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

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Riaghaltas na h-Alba

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# Executive Summary

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

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

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

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

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

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

### Recommendation Seven
The Scottish Government should ensure that further research is carried out to explore several troubling findings which we could not address in this rapid review. These include the finding by Public Health Scotland of a significant increase in anxiety and depressive episodes prior to a drug-related death between 2008 and 2018, and the increase in Drug-Related Admissions to General Hospitals.

On a larger scale, a replication of the Co-Morbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) Study in a Scottish city would be particularly relevant.

# Introduction

The current focus on co-occurring mental health conditions and substance use disorders in Scotland is welcome as it is a problematic area of practice that requires urgent attention. The concern as to how to best help people with such co-occurring problems has been around now for several decades. There are strong indications that it has worsened as a day-to-day clinical issue in the last ten years, with data showing an increase in drug-related admissions to general hospitals with “mental and behavioural disorders” (Public Health Scotland, 2021). In part this is due to many new mind-altering drugs becoming available. Such drugs are also highly relevant to psychiatric and emergency medicine practice (e.g., see recent research on the relevance to psychiatric admissions of Novel Psychoactive Substances at the Royal Edinburgh Hospital. (Mogford et al, 2019)).

However, even before this expansion in the types and amounts of drugs available, such comorbidity was already an area of immediate concern in Scotland with high levels of co-occurrence between both problematic licit and illicit drug use and mental health conditions. Often the co-occurrence was talked of as “Dual Diagnosis.” This high level of concern led to the “*Mind the Gaps*” (2003) and “*Closing the Gaps*” (2007) reports. These reports, however, did not have the impact on clinical practice that had been hoped for at the time. Mental Health Services and Substance Use Services still need to find better ways of working together for the benefit of their patients as evidenced by the recent inquiries in Tayside (Dundee Drug Commission ,2018; The Independent Inquiry into Mental Health Services in Tayside, 2020). Scotland is again examining the issue of co-occurrence at this time and we can also draw on recent reports from England (Public Health England, 2018) and Northern Ireland (Northern Ireland Assembly, 2021) which focussed on this topic.

The current task, then, for all practitioners and managers, is to ensure a shift in culture in this area and to bring about better integrated care within mental health and substance use services for the benefit of all patients with co-occurring disorders. This is the context for this Rapid Review, commissioned by the Minister for Drugs Policy and the Minister for Mental Wellbeing and Social Care.

Our report has aimed to be complementary to the recent Mental Welfare Commission (MWC) for Scotland report on the same issue – *Ending the Exclusion: Care, treatment and support for people with mental ill health and problem substance use in Scotland* (MWC, 2022). We are aware that the Mental Welfare Commission report has captured views from patients and their families, from primary care services and from secondary care practitioners, in both mental health and substance use services. Our own time-limited review has aimed to add to this but due to the limited time we were unable to consult as widely as we would have wished. The Mental Welfare Commission report has strong representation from people with Lived and Living Experience and from the relatives of those with co-occurring disorders and their voice shows that we need to strive harder to improve services for those with co-occurring disorders.

This document is the final part of a suite of three reports, and we cross reference where relevant to the other two documents. We also draw on a series of consultations and discussions with some key stakeholders over the past six months

in coming to our recommendations. These were mainly professionals who share the goal of bringing about change in this area of work. The other two documents in our suite are **1) a literature review**, based on search terms that we provided and **2) a research survey of addiction services** which we also helped design. These other two documents are hopefully self-explanatory around methodology and findings. We draw on these findings in setting out our recommendations here.

The literature review suggests that building formal and informal service integration and networks around co-occurring disorders will be of benefit (e.g. Anderson et al,2013). It is hoped that the five Health Improvement Scotland Pathfinder projects represent a significant step in this direction and may function as a role model for the other Health Boards that are not included in this initiative. The HIS Pathfinder projects are being implemented in NHS Tayside, NHS Grampian, NHS Lothian, NHS Lanarkshire and NHS Greater Glasgow and Clyde. They are designed to improve services for those with co-occurring disorders.

We would also strongly support the roll out of the NHS Education for Scotland TURAS learning modules on motivational interviewing for substance use disorders to mental health services to help increase the skills of mental health practitioners in relation to substance use screening and intervention. This would include training on how drug screening tests and blood tests/alcohol biomarkers can help in detecting hidden substance use that may be relevant to the mental health issue.

