MEETING THE NEEDS OF PEOPLE WITH CO-OCCURRING SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS

Report of the Joint Working Group

Scottish Advisory Committee on Drug Misuse (SACDM)
Scottish Advisory Committee on Alcohol Misuse (SACAM)
mind the gaps
MEETING THE NEEDS OF PEOPLE WITH
CO-OCCURRING SUBSTANCE MISUSE AND
MENTAL HEALTH PROBLEMS

Report of the Joint Working Group

Scottish Advisory Committee on Drug Misuse (SACDM)
Scottish Advisory Committee on Alcohol Misuse (SACAM)
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>1</td>
</tr>
<tr>
<td>Mr Hugh Henry, Deputy Minister for Justice</td>
<td></td>
</tr>
<tr>
<td>Mr Tom McCabe, Deputy Minister for Health and Community Care</td>
<td></td>
</tr>
<tr>
<td>Chapter 1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Chapter 2 Executive Summary and Recommendations</td>
<td>11</td>
</tr>
<tr>
<td>Chapter 3 The Nature and Extent of the Problem</td>
<td>21</td>
</tr>
<tr>
<td>Chapter 4 Existing Service Provision in Scotland</td>
<td>31</td>
</tr>
<tr>
<td>Chapter 5 Assessment, Intervention and Support</td>
<td>49</td>
</tr>
<tr>
<td>Chapter 6 Planning and Delivery of Services</td>
<td>63</td>
</tr>
<tr>
<td>Annex A Key statistics on alcohol, drug use, mental health and co-occurring substance misuse and mental health problems</td>
<td>71</td>
</tr>
<tr>
<td>Annex B The National Programme for Improving Mental Health and Well-Being</td>
<td>79</td>
</tr>
<tr>
<td>Two initiatives: ‘see me’ and ‘Breathing Space’</td>
<td></td>
</tr>
<tr>
<td>Annex C Model of Service Provision in Ayrshire and Arran</td>
<td>81</td>
</tr>
<tr>
<td>Annex D Midway Project: A Partnership Approach to Housing Support</td>
<td>85</td>
</tr>
<tr>
<td>Annex E Mental Health Foundation Research Executive Summary</td>
<td>87</td>
</tr>
<tr>
<td>References and further resources</td>
<td>89</td>
</tr>
<tr>
<td>Definitions</td>
<td>95</td>
</tr>
<tr>
<td>SACAM/SACDM Working Group Members</td>
<td>97</td>
</tr>
</tbody>
</table>
MINISTERIAL FOREWORD

People with a combination of mental illness and substance misuse problems face many challenges, and are themselves a substantial and particularly challenging group. We are grateful to the Working Group, set up by the Advisory Committees on Drug and Alcohol Misuse, for its thorough and honest appraisal of their needs and how these needs should be met.

There are strong messages in the report for all of us. We need to challenge the perceptions and attitudes that people have about mental illness and substance misuse, and ensure that everybody receives respect and a proper response to their problems. The report highlights the need for better promotion and prevention activities; improved education and awareness; more effective care and treatment services, backed up by improved standards; and better strategic planning. Interventions can and do work, particularly if delivered early enough and involving the client in a meaningful way.

The report acknowledges that much progress has already been made by the Executive to ensure social justice and inclusion for vulnerable people. It highlights the opportunities which exist through Partnership for Care, Joint Future and Integrated Care for Drug Users to improve effective partnership working and the delivery of more flexible and integrated care. However, it also challenges us to do more.

We fully support and accept the recommendations of the Working Group and are already working with key stakeholders on their implementation. By doing so, we offer hope to the many vulnerable individuals who rely on these services.

Hugh Henry

TOM MCCAIBE MSP
Deputy Minister for Health and Community Care

October 2003
CHAPTER 1

INTRODUCTION
CHAPTER 1: INTRODUCTION

1.1 There is a large group of men and women in our society with a mixture of mental health problems and problems arising from alcohol and substance misuse. Many lead troubled lives, seeking help from individual services, both voluntary and statutory, from time to time. But the individual’s experiences and service components do not generally run smoothly. The client’s experience and the way that services perceive themselves and others are not coherent.

1.2 The Scottish Advisory Committees on Drug and Alcohol Misuse (SACDM and SACAM) are each chaired by a Minister in the Scottish Executive, and regularly bring together experts from the field and officials. From their awareness of the problem, both Committees agreed in 2002 to commission jointly a working group to address the needs of people with co-occurring substance misuse (including alcohol) and mental health problems.

1.3 An increasingly large number of people, across all socio-economic groups, have very complex, changing and deep-rooted problems. They are often excluded from mainstream social life, employment, experience of caring services and often, too, from families and those closest to them. Many are victims of previous traumatic events, the effects of which have not been adequately addressed and often have continued for many years. These experiences range from bullying at school, broken and dysfunctional family life, sexual or other abuse, and exclusion from the mainstream of society. Because of the nature of these difficulties, and out of fear of further adverse experience, they may deliberately conceal the extent of the underlying influences and events which have contributed to their problems.

1.4 It is often unclear why people appear to experience multiple problems at particular times, or which problem comes first. Substance misuse is often a way of coping with low self-esteem, the reality, memory or continuing effects of abuse, or a mental health problem. In terms of need for help, it is no matter which is cause or consequence.

“If you are looking at drugs you are looking at people depressed. You cannot see a drug addict out there that is not depressed, that is not stressed out.’
Mental Health Foundation Research 2003

1.5 What is clear, however, is that people with co-occurring substance misuse and mental health problems are important as individuals and as a group: that they need support, understanding, advice and care; that people in a range of public services and professional disciplines can respond more positively and effectively to their needs, be they decision-makers or care workers.

1.6 This report sets out to describe what it would take to offer a better future. It focuses on the current needs of those people, but also addresses the wider needs of those who may be vulnerable to developing similar problems in the future. While prevention will always be more successful than care, treatments described in this report are successful in a high proportion of those in care of various forms.
Who should read this report

1.7 Leaders, planners and commissioners of public services, should read this report, particularly those responsible for caring services. This report also presents challenges for a range of people:

- the general public, regarding their attitude and understanding as to why people with substance misuse and mental health problems may behave as they do;

- public representatives and commentators, in understanding that the determinants of people’s problems often lie in adverse life experiences and their manifestations;

- policy-makers, in understanding the need to integrate support for vulnerable people, and to deal sensitively with the consequences of past events;

- commissioners of services, in creating integrated strategies and environments for effective services, with the voluntary sector core to the creation of local strategy as well as to care provision;

- the specialist community in health, social and voluntary care, housing and education, and the criminal justice system in their responsibility as leaders, trainers, setters of standards, experts, carers and advocates;

- front line staff in offering support, understanding and promoting confidence in would-be service users, through training, awareness-raising and the capacity to respond; and

- people with multiple problems themselves, and their carers, who can expect to meet people who listen, who are sympathetic and understanding, who can help and, together, offer better prospects in the future.

THE WORKING GROUP AND SCOPE OF REPORT

Remit

1.8 The remit of the Working Group, agreed at its first meeting, was to:

- determine the nature of mental health problems of drug and alcohol users;

- look at the available evidence on the extent of the problem in Scotland;

- look at available interventions and their effectiveness;

- identify the implications for treatment and care services; and

- make recommendations to SACDM and SACAM with a view to the Scottish Executive taking action, in partnership with the key agencies and those with multiple problems themselves and their carers, to improve the well-being, support and general outlook for this Group.
Membership

1.9 Membership of the Group covered a wide range of professional expertise and reflected experience across Scotland. A full list of members can be found at the end of the report. Their work was also informed by consultation with people with co-occurring mental health and substance misuse problems.

Scope of the report

1.10 The report is based on:

- examination of the relevant scientific literature;
- examination of the available information on the nature and scale of the problem;
- the evidence which underpins the Scottish Executive Health Department Joint Future Agenda, including Integrated Care for Drug Users: Principles and Practice published by the Effective Interventions Unit (EIU) in October 2002; and
- commissioned research on service users' views of the nature and history of their problems and their experiences of existing services.

Definition

There are a number of definitions in this field.

1.11 **Substance misuse** refers to the problem use of prescribed or illicit drugs, and/or alcohol, while the term **dual diagnosis** or **co-morbidity** refers specifically to the co-existence of **diagnosed** mental health problems (irrespective of their severity) and substance misuse but also a range of other conditions.

1.12 The term **co-occurring substance use and mental health problems** is used more generally to acknowledge that not all mental health problems have been diagnosed, nor are all forms of substance use considered to be problematic. The Working Group therefore adopted the definition **co-occurring substance misuse and mental health problems** in this report. Taken together, these problems give rise to significant impairment and disability for which people affected need advice, support and services, in order to follow a more integrated life course. The severity and nature of a person's problems are liable to change over time. Each problem, however, would be significant enough to merit planned care on its own.

1.13 Although nicotine addiction and abuse of prescription drugs would not necessarily be the sole criterion for designating substance misuse, these matters may be significant problems within the overall picture.
CHAPTER 2

EXECUTIVE SUMMARY AND RECOMMENDATIONS
CHAPTER 2: EXECUTIVE SUMMARY AND RECOMMENDATIONS

EXECUTIVE SUMMARY

Introduction (Chapter 1)

2.1 ‘Mind the Gaps’ is a report for people with deep-seated and multiple problems which often have complex and multiple causes. They have co-occurring mental health and substance misuse problems and often occupy the margins of our society. Most can benefit from help and support of many types. But there are shortcomings and gaps in the help that is available. This report seeks to address them. The Working Group has taken account of the following policy initiatives, which already exist or are being developed; and all seek to narrow or close gaps in advice and support:

• towards social inclusion;
• towards a successful and sustainable economy, with good employment prospects, training experience and opportunities;
• towards reducing homelessness;
• towards targeted provision of housing support services; and
• towards creating equitable access to a range of care services, regardless of boundaries, and designed to meet the needs of people as clients or patients.

2.2 The report serves to underline the importance of sustained implementation of social, health and economic policy and delivery of effective public services which promote inclusion. The main challenges ahead are to create the climate of public and service attitudes, and the culture of good practice, which promote the well-being of this group of people.

2.3 Many people with co-occurring substance misuse and mental health problems have had bad early life experiences and grown up to lead troubled young adult lives. Therefore this report focuses on the need for continuing effective endeavours to ensure:

• education on the problems that drugs and alcohol can cause and greater understanding of mental health;
• firm but fair means of crime prevention, management and justice;
• earlier detection of abusive experiences, by facilitating disclosure and acceptable intervention;
• early intervention and support; and
• the right conditions to enable participation in the community, including positive education experience and peer support.
The Nature and Extent of the Problem (Chapter 3)

2.4 The nature of co-occurring substance misuse and mental health problems is complex with a number of interacting continuums such as severity; type of mental health problem; type and amount of substance misused as well as change over time.

2.5 It is a major and growing problem. The evidence in this report comes from a variety of sources with Scottish data supplemented by information from other parts of the UK and elsewhere.

2.6 In summary the evidence shows that:

- up to 3 in 4 drug using clients have been reported as having mental health problems;
- up to 1 in 2 patients with alcohol problems may also have a mental health problem;
- up to 2 in 5 people with mental health problems may have a drug and/or alcohol problems; and

2.7 The evidence also shows that people who experience co-occurring substance misuse and mental health problems also often experience other complex social problems, such as unemployment, homelessness, violence and childhood trauma which can occur over long periods of time.

2.8 Clients are also likely to present to services with combinations of needs other than solely substance misuse or mental problems or combinations of these two.

Existing Service Provision in Scotland (Chapter 4)

2.9 There have been a number of recent policy developments in the field of mental health service provision. As yet these have not led to a consistent improvement across the country in the collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild to moderate mental ill health.

2.10 The separation of the planning processes for services for those with co-occurring substance misuse and mental health problems, through Drug and Alcohol Action Teams (DAATs) and Joint Mental Health Commissioning Groups at local level can inhibit joint service provision for this client group.

2.11 The Joint Future Agenda for health and social care services offers the prospect of better outcomes for those with co-occurring mental and substance misuse problems, through an integrated approach to the management, financing and day to day running of services. The drive towards integrated care for drug users, based on the principles of Joint Future, is now gathering momentum following the publication of Integrated Care for Drug Users: Principles and Practice published by the Effective Interventions Unit (EIU).
2.12 The National Programme for Improving Mental Health and Well-Being in Scotland, further endorsed within Partnership for Care, aims to undertake a number of measures to promote mental well-being, preventing mental health problems and ensuring early identification and action when problems occur. The findings of our research confirms the need for this action.

2.13 There is a lack of professional consensus on the role of secondary mental health services in the treatment of personality disorder in Scotland. Apart from policy initiatives for mentally disordered offenders, there is no Scottish guidance. With only a few exceptions, service provision is rudimentary, despite a growing evidence base for effective practice, intervention/management and the solid evidence of the likelihood that such individuals are at high risk of becoming dependant on substances.

2.14 There is a lack of systematic service provision for people who have survived earlier traumatic experiences. Research studies and anecdotal evidence suggest that many NHSScotland staff are uncomfortable with their level of skills in handling disclosure of this type. The range of necessary services which should be provided is currently being examined by the Scottish Executive Health Department.

2.15 There are currently variations in the provision of services for those suffering from mental health and substance misuse problems. Issues include:

- some mental health services working on too narrow a model of assessment and care;
- general lack of communication at both operational and planning levels between addiction and mental health services;
- lack of clarity in defining clients with co-occurring mental and substance misuse problems (‘multi-problematic’, as opposed to ‘dual diagnosis’), with poor assessment by generic workers and primary diagnosis often reflecting source of referral rather than causation;
- lack of specified core competencies, and thus training for staff in generic and front-line services;
- lack of willingness to work with this client group, and stigmatisation associated with their problem; this sometimes results in treatment not being offered and inappropriate and rapid referrals on to other services when their significance is not clear;
- the need for aftercare support to be planned as an integral part of treatment to prevent recurrence; and
- the need for better partnership with the voluntary sector in delivering services to this client group.
Assessment, Intervention and Support (Chapter 5)

2.16 There has been a history of separation in NHSScotland at operational and planning levels between mental health and substance misuse services, with the result that services are at risk of failing to provide fully joined up care for those who have co-occurring problems. If an experience of effective services is to be achieved for the service user, not only must the providers share a broadly similar understanding of what types and sequences of care are appropriate, they must also be able to apply these flexibly and jointly across both professional and organisational boundaries.

2.17 These issues need to be addressed and resolved by better joint service planning, systems of care and delivery, workforce planning and governance, before there can be any opportunity of developing truly integrated pathways of care. As before, mechanisms now exist, deriving from the Joint Future Agenda and Partnership for Care, which facilitate this process.

2.18 What this report is seeking to achieve is a service that:

- has a sufficiently diverse skill mix to allow ready access to both specialist and generic services as a client’s needs become apparent;
- is populated by workers confident enough of their own abilities to construct practical care plans in the face of complex problems;
- is well enough understood by generic workers to allow them to contribute to tackling the less complex issues, partnering the specialist service; and
- is understood and accepted by other potential providers, as well as care funders and commissioners.

2.19 Proper assessment is the key to establishing with the individual as complete a picture as possible of all their needs – health, physical and mental; social needs; housing; employment and their state of readiness to change – in order to be involved in the care most likely to promote a positive outcome.

2.20 There is robust evidence that different interventions can work for this client group. These should be as broadly based as possible and include social, education and employment elements. They are:

- engagement – simple listening skills, courtesy and respect are the foundation of this;
- meeting basic needs – such as safety, accommodation and food;
- persuasion – the point at which the person’s perceptions about their problems can be discussed and better understood;
- active intervention – mostly carried out collaboratively in the community; and
- early intervention – this should be the basis of the treatment system of known effectiveness, tied into broader prevention work.
Planning and delivery of services (Chapter 6)

2.21 People with co-occurring substance misuse and mental health problems present an extreme challenge, but nevertheless deserve access to the most appropriate and timely services.

2.22 Treatment and care can and does work for this client group, although there is no UK evidence on what model of care is most effective.

2.23 NHS Boards and partner local authorities should consider the needs of this care group in their entirety, and a programme budget allocated to be managed as a whole, whether or not there is a defined severe or enduring mental health illness present.

