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

HEALTH AND SOCIAL CARE

social research

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

Health & Social Care Analysis

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Key Findings

- **Of the 349 individuals approached as part of the survey of people working within substance use services in Scotland, responses were received from 93 (27%) individuals from across 79 different services.** Two respondents from criminal justice services have been excluded from the overall analysis as these services were outside the scope of the survey.

- **The largest number of responses came from respondents working within the Alcohol and Drug Partnership (ADP) areas of Aberdeen City (12%) and Glasgow City (12%).** No responses were received from Falkirk, Orkney and Sheltand ADP areas.

- **Relating to the National Health Service (NHS) Health Board areas, the largest number of respondents worked within NHS Greater Glasgow and Clyde (23%).** NHS Orkney and NHS Shetland were the only health boards that did not have any responses.

- **The majority of respondents (98%) described their services as community based, with 13% of individuals responding from residential services.** The largest occupational group to respond (48%) were those in leadership positions within the service (e.g. Chief Executive Officers, managers, team leaders), followed by clinical staff (38%).

- **Around three quarters of respondents (76%) said that the majority of service users who attend their service presented with co-occurring substance use and a current mental health concern.** Over half of respondents (51%) estimated that “most” of their service users did and a quarter (25%) of respondents estimated that “more than half” did so.

- **Two fifths of respondents (42%) estimated that “less than half” of service users with co-occurring substance use and mental health concerns present with a formal diagnosis.** Around a third (33%) estimated that “most” or “more than half” did so.

- **The majority of respondents (62%) reported that their service uses some form of mental health screening tool, while just under a third (32%) said they used none.** The General Health Questionnaire was reported to be the most widely used tool amongst respondents (46%).

- **The main substances reported by respondents to be “commonly” or “very commonly” used by people presenting at their service with co-occurring substance use and mental health concerns were alcohol (99%), benzodiazepines (87%), cannabinoids (86%), cocaine (85%), opiates (77%), gabapentinoids (70%), methadone (66%) and prescription only drugs (62%).** The problematic use of ketamine, nitrous oxide, crystal meth, mephedrone, novel psychoactive substances (NPS), gamma hydroxybutyrate (GHB) and solvents such as gamma butyrolactone (GBL) were also mentioned by respondents.

- **Less than half of respondents (37%) said that amphetamines were "commonly" or "very commonly" used by people presenting at their service with co-occurring substance use and mental health concerns.**

- **The majority of respondents (63%) reported that their service offers mental health support, whilst over a third (37%) reported they did not.** Respondents reported offering treatment either 'very commonly' or 'commonly' for anxiety disorders (91%), mood disorders (86%) and post-traumatic stress disorder (75%).

- **Of those who did not provide mental health support, the majority (85%) reported that they referred these service users to another service where there was an identified need that their service could not meet.** Where made, most referrals tended to be to community mental health teams (86%), to general practitioners (66%), local third sector organisations (62%), and online resources (62%). The majority (90%) reported that the referral does not mean that the individual leaves their service.

- **Over half of respondents (55%) reported that there was a protocol in place to coordinate the care of individuals supported by more than one service, however over a third (36%) reported that there was none.** Where a protocol was in place, the majority of respondents (86%) reported that it was used. Some noted that their service revised their protocol "continually" or "as needed". Others detailed different timeframes, with most respondents reporting that protocols were reassessed annually, although some noted it was "very overdue".

- **Good communication and collaboration between services and service users were identified as key determinants to understanding whether a protocol was functioning appropriately.** Where no formal care management protocol was in place, respondents stressed communication with service users and between services as key to ensuring continuity of care.

- **Specific challenges around meeting the needs of different service user groups were highlighted by respondents.** These included specific mention of people experiencing homelessness, non-English speaker, women, members of the LGBTI community and people with physical disabilities.

- **Key barriers to effective service delivery for people with co-occurring problem substance use and mental health concerns were discussed by respondents.** Respondents suggested areas of improvement to services include flexibility in service delivery, increased scope for outreach (e.g. home visits), improved referral pathways between services and the creation of local "hubs" where substance use and mental health services are located in the same place, allowing individuals to be jointly assessed and treated.