Similarly, there should be parallel training for addiction workers around mental health screening and treatment. Both workforces should come together at a local level for training around co-occurring Mental Health Conditions and Substance Use Disorders and training on how best to respond to the needs of this client group. Rotation of staff and shadowing between the services would also help with such learning and aid integration.

A key point in all of this training is to give practitioners a more complex understanding of the issues of co-occurrence such that they will keep an open mind in each case about the relationship between the substance use and the mental health condition in relation to issues of cause and effect. In reviewing this whole area, we have considered substance induced mental health problems as being part of co-occurrence. The training should also reinforce the philosophies of “No Wrong Door” and “Everybody’s Job” in relation to the Four Quadrant model.

Given our remit was to consider alcohol as well as drugs in relation to mental health care it is worth reminding ourselves as to the links between population alcohol consumption, depressive illness, and suicide rate (unlike in *Closing The Gaps* we were not asked to look at Alcohol Related Brain Damage in our review).

In the past six decades, alcohol consumption in Scotland gradually rose to such levels that patients with alcohol use disorders were increasingly presenting in psychiatric clinics and in medical and psychiatric wards with alcohol-induced mood disorders and suicidal crises. This association between alcohol use disorders and depression and anxiety has been well described (Schuckit,1994; Schuckit and Hesslebrock, 1994). Consideration of problematic use of alcohol, along with that of

drugs, needs to be embedded in the Scottish national mental health and suicide prevention strategies. We are aware this is being addressed at this time.
The recent updated NICE Guideline on Self Harm (NG 225) should also be mentioned here as this does consider alcohol and drug use in relation to self-harming behaviours (NICE, 2022).

A particular concern that needs to be addressed in local interface protocols between mental health services and substance use services is how to respond to people with co-occurring disorders presenting in crisis if they are not admitted to inpatient care. Mental health crisis teams have seven day coverage where substance use services often do not have such coverage. Follow up at a weekend may be necessary in some cases and local protocols should address how this is realised.

Adequate provision of services for emergency detoxification from alcohol and emergency stabilisation for drug use should be considered to deal with patients presenting with a suicidal crisis. This often entails admission to general medical and psychiatric care, and we would strongly argue this is a legitimate use of psychiatric beds. Alcohol and drug-induced major depression is one of the commonest comorbidities. An expansion of inpatient stabilisation provision for drug users in crisis should also be considered, in relation to the goal of reducing drug deaths, where stabilisation in the community is felt to entail undue risk. Unstable drug use is particularly associated with mental and behavioural disorders.

We have made seven recommendations in our executive summary, and we will now explain below the rationale of these recommendations. We intend to assist the Scottish Government in developing an implementation plan for these recommendations.

# Recommendations

## Recommendation One

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

Further Detail on Recommendation One

1.1 All Chief Officers should appoint a responsible individual who is accountable to the government for ensuring that mental health and substance use services are integrated in their area. The individual should be responsible for agreeing a local protocol for joint working, if not already agreed, and ensuring that it is implemented as per the 'Everyone's Job' and 'No Wrong Door' policies. If there is no such responsible individual, then this duty is by default the responsibility of Chief Officers. This protocol for local implementation should be produced within the next year if it is not already in place. This protocol should be produced, or revised in relation to our recommendations, within the next year.

Context and evidence

1.2 It is clear from the literature review that the co-occurrence of a mental health conditions and problem substance use is related to poor psychological health (Khan, 2017; Roncero, et al., 2016), high medical needs (Becker, Boaz, Andel, & Hafner, 2017; Khan, 2017), sub-optimal levels of engagement in treatment (Litz & Leslie, 2017) and elevated likelihood of engagement with the criminal justice system (Balyakina, et al., 2014). When patients with co-occurring mental health and substance use problems interact with the healthcare system, they report high levels of unmet needs (Bruce, Gwaspari, Cobb, & Ndegwa, 2012; Khan, 2017) and often cite judgmental attitudes and a skills deficit among providers (Lawrence-Jones, 2010; Nutt et al,2017).These issues are important from a patient-centred and ethical standpoint. Moreover, however clinically patient satisfaction with care is associated with better outcomes (Bird, et al., 2020). The research literature highlights that this specific patient population, i.e. co-occurrence of a mental health conditions and problem substance, is highly complex, and that researchers and clinicians believe intervention is needed to enhance care and improve outcomes.