2.24 Planners and commissioners of services need to be aware of the nature and scale of the problem for this population, so that resources are targeted appropriately. Service commissioners should concentrate on looking to see how gaps in current service provision, its profile, culture and flexibility to respond, might best be met. They should look to do this, where possible, through mainstream generic services, with easy referral to meet more specialised needs. The voluntary sector should play a key role in both planning and delivery care to this client group, being resourced accordingly.

2.25 The following should be key features of service provision:

- early intervention, which is likely to be cost-effective, avoiding inappropriate referrals to more expensive specialist services;
- broadly based interventions, to include social, education, and employment elements;
- person-centred interventions, not based on existing service availability;
- advocacy, with key workers helping service users through treatment and care services and;
- positive expectations of what can be achieved through treatment and intervention being emphasised to client and to service providers alike.

2.26 Staff, whether in mental or substance misuse services, need to develop the skills necessary to identify and understand clients with co-occurring problems, to develop the confidence to deal with them, and to be given the capacity to cope. Training and continuous professional development should include:

- development of assessment skills based upon substance misuse and mental health assessment frameworks;
- integration of knowledge of drug and alcohol trends for individuals with mental health problems, into practice; and
- effective working with a range of mental health interventions and treatment modalities.

2.27 Effective staff supervision, both clinical and managerial, is equally important. Support mechanisms should also be in place for staff at all levels to help them cope with this particularly challenging client group.
RECOMMENDATIONS

Prevention

1. The Scottish Executive should continue its social justice approach and social inclusion policies to further reduce the impact for those with adverse life experiences to allow them to fully participate in community life.

2. Bullying, detection and management of abuse and other trauma are key measures for early intervention to avoid manifestation of problems of vulnerable children in later life. The Scottish Executive should implement in full the Scottish Needs Assessment Programme/Public Health Institute for Scotland (SNAP/PHIS): *A Review of Child and Adolescent Mental Health Services*. A Short Life Working Group has been set up by the Scottish Executive Health Department to review services which should be available to those adults who have earlier experience of trauma. This is due to report at the end of 2003.

3. The Scottish Executive and local decision-makers, including Drug and Alcohol Action Teams, should give priority to evidenced-based education and prevention work to reduce substance misuse and to address the treatment and care needs of those with substance misuse problems.

4. The Scottish Executive should continue to address the need for greater awareness and understanding of mental health and mental illness, and maintain the work to eliminate the stigma and discrimination associated with mental ill-health, as part of the *National Programme for Improving Mental Health and Well-Being*.

Standards and strategic planning

5. NHS Quality Improvement Scotland, together with the Care Commission for Scotland, should consider the development of standards for integrated services for people with co-occurring substance misuse and mental health problems, ensuring the application of best practice and holistic and integrated care across services. As far as possible, clients should be involved in developing such standards.

6. A joint approach, involving the Scottish Executive Health Department Mental Health Division, the relevant professional organisations, and NHS Education Scotland should produce specific Scottish guidance on the identification, assessment, workforce training and treatment of people with personality disorder.

7. Drug and Alcohol Action Teams, Mental Health Commissioners and other statutory and voluntary caring agencies should work jointly and across boundaries to ensure adequate and integrated service provision locally for those with co-occurring mental health and substance misuse problems, including clients with personality disorder. The establishment of Community Health Partnerships should help to facilitate this joint working.

8. Planners and commissioners should develop tiered treatment and care services for this client group within the principles of Joint Future and *Integrated Care for Drug Users* to
ensure greater communication and more effective joint working between substance misuse, mental health and other relevant services (statutory and voluntary).

9. Planners and commissioners should work to ensure flexible and seamless services with appropriate links to the criminal justice system and to wider social interventions, including housing support, provision of accommodation, life long learning opportunities, employment and other measures to assist with the social integration of service users.

10. Planners and commissioners should make better use of existing points of contact with the client group who may present in crisis through the criminal justice system and attendance at Accident and Emergency (A & E) departments. Rapid referral to appropriate services will provide a useful start to lasting engagement with the client.

11. Drug and Alcohol Action Teams should include action on service provision for this client group within their annual Corporate Action Plans, and within local Alcohol Action Plans.

12. Planners and commissioners should expand the role of the voluntary sector in the planning and delivery of services in recognition of its particular skills, experience and expertise in dealing with this challenging client group.

**Delivering better services**

13. Service providers should raise expectations among staff as to the positive treatment outcomes which can be achieved for those suffering from co-occurring substance misuse and mental health problems through staff training, education, and application of management principles of continuous improvement and positive feedback.

14. Service providers should raise awareness among users of the possibility of positive treatment outcomes and involve them in the development of plans for their own treatment and care in a meaningful way.

15. Service providers should ensure that information on local services is more readily available in suitable format, accessible to users and referring agencies.

16. Service providers should ensure that advocacy services are integral to the care plans for this client group.

17. Service providers in generic mental health services should re-examine their attitudes to those clients using substances to develop more positive and holistic/integrated responses to their care.

18. Service providers should ensure that staff working with this group, whether in the NHS, local authorities or the voluntary sector, receive continuing support and encouragement.
Training

19. Service providers should ensure that staff in both substance misuse and mental health services are trained to develop the skills and confidence necessary to identify and understand clients with co-occurring problems.

20. STRADA (Scottish Training on Alcohol and Drug Abuse) and other training providers should develop further training provision covering staff attitudes and service redesign in order to reduce stigma and encourage user participation in services.

21. Training and service providers should ensure that there is greater emphasis on joint training between the medical profession and other professionals and staff of voluntary agencies who also have a role to play in providing care and support for this client group.

Research and information

22. The Effective Interventions Unit (EIU) should ensure that its research findings on the nature and extent of health and social services provided to people with dual diagnosis are widely disseminated and that its report identifies the need for further work and evidence of implementation which may, for example, include evaluating promising examples of practice.

23. Information and Statistics Division (ISD Scotland) should consult with service commissioners and providers to improve information for management, epidemiology, and future planning within the context of integrated care.

24. ISD Scotland and relevant health, social and voluntary care, addiction and mental health services should consider the development of national data standards for mental health and substance misuse information to support local data collection and monitor implementation of other recommendations in this report.

25. The research community should work with all stakeholders to improve the evidence, information and skills base to support services for this client group.

Implementation

26. The Scottish Executive should draw up an Implementation Plan to ensure that the above recommendations are carried out.
CHAPTER 3

THE NATURE AND EXTENT OF THE PROBLEM
CHAPTER 3: THE NATURE AND EXTENT OF THE PROBLEM

This Chapter:

- presents information on the nature and scale of co-occurring mental health and substance use problems in Scotland (see Chapter 1 for discussion of definitions). Key statistics are outlined in Annex A.

Evidence regarding the nature and scale of the problem

3.1 The evidence comes from a variety of sources including routinely collected national datasets, general population surveys, and research studies. Scottish data has been supplemented by information from other parts of the UK and around the world. The evidence highlights the ways that people who experience co-existing substance misuse and mental health often have other complex, inter-related, serious problems. For example, there is evidence that those who experience unemployment, homelessness, violence and childhood trauma are also more likely to experience mental health/substance misuse problems.

A complex and dynamic picture

3.2 Co-morbidity brings with it a number of complex and variable features. First, there are continuums between severe and mild mental illness, severe and mild drug misuse, and severe and mild alcohol misuse. However, within each of these three major spheres (mental health, drugs and alcohol) there are also continuums that relate to different types and severities of mental illness, of illicit drug use and of alcohol misuse. The high prevalence of polydrug use further complicates the review task. Another dimension is the different pictures of co-morbidity which result from snap-shots or following people over time. Lastly there are a range of possible relationships between substance misuse and mental health:

- primary mental health disorder may lead to substance misuse;
- substance misuse may worsen mental health disorder;
- substance misuse (intoxication/dependence) may lead to mental health problems;
- withdrawal from substance use often leads to mental health problems; and
- substance misuse and mental health problems may develop concurrently.

3.3 Estimating prevalence from large general population studies is likely to underestimate the true picture. Conversely, estimation from research in specialist services can overestimate prevalence in the general population. What is certain is that those who experience co-morbidity are not a homogenous group and that individuals’ problems are likely to change over time.
3.4 It is possible to group existing evidence into four broad categories:

- information on the prevalence of mental health problems, drug and alcohol misuse in Scotland;
- information gathered from those whose primary problem is identified as a substance misuse problem;
- information gathered from those whose primary problem is identified as a mental health problem; and
- information from the general or other populations on co-existing substance misuse and mental health problems.

Prevalence of alcohol problems in Scotland

3.5 Alcohol problems, that is, hazardous and harmful levels and patterns of drinking and their consequences, are a major concern for Scotland. In general, men are more likely than women to have problems with alcohol and younger age groups are more likely to drink to excess. Seven percent of men and 3% of women continue to drink at a level which is thought to pose a potentially serious risk to health (Scottish Health Survey 1998). Trends suggest that alcohol use is increasing, particularly for young women. Of concern is the concurrent trend in alcohol related harm, such as the rise in alcohol related deaths. Vulnerable populations such as those in prison, homeless or less affluent groups have higher rates of alcohol problems. Alcohol problems account for a considerable use of health service resources. It is estimated that alcohol problems cost Scotland at least £1 billion each year.

Prevalence of Drug Problems in Scotland

3.6 As with alcohol, drug misuse is a major problem for the Scottish population. One in 20 adults report having used drugs in the previous month, with higher use reported by males and younger age groups. Trends suggest that drug use is tailing off from a peak in the mid nineties. However, drug related deaths continue to show an upward trend. As with alcohol, drug misuse is higher in vulnerable populations such as prisoners and those living in less affluent areas.

Prevalence of Mental Health Problems in Scotland

3.7 In Scotland, far more profound even than both alcohol and drug problems is the burden of mental health problems. In contrast to both drugs and alcohol problems, these are more likely in women and in the middle years. Trends have been more difficult to determine due to changing service delivery (from hospital to community settings) where information collection has not been as developed and lack of long term community surveys on mental health. Of great concern has been the rise in suicide rates particularly in young men where substance misuse (both drugs and alcohol) is a known risk factor.

3.8 There is a perception from service providers in Scotland that the co-morbidity client group appears to be growing and presenting in large numbers to both addiction and mental health services. What evidence there is for this, particularly in Scotland, is set out below.
People with substance misuse problems with associated mental health problems

3.9 The Scottish Drug Misuse Database (SDMD) was set up in 1990 to collect information on individuals who seek treatment for problem drug use. Information is collected on each new client, defined as those who are seeking treatment for the first time, or who are seeking treatment after an interval of at least six months. Contributors to the database include specialist addiction services and a number of GPs. Alcohol misuse is only recorded when it is used in conjunction with illicit drugs.

3.10 Data from the SDMD shows that between April 2001 and March 2002, over 40% of individuals who sought treatment for problem drug use (3,236 out of a total of 10,798 individuals) reported that their mental health was one of the issues which led them to seek treatment (see Figure 1 below). It is likely that data on mental health in SDMD may not necessarily be complete or consistent across Scotland. In a recent study in England by Weaver, 75% of drug misusers attending treatment were found to have one or more psychiatric disorders. A large study in the USA (the Epidemiologic Catchment Area (ECA) Study) found 64% of those being treated for drug disorders had an associated mental health disorder (Regier et al 1990). What is clear is the high prevalence of mental health problems in those presenting to drug treatment services.

Figure 1 Individuals attending drug treatment services with mental health problems, April 2001 – March 2002, by age and sex, n=7,752.

Source: Scottish Drugs Misuse Database

3.11 There is no equivalent national database for specialist alcohol services. Data are collected from people attending Local Councils on Alcohol, voluntary alcohol counselling services present in every local area in Scotland. However, the presence of co-occurring mental health problems are currently not recorded. The ECA study also found that 55% of
those attending for treatment of an alcohol disorder had a co-morbid mental health disorder (Regier et al 1990). An English study which screened patients attending a community alcohol service found high prevalence of history of childhood sexual abuse, adult sexual abuse or assault (Moncrieff 1996).

3.12 Evidence from a nationally representative sample of Scottish general practices provides further evidence of an association between substance misuse and mental health problems. A third (35.2%) of consultations with drug misusing and half (51%) of consultations for alcohol misusing patients were found to relate to either mood or anxiety-related disorders. In comparison, fewer than a fifth (17.6%) of patients who do not misuse drugs or alcohol consulted their GPs for these problems.

3.13 Data from the National Treatment Outcomes Research Study (NTORS) in England and Wales, a prospective study of addiction treatment outcomes, has revealed that a fifth of all NTORS clients received treatment for a psychiatric illness prior to seeking treatment for their drug misuse problem (Gossop et al 2002), and polydrug use was particularly related to psychiatric problems (Marsden et al 2000). This same study found increased levels of psychological problems, including those with psychotic and paranoid features, among drug users who were also dependent on alcohol. Women drug users were found to be significantly more likely than men to report suicidal thoughts in the three months prior to seeking help for their drug use (Marsden et al 2000). A similar study Drug Outcomes Research in Scotland (DORIS) is underway, but results are not yet available.

3.14 The ECA study found, in the general population, the commonest mental health disorders for those with both alcohol and drug disorders were anxiety disorders (19.4% and 28.3% respectively) (Regier et al 1990). Many clients with drug and alcohol problems are diagnosed additionally with personality disorder, a condition frequently considered to complicate mainstream psychiatric interventions. A recent review of studies estimating prevalence of personality disorder in those with substance misuse problems found a median prevalence of 56.5%. However, these studies may have a bias towards higher prevalence as they are largely based on those attending specialist addiction services. What is also evident is that personality disorders, although more prevalent than in the general population, appear less prevalent in people with alcohol problems compared to those with drug problems (Welsh 2002).

3.15 Smaller scale local research highlights an association between social disadvantage, mental health and drug/alcohol misuse. A study by Gilchrist of female drug users attending a crisis centre, a drop-in and a methadone clinic in Glasgow found that 71% (184/260) had a lifetime experience of emotional abuse, 65% (168/260) had been physically abused, and 50% (129/259) had a history of sexual abuse (Gilchrist 2002). High incidences of traumatic experiences among women drug users are further supported by evidence from the USA and Australia (Broom 1994; Russell S and Wilsnack S 1991; Boyd 1993).

3.16 Our knowledge about young people, substance misuse and mental health in Scotland is limited. However, data from the Scottish component of the 1997/98 Health Behaviour in School-Aged Children (HBSC): World Health Organisation (WHO) Cross-National Survey showed that 15-year-olds who report drinking alcohol at least once a week were significantly more likely than their peers to report feeling low, feeling irritable and having sleep problems. Similar results were found among 15-year-olds who reported using drugs at least once a month.
People with mental health problems and associated substance misuse

3.17 The form SMR 04 contains information across Scotland about all patients leaving a psychiatric hospital. In the period April 2000-March 2001, there were 33,962 patient episodes of which 14.2% (4812) had an alcohol related diagnosis and 5.2% a drug related diagnosis. For those with an alcohol related diagnosis, the most common mental health diagnosis was depression (12%) whereas for people with a drug related diagnosis, schizophrenia was the most common diagnosis (14.8%). These data are likely to over-represent those with a severe or acute mental health problem (as these people are more likely to be admitted to hospital). They may also under-record substance misuse. Weaver’s study (Weaver in press) also examined those attending mental health services in England and found that 44% had problem drug and/or alcohol use. There is no national data collection from community mental health services in Scotland. The ECA study found that 20% of those with mental health problems seen in a service setting had a substance misuse disorder (Regier et al 1990).

3.18 SMR 01 reports are returned for all patients leaving an acute hospital. The most common mental health diagnosis in those with either an alcohol or drug related diagnosis was of poisoning (accidental or intentional) and self harm (ISD).

3.19 Substance using behaviour has been shown to be an important factor in deaths from suicide. In 2001 alone, one-quarter (25.9%) of drug-related deaths in Scotland were attributed to intentional self-poisoning or poisoning with undetermined intent (General Records Office Scotland (GROS) 2001). Moreover, of all Scottish suicides between 1997-2001, of people who had previously been in contact with mental health services, over half (56%) had a history of alcohol misuse and over a third (37%) had a history of drug misuse. One in five of these individuals (19%) had a primary diagnosis of alcohol dependence; one in ten (10%) had a primary diagnosis of drug dependence (Appleby et al 2001).

