Healthcare Improvement Scotland

Launch Event: Mental Health and Substance Use Protocols

Mental Health Improvement Portfolio
Monday 18 March 2024
13:30 – 16:00

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Healthcare Improvement Scotland

Diana Hekerem

Associate Director
of Transformational Redesign,

Healthcare Improvement Scotland

NHS SCOTLAND

Agenda

Time	Topic	Lead
13:30	**Welcome and introduction**	Clare Morrison, Director of Community Engagement & System Redesign, Healthcare Improvement Scotland
13:35	**Ministerial welcome (*video*)**	Christina McKelvie MSP, Minister for Drugs and Alcohol Policy and Maree Todd MSP, Minister for Social Care, Mental Wellbeing and Sport
13:45	**Introducing Healthcare Improvement Scotland's Protocol Programme**	Diana Hekerem, Associate Director of Transformational Redesign, Healthcare Improvement Scotland
14:00	**Findings from the RECO study – Realist Evaluation of service models and systems for CO-existing serious mental health and substance use conditions**	Professor Elizabeth Hughes, Professor of Substance Use Research, Glasgow Caledonian University
14:15	**Co-Occurring Mental Illness and Substance Use Disorders - How do we improve our systems in Scotland?**	Dr Iain Smith, Consultant Addictions Psychiatrist, NHS Forth Valley
14:35	**What are the challenges you see with local protocol development and implementation?** ***Breakout Session***	All
14:50	*Feedback to the room*	All
14:55	Comfort Break	
15:05	**NHS Tayside – working better together**	Dr Jennifer Breen, Consultant Counselling Psychologist and Operational and Clinical Lead
15:20	**Involving people with lived experience**	Aidan Mitchell, Policy and Public Affairs Officer, Change Mental Health and Katy McLeod, Programme Manager for Peer Research & Engagement, Scottish Drugs Forum
15:35	**Healthcare Improvement Scotland's offer of support**	Benjamin McElwee, Senior Improvement Advisor, Healthcare Improvement Scotland
15:40	**How can you be supported to test, learn and share? What would help?** ***Breakout Session***	All
15:55	**Next steps**	Diana Hekerem
16:00	Close	

Healthcare Improvement Scotland

Clare Morrison

Director of Community Engagement & System Redesign, Healthcare Improvement Scotland

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Ministerial Welcome

Christina McKelvie MSP, Minister for Drugs and Alcohol Policy

Maree Todd MSP, Minister for Social Care, Mental Wellbeing and Sport

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Meet the team

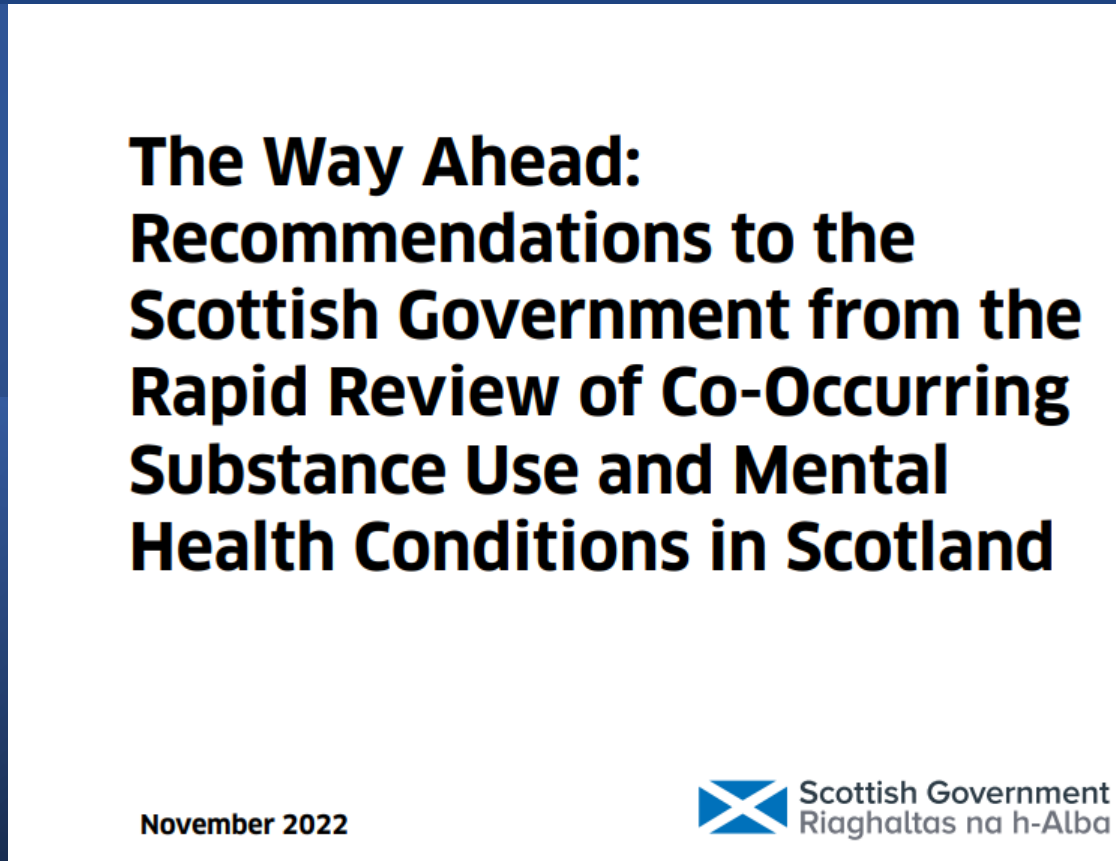
Rachel King
Portfolio Lead
Mental Health Improvement and Redesign Portfolio

Benjamin McElwee
Senior Improvement Advisor
Mental Health and Substance Use

Chanpreet Blayney
Consultant Psychiatrist and Clinical Lead

Diana Hekerem
Associate Director of Transformational Redesign

Context


The Way Ahead:
Recommendations to the Scottish Government from the Rapid Review of Co-Occurring Substance Use and Mental Health Conditions in Scotland
November 2022
Scottish Government
Riaghaltas na h-Alba

The Way Ahead: Rapid Review: Recommendation 1

Each area to have an agreed protocol in relation to the operational interfaces between mental health services and substance use services…

…owned and monitored by a responsible individual at a senior management level, with clear oversight of both service areas.

Context

Co-Occurring Substance Use and Mental Health Concerns in Scotland: A Survey of Scottish Drugs and Alcohol Services

Context


NCISH
The National Confidential Inquiry into Suicide and Safety in Mental Health
Safer services:
A toolkit for specialist mental health services and primary care
MANCHESTER 1824
The University of Manchester
HQIP
Healthcare Quality Improvement Partnership

Context

“

….there’s mental health, there’s people with housing, there’s people with drug problems, all these agencies really need to get together and go like here this is what they need, cause they’re no.

”

Context

“

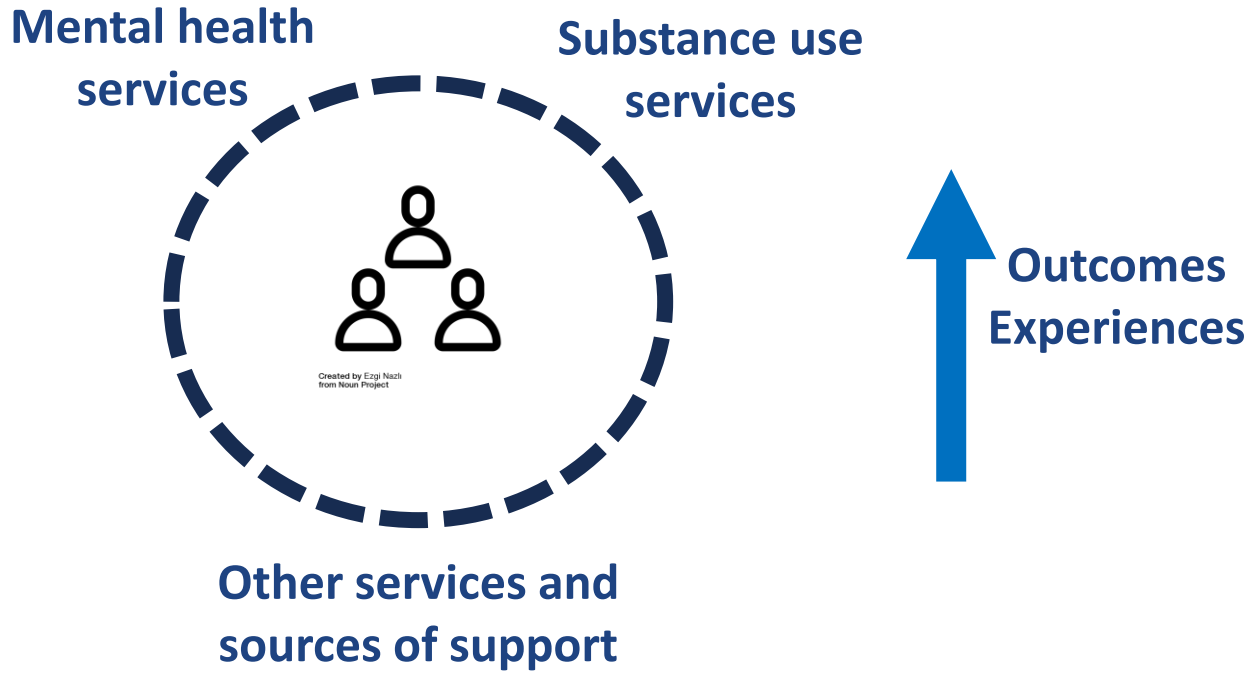
So it wasnae about statutory services or medication or psychiatrists or putting labels on why I was the way I was...

it was having all that sort of support through recovery cafes, support groups, that sort of thing."