1.3 The Scottish government has issued key documents in this area: *the Mental Health Strategy* (2017) and *Rights, Respect and Recovery* (2018b) both outline how services should treat people. This includes trauma-informed approaches that recognise the link between substance use, mental health issues and adverse experiences; staff and systems that do not stigmatise people who use substances; and person-centred services that wrap around the individual, not the other way around. Likewise, The Delivery of Psychological Interventions in substance misuse services in Scotland (Scottish Government, ) provides a guide for commissioners, managers, trainers and practitioners on implementing several of the ambitions in the Scottish Government's Mental Health Strategy, particularly those around integrated treatment for mental health issues and problem substance use. This theme of

integration is further explicitly stated in the *Mental Health Transition and Recovery Plan* (Scottish Government, 2020). This explicitly states that the Scottish Government will work with partners to explore opportunities for integrating addiction and general mental health services where possible. It is supported by *The Mental Health Strategy 2017-2027* (Scottish Government, 2017), which details two actions for work on co-occurring mental health condition and problem substance use.

1.4 This is reinforced yet again by *Medication Assisted Treatment (MAT) Standards* and standard nine in particular. This states that all people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery. People have the right to ask for support with mental health problems and to engage in mental health treatment while being supported as part of their drug treatment and care (Scottish Government, 2021).

1.5 The final report of Scotland's Drug Deaths Taskforce *Changing Lives*, published in 2022, continues this theme of improving care through more integrated working between mental health and substance use services. Ideally, under the report's recommendations, a single lead professional should, with the patient's consent and involvement, take a coordinating role in developing and overseeing a holistic care package.

1.6 Two key principles should be embedded and explicit in all protocols, taking account of locality populations and needs. The first is its Everyone's Job- Commissioners and providers of mental health, and alcohol and drug use services have a joint duty to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions. The second is 'No Wrong Door'. Providers in alcohol and drug, mental health and other services should have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point within the overall mental health and substance use system.

1.7 Given the evidence of the benefits of a holistic and patient-centred approach, and the clear government expectation around joint working, it is expected every organisation in Scotland with responsibilities for delivering Mental Health and Substance Use care will produce a protocol within 12 months, with the responsible individual or in lieu of this the Chief Officer responsible for its implementation, and who will mandatorily report on its implementation to the minister as part of performance management. Each organisation will have a clear, transparent, and accountable governance structure with robust oversight and auditing with the responsible individual having overall responsibility for ensuring this.

1.8 The need for such a protocol is illustrated by our survey. This demonstrates that the majority of respondents (75%) to the survey indicated that more than half of individuals who attend substance misuse present with co-occurring mental health conditions. We are aware one Health Board area has had such a protocol since 2011 but it is not clear if such a protocol exists in other areas. The MWC report highlights that such a protocol may have an effect. The National Confidential Inquiry into Suicide and Safety in Mentally Health *Safety Toolkit* appears to have an effect in lowering the suicide rate in patients with a co-occurring substance use disorder

within the mental health service population. This protocol will also benefit the Substance Use Service patient population in addition.

**Recommendation Two**

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

Further Detail on Recommendation Two

2.1 It is important that local areas are judged on key indicators to ensure that better care is provided for people with co-occurring mental health and substance use disorders. Mostly importantly, we recommend that clear exception reporting of non-acceptance of patient referrals is captured and audited. The number of non-accepted referrals to addiction teams or mental health teams must be mandatorily recorded, reported, and be subjected to scrutiny through the organisations' Clinical Governance Committees (CGC). The CGC should be responsible for reporting this information to the Scottish Government through agreed reporting arrangements.

Context and evidence

2.2 The principles of 'everyone's job' and 'No wrong door' can also be found within the Dundee Drugs Commission published report "*Responding to Drug Use with Kindness, Compassion and Hope"* in 2018. This report explores the root causes behind the rise in drug-related deaths in Dundee and provides recommendations for practice intended to improve service provision for those who are currently experiencing a substance use problem in Dundee and work towards reducing drug-related deaths in the city.