Co-occurring mental health and substance misuse in population studies

3.20 The most robust UK wide source of information on the prevalence of co-occurring mental illness and substance misuse (alcohol and illicit drugs) is the survey of Psychiatric Morbidity Among Adults in British Households. The most recent survey in 2000 (Coulthard et al 2002) of a representative sample of 16-74 year olds living in private households, found important differences in levels of substance misuse between men and women and between people with different types of mental health problems. The results show that people who report obsessive compulsive disorders have particularly high rates of hazardous drinking, as well as alcohol and drug dependence. Individuals are also more likely to misuse substances if they report any form of neurotic disorder compared to those who do not report these problems. For example, less than 1% of the population are classified as being moderately or severely dependent on alcohol, but this figure rises to 2% for people with a neurotic disorder, 5% among those with a phobia and to 6% among those with two or more neurotic disorders (Coulthard et al, 2002, p. 53). The above survey includes a Scottish sample of 919 which reports Scotland has slightly higher rates of alcohol dependence and markedly higher rates of drug dependence.

3.21 In relation to gender differences, women were found to be more likely than men to report a form of neurotic disorder (20% of women compared to 14% of men) (Singleton et al 2001), but men with any form of neurotic disorder were more likely than women to engage in hazardous drinking, to be dependent on alcohol, to be more heavily dependent on alcohol, and
to use and be dependent on illicit drugs.

3.22 In the USA, the ECA population survey (Regier et al 1990) found that just under 1 in 3 (29%) of people with a mental disorder had a lifetime experience of a substance use disorder (22% an alcohol disorder and 15% a drug disorder), just over 1 in 3 (37%) of those with an alcohol disorder had a lifetime experience of a mental health disorder and 1 in 2 (53%) of those with a drug disorder had experienced a mental health disorder.

3.23 A national epidemiological study in England, due to report shortly, has assessed the patterns and prevalence of co-occurring of substance misuse and mental health problems in general practice (Frischer 2003 in press). Co-morbidity increased by 62% between 1993 and 1998 from a rate of 50/100,000 to 81/100,000. The average practice sees four co-morbid cases per year.

3.24 The UK wide Psychiatric Morbidity Among Adults survey is household based and is likely to under-report the relationships between mental health and substance misuse for people living in residential, hospital and custodial settings. The evidence suggests that these populations experience the most severe forms of mental illness and substance misuse problems. Office for Population Census and Survey (OPCS) survey data relating to relatively large samples of people living in institutional settings and the homeless and roofless populations provide important insights. In an institutional sample (n=755) 10% reported ever using illicit drugs (for those who experienced schizophrenia, delusional or schizo-affective disorders this figure was 7%, 18 % for those with affective disorders and 22% for those with neurotic disorders). In comparison, 28% of the homeless sample and 46% of those attending night shelters (total sample n=1061) reported drug use. Eight per cent of the homeless population reported having injected drugs but this figure rose to 14% among night shelter attendees (Farrell et al 1998).

3.25 In Glasgow, a survey of over 200 homeless people (Kershaw et al 2000) reported that 44% met the criteria for at least one mental health diagnosis (excluding substance misuse). The most common disorders were generalised anxiety disorder (21%), mixed anxiety and depressive disorder (13%) and depressive episode (11%). A quarter of the sample reported a level of neurotic symptoms likely to need treatment. Overall 25 % showed evidence of drug dependence but in the 25-34 year age range this rose to 70 %. Eighteen per cent of the sample was heroin dependent. In relation to alcohol consumption, hazardous patterns of drinking were higher in men than women (60% compared to 16%). However, of the total sample 54% reported hazardous consumption, with this figure rising to 63% for those over 55 years.

3.26 Similarly in the USA, high prevalence rates of co-morbidity are found in institutional settings, with a lifetime prevalence of 71.9%, more than twice that found in the community population (Regier et al 1990).

3.27 Recent discussions with voluntary sector providers in Glasgow have identified that mild to moderate mental health problems are extremely common in homeless people, appear to be linked to experience of trauma such as sexual, physical and emotional abuse and often appear in tandem with drug or alcohol abuse. Post-traumatic stress disorder was thought to be under diagnosed whereas mild to moderate mental health problems were thought to be over attributed to a diagnosis of personality disorder.
Information gaps and developments

3.28 Much of the above evidence comes from continuously collected national datasets, national surveys and research studies. There are, however, key services from which there are no current national databases. Services such as community mental health, police and A & E could also potentially collect information on those with co-occurring substance misuse and mental health problems.

3.29 What is also apparent on reviewing the evidence is that there is a need to enhance data collection on co-occurring substance misuse and mental health within current national datasets (including surveys). With the implementation of initiatives such as Joint Future and Integrated Care for Drug Users there is the opportunity to develop collection and collation of information that is person centred and covers the full range of their needs.

3.30 There is a wealth of information collected locally as part of patient/client care. A variety of local data collection systems are in place in health, social and voluntary care, addiction and mental health services. The more generalist services such as general practice, generic social work, the police also have local systems. The Improving Mental Health Information Project at ISD Scotland has been conducting an audit of information systems in use by the NHS throughout Scotland for mental health services. A similar exercise for social work information systems was carried out by the Scottish Social Care Data Standards project (SCDS) (2003). All 32 local councils have (or are acquiring) a computerised main social care client information system. These however vary considerably in functionality including support for joint working such as through the Joint Future Agenda.

3.31 There are currently no national data standards for either mental health or addiction information collection to support these local initiatives. An example of a local information system in the addiction field is the Ayrshire and Arran Common Addictions database which has been developed to collect client/patient information on those presenting to addiction services in Ayrshire and Arran. Details of the mental health profile are collected both through the completion of an assessment tool and the SMR24. Further details are also collected on those referred to the dual diagnosis service. The database will be able to interface to a central information store to allow exchange of information between Joint Future partners.

Conclusion

3.32 People at risk of social exclusion are more likely to experience ill health (World Health Organisation (WHO) 1998). The focus of this report is the provision of services for people who experience co-occurring substance misuse and mental health problems. Accordingly, this chapter has documented the evidence of these problems in Scotland.

3.33 Co-occurring problems are present for many of those seeking care from both addiction and mental health services as well as for the wider population. It is striking that people who experience co-occurring substance misuse and mental health problems also often experience other complex social problems. For example, there is evidence that those who experience unemployment, homelessness, violence and childhood trauma, are also more likely to experience mental health and substance abuse.

3.34 At this point, the research base does not allow us to identify precise elements of social disadvantage, or to make statements relating to causal pathways. However, it is important to acknowledge that people who experience co-occurring substance misuse and mental health
problems also often simultaneously experience multiple other forms of deprivation over long periods of time. It is also the case that clients seek help from services with combinations of needs other than just solely substance misuse or mental problems or combinations of these two.
CHAPTER 4

EXISTING SERVICE PROVISION IN SCOTLAND
CHAPTER 4: EXISTING SERVICE PROVISION IN SCOTLAND

This Chapter:

- outlines the policy context within which mental health and addiction services in Scotland are provided;
- describes mental health services in Scotland, including services for people with additional care needs;
- describes a number of service approaches in different parts of Scotland and in different service setting;
- refers to the findings of recent research into the experiences of service users with co-occurring mental health and substance misuse problems; and
- identifies gaps in current service provision.

4.1 The Chapter highlights that there has been much progress in recent years in devising policy and guidance which seeks to address the health and wider social needs of our most vulnerable members of society, including those with substance misuse and mental health problems. Despite this progress, however, the negative experiences of some of those with co-occurring problems, expressed during our research into users views (see Annex E), highlights that much work has still to be done to bridge the gap between aspiration and practice in many areas.

‘............I am actually just waiting on a new CPN just now. I’ve seen them all before. I’ve seen drug counsellors, I’ve seen psychiatrists, psychotherapists. I’ve never felt as if anybody took me seriously enough..... .....Drug counsellors, people like that, they look at you as if you are over-exaggerating, as if you are blowing things out of proportion – ‘things cannae be that bad, come on’ – you know what I mean? And things are that bad but how can you prove it? Have you got to wait until you do that to yourself?...because the minute you mention drugs, it does go into their heads, ‘oh it’s down to drugs, it’s got to be she’s a junkie.’

Mental Health Foundation Research 2003

THE POLICY CONTEXT

Mental Health Services

4.2 The current policy on the organisation of mental health services is set out in A Framework for Mental Health Services in Scotland (1997), Our National Health, (2000) and Partnership for Care, (2003). Taken together these documents describe how the Scottish Executive, working with the statutory agencies, the voluntary sector and others, has introduced and developed a number of policies and initiatives to improve the planning, delivery, quality and accountability of mental health services.
4.3 **Partnership for Care** continues these objectives for mental health services, not least by the plans for mental health to be a client group for the Joint Future initiative by April 2004. Care networks for the organisation of seamless care for users of mental health services will be actively promoted. **Partnership for Care** also confirms steps to be taken to address a variety of workforce issues and recognises the important role for primary care in the seamless organisation of mental health care. Each initiative underlines further the need and benefit of joint working for better services.

4.4 Achieving the goal of improving Scotland’s health involves addressing not just physical health, but also the mental health and well being of people and the communities within which they live. Commitments to health improvement made in *Our National Health* saw the beginning of an ambitious *National Programme* aimed at improving mental health in Scotland. The *National Programme*, further endorsed within **Partnership for Care** aims to:

- raise awareness of mental health issues;
- promote positive mental health and well-being;
- promote effective prevention of mental health problems;
- encourage and support action for early identification, and intervention when mental health problems occur; and
- support recovery from mental ill health.

4.5 Local progress toward improved services has been examined since 2000 by the Mental Health and Well-Being Support Group, using the *Framework* objectives as a template for local progress. Two rounds of visits to the relevant agencies and users of services in all 15 Health Board areas have been completed to date. The Support Group's findings can be found at [www.show.scot.nhs.uk.mhwbsg](http://www.show.scot.nhs.uk.mhwbsg).

4.6 Good quality, credible information accepted by all parties is essential to make national and local progress to better services. Four linked sources aim to make improvements. These are as follows:

- Improving Mental Health Information Project (working across partner organisational boundaries to agree on data sets and processes in order to provide essential care management and outcome planning information);
- NHS Quality Improvement Scotland;
- Mental Health and Well-Being Support Group reports; and
- Mental Health Services Improvement Network (comprising national bodies with broadly similar aims).
Alcohol Services

4.7 The Plan for Action on Alcohol Problems, published in January 2002, sets out measures to reduce alcohol-related harm in Scotland. Local co-ordination of activity in support of the plan is the responsibility of Alcohol Action Teams (AATs) or DAATs.

4.8 A Framework for Alcohol Problems Support and Treatment Services (Sept 2002) has subsequently been published and all local AATs have drawn up 3-year local strategies on how they plan to meet identified need for support and treatment within their areas. These include action in support of services for people with alcohol problems who also have significant mental health or drug problems.

Drug Misuse Services

4.9 Current policy on tackling drug misuse, including the provision of treatment and care, is set out in the national strategy Tackling Drugs in Scotland: Action in Partnership (1999) and in the Scottish Executive’s Drug Action Plan Protecting Our Future (2000). Local co-ordination and delivery of services is the responsibility of Drug Action Teams (DATs) or DAATs, in partnership with agencies with responsibility for drug issues at local level. These include health, social work, education, police, prisons and the voluntary sector.

4.10 In 1999, the UK Department of Health published Drug Misuse and Dependence: Guidelines on Clinical Management. More recently in October 2002, the EIU within the Substance Misuse Division of the Scottish Executive Health Department published ‘Integrated Care for Drug Users: Principles and Practice. This sets out the evidence base for integrated care and offers a framework for the development of the key elements of integrated care including assessment, information sharing and planning and delivery of care.

Joint Future Agenda/Integrated Care for Drug Users

4.11 The Joint Future Agenda seeks better outcomes through an integrated approach to the management, financing and day to day running of services (www.scotland.gov.uk/health/jointfutureunit). In particular, it improves partnership working through joint resourcing and joint management, improves access to services through single shared assessment and improves results through its drive to joint services.

4.12 The Joint Future Implementation and Advisory Group has agreed that full implementation across all community care groups should be achieved by 1 April 2004. Amongst those services which have been identified as being well placed to make an early transition to the joint arrangements are drug misuse services and mental health services.

4.13 The aim of Integrated Care for Drug Users is to support the planning, design and delivery of services for drug users who, in most cases, have multiple needs eg employment, housing, offending behaviour, family and social relationships etc. The development of Integrated Care for Drug Users is now being taken forward by DATs. The key elements are: accessibility of services, including action on needs assessment and waiting times; assessment of the individual, based on the principles of single shared assessment; planning and delivery of care, with the emphasis on co-ordination of care designed to meet the assessed needs of the individual; information sharing across the range of services; and monitoring and evaluation.
Services for homeless people

4.14 Current policy on the health of homeless people is outlined in *Our National Health* (2000) and in the *Health and Homelessness Guidance* (2001). The guidance sets out the framework for the activity required of NHS Scotland to improve the health of homeless people. All NHS Boards were required to produce and implement Health and Homelessness Action Plans, which were based on an assessment of the health needs of homeless people in each NHS Board area. With high numbers of homeless people experiencing co-occurring substance misuse and mental health problems, structural and attitudinal barriers have made addressing such issues very challenging. As a result this is currently a focus within local Health and Homelessness Action Plans.

4.15 In addition, in its final report, the Scottish Executive Homelessness Task Force, set up in 1999 made a specific recommendation regarding access to mental health services for those with substance misuse problems. Recommendation 46 states that ‘NHS Boards should address the provision of mental health services to homeless people to minimise the barriers to access. Being free from substance misuse should not be an automatic pre-condition for access to services.’ This recommendation, along with the other 58 made by the Task Force has been accepted in full by Cabinet and endorsed by the Scottish Parliament.

> ‘When you’re drinking you just don’t give a damn, but when you’re coming off the drink you realise the things that you’ve let go, your rent, electricity, any bills that you’ve got, any problems that you’ve got and then ye start worrying about these things. That’s when you’re coming off the booze, when you’re on the booze all these things don’t matter.’

Mental Health Foundation Research 2003

HEALTH SERVICES IN SCOTLAND FOR PEOPLE WITH PARTICULAR DIFFICULTIES

Survivors of trauma

4.16 WHO estimates that 20% of females have experienced some sort of abusive sexual experience by the time they reach the age of 16 years. The figure for males appears to be lower, but this may be due to greater reticence to report on their part. There is no information about what the Scottish figures might be, but also little reason to suppose that they would show major differences. Abusive experiences in childhood relate not only to sexual matters, but also to bullying and violence – direct experience, threats of it, and witnessing it within the family or care group, and the experience of care breakdown. The so-called ‘looked after’ children and young people, with fostering and care home experience, are particularly at risk of having had such experience. Such abusive experiences lie behind the presentation of many mental health problems – drug and alcohol misuse, eating disorders, depressive experiences, violent outbursts, suicidal feelings and suicidal behaviour, as well as incessant anxiety and a lack of well-being.

4.17 There is a growing body of evidence from neurobiological research in the USA about women with a history of abusive experiences (the work has not been done on men as yet), particularly those who have continued to experience symptoms of post-traumatic stress
disorder. The research shows consistent persisting abnormalities in hormonal stress responses, the relative size of certain brain nuclei, and under function of the parts of the brain concerned with new learning and social adaptation. As yet, it is not clear to what extent specific treatment or therapies can make a significant difference, but it does begin to clarify the nature of a link between early experience, and subsequent behaviour, so often distressing and harmful to the individual herself as well as to others.

4.18 All of these constitute mental health problems, but people do not necessarily come to the attention of services, whether statutory or voluntary. This may be through fear of stigmatisation or through not knowing that the problems resulting from past experiences can be helped. Services are available in a patchy distribution throughout Scotland, provided by voluntary organisations, social care or health services. Although there is an increasing evidence base for the benefits of intervention, particularly by directive counselling or psychological therapies, provision is not systematic.

4.19 Beyond Trauma (2001) is the report of a qualitative research study which explored the views and experiences of survivors of trauma and staff working in the statutory and voluntary sectors in Edinburgh. Survivors of abuse found mental health services to be operating on too narrow a model of assessment and care. Survivors welcomed the opportunity for disclosure of troublesome information. Often they had not spoken about these matters for many years. However, staff seemed to believe that speaking about such matters would ‘open a can of worms’ which would ultimately be more damaging to the individual. The user view was that intervention had to be decided upon jointly – this was not an area where professionals could decide unilaterally what action was appropriate and when it should be undertaken. Finally, the report showed that there was mutual misunderstanding about the roles of the statutory and voluntary sectors.