Contents

1. Introduction

The level of harms from alcohol and drugs in Scotland are high in comparison to the rest of the UK and Europe, and cause avoidable damage to people's lives, families and communities. Tackling the high level of drug related deaths and harms in Scotland is a priority for the Scottish Government. On 20th January 2021, the First Minister made a statement to Parliament which set out a National Mission to reduce drug deaths and improve lives through improvements to treatment, recovery and other support services. One of the objectives is to address the requirements of people with multiple and complex needs, which includes people experiencing both substance use and mental health concerns.

In October 2021, the Minister for Drug Policy and the Minister for Mental Wellbeing and Social Care announced a rapid review of mental health and substance use services to better understand the current provision of services in Scotland. The announcement was made in the context of current commitments by the Scottish Government to improve the support available for those who have mental health concerns alongside problem substance use.

This report presents the results of a survey of individuals working within services that provide support to people who use drugs or alcohol in Scotland. The survey was undertaken to better understand the provision and availability of care for people who experience co-occurring substance use and mental health conditions in Scotland.

This report forms part of a wider research project exploring the provision of support for people with co-occurring substance use and mental health concerns in Scotland. It is published alongside a review of the literature and evidence on co-occurring substance use and mental health concerns and the integration of mental health and substance use services over the past 20 years in Scotland.

2. Methodology

A survey was sent by email to a total of 349 individuals who work within services that provide support to people who use substances. This includes contacts from the 189 front line services across Scotland who respond to the Drug and Alcohol Information System (DAISy)[1], the 42 members of the residential rehabilitation providers group, and the Scottish Addiction Specialist Group, a semi-formal group of 118 key individuals working in substance use services in Scotland.

The criteria for inclusion in the survey were individuals that worked within Alcohol and Substance Use services in Scotland, however those that were based in criminal justice services were excluded. While the individuals contacted were not asked to distribute the survey further, it is possible that they may have done so resulting in a wider sample than was approached.

The survey questions were designed to provide a snapshot, at the time of completion, of the provision and availability of the support available to address mental health needs within substance use services. The survey comprised of 26 questions[2] (see Appendix A) that were developed in consultation with clinical experts. Questions were included on current approaches to service provision, referral pathways, integration of mental health and substance use services, gaps in provision and examples of good practice. The survey was conducted between 28 September and 4 October 2022.

[1] DAISy is a national database designed to capture referrals to all tier 3 or 4 drug and alcohol treatment services in Scotland. The DAISy website is run by Public Health Scotland (PHS).
[2] Questions 11 and 12 are excluded from the analysis as a result of a survey design error.

3. Main findings

3.1 Response rates and respondent information

Of the 349 individuals who were approached to complete the survey, 93 (27%) responded. Two respondents from criminal justice services have been excluded from the overall analysis as these services were outside the scope of the survey. Therefore 91 respondents (26% of those approached) are included in the overall analysis.[3]

It should be stated that the sample is not representative of all services that provide support for people who use substances in Scotland. The respondents self-selected to participate in the survey meaning that there may be some bias in the results. The survey results should therefore be treated with caution throughout and be regarded as indicative only of the views of the respondents that completed the survey. Despite this, it provides a useful insight into the provision and availability of care for people who experience co-occurring substance use and mental health concerns in Scotland.

The respondents worked across 79 different drug and alcohol services in Scotland. The majority of respondents (71) were from different services. However in 20 cases, a response was submitted by more than one member of staff from the same service. One service had four related responses, two services had three responses each and five services had two responses each. There were also two services that had two respondents who worked within different NHS Health Boards. It is important to note that responses have not been consolidated where multiple responses from the same service have been received. Data is presented from the point of view of the respondents, not the services.

The largest number of responses came from respondents working within the Alcohol and Drug Partnership areas of Aberdeen City (12%) and Glasgow City (12%) (see Table 1). There were also several respondents working within Edinburgh (11%), Dumfries and Galloway (8%) and Highlands (7%). The rest of the partnership areas had a few respondents working within them. There were no responses from Falkirk, Orkney and Shetland.

Table 1: Total number and percentage of respondents by Alcohol and Drug Partnership Area

Alcohol and Drug Partnership Area	Number of respondents	% of respondents
Aberdeen City	11	12%
Glasgow	11	12%
Edinburgh	10	11%
Dumfries and Galloway	7	8%
Highland	6	7%
Falkirk	0	0%
Orkney	0	0%

[3] Responses are sometimes aggregated to protect the anonymity of individual respondents.