2.3 These include recommendations related to mental health service provision including the full integration of substance use and mental health services and support, highlighting the belief that trauma, violence, neglect, and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems. In their call for evidence, the most common and consistent finding was that there was "a lack of mental health support for those who experience problems with drugs" (page 45). This message was usually expressed as either: a reluctance of statutory drug treatment services to work with mental health problems (i.e. where those presenting to substance use services are told 'we only deal with drug problems, not mental health'); or the perceived refusal of mental health services to work with individuals unless they addressed their drug use first. Clearly not only is this segmenting of care not patient centred or holistic, it is not Scottish Government policy; and most importantly, has a detrimental impact upon some of the most vulnerable populations in Scotland.

2.4 In Dundee, substance use and mental health did not operate jointly to complement each other's work. Patients who needed to be referred to substance use services were discharged without a relevant referral. For some patients in mental health services, if they took an overdose, they were discharged from mental health

services and referred to the Integrated Substance Misuse Service (ISMS) which provides both substance use and mental health services. Rather than the exception, it was proposed that management of both mental health and substance misuse should be within a single service as the default, unless there are extenuating, exceptional clinical reasons to justify this approach.

2.5 As a specific cohort homeless people have a much higher risk of death from a range of causes than the general population and it is not uncommon for those who are homeless to experience co-occurring mental health and substance use issues. Around 30% of homeless people have evidence of a mental health problem while 19% have a drug and/or alcohol-related problem (Scottish Government, 2018a).

2.6 A recent study by Tweed et al (2022) linked a population register of adults resident in Glasgow to administrative datasets and found that homelessness, opioid dependence, justice involvement, and psychosis commonly co-occur in homeless people and produce poor patient outcomes. Thus, the need to build relationships in particular with homeless, and other marginalised groups is paramount, and will be facilitated by having a universal ‘no wrong door’ and ‘everyone’s job’ ethos where exception reporting is at a minimum.

2.7 Effective therapeutic relationships are known to be key determinants in the success or failure of treatment strategies for patients with substance use disorders (Miller W. R., 2009) while negative attitudes by health professionals may detract from patients' sense of empowerment and self-efficacy and may lead to worse treatment outcomes (Luoma, et al., 2007; Schomerus, et al., 2011). Anderson (2011) also explored the multiple and interlocking factors that can contribute to poor responses to people with multiple and complex needs from a range of front-line services (including health, social care, welfare, and housing and criminal justice agencies). As well as drawing attention to the service user’s experience of these services, this review illuminated the many individual, organisational and structural challenges that workers within these services negotiate.

2.8 Therefore it becomes clear that organisations must embed structural and cultural strategies to understand the people they are tasked to help, by providing the right training and support to their staff within a wider ethos service can help and empower service users to make positive changes.

2.9 From our survey, a substantial minority of substance use services - 37% - reported they did not offer mental health support. This aligns with the Mental Welfare Commission report which underlines many patients experiences of lack of holistic or joined up care, and a clear disregard for the ‘no wrong door’ ethos. This disenfranchises some of the most vulnerable groups again, by mandating onward referral, another assessment, engagement with other appointments where people have physical & mental disability and where language barriers exist, and also within LGBT+ communities who already experience more obstacles than the general population. It is not patient centred, nor holistic, and evidence shows it leads to poorer outcomes and harms patients.

**Recommendation Three**

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

Further Detail on Recommendation Three

3.1 The four-quadrant model implies that mental health services should be able to deal with substance use issues in their patients up to a point and that substance use services should be able to deal with mental health issues up to a point. The four quadrants model also implies that mental health services should be screening and testing for substance use disorders and that substance use services should be undertaking mental health screening. Often, co-occurring disorders go undetected.

3.2 The scope for cross-referral between services is also limited, implying integrated treatment at the locus of care is the best approach (e.g. findings of the COSMIC study, DMRI, 2002; Weaver et al,2003). In terms of external monitoring of MAT standard 9, this is something that is measurable. The fact that substance use services are also providing mental health care needs to be made explicit so that patients are not feeling that their needs are unmet. Again, this should be a measurable aspect of care to understand whether service users feel like their co-occurring concerns are being dealt with, even when they only interact with either mental health services or substance use services.