4.20 Similar issues were raised in two small-scale surveys undertaken in Glasgow in 2001 to inform the work of the Homelessness Planning & Implementation Group. The first survey asked about homelessness workers’ perceptions of the effect of trauma on homeless people, and the other asked for information from homeless people with mild to moderate mental health problems on how these problems affect their lives and what service responses might be helpful to them.

4.21 The surveys found that many, if not most, homeless people experience some mild to moderate mental health problems which manifest in a range of symptoms, which can be exacerbated by addiction. Many of these problems are likely to be linked to experience of trauma, often rooted in childhood experience of abuse. It was found that for many vulnerable people, substance use operates as a type of self-medication which dulls emotional pain. The co-existence of mental health and addiction problems makes it even harder to access support and help.

4.22 The surveys concluded that rather than receiving purely medical interventions a homeless person with mild to moderate mental health problems requires broad-based support across the full range of the individual’s needs – emotional, psychological, social and accommodation-related. Services need to work more closely together to achieve this. Many services already offer support around mild to moderate mental health problems as part of generic support. However, a lack of understanding, confidence, skills and resources often means that workers are reluctant to get too involved, and that responses may be at best limited in effectiveness, and at worst potentially harmful.
4.23 There is no reason to believe that these issues are isolated to the study areas in Scotland. The Health Minister gave a commitment in 2002 to the Cross Party Parliamentary Group on Survivors of Sexual Abuse that the range of necessary services which should be provided would be examined by the Health Department. A Short Life Working Group, including service users and both statutory and voluntary service providers, will report later in 2003.

**Suicide among young men**

4.24 The suicide rate among men in Scotland has shown an upward trend and plateau over the past 30 years. The male suicide rate is now about 75 per cent higher than it was at the start of the 1970s. Over the past 30 years the greatest increase in suicide incidence has been found in the 15-34 year age groups. The risk of suicide is now highest among 25-54 year olds. Among men, over one in six deaths in the 15-24 age group, over one in four of deaths in the 25-34 age group and one in eight deaths in the 35-44 age group are by suicide. Similar trends have been noted for women, although the proportion of deaths attributable to suicide is lower. In addition over 7000 people are treated in hospital following episodes of self-harm each year.

4.25 Substance misuse (both drug and alcohol) is a known risk factor for suicide and suicidal thoughts. In a recent survey (2002), carried out by the Office for National Statistics, 4% of people who were not alcohol dependent had at one time thought about suicide. This proportion increased to 9% among those moderately dependent on alcohol and rose to 27% of the severely alcohol dependent group. Those who were dependent on drugs (other than cannabis) were around five times more likely than the non-dependent group to have ever attempted suicide, 20% compared with 4%. Of 382 drug-related deaths in Scotland in 2002, 30 (8%) were as a result of intentional self-poisoning: in a further 55 deaths (14%), it was not clear if the death was accidental or suicide.

4.26 While 25% of people who commit suicide have been in touch with services in respect of a mental health problem the majority have not sought this form of help before taking their own lives.

4.27 Taking action to prevent suicide will involve a combination of efforts across many aspects of Scottish life: eradicating poverty, addressing social exclusion, tackling inequalities, improving educational opportunities, improving health. Action must involve people from a range of organisations, professions and groups, with sustained effort required over a long period of time.

4.28 To support and encourage this action, in December 2002, the Scottish Executive launched *Choose Life: a National Strategy and Action Plan* aimed at addressing the rising rate of suicide in Scotland. The strategy looks for both national and local actions to address the risks and to provide better responses to people who are at risk of suicide and those affected by suicidal behaviour. The priority groups for whom the strategy recommends appropriate actions and investments be addressed include young people (especially young men), and people who abuse substances. Guidance was recently issued to local community planning partners will look for plans for implementing the strategy in local areas to be developed by December 2003.
4.29 This strategy and the actions to be taken form a key part of the work of the National Programme. From this Programme, £12m of new money will be invested from 2003 – 2006 on supporting the implementation of this National Strategy and Action Plan.

4.30 Two other initiatives within the National Programme are also of particular relevance:

- ‘see me’: campaign to address the stigma which can be associated with mental ill-health; and

- ‘Breathing Space’: an advice line for young men with low mood or depression.

These are outlined in detail in Annex B.

**Drug-induced psychosis**

4.31 This term refers to those psychotic symptoms which arise specifically as a result of intoxication with a drug but which continue beyond the point at which the drug is fully eliminated from the body. Symptoms will only recur if there is re-exposure to the drug and will have a demonstrably different course, outcome and prognosis, compared to other psychoses.

4.32 There are three possibilities to explain why psychotic symptoms may be present in the context of drug use:

- the symptoms may be induced by drug use in the absence of an independent psychotic disorder (usually as part of an intoxication or withdrawal state);

- the symptoms may be induced by drug use in the presence of an independent psychotic disorder; or

- the symptoms of psychosis may be aggravated by drug use in pre-existing independent psychotic disorder.

4.33 The first point of contact with psychiatric services is usually an out-of-hours emergency admission from a crisis situation to an acute adult psychiatric ward. Despite meeting the existing criteria for detention, (of mental disorder, risk to self or others, and no alternative management being possible), often an assumption is made that the Mental Health Act (1984) cannot be used in such circumstances. A valuable opportunity to engage with the patient may be lost as a result of unwillingness by ward staff to tolerate the different kinds of confrontational behaviour that are often seen. Client contact should be made with whatever substance misuse and mental health agencies (if any) have been dealing with the client before discharge. This will avoid damaging any mutually agreed treatment plan which is already in place.

**People with schizophrenia and a substance misuse problem**

4.34 In 2000, the then Clinical Standards Board (now part of NHS Quality Improvement Scotland) published its *Standards for Schizophrenia*. The statement for Standard 11 – Misuse of Alcohol and Illicit Drugs – sets down that ‘every person who has a diagnosis of schizophrenia has their use of alcohol and illicit drugs reviewed whenever their needs are
assessed by a multi-disciplinary mental health team. A person who misuses alcohol and/or illicit drugs has access, where appropriate, to the specialist addiction services’.  

4.35 The National Report (2002) published by Clinical Standards Board for Scotland (CSBS) on the implementation of the first tranche of the Schizophrenia Standards noted that the use of alcohol and illicit drugs by most patients with schizophrenia is reviewed regularly. Also, in most Primary Care Trusts, users have access to specialist addiction services. However, the report noted challenges, including the variation that exists in approaches to the provision of specialist addiction services throughout the country. The report said there was no systematic audit of these services anywhere in Scotland. Systematic and proactive approaches to the provision of information about alcohol and illicit drug use for users and carers was also noted for its absence. There are few local health promotion programmes that specifically address the use of alcohol and illicit drugs by people who have a diagnosis of schizophrenia.  

4.36 It was found that, generally, staff are not currently given specific training in caring for people with schizophrenia who also misuse alcohol and/or illicit drugs. The CSBS Report recommends that the role of specialist addiction services in caring for people with schizophrenia is reviewed to enable models of best practice to be identified. In addition, training in caring for people with schizophrenia who also misuse alcohol and/or illicit drugs should be included in staff learning plans. In 2000, no Trust met this criterion, and only 4 out of 18 Trusts partially met it.  

4.37 The Standards recommend that there is a policy regarding the use of alcohol and illicit drugs on all Trust premises (hospital and community based) and that guidelines detailing the procedure to be followed when a user or carer is found in the possession of alcohol and/or illicit drugs on Trust premises are followed. Again in 2000, only 9 out of the 18 Trusts had such guidelines. Co-incidentally with the publication by CSBS of the National Report, the Scottish Executive Health Department released NHS Health Department Letter (HDL) (2002) Managing Incidental Drug Misuse and Alcohol Problems in Mental Health Care Settings, which promotes safe care, prevention and considered approaches. That guidance links also to the Support Group report on Risk Management (2000), available from www.show.scot.nhs.uk/mhwbsg. The measures suggested have broad application to most community care settings.  

Personality disorder  

4.38 The National Institute for Mental Health in England has recently published Personality disorders – no longer a diagnosis of exclusion (2003). This gives guidance on the identification, assessment and treatment of people with personality disorders and aims to ensure that people who are in significant difficulty or with significant distress are seen as being part of the legitimate business of mental health services. It estimates that the prevalence of personality disorders in the general population is between 10 and 13%. People with personality disorders are at a much higher risk of developing substance misuse problems.  

4.39 Secondary NHS Scotland mental health service workers have grown to believe, wrongly, that there is little therapeutic care that can be provided for people with personality disorders. The processes of assessment and categorisation are not well developed in day to day clinical practice. As a result there are only rudimentary services currently available for
those diagnosed as having personality disorders in Scotland. These are mainly located within forensic settings, where approaches tend to be short-term and too focussed to meet the needs of the client group. This often results in premature self-discharge, with no follow up, unfairly leaving partner agencies, who have little expertise, to provide support. There is a need for a triple approach which changes staff attitudes, demonstrates the evidence base, and provides training in the necessary competencies.

4.40 Often the assumption is made that disordered behaviour seen in the present is indicative of a pattern going back to early adulthood, thus making the individual ‘untreatable’. This contradicts knowledge about the vulnerability of some people to particular stresses and the effect of illicit substance use, which can lead to behaviour called ‘borderline’ personality disorder. The condition is containable given the right approach, over time, by knowledgeable people working in a committed service. The knowledge and skills are teachable and can be acquired. Unfortunately, there is no current guidance available on treating the condition in Scotland. The Executive is however looking at its response to the guidance recently issued south of the border Personality Disorder: No Longer a Diagnoses of Exclusion.

EXISTING MODELS OF CARE FOR THOSE WITH CO-OCCURRING SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS

4.41 There are a number of different models of care operating in Scotland for those with co-occurring substance misuse and mental health problems. It is likely that current provision will have had as much to do with how services have evolved over the years in particular areas, however, rather than as a result of services being developed and adapted to meet the continuing assessment of needs of this client group. We also recognise that the key to successful services may also not necessarily be about the structure of those services, but the people involved, their skills, approach and commitment.

4.42 Services are provided in a range of care settings, from community settings, through primary care to specialist mental health services. In terms of specialist services, we outline below different models operating in Ayrshire & Arran and Glasgow, with a brief informal look at specialist services elsewhere. The EIU of the Scottish Executive Health Department is currently undertaking more detailed work into current service provision for co-occurring mental health and substance misuse problems, which will report at the end of 2003.

Ayrshire and Arran

4.43 A service has been developed in Ayrshire & Arran (population 390,000), following recognition that a large patient group consisting of those suffering from co-occurring mental health and substance related problems were not accessing the range of services that met their needs. A small, skilled and willing staff group were brought together to provide a direct service to this client group, including advocacy, liaison and shared care with both addiction and mental health workers. Training and personal development were key aspects of the development of the service. The team now comprises consultant psychiatrists, 5 community psychiatric nurses, an occupational therapist and a social worker.
4.44 Care programmes are planned in full consultation with the client, not in terms of primary or secondary diagnoses, but based on a pragmatic analysis of presenting problems, along with a thorough assessment of attendant risk. Care is rarely provided solely by the dual diagnosis team, but in liaison with mainstream services. In addition to the local addiction services and community mental health teams, there is also continuing and constructive dialogue with other organisations relevant to the client’s care, including Local Health Care Co-operatives (LHCCs), the courts, the local A & E department and the local prison.

4.45 A residential support unit for people with dual diagnosis problems has now been established locally. It too has liaison and shared care roles.

4.46 A full description of the current service operating in Ayrshire and Arran, how it has evolved and indicative costings are outlined in Annex C.

Glasgow: Co-morbidity Evaluation and Treatment Team (CoMET)

4.47 An Addiction Psychiatry Service for Substance Misusers (non-alcoholic) was identified as a priority by the Greater Glasgow DAT in its Strategy Getting to Grips with Drugs in Greater Glasgow, following research by a DAT sub-group. The service, which deals with those with severe and enduring mental illness, combined with opiate use, became fully operational in October 2000 and now has designated staff for clients from each of the four local mental health sectors.

4.48 The team comprises a consultant psychiatrist, community psychiatric nurses (CPNs), social workers, psychologists and administrative staff. The CoMET team accepts referrals from a wide range of agencies, including the Glasgow Drug Problems Service, the Drug Crisis Centre, GPs, social work services and voluntary organisations. There is a simple referral form and the team has its own comprehensive assessment tool. A case management approach is adopted with particular emphasis on risk assessment.

4.49 Although the team has a wide range of skills due to its multi-disciplinary nature, there is a commitment to joint working and close relationships have been established with other agencies. Successful liaison and shared care is now the norm, resulting in fewer inappropriate referrals and more professionals being willing to share in the care of patients. The team has several prescribing clinics which operate in health and resource centres throughout Glasgow. Advice clinics have also been established in the Drug Crisis Centre and the Drug Problem Service. Assertive outreach and motivational interviewing in these settings have proved to be successful in preventing clients falling through gaps in care.

4.50 The co-morbidity service has undoubtedly met needs which were not previously satisfied, although it is acknowledged at local level that there is a need for dedicated inpatient beds and for more support and training to non-specialist staff, who have to treat mild to moderate mental illness.

Glasgow: Community Addiction Teams

4.51 Glasgow is currently developing service provision through proposals for Community Addiction Teams (CATs), piloting of which commenced in two areas in June 2003, before roll-out across the whole of Glasgow.
The CATs target those with primary drug and alcohol problems, who may also have co-occurring ‘mild to moderate’ mental health problems. The CATs assess, care plan and manage people into specialist health services – in-patient and partial hospitalisation and into purchased independent sector services. CATs also offer a range of specialist psycho-social interventions around addiction and mental health problems. They are staffed by addiction workers and mental health and physical health nurses.

For many people with severe or enduring mental illness, care management will normally be undertaken by mental health services, but CATs offer specific addiction related interventions.

The key features of the model are:
- direct access for clients to CATs and primary care services;
- CATs linked to psychiatric team and Community Mental Health team at defined stages;
- training and support to providers, including GPs;
- identified referral routes through a tiered structure of services to meet complex needs;
- care management into, through, and out of services; and
- residential services purchased from the independent sector.

Elsewhere in Scotland

Elsewhere, the picture across Scotland is one of patchy service provision. In Grampian, Forth Valley and Fife there is little specific provision and individual patient care is dependent upon the working relationship between addiction and mental health services and varies according to time and person. NHSLothian has recently appointed a director of its prescribing service which notionally will allow the 2 consultant psychiatrists currently providing this service to spend most of their time working with clients with co-occurring problems. Services in NHSBorders, and in the NHSWestern Isles have traditionally provided a completely generic service in which mental health workers are also expected to provide a service for drug and alcohol users. In NHSTayside the recent appointment to the post of senior lecturer in addiction psychiatry is expected to develop a service. NHSHighland has recently funded a number of community worker and CPN posts to work specifically in this area.

Primary Care Services

Primary care services undertake a wide range of work with this client group and their carers, often in conjunction with local authority services and voluntary agencies. Joint working is an area where primary care, through Local Health Care Co-operatives (LHCCs), has made good progress, with particular emphasis on the provision of services to socially excluded people through flexible funding and contractual arrangements such as Local Development Schemes and Personal Medical Services. This includes early brief interventions to tackle alcohol and drug use; on-going shared care of drug users; the screening for, and the management of, mild to moderate anxiety and depressive illness in those with substance misuse problems; and referral to psychiatric and psychosocial services. Primary care services also provide a ‘safety net’ for people who do not otherwise fit defined
models of service provision – and it is for primary care to ensure that the complexity of their situation is appropriately managed.

4.57 The Primary Care Modernisation Group has highlighted the management of mild to moderate mental health as a priority; and the Centre for Change and Innovation is leading a project ‘Doing Well by People with Depressive Disorders’ which seeks to facilitate change and service redesign in the management of people with depressive disorders.

4.58 LHCCs are regarded as the key building blocks for primary care services and have made good progress in developing into responsive and inclusive organisations which are now a principal focus for the planning and development of community based services. LHCCs will evolve into Community Health Partnerships to reflect a new and enhanced role in service planning and delivery, within the community planning structure, so that innovation and service improvement is led by people working in the frontline in the NHS.