Shetland	0	0%
Other[4]	46	51%

Base: 91 respondents

Relating to the National Health Service (NHS) Health Board areas, the largest number of respondents worked within NHS Greater Glasgow and Clyde (23%) (see Table 2). NHS Grampian (18%) and NHS Lothian (16%) were the next most common health boards that the respondents worked within. NHS Orkney and NHS Shetland were the only health boards that did not have any responses.

Table 2: Total number and percentage of respondents by NHS Health Board area

NHS Health Board	Number of respondents	% of respondents
NHS Ayrshire and Arran	5	5%
NHS Dumfries and Galloway	7	8%
NHS Grampian	16	18%
NHS Greater Glasgow and Clyde	21	23%
NHS Highland	7	8%
NHS Lothian	15	16%
NHS Orkney	0	0%
NHS Shetland	0	0%
NHS Tayside	5	5%
Other[5]	15	15%

Base: 91 respondents

Most respondents (98%) described their services as community based. Just over half (51%) self-described as a community addiction service, while 13% of respondents said that their service was a residential community service. Some respondents reported that they provided multiple services in the community (7%), such as a combination of community addiction and primary care. The remaining respondents stated their services were based in primary or emergency care, counselling, employability, harm reduction, homelessness support, housing recovery, stabilisation units, rehabilitation, social housing, young people and social work.

The largest number of responses were received from those in leadership positions within a service (e.g. Chief Executive Officers, managers, team leaders), which accounted for 48% of the respondents (see Table 3). Respondents' professions also included clinical staff (37%), such as consultants, doctors, nurses, paramedics and medical officers. The remaining respondents were support workers, social workers, mental health counsellors and housing officers.

[4] "Other" includes the Alcohol and Drug Partnership areas of Aberdeenshire, Angus, Argyll and Bute, Borders, Clackmannanshire and Stirling, Dundee, East Ayrshire, East Dunbartonshire, East Renfrewshire, Fife, Inverclyde, Mid and East Lothian, Moray, North Ayrshire, North Lanarkshire, Perth and Kinross, Renfrewshire, South Ayrshire, South Lanarkshire, West Dunbartonshire, West Lothian and Western Isles which have been aggregated due to low number of respondents.

[5] "Other" includes NHS Borders, NHS Fife, NHS Forth Valley, NHS Lanarkshire and NHS Western Isle which have been aggregated due to low number of respondents.

Table 3: Total number and percentage of respondents by their occupation

	Occupation	Number of respondents	% of respondents
Leadership Positions	Manager	31	34%
	Team Leader	9	10%
	CEO	*	*
Clinical Staff	Consultant Psychiatrist	13	14%
	Nurse	9	10%
	Doctor	6	7%
	Medical Officer	*	*
	Paramedic	*	*
Other	Support Worker	8	9%
	Counsellor	*	*
	Social Worker	*	*
	Housing Officer	*	*

* low bases >5 responses have been suppressed for anonymity

3.2 Profile of the service users with co-occurring substance use and mental health concerns attending substance use services