3.3 There is also a group with high mental health needs and high substance use needs, where joint working between services is required. The system of care around such patients needs to be able to deal with issues of diagnostic uncertainty. A good example in this regard is the category of “drug-induced psychosis”. The Mental Welfare Commission for Scotland Report (2022) on *The use of mental health legislation for individuals with ‘drug-induced psychosis* is a useful guide in this regard. It makes it clear that the Mental Health Act in Scotland can be applied if warranted in such cases.

3.4 In this group, if psychotropic medication is initiated on an inpatient basis, the same service ideally should be offering follow up on return to the community and decide whether the psychotropic medication should continue. There is growing evidence that a significant minority of patients diagnosed with “drug induced psychosis” go on to have their diagnosis revised to a severe and enduring mental illness.

3.5 The fourth quadrant – low mental health and low substance use patients – is within the competence of primary care services. However, there should be clarification as to whether Primary Care Mental Health Teams feel equipped or have sufficient resources to deal with this patient group in relation to low severity substance use disorders.

Context and Evidence

3.6 The four-quadrant model is in Closing the Gaps, taken from an English document from the Department of Health (2002) *Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide*. It can also be traced back to a SAMHSA publication from 1997: *Improving Services for Individuals at Risk of, or with, Co-occurring Substance-Related and Mental health disorders.*

3.7 We would recommend the Mental Welfare Commission for Scotland report 'Ending the Exclusion' is read with the four quadrants model in mind. The idea that Substance Use Services should have in reach from mental health services is an interesting one but, as per the four-quadrant model, Substance Use Services should also be competent to deal with mild to moderate mental health problems in their core client group. The limitations of such care should be agreed in the local interface protocol. Link workers between mental health and substance use services would certainly be welcome along with regular liaison meetings to discuss the best response to cases that are in common between the services.

3.8 We would not favour separate Dual Diagnosis teams in Scotland, and we have knowledge of such a team failing in one of our major cities. Our evidence from the literature review suggests there are other effective ways to improve services in keeping with the "Everybody's Job" and "No Wrong Door" principles.

3.9 We would also like to see increasing cooperation between Mental Health services and Substance Use Services to promote integration and flexible working. Local management arrangements should reflect this and also aim for such integration.

**Recommendation Four**

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

Further Detail on Recommendation Four

4.1 The issue of the resources needed to have adequate provision for services for those with co-occurring disorders was a common theme in our discussions with stakeholders. There is a strong argument that further enhancement of substance use services will in turn reduce the burden on mental health services and acute services. This follows from the fact that a proportion of co-occurring Mental Health Conditions are either induced by alcohol and/or drugs or if the mental health condition is independent, it may be exacerbated by the use of alcohol and drugs.

Context and Evidence

4.2 In particular the discussion that took place in Dundee at the joint meeting of general adult and addiction psychiatrists in Scotland in May 2022 raised this question of resources. The question was raised as to whether if addiction services were better resourced, would this reduce presentations to general psychiatry and to mental health services. There is certainly evidence for alcohol treatment having such an effect at a population level (see *Alcohol: No Ordinary Commodity*, Chapter 13 (Babor et al,2022) and the journal article by Brennan et al,2019, Modelling the potential impact of changing access rates to specialist treatment for alcohol dependence for local authorities in England: The Specialist Treatment for Alcohol Model (STreAM)).

4.3 In Scotland we have a lot of data on the consequences of alcohol and drug use – MESAS reports and PHS reports, local ADP needs assessments- analysing alcohol and drug deaths and alcohol and drug related admissions to hospital – but our data around treatment provision, treatment follow up and treatment quality and accessibility are less precise.

4.4 If this data were available in a quality assured way around treatment capacity, then they would generate a measure linking prevalence to service provision and service utilisation. We know that the Prevalence Service Utilisation Ratio or PSUR is an important indicator in any needs assessment at a local or national level. The Scottish Alcohol Needs assessment (Drummond et al.2009), for example, provides such measures and it would be a useful guide for the government to see this repeated for alcohol and also for drug services.

4.5 Two major international publications - *Alcohol: No Ordinary Commodity* (2022) (above) and *Drug Policy and the Public Good* (Babor et al.2019) - contain information on how adequate treatment provision for alcohol and drug use disorders in an individual country can have an impact at a population level including on mental health.