4.59 Opportunities exist, as never before, for primary care teams to work collaboratively with the rest of the NHS and partner agencies to ensure that the necessary skills, time and support – including that provided by specialists is available to deal with people with multiple problems. These developments are only possible by enabling professional staff to develop their roles, extend their skills and work more flexibly through training and development. Extended professional roles and skillmix changes place a greater emphasis on teamwork and many NHS services will be provided locally by an increasingly wide range of skilled staff working together as a team. Such teams will not be confined to particular buildings, but will work across communities and care settings so that patients can access services at a range of locations from a range of professional staff. This multi-disciplinary, and increasingly multi-agency approach is essential to support people with co-occurring problems through sustainable, integrated services and a seamless journey of care regardless of where, or how, they access it.

Services provided within a prison setting

4.60 The Scottish Prison Service (SPS) aims to provide an extensive range of services for offenders with co-occurring substance misuse and mental health problems. The main focus of their needs are being addressed by those working within the field of Rehabilitation and Care, namely Health and Inclusion Teams at both a local and national level.

4.61 SPS Policy initiatives, which exist or are being developed to address the needs of prisoners with this complex problem, are:

- **Inclusion Policy** which will incorporate the Addictions Policy, Social Care Policy and Learning, Skills and Employability Policy (2003)
- **Short Term Assessment Process** (2003)
- **Suicide Risk Management and Custodial Care** (2002)
- **Making a Difference** (2002)
• **Positive Mental Health (2002)**

• **Health Care Standards for Prisoners (1996)** and

• **Mental Health Care Nursing Practice Strategy (1995).**

4.62 These documents are available from the Rehabilitation and Care Directorate, Scottish Prison Service, Calton House, 5 Redheughs Rigg, Edinburgh, EH12 9HW.

4.63 **Positive Mental Health** aims to provide a setting which encourages positive mental health in all aspects of prisoner management and care, responding to mental health and individualised care needs, including addictions.

4.64 Currently all addictions services in the Scottish Prison Service follow a recognised care pathway, called the Addictions Integrated Treatment Care Process. A number of key individuals from establishments are involved in this process (addictions, health and social care staff, officers, psychologists, caseworkers and transitional care workers).

4.65 Where a prisoner presents with a mental health and substance misuse issue the Addictions Co-ordinator will represent the addiction team on the Multidisciplinary Mental Health Team. Joint care planning and prioritisation of the issues (i.e. addictions and/or mental health) with as much information being shared as possible will prevent fragmentation of care, aiming to improve the treatment outcome for the individual. Community partners are crucial to this integrated care process. The three phases of this process are assessment, action and transitional care.

4.66 Currently every prison in Scotland has a degree of mental health resource. These include first level mental health nurses (RMN, RNMH), consultant psychiatrists, social workers, psychology services, chaplaincy, GPs, addictions nurses and in some prisons, forensic mental health outreach services. However, the distribution of many of these resources is not consistent across Scottish prisons and, as a result the quality of mental health services differs from prison to prison. In terms of psychiatric services few prisons have contractual arrangements in place and this is currently being resolved.

4.68 A standardised Multidisciplinary Mental Health Team (MDMHT) working approach has been devised and will be piloted in four SPS establishments between June and September 2003. Lessons learned will be incorporated and help to clarify the resources required for adoption of this corporate approach. This standardisation will provide the foundation for all mental health activity in the SPS. Improvements will be made to the process of linking prisoners to external community mental health services. The Addictions Advisor and Mental Health Co-ordinator are currently developing protocols and guidance for those with a mental health and substance misuse problem.

4.69 Inclusion is a process whereby, having assessed and addressed needs and risk SPS puts ‘offenders back into society better equipped, and more able to be part of a community, than when they came into prison.’ Historically, prisons have been seen as places of isolation and exclusion. This does not sit easily with concepts of inclusion and reintegration. The SPS is undergoing a culture shift, which accepts the need to work with others if it is to maximise the opportunities for prisoners to be successfully re-integrated back into the community. The
SPS intends to develop the role of integrated care pathways and to adopt a cross-agency multidisciplinary approach involving key stakeholders.

4.70 At the present time SPS establishments are introducing ‘LINKS Centres’. The purpose of LINKS Centres are to provide physical settings where prisoners can be assisted with their re-integration back into their community and quite literally be ‘linked’ to a range of services and partners to assist with reintegration, resettlement and inclusion. The aim is that every prisoner, on liberation, has an individual Community Integration Plan (CIP). The CIP identifies needs and actions which will assist the work being undertaken with prisoners to make a difference in their lives, thereby reducing reoffending and enhancing inclusion.

**Services provided by the voluntary sector**

4.71 Both the generic and specialist voluntary sector drug services have been working with people with co-occurring mental health and substance misuse problems for a considerable time in many parts of the country, delivering a range of treatment and rehabilitation services at all points along the care continuum. They also provide social, primary health and mental health care services and may manage specialist resources including crisis units, day and housing support services, and training and employment projects. Increasingly the sector is working with those people unilaterally excluded from mainstream provision because of their complex and challenging needs. This includes extensive experience of working with people labelled as having personality disorders or as sociopaths. Flexible and inclusive working approaches have been developed to assist retention in service, despite managing severe challenging behaviour. As a result of the style of working and the relationships built up with service users, such organisations are more likely to encounter disclosures of childhood sexual abuse, violence or trauma and reports of self-harming.

4.72 As voluntary sector agencies are often the first point of contact, they may carry out the first assessment. This first assessment is crucial in developing support plans and onward referrals for partnership working, including treatment for people with co-occurring mental health and substance misuse problems. Agency workers report that, on occasion, they have received less than helpful responses from both general and mental health providers.

4.73 There is also a vast network of support provided by voluntary agencies not funded by statutory resources which offer respite and support. An example of a voluntary sector project which deals with those with co-occurring mental and substance misuse can be found in Annex D.

**Recent Research: Exploring the Experiences and Views of People with Drug/Alcohol Problems and Mental Health Difficulties**

4.74 In order to inform the content of this report, the Working Group agreed to commission a limited study of users views by the Mental Health Foundation and Turning Point Scotland. This involved consulting people with drug and/or alcohol problems and mental health difficulties and exploring their views about their problems, their experiences of services and their views about how services could be improved. An Executive Summary of the research is at Annex E.

4.75 The findings substantiate other work which indicates that people with co-occurring mental health and substance use problems are likely to have a wide range of needs to be
addressed, and this should be reflected in the kind of support that they are given. A person-centred and holistic approach, covering mental health, physical health and social needs, should be taken when designing, commissioning and delivering services. Access to services and therapies such as counselling, peer support, creative and alternative therapies is required. Access to support and advice on housing, employment and childcare is also important. Services also need to be more accessible and flexible, and it is important that service users are provided with the information they need about what services may be available to them.

‘If you’ve not got an address you can’t get a social worker, if you can’t get a social worker you can’t get a drugs worker and if you can’t get a drugs worker you can’t get help, it’s just a circle.’

Mental Health Foundation Research 2003

‘I wasn’t told about any services until I came in here and felt as if I was going to get help and there was light at the end of the tunnel.’

Mental Health Foundation 2003

CONCLUSIONS AND GAPS IN SERVICE PROVISION

4.76 Recent policy developments in the field of primary care and mental health service provision should lead to an improvement in the planning, delivery and accountability of mental health services, including those with mild to moderate mental ill health.

4.77 The Joint Future Agenda for health and social care services offers the prospect of better outcomes for those with co-occurring mental and substance misuse problems, through an integrated approach to the management, financing and day to day running of services. Applying the principles of Integrated Care for Drug Users should ensure that the multiple needs of this client groups are taken care of through better co-ordinated and integrated services, including housing, employment, treatment, criminal justice and other forms of support. A number of areas are already applying these concepts to services for people with mental health and addiction problems, but practice is not universal.

4.78 The National Programme, further endorsed within Partnership for Care, aims to undertake a number of measures to promote mental well-being, the prevention of mental health problems and the early identification and action when problems occur. The findings of our research confirms the need for this action.

4.79 The separation of the planning processes for services for those with co-occurring substance misuse and mental health problems, through DAATs and Joint Mental Health Commissioning Groups at local level, is not helpful to encourage joint service provision for this client group.

4.80 There is a lack of guidance in the treatment of personality disorder in Scotland, with only rudimentary service provision. A three pronged approach, changing staff attitudes, demonstrating the evidence, and training in the requisite skills, will be necessary.
4.81 There is a lack of the varied service provision that survivors of abuse require. The range which should be provided is currently the subject of other work led by the Scottish Executive Health Department.

4.82 There are variations in the provision of services for those suffering from mental health and substance misuse problems. Issues include:

- some mental health services working on too narrow a model of assessment and care;
- a lack of effective joint working between addiction and mental health services prevailing in some parts of Scotland;
- a lack of clarity in defining clients with co-occurring mental and substance misuse problems (‘multi-problematic’ as opposed to ‘dual diagnosis’), with poor assessment by generic workers and primary diagnosis often reflecting source of referral rather than causation;
- a lack of the necessary core competencies of staff in generic and front-line services;
- a lack of willingness to work with this client group, and a stigmatisation associated with their problem; this sometimes results in treatment not being offered and inappropriate referrals to specialist services;
- the need for aftercare support to be planned as an integral part of treatment to prevent recurrence; and
- the need for better use of the voluntary sector in planning and delivering services to this client group.
CHAPTER 5

ASSESSMENT, INTERVENTION AND SUPPORT
CHAPTER 5: ASSESSMENT, INTERVENTION AND SUPPORT

This Chapter:

- sets out the principles for the assessment of, and continuing support for those with co-occurring mental health and substance misuse problems, in line with the Joint Future Agenda and Integrated Care for Drug Users; and

- provides further information on the stages of intervention and appropriate approaches to treatment and care.

Basic principles and historical context

5.1 The provision of care for both substance misuse and mental health problems has long been recognised as requiring a broad range of participants. If a smooth passage through services for the client is to be achieved, not only must the providers share a broadly similar understanding of what types and sequences of care are appropriate, but they must also to be able to apply these flexibly and jointly across professional and organisational boundaries.

5.2 This aspiration is obviously compatible with, and a driver for, the implementation of both the Joint Future Agenda and Integrated Care for Drug Users. There are many examples of effective joint working or shared and integrated care in both substance misuse and mental health services. However few areas, if any, have managed to apply the process fully. The language of care and of strategy differs markedly between local authority, health and voluntary sector services, often leading to misunderstanding and subsequent difficulty in service provision. Those forms of working that depend upon professional or organisational identity are likely to result in a pathway of care which is less effective than those which work jointly.

5.3 If this is true of both mental health services and substance misuse services individually, then the problems are increased significantly when a further specialism is added into the mixture. These problems include the following:

- within NHS mental services, many of those staff concerned with treating adult mental illness are unhappy at the prospect of dealing with substance misusers;

- there has traditionally been a separation at operational and planning levels between the two services, with the result that both services, and those who need the services, are at risk of failing;

- skill deficits in substance misuse services when treating mental illness can lead, at the very least, to inadequate identification of problems and to misinformed interventions;
• the same deficits in the opposite direction are seen in mental health services, with the same consequences;

• both areas therefore become frustrated and irritated at the apparent difficulty that the other is having in providing what would be perceived as a good service, which in turn may further divide services; and

• the voice of service users rarely seem to be heard or heeded.

Resolving these difficulties will require:

• putting the clients’ needs at the centre of care;

• joint service planning;

• systems of care delivery;

• workforce training; and

• governance;

before there can be any opportunity of developing truly integrated pathways of care.

5.4 As already outlined in Chapter 4, different areas are addressing this problem in different ways. Some are developing specialist teams; some are targeting training and development at generic teams; others are developing integrated care pathways for substance misusers in the expectation that this will better serve those with more complex needs. These are valid local responses aimed at adapting existing situations, but they highlight the need for a national framework of practice based on evidence. This should allow decisions to be taken at local level as to which combination of responses will best suit a particular area in light of identified need, existing services and the related resource. The mechanisms now exist, deriving from Joint Future, Partnership for Care and Integrated Care for Drug Users to facilitate this process. Key to the success of this will be a new willingness to work across and through existing service boundaries, which is fundamental when dealing with this particular client group.

5.5 A wide range of health and social services should be readily available to this group. Sometimes this may need to be delivered in sequences which are not currently accepted or which may not, at first sight, appear to be entirely logical. In particular it may not always be possible in a community setting, where the majority of interventions will occur, to allow the theoretical debate of whether care for mental health issues and care for substance misuse issues should be parallel, sequential or integrated. Inevitably initial clinical and risk assessment will determine what can or cannot be done within that person’s current circumstances. For instance the usually accepted principle that detoxification from alcohol should precede assessment and treatment for depression might not be appropriate if the person is unwilling to be detoxified (given the common
perception by clients that alcohol is the only thing that helps lift mood). Similarly the person may be unwilling to accept residential care despite exhibiting alarming levels of risky behaviour as a result of low mood. Care sequences need to be constructed in a pragmatic way which gives most hope of a successful outcome for the client, rather than being driven by theory or practice deriving from a group with less complex care needs.

5.6 Local services therefore require:

- a sufficiently diverse skills mix to allow ready access to appropriate specialist and generic services as a client’s needs becomes apparent;
- to be staffed by workers who are sufficiently confident of their own abilities to construct practical care plans in the face of a complexity of rapidly shifting problems;
- to be well enough understood by generic workers so that they can contribute to tackling the less complex issues, partnering the specialist service;
- to be understood and accepted by other potential providers, as well as care funders and commissioners; and
- to have significant presence and the capacity for a prompt response in those parts of the community where significant numbers of the client group will be found, often in crisis, and therefore possibly more amenable to accepting help – A & E departments, in psychiatric crises/emergency/out of hours services and in parts of the criminal justice system.

These principles should be built into any national framework as basic good practice.

**ASSESSMENT**

**Why is assessment important?**

5.7 An effective assessment process is at the core of effective and co-ordinated delivery. Assessment aims to establish with the individual as complete a picture as possible of all their needs – care for health, physical and mental, social needs, housing and occupation – and their state of readiness to change, in order to identify and provide the most appropriate service/services likely to promote a positive outcome. Without this information, the individual may be offered support that does not match their needs and aspirations, leading to disillusion and dropout from services.
Protecting the welfare of children cared for by service users

5.8 In addition to assessing the needs of the individual, all agencies and professional staff working with individuals who misuse substances have a responsibility to protect the welfare of any children cared for by their service users. *Hidden Harm: A Report of the Working Group of the Advisory Council on the Misuse of Drugs*, published in 2003, highlights the problems of children whose parents misuse drugs.

5.9 *Getting Our Priorities Right: Good Practice Guidance for Working With Children and Families Affected by Substance Misuse* published by the Scottish Executive in February 2003 highlights good practice in working with substance misusing parents/carers. It clarifies expectations in terms of information sharing and confidentiality and provides guidance on deciding when children need help.

**Single Shared Assessment**

5.10 A key element of the Joint Future Agenda is the establishment of locally agreed, single shared assessment procedures for all groups within the remit of community care. Full implementation of single shared assessment for all community care groups, including those with mental health problems and those with substance use problems is due by 1 April 2004. However, as each care group is developing their own single shared assessment, there is risk that those with both substance misuse and mental health problems could be subject to assessment from both. There needs to be some proper co-ordination to ensure consistency.

5.11 In November 2001, the Joint Future Unit of the Scottish Executive issued guidance on single shared assessment. Within this guidance a minimum standards checklist was provided in order to ensure that local single shared assessment tools meet a number of specific criteria. The guidance notes, which accompanied this document, confirmed that the minimum standards checklist for single shared assessment would apply to all care groups.

5.12 The core data set in use is currently divided into 4 sub-sets, as follows:

- personal information core data set;
- assessed need core data set (components of need);
- care plan core data set; and
- important medical conditions guide.

5.13 Single Shared Assessment creates a single point of entry to community care
services and will lead to better use of resources and more effective outcomes for people in need. It:

- ensures that agencies adopt a holistic approach to assessing and meeting people's needs, reducing bureaucracy and duplication in assessment and planning care;
- should be person-centered and needs-led and be seen as a continuing process reflecting changing levels of need throughout a person’s care;
- is a shared process that supports joint working by seeking information once, coordinating all contributions from service providers, clients and people close to them;
- has an identified lead professional who co-ordinates documents and shares appropriate information;
- actively involves people who use services and their carers; and
- provides results which are acceptable to all agencies.