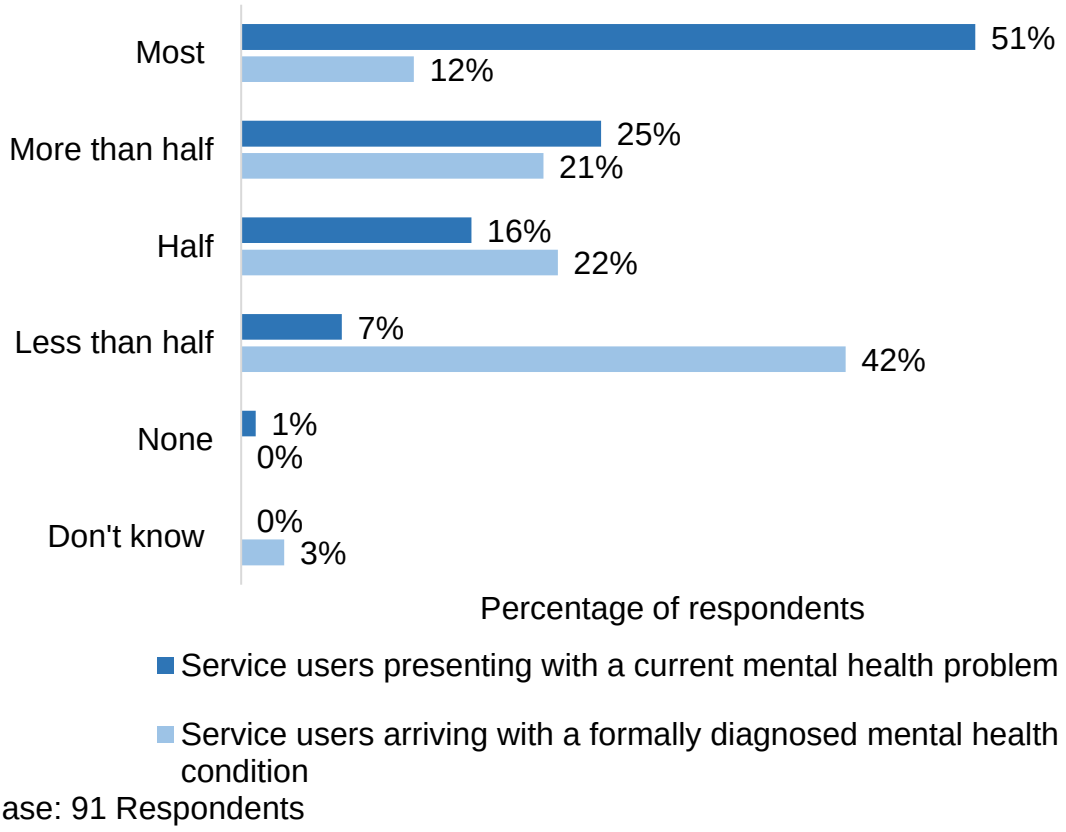
Respondents were asked to gauge what proportion of service users presented with co-occurring substance use and a current mental health concern at their service[6]. They were also asked to estimate the proportion of service users that arrived at their service with a formally diagnosed mental health condition.

Around three quarters of respondents (76%) said that the majority[7] of service users who attend their service presented with co-occurring substance use and a current mental health concern. Over half of respondents (51%) estimated that "most" of their service users did and a quarter (25%) of respondents estimated that "more than half" did so. There were 15 respondents (16%) that stated "half", and 6 respondents (7%) said "less than half". Only one respondent estimated that "none" of the current service users presented with co-occurring substance use and a current mental health concern.[8]

Two fifths (42%) of respondents estimated that "less than half" of service users service users with co-occurring substance use and mental health concerns presented with a formal diagnosis of a mental health condition. Around one in five respondents in each case estimated that "half" (22%) or "more than half" (21%) did so. Figure 1 shows the contrast between the respondents' estimates on the proportion of service users with co-occurring substance use and mental health concerns and those that had a formal diagnosis of a mental health condition on arrival to their service.

[6] A mental health concern was defined as being either diagnosed, self-defined, or that the respondent believed the service user could benefit from mental health support.
[7] "More than half" and "Most" aggregated
[8] The same respondent also answered "half" to the subsequent question on the proportion of patients arriving with a formally diagnosed mental health condition.

Figure 1: Percentage of respondents estimating the proportion of service users presenting with co-occurring substance use and either mental health concerns or a formally diagnosed mental health condition



Base: 91 Respondents

The majority of respondents (62%) reported that their service uses some form of mental health screening tool (see Table 4). Almost half of respondents (46%) reported using the General Health Questionnaire. Eleven respondents (12%) said they used the Beck Depression Inventory, while the remaining screening tools were reported as being used by less than 10% of respondents. Other examples of mental health screening tools used were GAD-7, ~~PHQ-9~~, Mental Health Assessment for Nurses and the Core 10. Of the 56 respondents that reported using a screening tool, around three quarters (76%) said their service used a single assessment measure. There were also 13 respondents (14%) that indicated their service used two or more screening tools.

Just under a third of respondents (32%) said they did not use a mental health screening tool within their service. Despite not using a tool, the majority (76%) of these respondents said that “most” or “more than half” of the service users presented with a co-occurring substance use and mental health concern, and around half (52%) said that “less than half” presented with a formally diagnosed mental health condition.