4.6 It may be that such work is underway in relation to the DAISY system, but we are concerned that figures on treatment initiation for alcohol are on the decline and that the quality and intensity of treatment has diminished in Scotland - see next recommendation. We are aware of evidence that outcomes in treatment of severe alcohol dependence can be greatly improved with more intense levels of treatment. (e.g. Krampe et al 2007: Outpatient Long-term Intensive Therapy for Alcoholics (OLITA): a successful biopsychosocial approach to the treatment of alcoholism).

**Recommendation Five**

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

Further Detail on Recommendation Five

5.1 The respondents to our survey indicated that 99% of services users who presented with co-occurring problem substance use and a mental health problem, also used alcohol. This illustrates well the health and social implications of Alcohol Use Disorders as a comorbidity with other substance use disorders and with mental health conditions at the current time in Scotland.

Context and Evidence

5.2 We believe that treatment for alcohol use disorders can also have a beneficial impact on mental health. (e.g., Allan et al,2002) That is why we believe there must be sufficient treatment capacity in Scotland. We have, however, found evidence that treatment for alcohol use disorders has been diminishing in Scotland (see: Alcohol harm profiles (shaap.org.uk)). Particularly, the data from treatment initiation returns shows a downward trend with no evidence that the need for such treatment has diminished. Within the SHAAP Health Board Alcohol Harm Profiles each of the mainland Health Boards show a substantial reduction in the numbers commencing alcohol treatment between 2016/2017 and 2020/2021. (This is graphed at bottom right of each infographic and the figures are derived from official returns). A similar downward trend in England led to a publication by Public Health England (PHE, 2018b) to examine the reasons for this. A similar inquiry in Scotland would be welcome.

5.3 We would ask all services and other relevant organisations to consider whether they have enough resource allocated to deal with alcohol treatment in their locality from within their overall budget (alcohol needs assessments have been conducted in the past using the PSUR measure described above).

5.4 The advent of generic addiction services opens up the possibility of an imbalance between drug treatment provision and alcohol treatment provision within services. This is particularly important to consider, given the strong causal link between alcohol use disorders and major depression and in turn attempted and completed suicide.

5.5 The creation of a strong strand of treatment services focussed on alcohol treatment may help alleviate the demand on both our acute hospitals and on our emergency mental health services.

5.6 With regards alcohol-related hospital admissions, it is unclear whether Scotland has the same provision as England in having systems that respond to such admissions in relation to aftercare. The ProACTIVE study in England, led by Professor Julia Sinclair, is currently researching the network of Alcohol Care Teams

in England at this time. The Scottish Government should also consider developing Alcohol Care and Treatment teams as in England that similarly bridge between acute hospital care and targeted community follow-up. There is an evaluation of such a team currently underway in South Glasgow. Further developments in this area should have evaluation built in.

5.7 Research which has been commissioned by SHAAP and undertaken by Figure 8 to look at alcohol care pathways in General Hospitals is particularly welcome. There is emerging evidence from England that assertively following up patients with an Alcohol Use Disorder who have presented to the General Hospital can reduce readmission considerably.

5.8 Innovations such as the Chapman Barker Unit in Manchester should also be considered in this regard. This is an alcohol detoxification and treatment unit that is able to take patients from acute medical wards, once medically well enough, to complete detoxification and commence treatment for recovery, including protective medication and treatment for any comorbid mental health condition.

5.9 The planned work to look at a refresh of alcohol brief interventions (ABIs) in Scotland is welcome given the previous successful initiatives in this area.

5.10 Another project that is worth considering in relation to new developments in alcohol treatment is the Primary Care Alcohol Nurse Outreach Service (PCANOS) in Glasgow, which concentrates on areas of severest deprivation working with Deep End GPs. The full evaluation of this service is awaited with interest.

5.11 The final element in this area is the awaited Alcohol Clinical Guideline in England about to be produced by OHID (previously PHE). It is welcome that Scotland will aim to adopt this guideline once published. It will contain guidance around dealing with Mental Health Conditions co-occurring with Alcohol Use Disorders and also it looks at the management of Alcohol related Brain Damage which was not within our own remit here.