5.14 The Joint Future Unit states that in order to achieve this:

‘Agencies should put in place single shared assessment processes and a single shared assessment tool. This should be done through the development of joint protocols to ensure agreement locally in the systems for and ownership of assessments and the provision of joint training for staff in assessment practice’.

5.15 Given the breadth of agencies with which initial contact may be made, it is likely that three levels of assessment are appropriate, in line with Joint Future guidance. These are:

- simple assessment (or screening);
- comprehensive assessment; and
- specialist assessment.

5.16 The EIU has collaborated with the Joint Future Unit to agree definitions of simple, comprehensive and specialist assessment relevant to drug users. They also collaborated in identifying the key items for two draft core data sets: the personal information data set and the assessed need core data set. Guidance is contained in Integrated Care for Drug Users: Principles and Practice. In addition the Unit has recently produced a digest of Assessment tools which have been shown to be appropriate and valid. This is also available on-line.
5.17 In addition there are two specialist instruments which are considered appropriate in screening for substance misuse in those with co-occurring problems:

- DALI – Dartmouth Assessment of Lifestyle Instrument (18 item interviewer administered);
- SATS – Substance Abuse Treatment Scale (measures progress); and
- CUAD – The Chemical Use, Abuse and Dependence Scale (measures substance misuse in those with co-morbid problems).

5.18 However, these assessment tools focus on health-related problems and take little account of socio-economic difficulties, which may often be just as important to the service user. The results should be interpreted cautiously taking account of their limitations.

5.19 Assessment involves several related elements. These are:

- **Detection** – to determine the nature and degree of substance use and psychological distress. This may initially involve the targeting of groups known to be at particular risk of developing co-morbid problems, such as those suffering from severe and/or relapsing mental health problems.

- **Formulation** – to determine the relationship between substance misuse, psychological distress and other relevant medical problems, taking into account the socio-economic context in which they occur. This may require a number of interviews and information from friends, family, other professionals and the use of drug tests.

- **Risk assessment** – to identify a hierarchy of need based on ensuring safety, accommodation, treatment and care. Key to risk assessment is the nature of the behaviour that is causing concern, the frequency and intensity of thoughts pertaining to it, how much planning has been developed to deal with it and whether or not there is the opportunity to carry out the plan. There may be a history of the same or similar behaviour and note should be made of the reasons why previous plans have not been carried out and of any strategies that have been developed to help reduce the risk. There are a number of clear predictors of risk which should be borne in mind.

- **Goal development** – to agree goals with the client which should be sequentially achievable within a harm reduction framework, and be flexible and adaptable in order to maximise opportunities for effective engagement and retention. If denial is thought to be an issue, tactics for approaching it should be factored into goal setting.
• **The planning of delivery of care** – to agree goals with other agencies. Inevitably this will depend on the resilience of the available network. A flow chart of care, including responses to failed or unexpected outcomes, can be useful as a way of minimising the likelihood of disengagement or of system failure.

• **Monitoring** – to provide a baseline to measure progress.

• **Communication** – with the client, their family, their carers, their close friends should be as transparent as possible to reduce the chance of failure.

• **Diversity** – to be sensitive to the interactions of need, prejudice and stigma amongst ethnic minorities, young people, disabled people, older people, and young mothers.

**INTERVENTIONS**

5.20 It is not the aim of this document to provide detailed guidance on clinical or social interventions for the treatment of those with either substance misuse or mental health problems or co-occurring mental health and substance misuse problems. These are well documented elsewhere. Guidance includes:

• *Drug Misuse and Dependence: Guidelines on Clinical Management* (UK Health Departments 1999)

• *Drug Treatment Services for Young People: A Systematic Review of Effectiveness and the Legal Framework* (EIU June 2002)

• *Drug Treatment Services for Young People: A Research Review* (EIU June 2002)

• *The Effectiveness of Treatment for Opiate Dependent Drug Users: An International Systematic Review of the Evidence* (EIU July 2002)

• *A Survey of NHS Services for Opiate Dependents in Scotland* (EIU July 2002)

• *Psychostimulant Working Group Report* (Scottish Advisory Committee on Drug Misuse August 2002)

• *Psychostimulants: A Practical Guide* (EIU September 2002)

• *Services for Young People with Problematic Drug Misuse: A Guide to Principles and Practice* (EIU January 2003)

• *Prevention of Relapse in Alcohol Dependence* (Health Technology Assessment Report No 3)
5.21 It is clear from the above publications that many different treatments and approaches work for this client group. Although the evidence of effectiveness is substantial and growing as the research base develops, there is no single approach that is universally effective for such a complex mix of conditions. It should be recognised also, that clients are likely to have particular difficulty in co-operating because of the influence of substances, the effect of mental disorder or the effects of previous trauma. Individuals may be particularly chaotic and unwilling, or unable, to self-advocate, when not offered the right types and levels of support they need.

5.22 There are some general principles which should be applied.

- Interventions should be presented in as simple and as understandable a way as is possible.
- Service providers need to be working in effective partnership with each other and with the client.
- Mutually agreed interventions need to be adaptable, flexible and to be attached to realistic goals – as true for workers as for clients.
- Interventions should take account of the degree of commitment to change, the readiness to change and the various factors which underpin this process.
- Staff who are not used to working with this group will need to recognise that, on occasion, they are having to deal with a set of behaviours which might not normally be tolerated and which might induce fear and anger. Staff should resist the temptation to attribute this sort of behaviour to a diagnosis of personality disorder. Many other influences are probably at work.
- Expectations of staff to the degree to which they are personally responsible for the process of intervention may need to be reduced.
- Changing working conditions for staff needs to be carefully managed. Staff need to feel fully supported in their work. Adequate training, supervision, career and personal development opportunities are critical to success.
- Given the high risk inherent within severe, enduring and relapsing mental illness and substance misuse, there needs to be a full understanding of, and a commitment to, the long-term nature of the work.
Stages of intervention

There are a number of identifiable stages of intervention.

Engagement

5.23 Establishing a therapeutic relationship can be long and drawn out, but begins from the point of first contact. The inequality implicit in the relationship and sense of disempowerment on the part of the client must be understood along with its potential for creating misunderstanding. Initial aims may be very different and to proceed adequately requires that a mutually acceptable middle ground be found. Attentive listening, courtesy and respect are the foundation of this. The use of normal referral routines may fail because of difficulty of understanding or fitting routine appointments into a chaotic lifestyle. The process of assertive outreach is often a useful way of making the initial contacts.

Meeting basic needs

5.24 From the complex range of needs generated by assessment, the basic needs of safety, accommodation and food come first. Support for benefit claims is important as well as providing alternatives to violent or dangerous environments.

Persuasion

5.25 There is a point at which the client’s perceptions about the reasons for their problems can be discussed and better understood and at which a more accurate understanding of their motivation for change can be assessed. Gentle debate as to alternative explanations can then begin, and the client can be introduced to other perceptions of what is happening to them. The aim is initially to understand the problem from the client’s perspective and then, by beginning to use techniques such as motivational interviewing and concepts such as the cycle of change, to influence motivation and encourage the belief in a positive outcome. This is best accomplished by using techniques that are empathic, client-centred, and non-judgemental whilst avoiding argument, facilitating accurate debate, gently feeding back discrepant statements and encouraging an awareness that change is possible after all.
Active intervention

‘It’s got emergency beds and you can walk in the door and get admitted and see doctors and nurses within 24 hours...You could be sleeping rough and have pneumonia or whatever and could be just about to die for all you know. If you didn’t come in here you wouldnæ be alive, you could be lying dead somewhere.’

Mental Health Foundation Research 2003

5.26 Most interventions are carried out collaboratively in the community. The diversity and complexity of difficulties may sometimes be best met by using the Care Programme Approach, but whether or not this is formalised, it is essential that care systems are properly planned and integrated in a way which is client-centred and which is fully understandable by everyone involved.

5.27 Allowance should be made for the most likely contingencies and exit strategies planned for those parts of the system which become redundant or prove to be ineffective.

5.28 The client should be fully aware of, and involved in, the construction of the plan and should have a clear mechanism by which they can rapidly access.

5.29 Services such as the police, local A & E department, doctor on call service, or the local Mental Health Officer may need to be aware of some of the situation, normally with the client’s understanding and involvement.

5.30 A care co-ordinator should be identified and be responsible for updating the plan and keeping the appropriate people informed.

‘If you had one person who knew about mental illness and about drugs, who you’ve got in the one place, so you are not having to jump from place to place and you don’t have to tell the same story all over again, you know when you’ve got the one person you can trust.’

Mental Health Foundation Research 2003

5.31 The plan should include all those interventions used in both the mental health and substance misuse arenas that are felt to be appropriate. They should be sequenced in a way that is acceptable to the client, rather than a way that neurobiological theory might dictate. For instance motivational interviewing, relapse prevention techniques and substitute prescribing might be tied in with anti-psychotic prescribing, anger management and cognitive hallucinatory control techniques.
**Early intervention**

5.32 Ideally early intervention should be the basis of the treatment system, tied into broader prevention work. Access to services should be rapid, flexible and appropriate to the individual’s need. Existing points of contact eg through the criminal justice system and A & E departments should be more fully recognised and utilised as gateways to care for this client group. There should be clear referral pathways to services appropriate to the individuals needs.

> ‘So I was twice near death but the hospital don’t care cause you are just a junkie. When I go to the hospital now I don’t get a tablet, I don’t get nothing. I don’t get a painkiller. Last week I went and I was getting pushed back out the door as soon as I went in.’

Mental Health Foundation Research 2003

> ‘It took 7 months to get to see someone…I went to see them within 4 weeks of relapse and it took 7 months for an appointment.’

Mental Health Foundation Research 2003

> ‘There is a long waiting list as well. A good three-month…to get into any one of them. By that time, you end up forgetting all about it. you cannot really be bothered with it anymore and then you turn back to drugs again.’

Mental Health Foundation Research 2003
CHAPTER 6

PLANNING AND DELIVERY OF SERVICES
CHAPTER 6: PLANNING AND DELIVERY OF SERVICES

This Chapter:

- looks at how services might be structured locally to meet the needs of those with co-occurring mental health and substance misuse;
- advises commissioners on key elements of service provision which should be available locally; and
- considers the wider needs of the client group.

Models of care

6.1 There is no UK evidence on what model of care is most effective in the treatment of those with co-occurring mental health and substance misuse problems. Whilst this document sets out what the essential considerations must be, it cannot recommend any particular model of service delivery. Those involved at a local level must agree on how they can meet the needs of service users in the light of their knowledge of the prevailing conditions. Matters such as workforce training and service redesign can be set in motion to allow the services to evolve. As indicated earlier, Partnership for Care, the Joint Future Agenda and Integrated Care for Drug Users are the key drivers for change to the way that services are planned and delivered. This should ensure a broad-based approach to service delivery. Just as important, is the style and culture of service delivery.

6.2 NHS Boards and partner local authorities should consider the needs of this group as one entity. A programme budget for the group should be allocated and managed as a whole, whether or not there is a defined severe or enduring mental illness present. Both NHS Boards and local authorities have continuing responsibilities under the Community Care Act 2002 to expand local joint working including the pooling of budgets.

6.3 Chapter 4 provides detail on two different models currently operating in Glasgow and in Ayrshire & Arran. What can be achieved for this client group will depend on local joint agreements on service re-design, which will inevitably be based on the existing service make up and demographic and geographical factors. The following framework offers a suggested approach to the grading of care which might be worthy of consideration for those planning and commissioning services. The framework is one within which Joint Future principles can apply.

Grading of care

6.4 The following diagram attempts to match increasing severity of need to increasing levels of specialism and conceptualises care in 4 or 5 steps, the availability of which forms a pyramid of specialisms. However, it is important to understand that this way of looking at individual need and the way services might respond is useful for analysis, but does not provide any kind of blueprint for the design of a local service. It is quite likely that an individual who has complex needs in one area of life will have simple requirements in others, but which are just as important to be met for the overall outcome.
GRADING OF CARE

5
Highly specialised, available at regional or supra-regional level

4
Specialist interventions for those with co-occurring problems

3
Generic Services with Specialist factors

2
Generic Services

1
Community and Social Response

Level of Need

4&5  Severe mental illness / severe substance misuse

3&4  Severe mental illness / some substance misuse
     Non severe mental illness / severe substance misuse

1, 2&3  Non severe mental illness / substance use / misuse
The steps which might be considered as part of this kind of graded system are outlined below.

**Step 1**

6.5 This might be the degree to which information about services and possible assistance is visible in the client’s community. It might include family, friends, social clubs, football teams, fellow pub clientele, churches – anyone who knows of the person, is aware of at least some of his or her difficulty and wishes to try and help. Although often ‘unskilled’ in service terms, this step has the advantage of being the most readily accessible, least stigmatising and most acceptable, based on a close knowledge of the individual. It is a level of care that can be very powerful and which is often undervalued, if not overlooked, by professional carers. Without doubt there are issues arising from the entitlement to confidentiality, and the risk of stigmatisation. However, the services can ill afford to neglect sources of continuing support for an individual, if arranged sensitively.

**Step 2**

6.6 Generic services, which might include schools, police, general practitioners, social workers, A & E staff and community workers. They are providing care and support in some form. Although there may be no substance misuse or mental health related specialist function, these workers will have some skills in the detection of difficulty. At present such workers may not feel confident to embark on exploration of difficulties, partly because of not wishing to precipitate a crisis, partly because of an unawareness of local services. There also needs to be continued contact and liaison for productive working.

**Step 3**

6.7 Generic services with some specialist function, for instance workers from the voluntary or statutory sector who specialise in either mental health or substance misuse services. These are people who may feel proficient or skilled to work in some arena and not another, although they will very often have some expertise by virtue of a degree of overlap in training.

**Step 4**

6.8 Specialist services, which intervene for people with co-occurring problems can be derived from the voluntary or statutory sector and have special expertise. While some are trained, many often gain expertise in the absence of adequate training in the particular difficulties brought by this group. They may or may not form a discrete service, one alternative being the dispersal of suitably qualified individuals into the teams providing the Step 3 service, thus producing a ‘virtual’ team. The advantages of such a model would include the onsite, gradual and fluid upskilling of generic workers. The disadvantage would be relative isolation and difficulty in accessing peer support.

**Step 5**

6.9 Those services offering a highly specialised treatment resource. This might include, as an example, an inpatient unit specialising in the long-term treatment specifically of those people with co-morbid difficulty and personality disorder. Whilst the other 4 steps could be seen as being appropriate within one NHS Board area or one local authority, Step 5 is much
more likely to be appropriately placed regionally or supra-regionally. Mapping this intervention sequence requires some delineation of the level of need within the population of those with co-morbid needs. ‘Severity boxing’ might produce the following:

Severe mental illness/severe substance misuse (Steps 4 & 5)

6.10 This would comprise the core client group of Step 4 and would be those whose illness and misuse have become so intertwined as to render causal explanation irrelevant. It is with this group that the most pragmatic responses to need will be made, often irrespective of formal diagnosis but rather responding to expressions of need. This group will be the most chaotic, least able to keep appointments, most likely to demonstrate a variety of risky behaviours and least likely to be able to keep up with the demands that society makes on them. They will require careful, well-communicated client-centred care planning with frequent intense input over very long periods of time and will usually benefit most from the input of a wide range of professions. Diagnoses might include severe and schizophrenia, severe and refractive affective psychosis and severe post traumatic disorder, including childhood trauma, with polydrug abuse, reported self-harm etc. Models of care for this vulnerable group who pose a number of risks need to be developed. The Low Threshold Methadone Project in Lothian, which deals with 30 to 40 individuals at any time, gradually engages people in treatment and staff relationships, as an essential preliminary to a move onto other services. This is one way of attending to the needs of a care group which otherwise can easily be overlooked.

Severe mental illness/some substance misuse (Steps 3 and 4)

6.11 Those whose needs might best be met by input from mental health services with support, advice and occasional episodes of shared care from Step 3. The Step 3 services may need to be helped in adjusting their expectations of their client group who may on occasion behave in ways that are difficult to accept. It would include those who misuse substances as a way of ‘self-medicating’.