Table 4: The number and percentage of respondents that reported using a specific mental health screening tool at their service

Type of mental health screening tool	Number of respondents	% of respondents
Beck Anxiety Inventory	7	8%
Beck Depression Inventory	11	12%
Hamilton Anxiety Rating Scale	8	9%
General Health Questionnaire	42	46%
None	29	32%
Other specified	13	14%
Don't know	6	7%

Base: 91 respondents

3.3 Substances involved in co-occurring substance use and mental health concerns

Respondents were asked about the types of substances used by people presenting at their service with co-occurring substance use and mental health concerns. Table 4 shows how commonly respondents reported different types of substances being involved in co-occurring substance use and mental health concerns.

Table 4: Percentage of respondents estimating the prevalence of the use of different substances by people with co-occurring substance use and mental health concerns

Type of Substance	Very common	Common	Occasionally	Never	I don't know
Alcohol	77%	22%	1%	0%	0%
Amphetamines	20%	18%	54%	4%	4%
Benzodiazepines (prescription/street)	70%	16%	9%	1%	3%
Cannabinoids (including synthetic)	57%	29%	12%	0%	2%
Cocaine (powder/crack)	57%	27%	12%	1%	2%
Gabapentinoids	25%	45%	22%	2%	5%
Methadone	41%	25%	24%	4%	5%
Opiates	48%	29%	16%	3%	3%
Prescription-only medicines	22%	40%	34%	0%	4%

Base: 91 respondents

Almost all of the respondents (99%) reported that alcohol was "commonly" or "very commonly"[9] used by people presenting at their service with co-occurring substance use and mental health concerns. Only one respondent answered that alcohol use was "occasionally" implicated. The majority of respondents also said that benzodiazepines (87%), cannabinoids (86%), cocaine (85%), opiates (77%), gabapentinoids (70%), methadone (66%) and prescription-only drugs (62%) were "commonly" or "very commonly" used by service users with co-occurring substance use and mental health concerns.

Less than half of respondents (37%) said that amphetamines were "commonly" or "very commonly" used by people presenting at their service with co-occurring substance use and mental health concerns. No respondents reported that alcohol, cannabinoids or benzodiazepines were "never" used by service users presenting with co-occurring substance use and mental health concerns. Other substances respondents reported were ketamine, nitrous oxide, crystal meth, mephedrone, novel psychoactive substances (NPS), gamma hydroxybutyrate (GHB) and solvents such as gamma butyrolactone (GBL).

3.4 Availability of mental health support and treatment within substance use services

Respondents were asked if their service is able to offer specific mental health support for service users who present with an undiagnosed mental health concern.

The majority of respondents (63%) reported that their service offers mental health support for service users who present with an undiagnosed mental health concern. Some of these respondents provided details on the type of support provided, which ranged from support from specialist staff (such as mental health nurses and psychologists) to specific interventions (such as consultant psychiatry and cognitive behavioural therapy).

Of the respondents who said their service offered mental health support[10], most (91%) said it was "common" or "very common" for their service to offer treatment for anxiety disorders (see Table 5). The majority of these respondents reported it was also "common" or "very common" for their service to offer treatment for mood disorders (86%) and post-traumatic stress disorder (75%). Less than half of the respondents said that their service commonly or very commonly offered treatment for attention deficit hyperactivity disorder (40%), alcohol-related brain damage (30%) and psychotic disorders (25%). Some respondents also commented that their service offered treatment for other mental health concerns including eating disorders, conversion disorder, learning disabilities, organic brain disorders and adverse childhood experiences.

[9] "Common" and "very common" have been aggregated in the text.
[10] 57 respondents

Table 5: Percentage of respondents estimating how often treatment is offered for mental health concerns at their service

Mental Health Condition	Very Common	Common	Occasionally	Never	I don't know
Alcohol-related brain damage	7%	23%	54%	14%	2%
Anxiety disorders (including general anxiety, obsessive compulsive disorder)	60%	32%	2%	5%	2%
Mood disorders (including bipolar disorder, depression)	51%	35%	7%	5%	2%
Personality disorders	51%	23%	16%	9%	2%
Psychotic disorders (including schizophrenia)	12%	12%	60%	12%	4%
Attention deficit hyperactivity disorder[11]	12%	28%	46%	11%	2%
Post-traumatic stress disorder	47%	28%	16%	5%	4%

Base: 57 respondents

3.5 Referrals arrangements for mental health support

Over a third of respondents (37%) said that their service did not provide mental health support. The majority of these (85%) reported that they referred these service users to another service. There were 5 respondents (15%) that reported their service did not offer referrals. The majority of respondents who indicated that their service made referrals reported that the referral did not mean that the service user had to leave their service (90%).