”

Mental Health and Substance Use Protocol Reference Groups

Where we want to get to



Healthcare Improvement Scotland

The RECO study: Realist Evaluation of service models and systems for CO-existing serious mental health and alcohol/drug conditions (COSMHAD).

Overview of findings

Professor Liz Hughes, Chief Investigator (RECO)
Professor of Substance Use Research
Glasgow Caledonian University

FUNDED BY
NIHR | National Institute for Health and Care Research

NHS SCOTLAND

Disclaimer

This study/project is funded by the NIHR Health Technology Assessment (award: 128128).The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

The RECO Team

- **Edinburgh Napier University/University of Leeds**

CI: Professor Liz Hughes

- **South London and Maudsley**
  - Dr Luke Mitcheson
- **Northumbria University**
  - Dr Sonia Dalkin
  - Dr Angela Bate
- **Avon and Wiltshire Partnership NHS Trust & University of Bath**
  - Dr Emma Griffith
- **Lived Experience representative**
  - Charlotte Walker
- **Liverpool John Moores University**
  - Prof Harry Sumnall
  - Dr Lisa Jones
  - Dr Jane Harris
- **University of Liverpool**
  - Dr Mary Madden
- **Kings College London**
  - Professor Gail Gilchrist
- **University of Birmingham and Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)**
  - Professor Alex Copello

Aims of the Presentation

- Background and context to RECO study
- Outline of RECO study
- Focus on case studies (WP3)
- Implications and recommendations

Background to the Study

Co-Occurring alcohol and/or drug use is common amongst people who use mental health services

Clinical Correlates

COSMHAD is associated with significant negative impacts on health and social outcomes, including:

- Increased risk of suicide and self-harm (Popovic et al., 2014).
- Violence perpetration and victimisation (Fazel et al., 2010; Witt, van Dorn & Fazel., 2013).
- Co-occurring problems are often associated with *increased* psychiatric hospital admissions (e.g. Lai, 2012).
- Co-occurring problems can impact *negatively* on the delivery of treatment & management of care during inpatient stays (DoH, 2006).
- co-morbid physical health problems (Robson, Keen & Mauro., (2008).

The RECO study

Funding: commissioned call (NIHR, HTA; 2018) based on recommendations from PHE (2017)

AIMS

- To generate Programme Theory (PT) using realist synthesis of evidence & stakeholder views identifying & describing contexts/associated mechanisms by which engagement & other health outcomes are achieved in service systems for COSMHAD & for whom these are most effective.

RESEARCH QUESTIONS

- What does existing literature suggest 'works' (demonstrated by engagement & other health outcomes) for COSMHAD, for whom, & in what circumstances
- What are the current range & types of service systems operate in the UK aiming to improve engagement/health outcomes for people with COSMHAD.
- What are the specific contexts and mechanisms that make COSMHAD models successful (or not), for whom and under what contexts.

Inclusion Criteria and focus of RECO

Focus

- Services (NHS & third sector) and commissioning stakeholders who provide care for people with COSMHAD.

Inclusion Criteria

- People who have co-occurring drug and/or alcohol use problems AND a primary diagnosis of a serious mental illness:
  - Including schizophrenia, psychotic disorders, bipolar affective disorder, schizoaffective disorder, severe depression.
  - Drugs include illegal drugs e.g. cocaine, cannabis, opiates & novel psychoactive substances; as well as over use/misuse of prescribed drugs (diazepam, opioids) & solvents.

Methods: Series of Interrelated work packages

Work Package (WP) 1: Development of Programme Theories (PT)

- Consulted with stakeholders e.g. clinical experts/experts by experience. IPT elicited in workshops and used to inform search strategy for the literature review.

- WP1 provided valuable insights into existing treatment models and practices for COSMHAD, allowing development/refining of an overarching PT (explanatory framework) of what works, for who, in which circumstances & why.

- Realist synthesis accepted for publication in Lancet Psychiatry (Harris et al, in press)

Methods: Series of Interrelated work packages (2)

Work Package 1: Realist Synthesis of evidence to develop initial programme Theories

Work Package 2: Mapping of UK COSMHAD Services

- *WP2a:* Information requests e.g. COSMHAD approach/treatment pathway sent to all relevant health and social care organisations in the UK.

- *WP2b:* Using WP2a data, 16 organisations received survey for more details e.g. approach to treatment/health economic data. Data further refined WP1 PTs by clarifying contexts COSMHAD treatment operates/models of service delivery.

Work Package 3: Case studies of service models

Overall programme theory (WP1)

Service delivery

- PT 1: first contact and assessment
- PT 7: Formalised networking opportunities
- PT 9: Mental health led services

Leadership and Governance

- PT 3: Encouraging collaborative case management
- PT 6: opinion leaders
- PT 8: co-ordinated care pathways
- PT 10: Evaluation and quality improvement

Workforce

- PT2: Staff attitudes
- PT 5: Continuous workforce development
- PT4: continuous exposure from undergraduate level
- PT 11: Recuiting and retaining talented staff

Work Package 2: Mapping of UK COSMHAD Services

WP2b:

- Responses thematically grouped , forming 3 types of models:
  - "**Comprehensive model**"- typically included lead senior clinician (specialist expertise in COSMHAD), training/supervision programme, additional workers supporting lead.
  - "**Lead and link worker**" - less comprehensive model typified by a lead clinician and link or liaison workers.
  - "**Network**" - shared group of interested services, some local champions/link workers, not including investment in a specific lead person.

We used these criteria to inform the sampling for the case studies so we had representation of all three types of models.

Case Studies

Method

NHS Ethical approval obtained.

Sites 6 case studies selected from services identified in the mapping and audit, all participants gave informed consent.

Video calls on Microsoft Teams were recorded and a transcription generated, then checked for accuracy and annonymisation.

Participants

Service Users

- 25 service users with a lived experience of co-occurring mental health and substance use

Carers

- 13 carers of people with co-occurring mental health and substance use

Staff

- 58 staff were recruited to online focus groups spanning mental health, drug & alcohol, community and inpatient settings and a range of professional roles

Leadership

- Organisational commitment to developing a consistent response to COSMHAD is critical – this means both within services as well as in the integrated treatment system more broadly.
- A culture in which the COSMHAD agenda is supported (in terms of workforce development, care pathways and support, and ethos of care) requires leadership.
- The role of the clinical specialist (often a consultant nurse, or allied health professional) serves many purposes- training, role model, support, supervision, care planning, multi-agency working- and is highly valued
- All levels of organisation: Leaders needed to exist at different levels of their organisation including at a senior, strategic level and operating at a more clinical management level.
- Supportive and engaged senior leaders (context) were needed to keep co-occurring disorders on the organisational agenda (mechanism – resource)
- In order to do this, senior managers need "*clout"* i.e. the authority and legitimacy to turn rhetoric into action (mechanism – resource).

“clinically credible leaders”

- Participants frequently discussed impact and effect of dedicated clinical leaders for COSMHAD.
- These were typically positioned at a clinical management level and generally took responsibility for training, local strategy and provided specialist supervision (context) (NHS AfC Band 7/8+)
- Often these posts were held or created by people who had a long-standing interest in co-occurring disorders and had been “*a sort of a pioneer for a long time*” (SP61, Case Study F) and if these roles were taken away, then there would be no one to keep co-occurring disorders on the organisational agenda and “*the whole system would fall apart*”
- Key role was all “*about relationships*” (SP10, Case Study C) (mechanism – resource) which encouraged joint working with other teams (mechanism – response) and increased accessibility for people with COSMHAD.
- They connected the front line staff with organisational strategy and responded to wider policy changes. They “*leads by example*” (SP16, Case Study C) by putting the skills they taught to staff into action, and this helped staff feel motivated and supported to continue in their work

Formalised Care Pathways and Inter-professional/agency working

- All six case study areas had COSMHAD policies which included a diagram and description of their pathway for people with COSMHAD.
- However, except for the trust COSMHAD leads, awareness of these policies and pathways by the staff were quite low (context). This was because there was not a sufficient drive to promote their policies.
- The extent to which COSMHAD pathways were implemented within a trust (mechanism – resource) was felt to be dependent on funding, commissioning priorities and senior level support (context).
  - *"drugs and alcohol is a poor sister, mental health is another poor sister and dual diagnosis has been locked up in a shed at the back of the garden…dual diagnosis is definitely not going to the ball"* (SP38, Case Study A).
- Accessing both mental health services and substance use services could be challenging because services are *"one size fits all"* which could lead to those not "fitting" dropping out (mechanism – response).