Non severe mental illness/severe substance misuse (Steps 3 & 4)

6.12 Those whose needs might best be met by input from the substance misuse services with support, advice and occasional episodes of shared care from Step 4. The Step 3 services may need to be helped in adjusting their expectations of their client group, who may on occasion be unwilling to accept personal responsibility for themselves to the degree that would normally be expected. It would include those who have milder forms of those being seen by Step 4 as well as those suffering the dysphoria implicit in severe substance misuse.

Non severe mental illness/substance use/misuse (Steps 2 & 3)

6.13 Those whose needs would be best met at the level of Step 2 with support, advice and shared care from Step 3, as appropriate.

6.14 The needs of these 4 groups can be met in a number of ways. The functions implicit in the structure above are more important than the structures themselves. The way in which they are achieved will often have their roots in the way that services are already structured. There may, however, be real tensions locally between:
• the exclusivity and expense, but potentially more effective outcomes, of having a Step 4 service;
• the potential burnout and de-skilling of an allocated specialist worker to Step 3 services to provide much needed support and advice for generic workers; and
• the more equitable, but potentially less effective service, of partially upskilling all generic workers.

6.15 These can only be resolved at a local level. It is important that the functions previously outlined are met. However, service standards setting for those in this client group would be helpful to underpin coverage and quality of services.

Needs assessment/service mapping

6.16 Planners and commissioners of services need to be aware of the nature and scale of the problem, so that resources are targeted appropriately. Evidence outlined in Chapter 3, however, shows the extent of co-occurring substance misuse and mental health problems already known throughout Scotland. Further extensive needs assessment work using epidemiological techniques at local level is probably not, therefore, required at this time. Service commissioners should concentrate on looking to see how gaps in current service provision, its profile, culture and flexibility to respond as highlighted within this report, might best be met.

6.17 This would be highlighted by service mapping and looking at the links and referral patterns between them in line with the Joint Future and Integrated Care Agenda. Within that, the following issues need to be taken into account.

• This client group is extremely challenging, but nevertheless deserves access to the most appropriate and timely services.

• These services should be available where there are existing facilities where this client population is likely to be found.

• Expectations of what can be achieved through treatment and intervention need to be emphasised to client and to service providers alike.

• Interventions should be as broadly based as possible, and include social, education, and employment elements.

• Commissioners should consider how best to pursue service re-design in order to address the needs of this client group within mainstream, generic services with easy referral to meet more specialised needs.

• Voluntary sector services should play a key role in planning and delivering treatment and care to this client group and should be resourced accordingly.

• Early intervention is likely to be cost-effective, avoiding inappropriate referrals to more expensive specialist services.
• Interventions need to be person-centred and not based on existing service availability. Services should aim to give the client as much involvement in decision making, partnership in care and sense of control as is appropriate in the circumstances.

• The ‘take this letter and go and see this person I have decided you need to see’ approach is highly unlikely to be helpful; successful service collaborations are likely to involve link workers who ‘stay with’ the client, especially the more chaotic individuals, in their early contacts with the service. This should reduce missed appointments and help to reassure clients of a genuine commitment from service providers. There are successful alcohol liaison nurse models, particularly in Edinburgh, which could be adapted.

• Independent Advocacy should be a key feature of service provision, with workers helping service users through treatment and care services.

• Liaison with service users and those who care for them is an essential part of the process of staying in focus and making sure what is done is as fit for purpose as possible. Who better than the users of the service to let those providing and those commissioning the service know how it was for them?

**Training and support**

6.18 The need for proper support and training for all staff has been emphasised throughout this document. Staff, whether in mental or substance misuse services, need to develop the skills necessary to identify and understand clients with co-occurring problems, to develop the confidence to deal with them, and to be given the capacity to cope. Training and continuous professional development should include:

• the development of assessment skills based upon substance misuse and mental health assessment frameworks;

• the facilitation and handling of disclosure about previous traumatic experiences;

• the integration of knowledge of drug and alcohol trends for individuals with mental health problems, into practice; and

• effective working with a range of mental health interventions and treatment modalities.

6.19 It is recommended that STRADA should take account of the detail of this report in a review of its material.

6.20 Effective staff supervision, both clinical and managerial, is equally important. Support mechanisms should also be in place for staff at all levels to help them cope with this particularly challenging client group.

*If it wisnae for him, ah widnae be here right now.*

Mental Health Foundation Research 2003
ANNEXES
ANNEX A

KEY STATISTICS ON ALCOHOL IN SCOTLAND

Alcohol consumption by age and gender

- 1 in 3 (33%) of men drink over weekly recommended limits. [Scottish Health Survey 1998].

- Although this proportion is less for women (15%), evidence shows that there is an upward trend, particularly in young women, of whom 1 in 4 (24%) drink excessively. [Scottish Health Survey 1998].

- Among current drinkers, 12% of men and 5% of women were identified as possible ‘problem drinkers’. [Scottish Health Survey 1998].

Young people

- Excessive drinking is most prevalent in younger adult age groups. [Scottish Health Survey 1998].

- The 2002 survey of Scottish schoolchildren (SALSUS) reveals that nearly 1 in 4 of 13 year olds and almost 1 in 2 of 15 year olds reported drinking alcohol in the previous week. [SALSUS Interim report December 2002].

- Drinking has increased over the past 4 years for 15 year old boys and 13 year old girls. Most (77%) 15 year olds reported they had been drunk at least once. [SALSUS Interim report December 2002].

Service use

- There were over 100,000 GP consultations in 2002 for alcohol related problems. People with alcohol related problems consult their GP twice as often as those who do not. [source: CMR, ISD].

- 3 in every 100 of all acute admissions (35,194/1,062,038) and more than 1 in 10 of all psychiatric admissions had an alcohol-related diagnosis (2,947/25,258). [source: SMR 1 and 4, ISD].

Deaths

- Alcohol related deaths have risen considerably over the last ten years from 684 in 1990 to 1,772 in 2001. [source data: GROS].


**Vulnerable populations**

- More than half of a sample of homeless people in Greater Glasgow in 1999 were drinking hazardously. \cite{Health and Well-Being of Homeless People in Glasgow ONS 2000}.

- A study of substance misuse in prisoners in England and Wales found that 58% of male remand prisoners and 63% of sentenced prisoners reported hazardous drinking in the year before they were imprisoned (30% of each group had severe alcohol problems). Amongst women, 36% of remand and 39% of sentenced prisoners reported hazardous drinking in the year before they were imprisoned with 14% and 11% respectively that had severe alcohol problems. \cite{Psychiatric Morbidity among Prisoners ONS 1999}.

- Men living in the most deprived areas (Deprivation Category 7) of Scotland are seven times more likely to die an alcohol related death than those in least deprived areas (Deprivation Category 1) (see Figure 1). \cite{Plan for Action on Alcohol Problems SE 2002}.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{alcohol_related_death_rates.png}
\caption{Alcohol-related death rates (1999) by Deprivation Category and gender (Source: GRO)}
\end{figure}

- People living in the most deprived areas of Scotland are seven times more likely to be admitted to an acute hospital with an alcohol-related diagnosis. Acute hospital inpatient admission rates with an alcohol diagnosis are seven times higher in Deprivation Category 7 than Deprivation Category 1. (1,461.3/100,000 compared with 189.6/100,000) (see Figure 2). \cite{Plan for Action on Alcohol Problems SE 2002}.

72
STATISTICS ON DRUG USE IN SCOTLAND

Drug use by age and gender

- In the 2000 Scottish Crime Survey, drug use in the last month was reported by 5% of those aged 16-59 (this compares with 6.4% for the UK population as reported by the UK Psychiatric Morbidity Survey). [Drug Misuse Statistics Scotland 2001].

- Drug use is commoner in males (8% of males had taken a drug in the last 12 months compared with 6% of females) and in younger age groups (37% of 16 to 29 year olds said they had ever tried drugs compared with 13% of those aged 30 or over). [Drug Misuse in Scotland: Findings from the 2000 Scottish Crime Survey 2001].

- It estimated the number of problem drug users (opiate/benzodiazepine) in Scotland in 2000 was 55,800 with an approximate male to female ratio of 2:1. [Hay G, McKeeganey, N & Hutchinson S 2001].

Young people

- Drug use is higher in younger age groups with 13% of 16-29 year olds reporting this for the last month. Trends from the Scottish Crime Survey suggest that drug misuse has been tailing off since a peak in the mid nineties, particularly in the younger age groups. These figures are however based on relatively small sample sizes. [Drug Misuse Statistics Scotland 2001]

- The 2002 Scottish schoolchildren survey (SALSUS) shows 8% of 13 year olds and 23% of 15 year olds reported using drugs in the last month, with boys more likely to report use than girls in both age groups. Trends from previous surveys show reported drug use in the last month has not changed significantly since 1998 [SALSUS Interim report December 2002].
**Service use**

- Compared with alcohol misuse, there are proportionally far fewer GP recorded consultations for drug misuse. In 2001 there were just over 10,000 GP consultations with a drug misuse diagnosis. [Drug Misuse Statistics Scotland 2002].

- The same is seen for hospital admissions. During 2001/02, there were 4736 admissions for drug misuse to acute general hospitals and 1134 admissions to psychiatric hospitals (3.3 per cent of total) with a main diagnosis of drugs misuse, making it the 9th most common condition. [Scottish Drug Misuse Statistics 2002].

- Over 10,000 new individuals were reported to the Scottish Drug Misuse Database as entering drug treatment. [Scottish Drug Misuse Statistics 2002].

**Deaths**

- Drug deaths are also far fewer in number than for alcohol. There were 332 drug related deaths in 2001. As with alcohol related deaths, trends show an upward rise with a 36% increase since 1996 (244). [Scottish Drug Misuse Statistics 2002].

**Vulnerable populations**

- Although the majority (72%) of prisoners do not report drug use in the last month, 28% do, a much higher proportion than the general population. [Fifth Scottish Prison Survey 2002].

- 1 in 5 of those reporting drug misuse in the last year in the general population were unemployed. [Scottish Crime Survey 2000].

- Again as for alcohol, a deprivation effect can be seen for drug misuse with higher rates in more deprived areas. For example, there is an association with deprivation on GP contact rates for patients with a diagnosis of drug misuse. [Drug Misuse Stats 2002]. There is also a marked deprivation association seen for hospital discharges with a diagnosis of drug misuse, particularly notable for males (see Figure 3).

- Lifetime experience of victimisation (bullying/violence in home/being homeless/sexual abuse) is higher for those who are drug dependent. [Psych Morbidity Survey].
Mental health problems by age and gender

- The Scottish Health Survey assesses psychosocial health using the General Health Questionnaire (GHQ 12). Scores of over 4 indicate possible psychiatric morbidity. 18% of women and 13% of men had scores over four. The highest scores were seen in the middle years for both sexes. [Scottish Health Survey 1998].

- The UK wide Psychiatric Morbidity Survey found that 16 per cent of the population were assessed as having a neurotic disorder with women having higher rates than men. The most common of these disorders, experienced by 9% of people, was mixed anxiety and depressive disorder. [Singleton et al 2001].

Young people

- For children aged 13-15, 5% of boys and 8% of girls had GHQ scores of over 4. [Scottish Health Survey 1998].

- Mental well-being of boys is better than that of girls and overall, children in primary school have better mental well-being than those in secondary school. [Currie and Todd 2003]
Service use

- Estimates from general practice in Scotland suggest that 10% of consultations are for a mental health problem. [CMR 1998, ISD].

- There were over 25,000 admissions to psychiatric hospitals in 2001, a 16% fall from the previous year. However, this is more likely to reflect changes in service from hospital based to community delivery rather than a real drop in prevalence. [SMR4, ISD].

Deaths

- Death rates due to suicide or undetermined cause for men have risen steadily over the last 25 years with particularly high rates for young men. Rates for women are much lower and have fallen over the same period. In 2000, 75% of deaths recorded as suicide or undetermined cause were for men. [GRO website].

Vulnerable populations

- For both men and women, the Scottish Health Survey found that those who were unemployed had an increased risk of higher GHQ score (i.e. possible psychiatric morbidity) compared to those in employment. [Scottish Health Survey 1998].

- The 2002 Scottish Prison Survey asks a series of questions relating to anxiety and depression. A majority of prisoners did report problems, with a significant minority experiencing problems on a daily basis. Although a standard instrument was not used, the questions were based on the GHQ. [Scottish Prison Survey 2002].

- The survey of homeless people in Glasgow found that 6% had a psychotic disorder, 44% a psychological disorder and 22% reported a long-standing mental illness. [Health and Well-Being of Homeless People in Glasgow ONS 2000].

- Qualitative local research in Edinburgh has shown that childhood sexual abuse trauma is perceived to be an important contributor to both mental health and addiction problems. [Nelson S. 2001].
STATISTICS ON SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS

Current prevalence in general population (US)

- 1 in 10 (13%) have a mental health problem
- 1 in 40 (2.8%) have an alcohol disorder
- 1 in 100 (1.3%) have a drug disorder

Lifetime prevalence in general population (US)

- 1 in 5 (22.5%) will have a mental health disorder
- 1 in 10 (13.5%) will have an alcohol disorder
- 1 in 20 (6.1%) will have a drug disorder

Current prevalence of co-morbidity in those with mental health/substance misuse problems in service settings (US)

- 1 in 5 (20%) of mental health patients have a substance misuse problem
- 1 in 2 (55%) of alcohol patients have a mental health problem
- 2 in 3 of drug clients (64%) have a mental health problem

Lifetime prevalence of co-morbidity in those with mental health/substance misuse problems (US)

- of those with a mental disorder, just under 1 in 3 (29%) will have a substance misuse disorder
- of those with an alcohol disorder, just over 1 in 3 (37%) will have a mental health disorder
- of those with a drug disorder, 1 in 2 (53%) will have a mental health disorder
ANNEX B

NATIONAL PROGRAMME FOR IMPROVING MENTAL HEALTH AND WELL-BEING

‘see me’ — ‘See me as a person, not a label.’ This is the message at the heart of Scotland's first national anti-stigma campaign. Funded by the Scottish Executive as part of the National Programme, ‘see me’ aims to break down the attitudes which lead to stigma and discrimination associated with mental health problems. ‘see me’ is an alliance of the following five mental health organisations: Highland Users Group (HUG), National Schizophrenia Fellowship (Scotland), Penumbra, the Royal College of Psychiatrists (Scottish Division) and the Scottish Association for Mental Health.

A sustained, high profile Scotland-wide anti-stigma and anti-discrimination campaign was launched 8 October 2002. The campaign uses a range of media, including TV and cinema advertising and production and dissemination of a range of anti-stigma resource materials and a website. (www.seemescotland.org) The campaign will also initiate, stimulate, promote and complement national and local anti-stigma action by agencies, organisations and groups in public, private and voluntary sectors. Refreshed advertising took place in February and March 2003. New advertising plans are currently in development. In addition, earlier in 2003, ‘see me’ campaign launched guidelines for the media responsible for reporting on mental health issues.

‘Breathing Space’ – The Executive is committed to developing measures to address high levels of suicide and depression. One initiative is ‘Breathing Space’ a telephone advice and referral service for people with low mood or depression, particularly for those, such as young men, who might not normally be in touch with health services.

Breathing Space aims to appeal in particular to young men who have been experiencing difficulties, or are feeling unhappy in their lives. It may be that they have specific problems or issues which they are finding hard to resolve. They may simply need someone to talk to.

Breathing Space is a confidential free-phone service staffed by specialist advisors who can offer callers information, advice and support as well as suggestions for a wide variety of other services which could be useful as an ongoing resource. (Each advisor is equipped with a database of local and national agencies).

The aim is to give people, young men in particular, the space and the means to improve their present situations and so prevent the development of more serious problems and reduce the incidence of mental illness. Breathing Space is available from 6pm–2am nightly and can be contacted on 0800 83 85 87. Their Website can be found at www.breathingspacescotland.co.uk

Breathing Space is one aspect of the Scottish Executive’s wider drive to tackle Scotland’s high levels of suicide. ‘Choose Life’, a National Strategy and Action Plan to Prevent Suicide in Scotland, was launched by the Minister for Health and Community Care in December 2002, with guidance for local authorities and their community planning partners, on implementation, issued in July 2003.
MODEL OF SERVICE PROVISION IN AYRSHIRE AND ARRAN

In 1995 it was apparent that a large patient group consisting of those suffering from concurrent mental health and substance related problems were not accessing the range of services that met their needs. Numbers were growing, presenting equally to addiction and mental health services and both staff and users were frustrated by ‘gaps’. There was a similar problem for local authority social work services. Despite inherent dangers (more boundaries, mismatch between demand and capacity) of creating a specialised service, it was felt that there was an immediate need for service development.