Respondents noted different criteria for referral at their service. Some respondents said that their service referred individuals if they had any mental health concern, while others specified that the severity of the mental health concern would determine whether an individual was referred or not. Measures of severity were reported to include suicidality, survival of an overdose, or if a service user was experiencing a mental health crisis. A number of respondents commented that referrals were often initiated at the request of the service user seeking support. Other respondents said that a lack of expertise, resources and staff within their services meant that they had "limited time to offer psychological interventions", requiring them to refer service users to other services.

[11] 56 respondents provided a response estimating how often treatment is offered for attention deficit hyperactivity disorder.

Most of the respondents who said that their service referred individuals to other services for mental health support referred them to community mental health teams (86%) (see Table 6). Respondents also reported referrals to general practitioners (66%), local third sector support organisation (62%) and online tools and resources (62%). A small number of these respondents (10%) said their service referred service users to an intensive home treatment team.[12] There were 26 respondents (90%) that selected more than one referral service. A few respondents also provided examples of referring service users to accident and emergency (A&E) mental health teams, community mental health nurses and mutual aid or peer support services.

Table 6: Number and percentage of respondents reporting on referrals made to different services for mental health support

Services to which referrals are made	Number of respondents	% of respondents
Community mental health team	25	86%
General practitioner	19	66%
Local third sector support organisation	18	62%
Online tools and resources	18	62%
Crisis teams	16	55%
Intensive home treatment team	3	10%

Base: 29 respondents

3.6 Protocols for coordinating care between multiple services

Respondents were asked whether a protocol was in place for coordinating the care of service users supported by more than one service and how protocols were improved upon.

Over half of respondents (55%) reported that there was a protocol in place for coordinating the care of individuals supported by more than one service[13]. A further 36% of respondents answered that their service did not have a protocol in place[14], while a few responded that they did not know (8%).

Where a protocol was reported to be in place, the majority of respondents (86%) reported that it was used[15]. A number of these respondents described how often the protocol was revised at their service. Some noted that their service revised their protocol "continually" or "as needed". Others detailed different timeframes, with most respondents reporting that protocols were reassessed annually, although monthly and quarterly were also mentioned. There were also respondents that stated it occurred every 2 years, with some noting it was "very overdue" and one commenting that it hadn't been revised since 2014.

[12] Respondents made reference to this service without providing a further definition of the support provided by these teams.
[13] One respondent did not answer the question.
[14] The respondents that answered "no" could also be due to their service not having service users that were supported by more than one service.
[15] Data were missing for two respondents.

Good communication and collaboration between services and service users were identified as key determinants to understanding whether a protocol was functioning appropriately. Service users were often "encouraged to be actively involved in their own care and support", with many respondents commenting that the service users' engagement was integral to understanding if a protocol was working. Engagement could take place, for example, through meetings between staff and service users to discuss individual cases or by service user feedback questionnaires. Some respondents said that clinical outcomes, measures, and other mental health indicators of the service user were used to understand if a protocol was working. Some respondents emphasised that good communication, collaboration and feedback between staff at their own service and that of the other service providers allowed them to evaluate and understand if a protocol was working.

Where no formal care management protocol was in place, respondents stressed communication with service users and between services as key to ensuring continuity of care.

3.7 Challenges experienced by and support offered to different groups of service users

Respondents were asked what the particular challenges experienced by different groups of service users were, and how the specific needs of these service users were supported.

There were a number of challenges that respondents highlighted for their services in meeting the needs of people experiencing homelessness. These included difficulties around attending appointments, a loss of contact with them, issues registering these service users at local general practitioner practices, and limited availability of secure housing when discharging them back into the community. To help overcome these challenges some respondents indicated that they worked collaboratively with other services to help provide support to service users who are experiencing homelessness by offering them housing. Respondents also said that some services have specific staff that provide to people experiencing homelessness, such as officers and nurse teams.