Formalised Care Pathways and Inter-professional/agency working

- **Clear and communicared pathways** were seen as beneficial in facilitating referrals between services (mechanism – resource), relieving the anxiety of having to access a new service (mechanism – response) and ensuring that they could move between services in a more coordinated manner (outcome)
- **Barriers to be addressed** (Differing KPIs, risk assessment requirements, multiple IT systems) which hinder functioning of pathways (mechanism - resource) prevent service users receiving comprehensive care (outcome).
- **Responsibility**: Participants also discussed accountability and responsibility, highlighting that it wasn't always clear who was responsible for ensuring that service users received care at both a practitioner and an organisational level.
  - a key staff member within services who they knew they could contact in times of need and who would provide referral and access to services they needed (outcome).
  - service that would regularly and proactively contact them to "check in".
  - Service users felt this would be invaluable when they were experiencing poor mental health as it would reduce their isolation and reassure them that someone cared and was attentive to their needs Participants felt this could prevent crisis and relapse which relies on blue light and primary care referrals (outcome).

Workforce Key Findings

- Training should be provided to MH and SU staff (and other relevant agencies) in a locality.
- Training should be supported by the wider organizational culture, practice- based learning and supervision in order to embed in practice.
- There needs to be an organizational commitment to workforce development opportunities (including protected time to allow this to happen).
- Workforce development related to COSMHAD has multiple benefits for staff including increased job satisfaction, confidence, and increased empathy for client group.
- Service users and carers noticed when some staff lacked confidence skills and knowledge and this reduced their confidence in the service provided; however, increased engagement when working with a skilled clinician.
- Networks are a powerful mechanism by which to improve interagency collaboration as well as support CPD

Positive Outcomes for workforce development

- Time pressures were a barrier to workforce development opportunities – particularly in inpatient and community mental health due to large caseloads and competing priorities. The consequence was that the training offered to staff had gradually been reduced by the management.
- Hence organisational commitment played an important role (context): "*they [leaders] kind of prioritize other training before the dual diagnosis and that's the realistic answer, isn't it really"* (SP45, Case Study D) and without this prioritisation, a culture shift could not be achieved. This is described by participant SP38 (Case Study A) as a barrier to staff developing compassionate values and confidence in their skills (mechanism – response)
- If training was to have any longer term impact on practice it must be accompanied by embedding positive attitudes into the structure and policy of teams as well as the wider organisation (mechanism – resource)
- However the positive benefits of training and supervision were felt by both staff and service users and carer participants

Service user and carer perspectives on workforce skills and confidence

- Service users and carers recognised the link between training and confidence in practice.
- Trained staff (mechanism – resource) who had confidence in their skills, experience of working with co-occurring disorders, and compassion and empathy towards clients (mechanism – response) lead to better therapeutic relationships with service users and carers (outcome).
- Lack of experience of working with people with COSMHAD wasn't just an issue with new staff, but also in more experienced staff, hence the need for continuous workforce development (mechanism – resource)
- A lack of experience in those providing care for people with co-occurring disorders (mechanism – response) could lead to poor communication between services (outcomes). Staff who had not been sufficiently trained (mechanism – resource) lacked confidence in their roles (mechanism - response) and delivered very *"formulaic"* care*;* felt like *"a box ticking exercise…it's all very formal and paperwork"* (P13, Case Study C)

Strengths and Limitations

Strengths

- 1st realist evaluation of service models for COSMHAD using robust methodology.
- Staff, Service Users/Carer focus groups/interviews completed. Particularly important as service user voice identified as lacking in the literature.
- Worked with people with lived experience/other stakeholders (e.g. expert clinical leads) throughout to ensure sense checking of findings/relevant steering of project.

Limitations

- Impact of COVID 19 pandemic: may have affected e.g. response rates (service mapping/survey) and the amount of PPI input (despite several attempts to engage).
- Due to social distancing restrictions, data collection moved to online methods for focus groups and interviews.
- It is possible that some services that do exist were not identified in this study.

Recommendations for Policy and Practice

- Closer integration of Mental Health (MH)/Substance use (SU) policy at government level required, reflected at local (place based) level to ensure services are commissioned to meet needs of COSMHAD. ISCs/ICBs/ICPs able to plan local integrated services addressing population need.
- MH services should take the lead responsibility for people SMHP, irrespective of co-occurring SU issues.
- Make first contacts count- attitudes and values- genuinely “everyones business”, with mapping of COSMHAD developments as part of Integrated Care agenda.
- Ensure that the issues of COSMHAD are included in the workforce development plans across MH/SU in England and the Devolved Nations of the UK e.g. pre-registration and as part of CPD.

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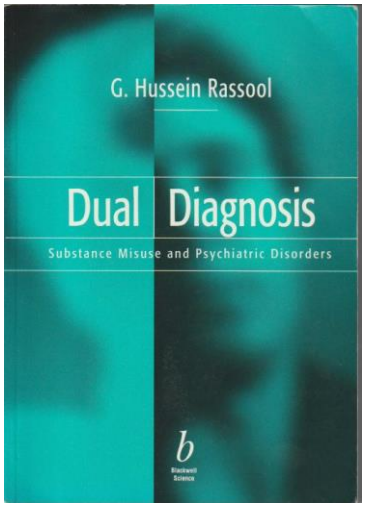
Co-Occurring Mental Illness and Substance Use Disorders-
How do we improve our systems in Scotland?

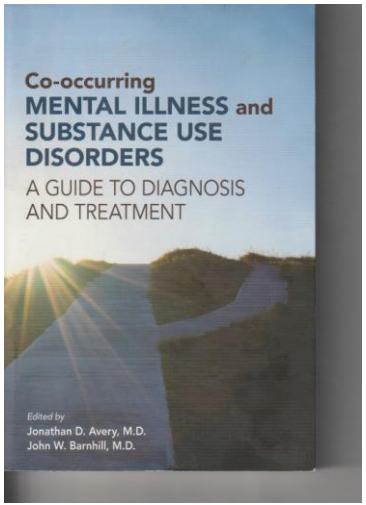
Dr. Iain D. Smith,
Consultant Addiction Psychiatrist,
Substance Misuse Service,
Stirling

Dr. David Mcmahon,
General Practitioner,
Homeless Complex Needs Service,
Glasgow

déjà vu-Dual Diagnosis becomes CODs

- Mind The Gaps(2003)
- Closing The Gaps(2007)





ISAM:Textbook of Addiction Treatment , Vol II-Part VIII,2021

The relationship between substance misuse and the various psychiatric symptoms and syndromes is complex

- The symptoms of the mental disorder e.g. depression may be a direct consequence of the substance misuse and may clear or improve with abstinence

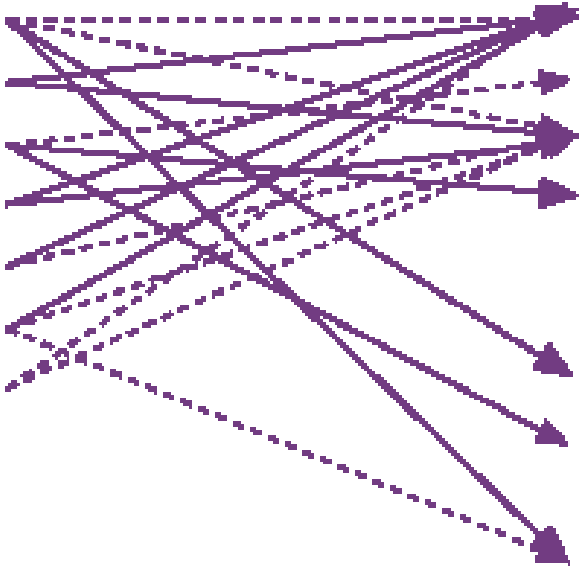
- The mental disorder may pre-date the substance misuse and may have directly contributed to the development of the substance misuse (e.g. secondary alcohol misuse/dependence).