The community service

The aims of the service are threefold:

- to create a small, skilled and willing staff group to provide a direct service to this unpopular and challenging group;

- to provide advocacy, liaison and shared care with both addiction and mental health workers in order to progress the client back into mainstream services; and

- to allow staff on both sides of ‘the divide’ to work through their concerns and to raise their levels of skill and confidence; and to provide appropriate training.

A community service, established initially with a full time CPN and a part time consultant psychiatrist, was therefore given the task of addressing these needs. The Community Service has now grown to the equivalent of 2 ½ full time consultant psychiatrists, 5 CPNs, an occupational therapist and a social worker. The team is now large enough to allow for a named link worker for each of the six main addiction agencies and for each of the 6 community mental health teams (CMHTs). Similar relationships are now being made with the prison, A & E, primary care teams, Housing, Richmond Fellowship, family support projects and community schools. To date other organisations are less willing to be involved, preferring to continue making blanket referrals to either addiction services or mental health services.

The characteristics of the community service are as follows.

- The criteria for the service are based on inclusion so that people with diagnoses such as personality disorder and chaotic users are no longer excluded from treatment. Interventions are negotiated with the mainstream services which allows it to feel comfortable in continuing treatment so that the patient is not lost to services.
• ***Care*** is not planned in terms of primary or secondary diagnoses but is based on a pragmatic analysis of presenting problems along with a thorough assessment of attendant risk.

• A **patient plan** is drawn up which clearly prioritises the sequence and ownership of actions to be undertaken (in full consultation with the patient and presented in a way that makes sense to them).

• Subsequent care is rarely provided solely by the dual diagnosis team and usually involves others. Liaison and the **sharing of care** with other organisations (often more than one) is the key to success and is always started by joint assessment with the referring partner.

• To meet need better the team has **developed skills** in three specific areas, namely sexual abuse interventions, care of post-traumatic stress and cognitive behavioural interventions in psychosis.

• To maintain a constructive dialogue with all those organisations that might interact with the service. This includes LHCCs, the Courts, the local A & E department and the local prison, but mainly the various addiction services and Community Mental Health Teams.

**Residential support unit**

Three years ago there was an opportunity to convert a 12 bedded alcohol rehabilitation unit into a residential support unit for people with dual diagnosis problems. This unit is staffed by nurses and an occupational therapist with regular input from social work, physiotherapy, debt counsellor, housing, pharmacy, and a reiki therapist. Although many had wished originally for a unit catering for the most chaotic and problematic members of this client group, the unit was deliberately designed as a rehabilitative/step-down unit on pragmatic grounds. Severe episodes of mental illness and severe episodes of withdrawal or other drug related problems are best dealt with in IPCU and detoxification beds respectively. The Unit provides a series of cognitive-behavioural packages designed to fit into the ‘stages of change’ model and directed at a variety of mental health problems ranging from anxiety to psychosis. These tend to be symptom and problem based rather than diagnosis based.

The unit has liaison and shared care roles. ‘Inreach’ is provided to the acute psychiatric wards and, in conjunction with the general hospital psychiatric liaison service, to general medical and surgical wards. A clear path from acute inpatient care to dual diagnosis has now been established. It starts with a joint assessment and staff providing medium to long-term preparatory input on the wards prior to admission. This has been the arena where the relationships with housing, benefits and family support has been most fruitfully developed and from which the community service has considerably benefited.

For some time there had been a desire to develop a joint project with the Scottish Association for Mental Health (SAMH) for those facing similar problems. A number of projects had been mooted. Transitional housing benefit and the accompanying capital grants have been the catalyst for setting up the service. The common problems shared with SAMH revolved around the difficulty of providing adequate community support for those with enduring mental health needs and co-existing drug or alcohol problems. Two of the 3 relevant local
authorities and the NHSBoard have sponsored the development of 75 hours per week of intensive community support in each authority area for people who, after community care assessment and dual diagnosis assessment, addressed as requiring intense community support. This has been invaluable in providing options to hospital admission or in facilitating successful discharge from hospital. As the project is now self-funding, the nature of transitional housing benefit is such as to hopefully allow it to grow as needed. To date 11 clients have been supported in this way.

Statistics from the two services are as follows:

<table>
<thead>
<tr>
<th></th>
<th>COMMUNITY SERVICE</th>
<th>RESIDENTIAL UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referrals</strong></td>
<td>399 – M 62%, F 38%</td>
<td>227 – M 70%, F 30%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>16-24 – M 16%, F 8%</td>
<td>M 15%, F 7%</td>
</tr>
<tr>
<td></td>
<td>25-54 – M 39%, F 18%</td>
<td>M 41%, F 17%</td>
</tr>
<tr>
<td></td>
<td>45-64 – M 7%, F 12%</td>
<td>M 14%, F 6%</td>
</tr>
<tr>
<td><strong>Alone</strong></td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td><strong>Work</strong></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td><strong>Criminal Record</strong></td>
<td>83%</td>
<td></td>
</tr>
</tbody>
</table>

**Substance use problem**

- Stimulants: 7%
- Benzos: 11%
- Cannabis: 4%
- Opiates: 23%
- Alcohol: 54%

**Main psychiatric diagnosis**

- Schizophrenia: 32%
- Affective Disorder: 34%
- Personality Disorder: 7%
- Panic Disorder: 18%
- None: 9%

**Costs**

The normal total cost of both services is approximately £400,000 per annum.
ANNEX D

MIDWAY PROJECT

A partnership approach to housing support

Midway was set up in 1996 for individuals with mental health problems, who were in psychiatric hospitals and their discharge would lead to them becoming homeless. Midway planned to support individuals making the transition from hospital to independent living in the community. To do this required the establishment of a tri-partite agreement between housing (who would provide accommodation,) health services and Turning Point Scotland.

In the initial set up protocols it was envisaged that service users would have a mental health diagnosis only. However it quickly became clear that these diagnostic criteria alone would exclude many potential service users as the majority of referrals had either a co-existing mental health and substance misuse problems or other complex needs. The project evolved to support service users with these complex needs and often chaotic lifestyles. Providing a flexible and individualised service for all has been the primary focus for Midway.

Midway endeavours to support individuals to maintain a tenancy through practical input and emotional support. This encapsulates all aspects of daily living and assistance in accessing mainstream services and benefits. Placement within Midway flats is temporary and service users are supported to access mainstream permanent tenancies from housing providers. The average length of stay is six months.

Working in a participative way with other professionals involved in an individuals care has further ensured that individuals progress to a mainstream tenancy. Midway has established close links with Social Work Services and health care providers. These relationships have ensured that service users continue to function at their optimum level with the knowledge that support networks are in place whenever a problem arises. This goes a long way to reducing anxiety in individuals and ensuring success of placement.

A good example of the successful move on of an individual is the case of Mr A who was referred to the project in February 2002 and offered a temporary flat in late February of that year. Mr A had little experience of managing a tenancy and living alone due to long term institutional care throughout his teens in a ‘list D school’ and in adulthood within prison, the state hospital and general psychiatric hospitals. As well as psychiatric and offending histories Mr A used drugs. At time of referral he was on methadone reducing regime and was still using cannabis. All these elements combined excluded him from majority of services. Prior to the placement, contact was made with a social worker, a community psychiatric nurse and consultant psychiatrist who were all involved in supporting this individual. All agreed to ongoing support and to Midway staff being the main link between all services and service user. Support plans were drawn up with the individual which clearly identified his needs and input needed from all those with responsibility for his care. His assessed needs included resettlement support, monitoring of mental health episodes and accessing benefits. In the August of that year Mr A moved into a permanent secure tenancy with Glasgow city housing. Midway continues to support him on an infrequent basis with Social Work Services and community psychiatric staff having a greater involvement now.
MENTAL HEALTH FOUNDATION RESEARCH

EXECUTIVE SUMMARY

Background

The Mental Health Foundation, supported by Turning Point Scotland, undertook consultation with people with co-existing drug and/or alcohol problems and mental health difficulties in the spring of 2003. The consultation explored their views about their problems, their experiences of services and their views about how services could be improved.

Methods

The consultation methods employed were focus groups and one to one interviews. Thirty four people were interviewed in focus groups and a further 11 people were interviewed individually. Whilst numbers consulted were small, participants had experienced a wide range of drug and/or alcohol and health related services. Overall, participants’ experience of specialist mental health services appeared to be limited.

All participants were currently experiencing mental health problems, of varying degrees, and had experienced significant substance problems at some point in their lifetimes, if not at the time of interview.

Findings

Experiences of mental health and substance use problems

- All participants’ experiences of mental health and substance use problems were clearly linked with one another.

- All participants identified a range of significant life challenges, which may have placed them at greater risk of developing mental health and/or substance use problems. Other life challenges had occurred as a direct or indirect result of mental health problems, substance use problems, a lack of appropriate support or combination of all three.

- Many participants stated that the key causes of their substance use problems and/or mental health problems, often lay in childhood experiences. Several causes were identified such as emotional trauma, domestic violence, family use of drugs/alcohol, poor relationships with parents, negative peer influences, poor social skills and experimentation.
• Many participants felt that, once addicted, they continued with their substance use as a coping mechanism, and/or because it was difficult to access services, and/or because of the culture and environment in which they were living (e.g. where peers used drugs and/or alcohol; family problems).

**Experiences of services**

Many participants had mixed and generally poor experiences of statutory health and social care services, but were more likely to report positive experiences of voluntary service provision. Positive aspects of service provision mentioned by respondents included:

• practical help with housing & employment, and support in accessing a wide range of services;
• quick or immediate access to services;
• positive and consistent relationships with workers; and
• peer support (for example in the context of group work).

Negative aspects of service provision mentioned by respondents included:

• a tendency for services to focus on one problem, rather than looking at the whole range of issues affecting the individual (some reported that they had been prevented from accessing mental health services until they had addressed their substance use problems, or that they had been rejected by mental health services after it had been discovered that they were encountering substance use problems);
• difficulties in accessing services due to long waiting times or inflexible appointment systems (particularly in accessing support before mental health or substance use problems became established or reached crisis point);
• poor staff empathy and in some cases discrimination (e.g. participants using illicit drugs felt that they were subject to greater stigma than those who did not);
• inadequate community based ‘aftercare’ support services (for example post - detox);
• lack of awareness of the range of services (specialist and mainstream) that were available, and not receiving sufficient information about the services that they were using.
REFERENCES


Regier D, Farmer M, Rae D, Locke B, Keith S, Judd L, Goodwin F, (1990)*Co-morbidity of Mental Disorders with Alcohol and other Drug Abuse Results from the Epidemiologic Catchment Area (ECA) Study JAMA 1990 264,19.


[www.drugmisuse.isdscotland.org/publications/local/SALSUS1812.PDF](http://www.drugmisuse.isdscotland.org/publications/local/SALSUS1812.PDF)


FURTHER RESOURCES


The National Programme for Improving Mental Health & Well-Being in Scotland

www.scotland.gov.uk/library5/health/npmh-01.asp


www.show.scot.nhs.uk/sehd/publications/PartnershipforCareHWP.pdf
www.show.scot.nhs.uk/sehd/publications/ExecutiveSummary.pdf


Improving Mental Health Information Project

www.show.scot.nhs.uk/isd/mental_health/mhipbase.htm


Health and Homelessness Guidance (2001) Scottish Executive


Getting to Grips with Drugs in Greater Glasgow (2002) Greater Glasgow NHS Board


  www.show.scot.nhs.uk/sehd/publications/mcbp/mcbp-00.htm

Dartmouth Assessment of Lifestyle Inventory (DALI)

  www.dartmouth.edu/dms/psychrc/pdf files/DALI.pdf
### DEFINITIONS

#### Chapter 1

| Mental health problems | [refers to] psychological states of mind where there individual almost always is distressed, is aware that this distress is out of proportion to events, and cannot control the experience. Commonly described as ‘mild’, ‘moderate’ and ‘severe’. |

#### Chapter 2

| Personality disorder | ‘a severe disturbance in the character, condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption’ (World Health Organisation [WHO] 1992, cited in Department of Health [DoH] 2003). |

#### Chapter 3

| Anxiety disorder | common, mild to moderately severe disorder with features of great apprehension, unreasonable fear of specific situations, often linked to signs of autonomic overactivity (increased heart-rate, sweating), experienced as panic when there is a sudden onset. |

| Polydrug use | misuse of more than one prescribed medication or illicit drug, and often includes alcohol. |

| Psychiatric disorders | see ‘mental health problems’. |

| Psychoticism/psychotic disorder | an individual is said to be psychotic by virtue of possession of true hallucinations, delusional belief and/or certain disorders of thought. |

| Paranoid features | false beliefs, unshakeably held, out of keeping with culture, that serious harm is intended to the individual. |

| Suicidal ideation | persistent, intrusive thoughts that the individual, or those around, would be better off were the individual to be dead. |

<p>| Schizophrenia | a major mental disorder, characterised by disordered thinking, hallucinations and delusions, blunting of emotions, and impaired capacity for self care, often taking a chronic course. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurotic disorder</td>
<td>(obsoleto) term for a mild to moderately severe mental disorder.</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>a major mental health problem, with alternate stages of great elation, loss of judgement, and overactivity or depressed mood, retardation, agitation and a bleak outlook. It is recurrent, suicide risk is high, and it is thought to have a biological basis.</td>
</tr>
</tbody>
</table>

**Chapter 4**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked after children</td>
<td>a technical term for children looked after by local authorities, subject to a court order, such as a child protection order.</td>
</tr>
</tbody>
</table>

**Chapter 5**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated care pathways</td>
<td>an Integrated Care Pathway (ICP) determines locally agreed, multidisciplinary practice based on guidelines and evidence, where available, for a specific patient/client group. It forms all or part of the clinical record, documents care given and facilitates the evaluation of outcomes for continuous quality improvement. (National Pathways Association) <a href="http://www.the-npa.org.uk">www.the-npa.org.uk</a></td>
</tr>
<tr>
<td>Cognitive hallucinatory control techniques</td>
<td>the use of psychological understanding, awareness and thought channelling as an alternative approach to medication for hallucinations.</td>
</tr>
</tbody>
</table>

**Chapter 6**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refractive schizophrenia</td>
<td>an episode of illness which responds poorly or not at all to the usual drug or psychological treatments.</td>
</tr>
<tr>
<td>Dysphoria</td>
<td>low mood.</td>
</tr>
</tbody>
</table>
SACDM/SACAM WORKING GROUP MEMBERS

Dr Andrew Fraser (Chair), Deputy Chief Medical Officer, Scottish Executive Health Department

Mrs Joy Barlow, University of Glasgow

Mr Nick Bland, Principal Research Officer, Scottish Executive Health Department

Mr Jim Carroll, Co-morbidity Evaluation and Treatment Team, Glasgow

Ms Iona Colvin, Glasgow City Social Work Department

Professor Ilana Crome, Keele University (School of Medicine)

Chief Inspector Tony Fitzpatrick, Association of Chief Police Officers Scotland (ACPOS)

Ms Gail Gilchrist, Glasgow NHS Board

Dr Tom Gilhooly, Woodside Health Centre

Dr Lesley Graham, ISD Scotland

Ms Maddy Halliday, Director Scotland & UK Development of Mental Health Foundation/Foundation for People with Learning Disabilities

Mr Andrew Horne, Turning Point Scotland

Dr Charles Lind, Ayshire & Arran NHS Board

Dr John Loudon, Principal Medical Officer, Scottish Executive Health Department

Mr Bill Moore, Scottish Executive Development Department

Dr Alison Richardson, Lothian Community Drug Problem Service

Dr Iain D Smith, Gartnavel Royal Hospital

Mr Charles Steel, Alcoholics Anonymous (Northern Service Office)

SECRETARIAT

Mrs Molly Robertson, Substance Misuse Division, Scottish Executive Health Department

Mrs Marion Goldsmith, Substance Misuse Division, Scottish Executive Health Department

Mrs Stella Fulton, Substance Misuse Division, Scottish Executive Health Department