Non-English speakers were also identified as a group of service users that experience specific challenges. Many respondents at services where non-English speakers were service users said that they offered interpreters. Most statutory services, and larger third sector organisations, had access to interpreters via the NHS or similar services, but some smaller organisations reported making use of Google Translate. However some noted that it was difficult to have an interpreter there for the duration of a person's involvement with the service stay due to the availability of the interpreter and the associated costs. In addition, some noted that interpreters could act as a barrier for effective treatment in a therapeutic community environment.

Respondents said that there were particular challenges faced by women who attended their services. They said that these women could be at risk from experiencing trauma, sexual exploitation, and issues relating to family relationships and the fear of losing custody of children. Respondents said that services supported

female service users by offering women-only groups and separate gender specific services such as female trauma groups and whole family approach teams that bring together adult and children services. They also emphasised providing privacy and security within their facilities.

Stigma around drug use or mental health was said to have made accessing treatment more difficult for some groups. A small number of responses also mentioned addressing the specific needs of the LGBTI community and those of young people. In addition, the issues services users with disabilities can experience in relation to their physical access to services were mentioned.

3.8 Suggested improvements to mental health support

Respondents were invited to report any further comments they had on how services could be improved to meet the needs of people with co-occurring substance use and mental health concerns.

A number of respondents discussed the issue around difficulties in **referring individuals to mental health services** and that once a referral had been made, this was often rejected on the basis that substance use was still an issue for that individual. Specifically, some felt that there were cases where an individual seeking support at a substance use service, should in principle have their primary support provided by a specialist mental health service. It was felt by some that lack of resources in mental health services contributed to care being focused on substance use, despite this not being where the focus should lie.

Respondents also highlighted the issue of **resourcing within substance use services**. It was felt that the limited numbers of support staff in services contributed to increased waiting times. Some respondents reported that they often feel like they were “firefighting” and dealing with issues reactively instead of taking the required time to develop relationships with service users and take a more holistic therapeutic approach. This was also felt to contribute to staff being less able to take a person centred approach, where multiple services provide support and care to an individual.

Specific suggested areas of improvement include flexibility in service delivery; increased scope for outreach (e.g. home visits); improved referral pathways between services, and the creation of local “hubs” where substance use and mental health services are located in the same place, allowing individuals to be jointly assessed and treated.

4. Key Considerations

The research shows that around three quarters of respondents (76%) said that the majority of service users who attend their service presented with co-occurring substance use and a current mental health concern. Therefore it is crucial to understand how substance use services can support these service users. There are some key considerations that emerged:

- Although the majority of respondents (63%) reported that their service were able to offer mental health support for service users who present with a new mental health concern, 37% of respondents said they were unable to. It is important to consider how to improve resources within more substance use services to be able to provide mental health support for people who use substances.
- Effective relationships and communication between services are required to encourage continued care for the service user.
- Procedures should be implemented to ensure that referral protocols are in place, followed and have an agreed revision date and process.
- Consideration needs to be given to addressing the different challenges experienced by specific groups of service users.
- It is necessary to promote cultural change in some services to reduce stigma towards people who use drugs.
- It would be beneficial to gather a representative sample of alcohol and substance use services in Scotland with which future research on services and service user needs could be conducted.

5. Appendix A – Survey Questions

1) Which Alcohol and Drug Partnership area do you mainly relate to?

Aberdeen City	□	Highland	□
Aberdeenshire	□	Inverclyde	□
Angus	□	Mid and East Lothian	□
Argyll and Bute	□	Moray	□
Borders	□	North Ayrshire	□
Clackmannanshire and Stirling	□	North Lanarkshire	□
Dumfries and Galloway	□	Orkney	□
Dundee	□	Perth and Kinross	□
East Ayrshire	□	Renfrewshire	□
East Dunbartonshire	□	Shetland	□
East Renfrewshire	□	South Ayrshire	□
Edinburgh	□	South Lanarkshire	□
Falkirk	□	West Dunbartonshire	□
Fife	□	West Lothian	□
Glasgow	□	Western Isles	□

2) Which health board area do you work in?