- The two disorders may exist coincidentally in the same individual e.g. schizophrenia and alcohol dependence

Where there is such comorbidity it makes treatment more difficult and outcomes tend to be poorer

MAJOR BURDEN OF DISEASE IN DEVLOPED COUNTIRES-RISK FACTORS AND DISEASES (Source: The World Health report)

Risk factor	% DALYs	Disease or injury	% DALYs
Tobacco	12.2	Ischaemic heart disease	9.4
Blood pressure	10.9	Unipolar depressive disorders	7.2
Alcohol	9.2	Cerebrovascular disease	6.0
Cholesterol	7.6	Alcohol use disorders	3.5
Overweight	7.4	Dementia and other central nervous system disorders	3.0
Low fruit and vegetable intake	3.9	Deafness	2.8
Physical inactivity	3.3	Chronic obstructive pulmonary disease	2.6
Illicit drugs	1.8	Road traffic injury	2.5
Unsafe sex[a]	0.8	Osteoarthritis	2.5
Iron deficiency[b]	0.7	Trachea/bronchus/lung cancers	2.4



Rapid Review complements other work

Rapid Review

HIS Pathfinder

Mental Welfare Commission

National Standards (e.g. MAT)

Drug Deaths Task Force Final Report

Why the Resurgence of Concern Over Co-Ocurring SUD and MI At This Time-1

- Strang Report:-

"Trust and Respect –Final Report of the Independent Inquiry into Mental Health Services in Tayside ,February 2020 ,David Strang CBE

Cross-refers to **Dundee Drug Commission Report**:-

"Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems."

AND

HIS Pathfinder projects in five HB areas:-

Mental Health and Substance Use Programme

We work with partners within NHS Tayside, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Lanarkshire to redesign care pathways to improve quality of care and health outcomes for people with mental health and substance use support needs.

The Way Ahead: Recommendations to the Scottish Government from the Rapid Review of Co-Ocurring Substance Use and Mental Health Conditions in Scotland

Published online 30/11/22

Two other components to review also published that day:-

Literature review

Survey of substance use service staff in Scotland.

In writing recommendations we consulted as widely as possible given time constraints including with MWC over their report-Ending the Exclusion-and HIS and MIST etc. Also we met with David Strang.

The Way Ahead - Executive Summary (1)

Executive Summary

Recommendation One

- The Scottish Government should ensure that each area has an agreed protocol in relation to the operational interfaces between mental health services and substance use services. Further, this protocol should be owned and monitored by a responsible individual at a senior management level, with clear oversight of both service areas.

Recommendation Two

- The Scottish Government should work with local boards and Integrated Joint Boards to improve data collection on care for people with co-occurring mental health and substance use disorders. This should include key indicators, such as the number of rejected referrals for people with co-occurring mental health and substance use conditions by either mental health services or substance use services.

Recommendation Three

- The Scottish Government should ensure that Health Boards, Health and Social Care Partnerships, Alcohol and Drug Partnerships and all practitioners are considering their work, in relation to co-occurring disorders, within the framework of the four quadrants model. This was shown in Closing the Gaps (2007) and is replicated in our literature review (Page 8). This should be part of the locally produced protocol.

Recommendation Four

- The Scottish Government should ensure an annual population needs assessment in relation to substance use treatment capacity which will in turn help with the treatment of mental health problems. We know that certain forms of substance use treatment improve the mental health of those with alcohol and other drug use disorders. The Scottish Government should ensure these needs assessments are happening and informing service provision at a local level.

I Psychiatric disorder: **LOW** severity	Substance use disorder: **LOW** severity	II Psychiatric disorder: **HIGH** severity	Substance use disorder: **LOW** severity
LOC: client served by primary care clinic		LOC: client served by mental health center	
III Psychiatric disorder: **LOW** severity	Substance use disorder: **HIGH** severity	IV Psychiatric disorder: **HIGH** severity	Substance use disorder: **HIGH** severity
LOC: client served by addiction treatment program		LOC: client served by mental health center with integrated COD program	

FIGURE 2–1. **Four-quadrant Model of Care for Co-occurring Disorders.**

COD=co-occurring disorder; LOC = locus of care.
Source. National Advisory Council, Substance Abuse and Mental Health Services Administration: *Improving Services for Individuals at Risk of, or With Co-occurring Substance-Related and Mental Health Disorders.* Rockville, MD, SAMHSA, 1997.

The Way Ahead – Executive Summary (2)

Recommendation Five

- The Scottish Government should commission a specific rapid review for alcohol treatment services given its health implications for Scotland and evidence that treatment in Scotland has been diminishing despite high levels of alcohol use disorders.

Recommendation Six

- The Scottish Government should ensure all mental health and substance use staff are trained on how best to assess and manage co-occurring mental health conditions and substance use disorders in a trauma-informed approach. This training should also be open to other professional groups.

Recommendation Seven

- The Scottish Government should ensure that further research is carried out to explore several troubling findings which we could not address in this rapid review. These include the finding by Public Health Scotland of a significant increase in anxiety and depressive episodes prior to a drug-related death between 2008 and 2018, and the increase in Drug-Related Admissions to General Hospitals. On a larger scale, a replication of the Co-Morbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) Study in a Scottish city would be particularly relevant.

Does Psychiatric Disorder Contribute to DRD Risk – Some interesting data

Table 16a: Percentage of Drug-Related Deaths by psychiatric condition experienced in the six months prior to death (2009-2018)

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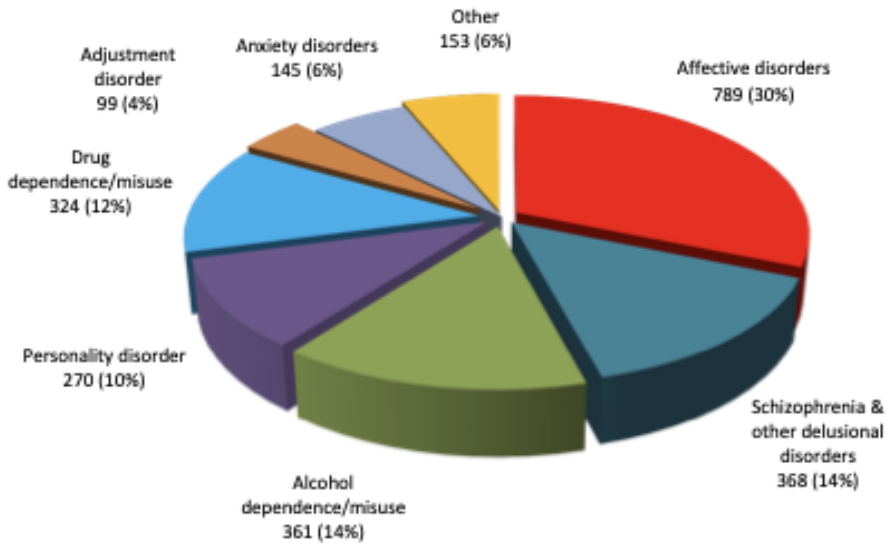
Psychiatric Condition	% of deaths									
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Depression	23.1	22.7	30.8	39.9	45.8	44.2	47.7	47.3	45.1	45.6
Anxiety	15.3	15.1	18.7	27.1	26.4	29.6	29.5	31.2	29.0	28.6
Personality Disorder	5.6	4.4	5.0	6.3	7.2	5.7	7.9	6.4	7.5	6.3
Schizophrenia	4.9	2.7	5.9	4.0	7.4	5.2	4.8	5.6	5.8	5.7
Other psychiatric conditions	3.9	4.4	2.5	2.9	3.3	5.4	5.3	3.1	4.9	5.0
Post Traumatic Stress Disorder	1.2	1.9	2.5	2.5	2.7	3.1	4.2	3.7	3.3	3.2
Bipolar Disorder	2.3	1.1	2.1	2.3	1.6	2.4	2.5	2.1	3.0	2.1
Psychotic Episode	1.2	1.1	1.1	2.3	2.3	2.9	2.5	2.4	2.1	1.6
ADHD/ADD	0.2	0.0	0.2	0.2	0.2	0.9	1.1	0.7	0.7	1.2
Obsessive Compulsive Disorder	0.2	0.5	0.2	0.0	0.6	0.5	0.2	0.5	1.1	0.3
Any psychiatric condition	**40.0**	**40.3**	**47.0**	**55.9**	**60.0**	**60.3**	**61.7**	**64.8**	**63.1**	**63.0**
No known psychiatric conditions	60.0	59.7	53.0	44.1	40.0	39.7	38.3	35.2	36.9	37.0

Source: NDRDD

NCISSMI – Suicides in the MI in Scotland and Alcohol and Drug Comorbidity (1)