5.12 Alcohol Related Brain Damage care and management is certainly an issue at the interface between mental health services-General Adult and Old Age Psychiatry-and Substance Use Services with many of the severe presentations of ARBD to be found in acute medical wards. An alcohol treatment service rapid review should certainly look at this co-occurring Mental Health Condition

**Recommendation Six**

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

Further Detail on Recommendation Six

6.1 We recommend that local protocols for both mental health and substance misuse services, as well as Health Boards, HSCPs/IJBs, ADPs and the forthcoming National Care Service, should include a clear section around staff education & cultural training. This is required to facilitate change around stigma, bias, and unconscious prejudices. Again, the responsible individual should be charged with ensuring this is integral to the document. The responsible individual will also report on the local training plan to the Scottish government within a year, and thereafter on an annual basis through agreed reporting mechanisms.

6.2 Educational development and support to those supporting people with mental health and substance misuse issues are key to producing an informed, resilient, and knowledgeable workforce. Relevant NES TURAS resources should be made available to all those in these services and to primary care. This would enhance practitioners' skills to support patients and their relatives and give confidence to those practitioners that the approaches they are undertaking is both beneficial, evidence based and supported by NES. This should be rolled out and available to all in an easily accessible form within the next 2 years.

6.3 Practitioners should be aware of the influence of social & economic circumstances on the wellbeing of their patients. As part of this the protocol, they must embed practices and ways of working which recognise these, and how they lead to Mental Health Conditions & Substance Use Disorders and the co-occurrence of the two. For example, trauma informed ways of working must be planned and implemented for individual patients. However, services should work with all other partners- education, third sector, local businesses etc - to end stigma and increase empathy. This would help individuals and Scottish society as a whole.

Context and evidence

6.4 It was noteworthy that Garrod et al (2020) explored the role that the education and training nurses received had on the levels of service provided to patients with co-occurring mental ill-health and problem substance use. From their systematic literature review, they found that education could be used as an intervention to improve attitudes and increase confidence and knowledge and that this had great promise in improving care and outcomes for patients with co-occurring mental ill-health and problem substance use. Louie et al (2018) report on the Pathways to Comorbidity Care (PCC) a multimodal training program that was developed to encourage an integrated service approach to improve clinicians' capacity to identify and manage co-occurring mental ill-health and problem substance use outcomes within drug and alcohol treatment settings anticipating that this multimodal training package will facilitate effective and integrated care.

6.5 Williams et al (2021) suggest that training and support for clinicians and health service providers may help reduce inadvertent discrimination and improve care for this population. They note that several studies have described the positive effects of targeted education to improve the knowledge and skills of professionals working with patients with problem substance use (Ding, et al., 2005; Howard & Holmshaw, 2010). Additionally, other organisational support systems such as supervision and opportunities to consult with experts have also been shown to enhance knowledge and confidence among health professionals, contributing significantly to an increased willingness to engage in collaborative care with these patients (Albery, et al., 2003; Ford, Bammer, & Becker, 2008).

6.6 Our survey found unique challenges around meeting the needs of specific groups i.e. homeless people, women, people who don't speak English, members of the LGBTQ+ community, and people with disabilities. Services themselves highlighted barriers to providing care currently including lack of resourcing, inflexibility in service delivery and the lack of clear referral pathways between organisations.

6.7 The Royal Colleges in Scotland, Deaneries and Colleges of Nursing have an important role to play in ensuring our workforce is competent in relation to dealing with co-occurring disorders. Psychiatrists in training for example have less opportunity to rotate through addiction psychiatry training posts and to try to compensate for this, the Royal College of Psychiatrists is introducing a new system of Workplace Based assessments where addiction specialists will assess trainees' knowledge on addictions in relation to cases presented by the trainee.

6.8 Trainee and trained healthcare professionals also benefit from interaction with people with lived experience of addictive disorders and such training sessions are to be encouraged.

**Recommendation Seven**

7. The Scottish Government should ensure that further research is carried out to explore a number of troubling findings which we could not address in this rapid review. These include the finding by Public Health Scotland of a significant increase in anxiety and depressive episodes prior to a drug-related death between 2008 and 2018, and the increase in Drug-Related Admissions to General Hospitals.

Further Detail on Recommendation Seven

7.1 The Scottish Government should work with partners, such as Public Health Scotland, to commission or undertake further research into the above reports and consider whether further policy initiatives are required. A replication of the COSMIC study (DRMI,2002; Weaver et al,2003) in Scotland would be particularly useful this and produce rich evidence for clinicians and policy makers. The Co-morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC) had a methodology that allowed for a local needs assessment in relation to the four quadrants model

Context and Evidence.