Ayrshire and Arran	□	Highland	□
Borders	□	Lanarkshire	□
Dumfries and Galloway	□	Lothian	□
Fife	□	Orkney	□
Forth Valley	□	Shetland	□
Grampian	□	Tayside	□
Greater Glasgow and Clyde	□	Western Isles	□

3) What is your job title?

4) What type of service do you work in? Please specify (e.g. community addiction service, residential rehabilitation, etc.)

5) What is the name of the service you work within? (this question is for the purpose of linking responses and will not be reported)

6) Of the patients currently attending your service, what proportion have presented with co-occurring substance use and a current mental health condition (either diagnosed, self-defined, or that you believe could benefit from mental health support)?

Most	More than half	Half	Less than half	None	I don't know
□	□	□	□	□	□

7) Of these, what proportion arrive with a formally diagnosed mental health condition?

Most	More than half	Half	Less than half	None	I don't know
□	□	□	□	□	□

8) What mental health screening tools do you use within your service?

Beck Anxiety Inventory	□
Beck Depression Inventory	□
Hamilton Anxiety Rating Scale	□
General Health Questionnaire	□
None	□
I don't know	□
Other (please specify)	□

9) How commonly are the following substances implicated for people presenting with co-occurring substance use and a mental health condition (diagnosed or undiagnosed)?

	Never	Occasionally	Common	Very common	I don't know
Alcohol					
Amphetamines					
Cannabinoids (including synthetic)					
Cocaine (powder/crack)					
Benzodiazepines (prescription/street)					
Gabapentinoids					
Methadone					
Opiates					
Prescription-only painkillers					

10) If another substance, please specify which and how commonly it is implicated.

11) Please provide an estimate of the percentage of people presenting with co-occurring substance use and a mental health condition (either diagnosed, self-defined, or that you believe could benefit from mental health support) who are:

Male □ **Female** □ **Other** □

12) Which age group do people presenting with co-occurring substance use and a mental health condition (either diagnosed, self-defined, or that you believe could benefit from mental health support) primarily correspond to?

Under 18	**18-25**	**26-35**	**46-55**	**56-65**	**Over 65**
□	□	□	□	□	□

13) Are you able to provide specific mental health support for people who present with a new mental health concern within your service?

Yes □ **No** □

14) If yes to 13, please detail the support provided.

15) If yes to 13, How often will your service offer treatment for the following mental health conditions?

	Never	Occasionally	Common	Very common	I don't know
Alcohol-Related Brain Damage					
Anxiety Disorders (including general anxiety, Obsessive Compulsive Disorder)					
Mood Disorders (including bipolar disorder, depression)					
Personality Disorders					
Psychotic Disorders (including schizophrenia)					
Attention Deficit Hyperactivity Disorder					
Post-Traumatic Stress Disorder					

16) If Yes to 13, If a treatment for another mental health condition, please specify which and how commonly it is offered.

If No to 13 continue here

17) Do you refer on individuals where you are unable to support them due to an underlying mental health concern?

Yes □ **No** □

18) If Yes to 17, What are your service's criteria for referral?

19) If Yes to 17, Where do you refer them to?

Crisis Teams	□
Intensive Home Treatment Team	□
General Practitioner	□
Community Mental Health Team	□
Local third sector support organisation	□
Online tools and resources	□
Other (please specify)	□

20) If Yes to 17, Does referral result in their leaving the service?

Yes □ **No** □

If No to 17 continue here

21) For individuals supported by more than one service (including your own), is there a protocol in place for coordinating their care?

Yes □ **No** □ **Don't Know** □

22) If Yes to 21, Is the protocol used?

Yes □ **No** □

23) If Yes to 21, How often is the protocol revised?

24) If Yes to 22, As part of this review process, how do you understand if this is working for individual service users?

If "I don't know" or "No" to 21, OR "No" to 22 continue here

25) If there is no formal protocol in place for coordinating care between services, what steps does your organisation take to keep in touch with the service user?

26) What are the particular challenges experienced by different groups of service users (minority groups, women, people who are homeless, people who do not speak English as a first language, etc.) and how do you do you support their specific needs?

27) Please provide any other comments (e.g. relating to how services could be improved in general to meet the mental health needs of people in substance use services).

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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