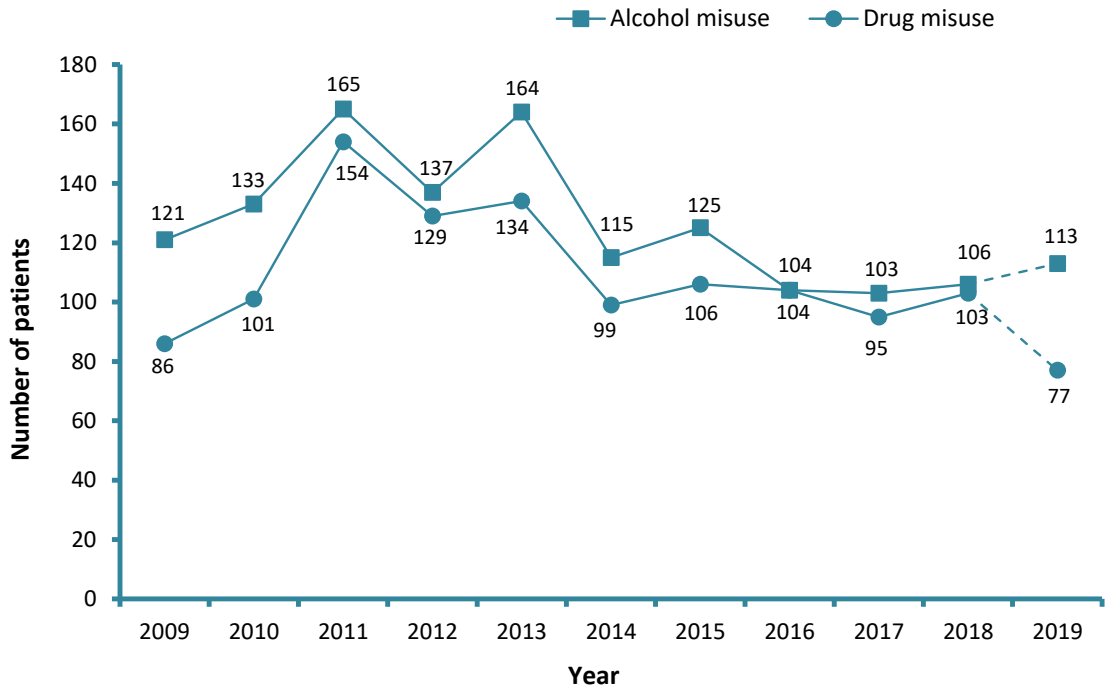
Figure 5: Patient suicide in Scotland: primary mental health diagnoses



*"other" diagnoses include: eating disorders, learning disability, conduct disorder, autism, somatisation disorder, ADHD, organic disorder, drug induced psychosis, dementia and other specified.

NCISSMI – Suicides in the MI in Scotland and Alcohol and Drug Comorbidity (2)

Figure 6: Patient suicide in Scotland: number with a history of alcohol or drug misuse



NCISSMI – Suicides in the MI in Scotland and Alcohol and Drug Comorbidity (3)

Table 3: Behavioural characteristics of patients who died by suicide in Scotland

Behavioural features	**Total=2,645**	
	Number	**%**
History of self-harm	1,576	66
History of violence	563	25
History of alcohol misuse†	1,386	55
History of drug misuse†	1,188	47

† includes estimated figures in 2018-2019

NCISSMI – A toolkit for specialist mental health services and primary care (1)

Reducing alcohol and drug misuse	Safer care in mental health services

Reducing alcohol and drug misuse

We recommend there are local drug and alcohol services available that work jointly with mental health services for patients with mental illness and alcohol and drug misuse.

Other clinical measures that could reduce suicide risk in this group are alcohol and drug misuse assessment skills in frontline staff and specialist alcohol and drug misuse clinicians within mental health services.

Our evidence

Across all UK countries, alcohol and drug misuse is common among patients who die by suicide (47% and 37% of all patient suicides UK-wide, respectively, higher in Scotland and Northern Ireland). However, only a minority of patients who died by suicide between 2008 and 2018 were in contact with specialist alcohol and drug misuse services.

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 management of patients with co-morbid alcohol and drug misuse.

Guidance

See the NICE guidelines on coexisting severe mental illness and substance misuse.

Embedding suicide prevention in drug and alcohol policy and services is an action in the strategy for preventing suicide and self-harm in Northern Ireland.

NCISSMI – A toolkit for specialist mental health services and primary care (2)

Reducing alcohol and drug misuse | **Safer care in mental health services**

Specialised services for patients with mental illness and coexisting alcohol and drug misuse

	Response		Date next review due	Comments
	Yes	No		
Specialist alcohol and drug services are available, with a protocol for the joint working with mental health services (including shared care pathways, referral and staff training).				
There is a specific management protocol or written policy on the agreed management of patients with coexisting alcohol and drug misuse.				
Protocols for managing self-harm patients who are under mental health care should highlight the short term risk of suicide, especially where there is coexisting alcohol and drug misuse.				
There is specific training in place for staff on alcohol and drug misuse assessment.				
There are specialist alcohol and drug misuse clinicians within mental health services.				

THE PLANET: PAGES 28&29

January 30, 2022 £2.20
No. 6067 - C

NDAY POST

Doctors reveal surge in psychosis linked to cannabis

Hospitalisations up 74% since use decriminalised

y Mark Howarth

he number of Scots uffering mental illness nked to cannabis has urged since use of the rug was effectively ecriminalised.

Figures reveal the number of sers being hospitalised because f psychiatric issues has climbed y 74% since 2016 when police egan warning those caught ith the drug for their own use.

The admissions data has rompted experts to call for a eassessment of the risks posed y cannabis in comparison to lass A drugs and alcohol and rgent action to bolster support or users trying to give up.

Professor Jonathan Chick, medical director of a world-lead- ng rehab clinic in the Borders, said the figures confirmed his experience, adding: "The eye has been taken off the ball with cannabis. We do need to worry about the numbers of young people presenting with psychosis and schizophrenia because of it."

In January 2016, Police Scotland changed the guidance to officers, advising that simple possession of cannabis could be dealt with using a warning rather than a report to the Fiscal and possible prosecution.

Comparing the data from 2015/16 to the latest figures reveals the number of prosecutions has more than halved from 1,809 to 877 in 2019/20. However, drug-related hospital stays due to mental or behavioural problems linked to cannabis use rose by 74% from 1,191 to 2,067 last year. And in 2020/21, a record 1,263 new patients sought hospital treatment for a range of psychiatric disorders blamed on the drug, including schizophrenia.

A recent report by Public Health Scotland states: "There has been a notable increase in the percentage of [psychiatric hospital] stays attributed to cannabinoids in recent years, increasing from 9% in 2014/15 to 18% in 2019/20."

Chick said the increasing potency of cannabis had led to an increase in people needing help at his Castle Craig clinic around five years ago but, he said, "first step" support services are already overwhelmed while his clinic rarely gets NHS referrals for cannabis.

He said: "We're dealing with both dependence and psychosis. Often, where there has been a second or third psychotic breakdown, there has been hospital or police involvement because of incidents of self-harm or harm to others. These patients have terrifying thoughts. It is a paranoid

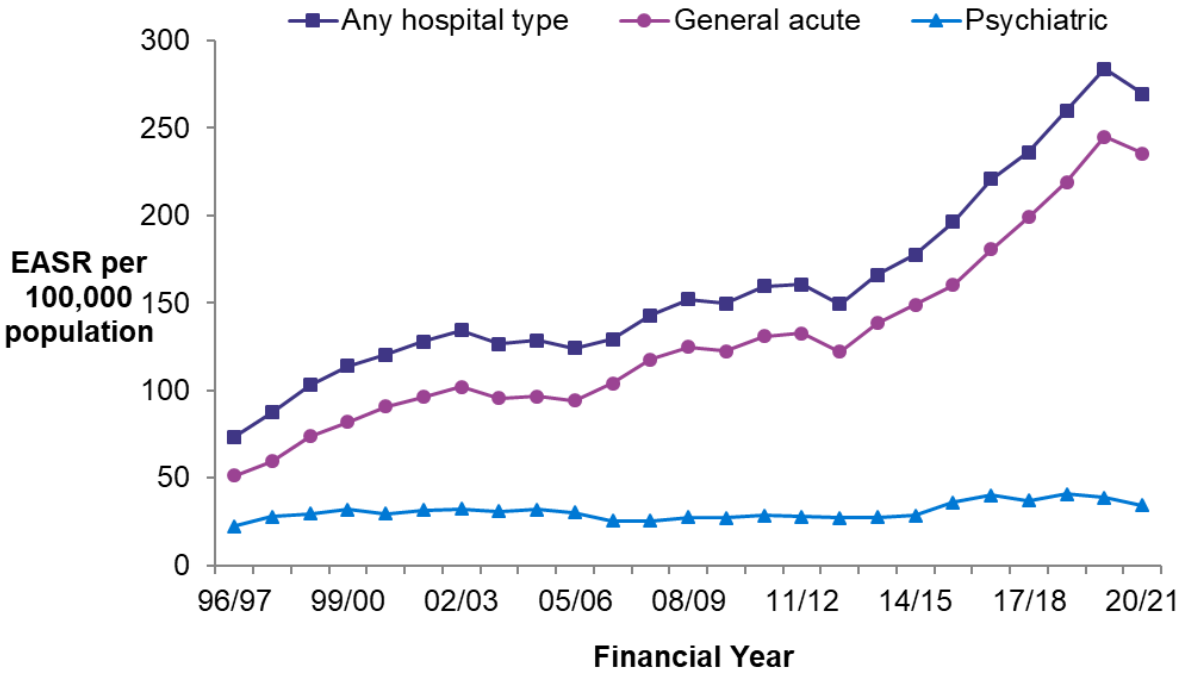
Continues on Page Four

THE BOAR WAR

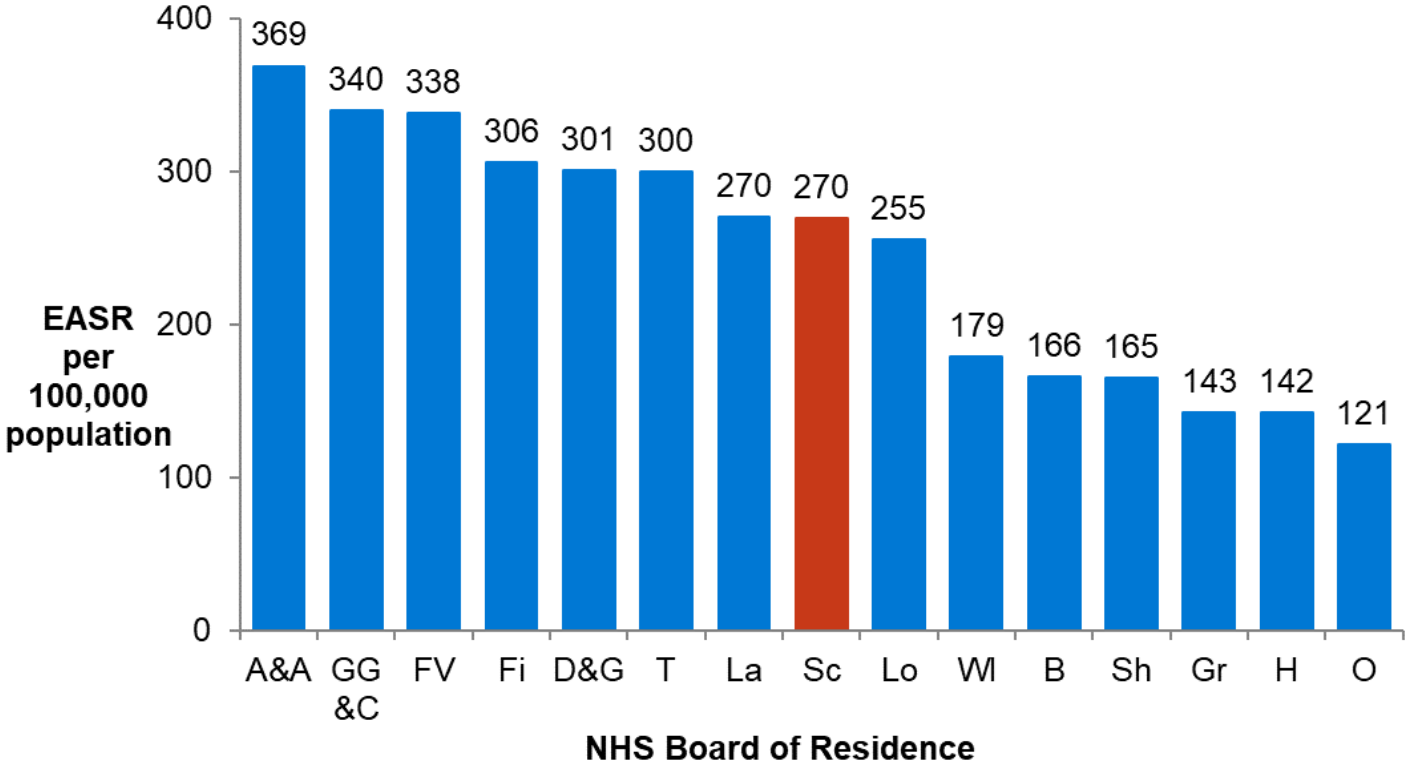
Drug-Related Hospital Statistics Scotland 2020-21

Publication date: 23 November 2021

Drug-related stay rates by hospital type (Scotland; 1996/97 to 2020/21)



Drug-related general acute/psychiatric combined stay rates. By NHS Board of Residence (Scotland; 2020/21)



EASR=European Age-sex Standardised Rates

COSMIC study conclusions

- Persons with substance misuse disorders are more likely to have a comorbid psychiatric diagnosis than the general population and those with a psychiatric diagnosis are more likely to have a substance misuse diagnosis.

- Assessment and management are more difficult in the presence of such comorbidity which is often unrecognised.

- Persons with substance use disorders may have poor access to mental health treatment and those with mental health problems poor access to substance use services

Management

- **Assessment:** MH & SM services fail to identify co-morbidity in a high proportion of patients
- Few patients meet criteria for joint management. Possibly ‘low potential’ for cross-referral?
- Drug & Alcohol services provide some MH interventions, >50% get no specialist care
- CMHTs provide interventions for very few patients with drug / alcohol problems (<20%)

Management

- Managers overseeing MH and SU services need to look at issues of integration in their area and ensure suitable protocols exist and that they are being implemented.
- Both MH and SU services need to be able to screen for SU and MH disorders respectively and to know how to address these disorders.
- Particular focus is needed on emergency and out of hour provision to be more responsive to those with SU issues presenting with a mental health crisis.

We must sustain momentum around current developments given the failures of past initiatives in this area and the particularly high prevalence of comorbidity between SU and MH disorders currently. While MH disorders may be secondary to substance use we can only be fully sure of this with careful follow up-**Example of "drug-induced psychosis"**

Breakout session 1:

What are the challenges you see with local protocol development and implementation?

Comfort Break

Returning at 15:05

Healthcare Improvement Scotland

NHS Tayside – Working Better Together

Improving care for Individuals with Co-existing Mental Health & Substance Use Difficulties in Tayside.

Dr Jennifer Breen, Consultant Counselling Psychologist.

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Governance

Governance arrangements covering the whole of Tayside. Separate arrangements are also made at a local level.

Leadership/Governance Group

Strategic Lead and Chair
Diane McCulloch, Head of Health and Community Care, Dundee Health and Social Care Partnership

Operational and Clinical Lead
Dr Jennifer Breen, Consultant Counselling Psychologist, Dundee Health and Social Care Partnership

Governance
IJB
Staff Side
ADP
MIST
HIS

MHSU Tayside Operational Group

Purpose
Deliver operational activities, share information across all workstreams and report to Governance Board

Membership
Angus, Dundee , & PK HSCP inc statutory & 3rd Sector

MHSU Local Operational Groups

- Angus HSCP level delivery group
- Dundee City HSCP level delivery group
- Perth and Kinross HSCP level delivery group

HIS MHSU Advisory Group

Purpose
Provide recommendations to the Governance Board as subject matter experts

Exploring MAT 9 – breaking it down

Components	Criteria	Questions
Mental health services have		
9.1 -6 Procedures in place to ensure that staff in mental health services are up to date with local substance use treatment pathways and the referral criteria for NHS primary and secondary care services, social care and third sector agencies;	1. Clear articulation of pathways 2. Guidance around criteria and thresholds 3. Communication/distribution plans.	1. What documentation do we have? 2. How might informations be best shared? 3. How do we decide the named service? 4. How do we audit and evaluate

Exploring MAT 9 – breaking it down

Components	Criteria	Questions
Mental health services have		
9.5 training and workforce development plans to ensure staff are trained and supported.	1. Identify relevant MHSU Training 2. Categorise criteria based on competencies/role/remit 3. Delivery plan	1. What training do we have? 2. What training is missing? 3. How can we share resources and delivery responsibilities 4. How do we audit and evaluate

Process

Benchmarking

Purpose

- Bring together people from across mental health and substance use services to explore:
- Exploring the MAT 9 criteria
- Outlining current practice
- Highlighting where things are working well, and
- Discuss opportunities for improvement at key transition points

Mapping Cases

Purpose

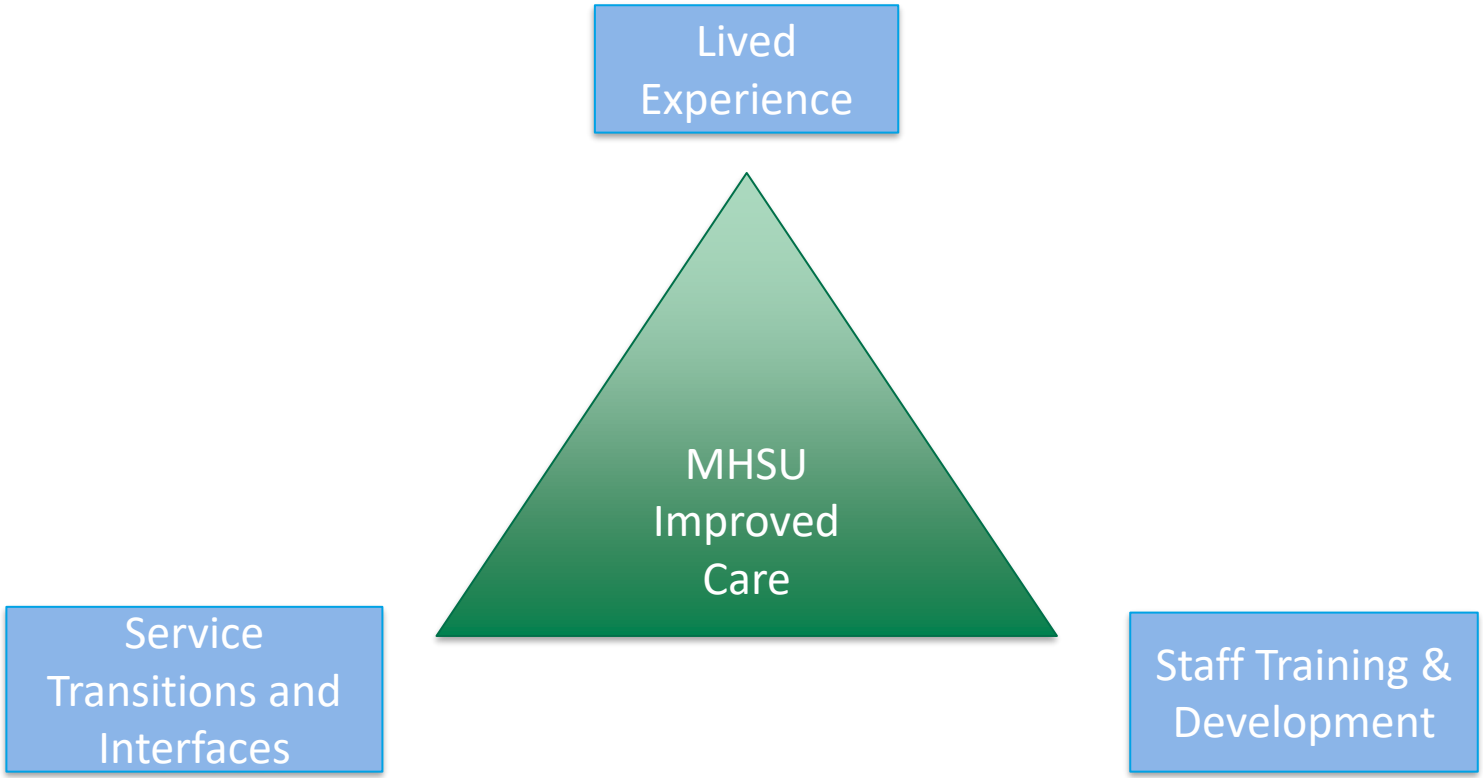
- 2 X Case Study Per locality
- Local operational aspects - referral, screening, and assessment and allocation to staff, joint working .
- Specific challenges in the system such as service gaps, lack of access to services, repetition or waiting times.
- Knowledge and training gaps/opportunities for staff

Action Planning & Sustaining Change

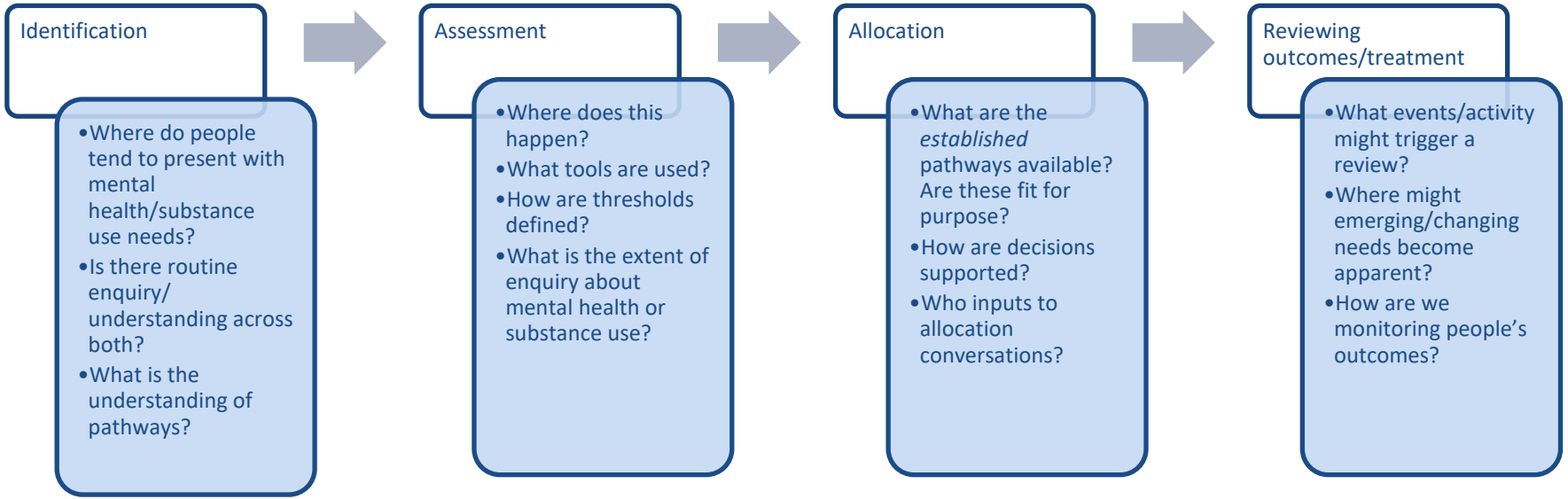
Purpose

- Develop, enhance, and formalise multi agency working
- Implement new models of transitions, screening and joint working
- How to evaluate outcomes and impact
- Agree and implement MHSU training plans
- Join training resources
- Gather lived experience knowledge via consultation of changes

Workstreams



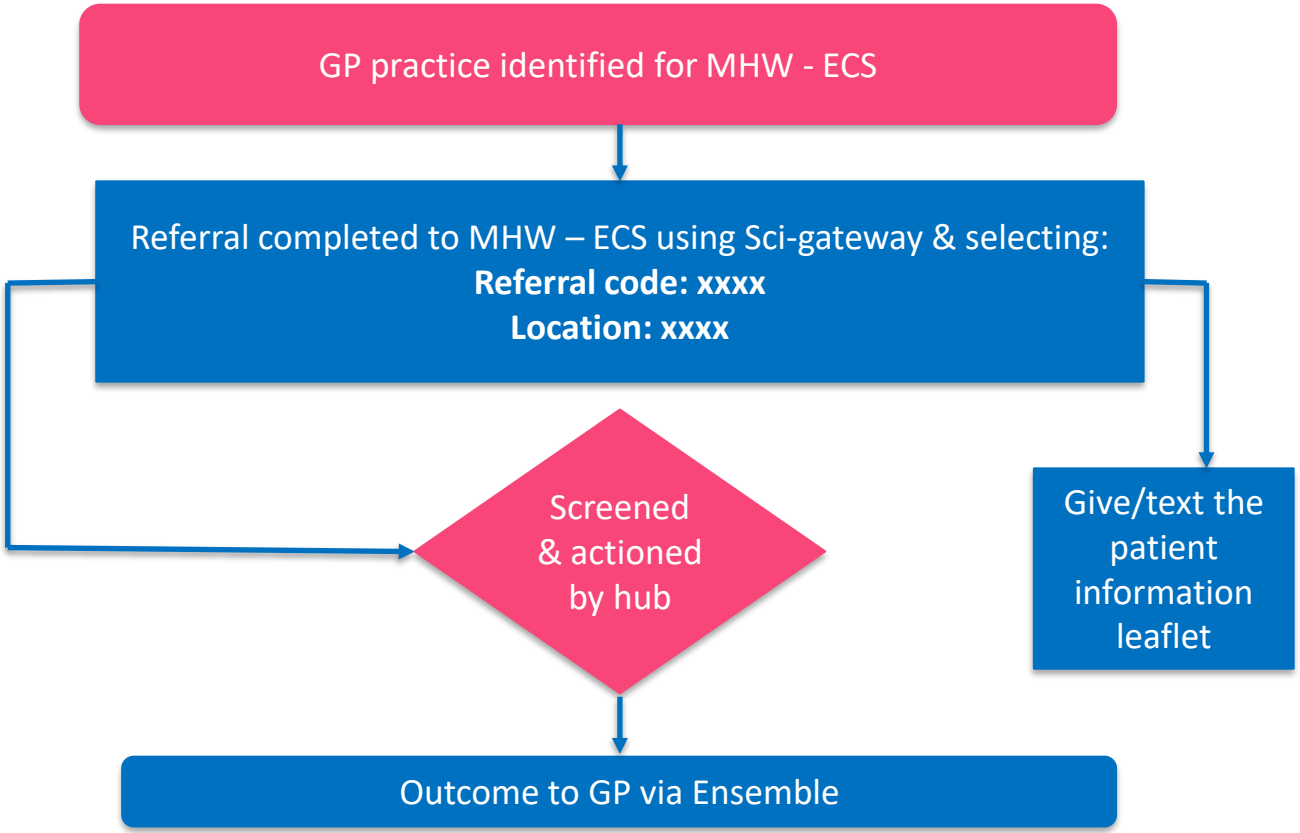
Exploring Transitions and Interfaces



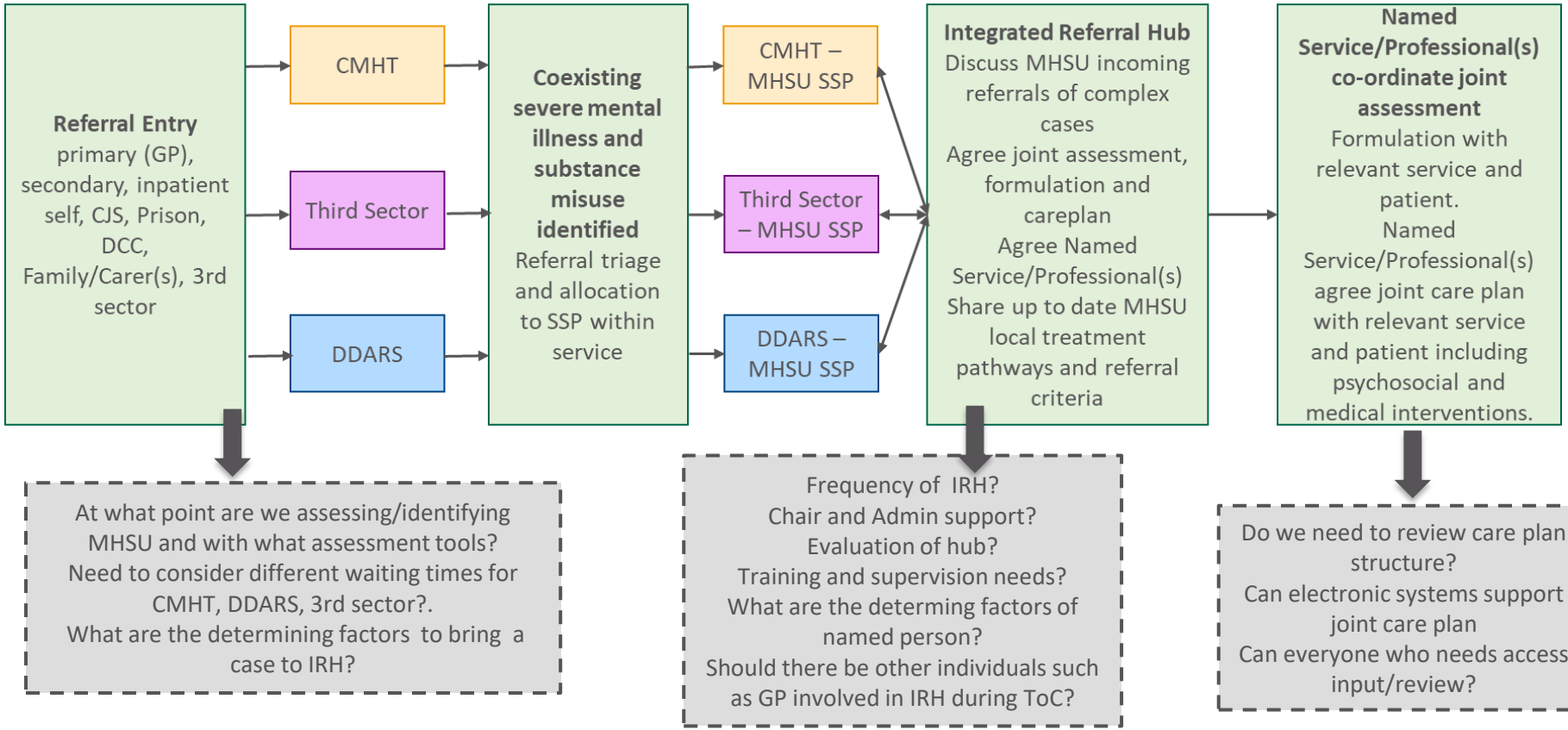
Angus Enhanced Community Support (ECS) Mental Health & Wellbeing Hub

Key info to be included in referral:

GP & patient expectation of referral, current/previous suicide attempt or self harm, alcohol/substance use, adult/child protection/vulnerability, or other consideration e.g war veteran



A new way of working – Dundee Proposal



Training SLWG - aims and objectives

The role and remit of the Group is to consider and make recommendations to the Tayside Delivery Group on:

- Identifying a key set of learning resources
- Producing a work-force development and training plan which provides guidance on a tiered, role-led approach to training of staff
- Identification of a methodology which will deliver and evaluate training
- Governance arrangements to support the new planning and delivery framework

Within the context of mental health and substance use services this will involve an emphasis on:

How to develop skills within the mental health workforce to respond to substance use needs; and develop skills within the substance use workforce to respond to mental health needs	A clear articulation of the different levels of knowledge/skills required across different job roles, linked to established 'Tiers' of intervention and the Four Quadrants model	Processes for ongoing support and supervision to ensure that training/skills are utilised and supported

Lived Experience

- Engagement and involvement work to date
- Quality of existing engagement and involvement work
- Knowledge gaps or underrepresented groups
- Further work to be undertaken

Still To Do....

Angus

By April 2024 there will be an outline and plans for a ToC to further enhance joint working.

- Driver Diagram session with Staff
- Evidence review of methods for peer support

Dundee

By April 2024 MACH will be launched, with an evaluation plan.

- Launch 06 April
- Agree Screening Tools

P&K

By April 2024 there will be an outline and plans for a ToC to MAT 9 implementation and broader systemic change.

- Driver diagram and SOP to complete
- Lead Officer to sign off on areas of focus

Training & Development

By April 2024 there will be a minimum recommended training and implementation plan for MHSU Services.

- Training plan sign off.
- Implementation & launch date tba

Lived Experience

By April 2024 there will be an understanding of focus areas for further engagement, along with more clarity as to how learning will inform decisions.

- Gap analysis inc research methodology.
- Consultation Group

MHSU Protocol

Healthcare Improvement Scotland

Change Mental Health

Involving people with Lived Experience

Aidan Mitchell

Policy and Public Affairs Officer, Change Mental Health

Katy McLeod

Research and Peer Engagement Programme Manager, Scottish Drugs Forum

NHS SCOTLAND

Why we wanted to get involved

Why?

- We are passionate about the inclusion of lived experience within our services.
- The co-occurring nature of these conditions mean that we are already assisting those with substance use issues.
- We hear the same issues over and over – we have a desire to help seek change.

change MENTAL HEALTH

Why we wanted to get involved

Why?

- Our peer research work confirms other findings in that the majority of people we work with face co-existing mental health and substance use issues yet the two remain poorly integrated in terms of service response
- Problems with accessing support for mental health is a top feature of our living experience engagement work
- We wanted to ensure the voices of those those currently in treatment had the opportunity to be heard

SDF
Scottish Drugs Forum

Reflections from the first meeting

How did it go?

- Finding participants.
- A real need to be heard properly.
- How can we do the simple things well.
- Opportunity for Lived Experience to shape the group.

Opportunities to get involved

What can you contribute

- We want to hear from the widest possible range of voices.
- Opportunities for additions to the group, upon discussion.
- Opportunity for group leaders to meet with organisations to hear more.

Healthcare Improvement Scotland

Mental Health and Substance Use Protocol Programme

Benjamin McElwee

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Mental Health and Substance Use Protocol Programme

Sept 2023 – Spring 2024

Discovery

Created by JOSHUA MINER
from Noun Project

Mental Health and Substance Use Protocol Programme

Sept 2023 – Spring 2024 | **Discovery**

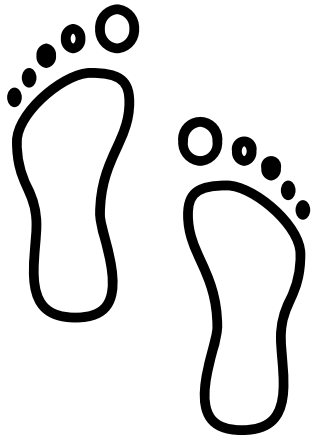
Spring 2024 – Autumn 2025 | **Test. Implement. Iterate.**

Autumn 2025 – March 2026 | **Sustain**

Breakout session 2:

How can you be supported to test, learn and share? What would help?

Next Steps



Evaluation

Please use the link in the chat box or scan the QR code below

feedback

Thank you for joining us – please keep in touch

Twitter: @online_his

Email: his.mhportfolio@nhs.scot

Web: healthcareimprovementscotland.scot

To find out more visit:
https://ihub.scot/improvement-programmes/mental-health-portfolio/mental-health-and-substance-use-programme/

Healthcare Improvement Scotland

Supporting better quality health and social care for everyone in Scotland