7.2 A striking finding in the recent and detailed Public Health Scotland report on drug-related deaths in Scotland up to 2018 (PHS,2022) is the significant increase in the numbers of individuals being diagnosed with anxiety and depression in the six months prior to their death due to “accidental” drug overdose. We need to better understand what this increase means.

7.3 We highlight this passage on Page 28 of the report: “In 2017 and 2018 63% of people who had a Drug-Related Death had a specific psychiatric condition recorded in the six months prior to death (2017:567; 2018:665). Prior to this, the percentage steadily increased between 2009 (40%) and 2016(65%)”. The report urges caution in interpreting these figures “due to data quality issues” but in our view it is a trend in need of explanation in relation to co-occurring disorders.

7,4 These figures are compiled from returns from each local area after inquiry into the circumstances of each death. Information from police reports and health records inform whether someone is recorded as having a mental disorder in proximity to their death. The only two categories of mental health conditions that appear to have risen in this way are anxiety and depression. Other categories such as PTSD, personality disorder etc have remained static.

7.5 This finding is particularly relevant when we consider that some of the “accidental” drug overdose deaths may have been deaths with suicidal intent. The work of Neale (2000) is relevant showing that some of those with non-fatal overdose had such intent and finding that in those who died a significant minority may have intended to take their lives. This point is also looked at within the PHS 2022 Report which tries to differentiate intentional and unintentional drug-related deaths (40% of cases where overdose was deemed intentional had previous suicide attempts compared to 18% in the “non-intentional cohort”). This raises the question as to

whether better addressing comorbid depression in those at risk of a drug-related death may in turn reduce the number of deaths in this at-risk group.

7.6 Another report from Public Health Scotland (2021) that is worthy of further research is the November 2021 report on Drug-Related Hospital Admissions. This shows a rise in such admissions throughout Scotland, particularly into medical wards, with local patterns of rise that do not seem to mirror the parallel local statistics on drug-related deaths. Research that looks at the types of clinical presentation in relation to the types of drugs used and whether follow up is offered and the type of follow up would be informative given the rising trend.

7.7 The drug-related hospital admissions are an opportunity for intervention for co-occurring disorders and the development of Non-Fatal Overdose (NFO) services around Scotland is welcome in this regard. Such services need to be present in all areas where NFOs are common. They function as a bridge between inpatient care and appropriate care on return to the community. Evaluation of these services is vital.

7.8 A particularly helpful piece of research in guiding our review was the COSMIC study (Weaver et al ,2003;DRMI,2002)), It is now twenty years old, and the research was undertaken in London. In this study they looked in one locality at an alcohol treatment service, a drug treatment service and a mental health service. They looked for co-occurring disorders in these three groups over a year and asked if the co-occurrence was recognised. In addition, they asked the question as to whether cross-referral was needed or whether the comorbidity could be dealt with within the treating service.

7.9 If the same methodology could be replicated in urban Scotland it would help inform future developments in the care of patients with Co-occurring mental health and substance use disorders. Such a study might be contemplated in relation to one of the HIS pathfinder projects. Such a project could be costed and tendered in order to facilitate a more in-depth knowledge of how services in one location are dealing with the complexities of helping the range of comorbidities under the rubric “Co-occurring Mental Health and Substance Use Disorders”.

7.10 The future evolution of practice in this area in Scotland should look at developing care pathways for specific comorbidities. Examples might be ADHD and harmful use of stimulants or benzodiazepine dependence and anxiety disorder. In addressing clinical scenarios such as these mental health and substance use services should cooperate and pool resources to better help these patient/client groups. In the United States, Substance Abuse and Mental Health Service Administration (SAMHSA) produces Treatment Improvement Protocols (TIPs) (e.g. SAMHSA,2020) to review best practice with co-occurring disorders. Although these issues are addressed within specific SIGN and NICE guidelines and within the clinical guidelines for drug dependence (“The Orange Book”)(Department of Health,2017) and the forthcoming Alcohol clinical Guideline from OHID, local and national protocols in Scotland should look to evolve in relation to specific forms of co-occurring disorder e.g., ADHD and specific substance use disorders might be an example, among others.

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