessment' in this service is the initial referral or if the individual has 'self-referred' then this will be considered the assessment. By adopting a 'one-stop-shop' approach this reduces the necessity for the individual to re-tell their story as they will be met with a team that is cohesive, communicates effectively and is motivated to keep the individual at the centre of their service. If an individual decides they do wish to have input with a specialist from the Hub for example an occupational therapist, an additional more in-depth assessment will be undertaken

Of the 850 referrals into the Hub none were 'rejected'. Many were supported to consider their mental and physical well-being, harm reduction in terms of risky substance use, housing and income maximisation. There was also support with parenting and relationships and signposting to social supports within communities.

We also heard about North Ayrshire Drug and Alcohol Recovery Service (NADARS). NADARS comprises professionals including nurses, social workers, addiction workers, occupational therapists, GP and pharmacist prescribers and staff with lived experience of alcohol and/or drug issues. In recognition that many individuals present to NADARS with co-occurring mental health conditions and problem substance use, NADARS staff also include psychological therapists, registered mental health nurses and consultant psychiatrists. NADARS continues to evolve, responding to the needs of individuals including responding to physical and sexual health and wider family and social issues. They have one door and it is open for support.

The North Angus Hub and NADARS are evidence that when services take on the responsibility to join up support, it works.

Chapter 5: Conclusions and recommendations

Scotland's problems with alcohol and drug misuse are well known, with recent reports showing shockingly high levels of death due to problem drug use and rising numbers of deaths due to problem alcohol use.

The Mental Welfare Commission's own data, and that of government and health authorities in Scotland, show rising rates of mental ill health.

This report looks at the combination of these issues for our population. It finds that services are not meeting the needs of people who have both mental ill health and problems with alcohol and/or drugs. Those providing the services know this; they told us.

This is not for want of a lack of evidence or guidance on how to tackle it. There is abundant guidance, standards and policies at a national level. We found a failure to implement the guidance at the local level and translate it into coordinated, integrated support for some of the most vulnerable adults and their relatives.

This requires focus on developing the capacity and the resilience of the workforce and measures to retain staff. We heard repeatedly about the lack of staff. Without a skilled, compassionate, committed workforce, it will be increasingly difficult to deliver the care and treatment people rightly expect from public services. This focus on the workforce should include measures to improve skills in assessment of problem substance use and mental health conditions, trauma-informed approaches to care, and reducing stigma towards people who have a complex health problem.

It also requires managers/leaders at the local level to develop clear local protocols and models of delivery that operationalise national guidance and provide clarity to front-line professionals. There is then a need to embed new models and for awareness raising of protocols that emphasise the joined up working, holistic care that existing guidance and standards seek to direct and prevent the 'bouncing' of individuals between services that we were made aware of.

We must ensure that 'No Wrong Door' means that every door is open.

There is hope. The Angus Hub rejected none of their 850 referrals. The NADARS integrated approach works with people, as individuals, holistically addressing whatever is important to them. They show it can be done; there can be no excuses, the exclusion that many individuals and their families and carers experience must end.

Recommendations

To health and social care partnerships (supported by health boards and local authorities) by October 2023:

1. There should be a clear written policy/service delivery model reflecting national standards and guidance, outlining the expectations for the holistic, joined up care of people with a co-occurring mental health condition and problem substance use (if one does not already exist)*.
2. Audits should be undertaken to ensure that every person with a co-occurring mental health condition and problem substance use has a documented care plan with a care-coordinator identified.
3. Protocols should be in place detailing agreed approaches for people who disengage with services and this includes people with co-occurring mental ill health and problem substance use.
4. Psychiatric Emergency Plans should be reviewed to ensure that sections that set protocols for the care and treatment of those individuals presenting intoxicated provide a mechanism for contemporaneous and subsequent engagement.

To NHS Education for Scotland (NES)

5. NES to consider with relevant stakeholders, and report on how educational and improvement programmes for professionals working in mental health, addiction services and social care might:
    a. Embed a trauma-informed approach to care and treatment of people with mental health conditions and problem substance use;
    b. Address stigmatising attitudes within professionals towards people with mental health conditions and problem substance us.

To The Scottish Government

6. The Scottish Government should monitor the delivery of the above recommendations and work with health and social care partnerships (and associated health boards/local authorities) and NES to support consistency and address any barriers to delivery over the next 12 months.

** In the **absence** of or pending such a written policy/service delivery model for integrated care for this group**, to avoid any inadvertent exclusion now**, the Commission considers that the lead service for this group that require secondary care mental health services and addictions services**, should be secondary care mental health services (with support from addictions services as needed).*

Appendix 1: Participants at consultation and questionnaire stages of this project

Stage	Who we consulted	Number of people/ organisations
Consultation	Aberdeenshire HSCP, Clackmannanshire and Stirling HSCP, Scottish Prison Service, National Drugs Death Taskforce, NHS Western Isles, Community Integrated Care (third sector), Glasgow HSCP, Highlands & Islands HSCP, Scottish Recovery Consortium, Mid & East Lothian Drugs, Scottish Government (Alcohol and Drugs Partnership Support Office), Police Scotland, Public Health Scotland, Veterans First Point, Scottish Health Action on Alcohol Problems (SHAAP), Falkirk Council, Scottish Recovery Consortium, Midlothian Substance Misuse Service, Nemo Arts, Social Work Scotland	20 organisations
	Focus group with lived experience: Scottish Families Affected by Alcohol and Drugs	15
	Individuals & Carers	4
Surveys	Individuals with lived experience – face to face	29
	Individuals with lived experience – online responses	36
	Carers/families – face to face visits	12
	Carers/families- online responses	65
	General Practitioners- online responses	89
	NHS Secondary care professionals – online responses	95
	Non NHS professionals- online responses	61

Acknowledgements

The Commission would like to thank Dr Paula McCahon who contributed to this work whilst on placement at the Mental Welfare Commission for Scotland.

If you have any comments or feedback on this publication, please contact us:

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk