Co-morbid Mental Health and Substance Misuse in Scotland

Substance Misuse Research
SUBSTANCE MISUSE RESEARCH

Co-morbid Mental Health and Substance Misuse in Scotland

Claire-Louise Hodges¹
Sheila Paterson²
Matira Taikato³
Sarah McGarrol²
Ilana Crome⁴
Alex Baldacchino⁵

¹Senior Research Fellow, Centre for Addiction Research and Education Scotland (CARES), University of Dundee
²Research Fellow, CARES, University of Dundee
³SPR in Psychiatry, NHS Tayside
⁴Professor in Psychiatry, University of Keele
⁵Director, CARES, University of Dundee

May 2006

Scottish Executive Social Research Substance Misuse Research Programme
Acknowledgements

The authors would like to thank:

Neil Parrett for his part in field work and analysis

Caroline Robertson for data collection and input

Aileen Yell for transcriptions

Dr David Gerber, Dr. Elizabeth G. Willox, Dr Claire McIntosh, Dr Maureen McVicar, Dr Mike Kehoe and Mr Bernie Carroll for interviewing service users

All those who participated in this research and others who helped realise the completion of this project

The Scottish Executive Research Advisory Group for advice and support
Executive Summary

Background

This document describes a research project on the nature, scope and impact of existing service provision in Scotland for people with co-existing mental health and substance misuse problems. The study was commissioned by the Scottish Executive in 2003 to extend current international evidence regarding co-morbidity, address perceived gaps in information on the quality of the provision of care for this client group and help inform the development of the co-morbidity agenda in Scotland.

The research fits within the wider strategic context in the UK, complementing other initiatives or strategies, such as the National Service Framework recommendations for people with dual diagnosis, the *Mind the Gaps* report of the SACAM/SACDM Working Group, the Health Advisory Service publication on Standards for Mental Health Services, the Royal College of Psychiatrists information manual on co-morbidity and the Department of Health Mental Health Policy Implementation Guide for Dual Diagnosis.

Aims and objectives

The main aim of the study was to identify the broad range of health and social care needs of people with co-morbid mental health and substance misuse issues in Scotland. Key issues included the quality of current provision and organisation of health, social care and the voluntary and independent sectors in addressing these needs, common factors that might impede this provision, the interrelation of different services and examples of good practice.

The researchers interviewed commissioners, service providers and service users to obtain a range of perspectives on these issues. As decision makers and future planners, the commissioners helped to establish local strategic and bureaucratic contexts. Providers from the independent, voluntary and statutory sectors gave the research an operational perspective. The views of service users on the services they utilised, their expectations and experiences, provided valuable new insights and made a unique contribution to the project.

Methods

The main methods of data collection included in-depth, semi-structured face-to-face interviews with 38 service users and 26 commissioners, and focus group discussions, held with 90 service providers directly delivering interventions to service users. The narratives were explored using Framework Analysis (Ritchie and Spencer 1994); a type of thematic analysis specifically developed for the public sector.

Commissioners

Commissioners interviewed for the project were core individuals from different sectors who occupied senior managerial positions and had planning and commissioning responsibilities for their respective service sectors. They included Directors of Social Services, Public Health Physicians, Drug and Alcohol Team co-ordinators and Lead Officers in Mental Health.

Interviews explored the commissioners’ broad views of issues relating to co-morbidity and examined specific features of relevant policy and practice.
Providers

The providers consisted of a cohort of participants from diverse backgrounds, with either primary contact with co-morbid individuals, for example, addiction services or mental health services, or secondary contact, such as homeless associations and housing agencies.

The discussions were conducted in relation to real co-morbid case histories in the form of vignettes. The vignettes covered different mental health and substance misuse combinations frequently encountered, including depression/anxiety and alcohol misuse and possible schizophrenia and cannabis use. Focus group topics included issues around practice and policy, assessment, treatment interventions and wider organisational issues.

Service users

The sample of 38 respondents included more males (30) than females (8), similar numbers across different age-bands, a spread of co-morbid combinations, some people with complex personal and social situations and some respondents with less severe issues.

Interviews were based around service users’ experiences and perceptions of service provision in relation to their mental health and/or substance misuse problems. The interviews provided insight to the different ways of accessing services, the types of treatment received, helpful and limiting experiences and what might be better provided in the future.

Accessibility and availability

Signposting: The degree to which services were advertised and the level of knowledge regarding the nature, remit and limitations of services were insufficient to guide the service user either to or through the service maze. Booklets and pamphlets went out of date quickly and often appeared or were available only in a limited number of facilities, most notably in general health facilities. In the absence of a ‘live’ and regularly updated directory of service remit and availability, providers were likely to continue to rely on historical links to services rather than on what was actually available.

Structural obstacles: The structure of existing services and their service philosophies were considered by many as creating barriers for co-morbid service users who might need input from a number of different service providers. Reports suggested that traditional trajectories rather than client-centred thinking often influenced decision-making about approaches to service users. As a result, there were debates between services as to who should take responsibility for service users with different presenting problems.

Management of mild to moderate mental health problems in substance misusers: Individuals with substance misuse-related issues often did not have sufficiently severe mental health problems to be eligible for attention from community mental health teams which prioritised severe and enduring mental illness. The majority with mild to moderate mental health issues were then sometimes inappropriately managed by substance misuse agencies or by primary care services.

Management of mild to moderate substance misuse problems in those with mental health problems: Similarly, individuals who used substances such as cannabis that were commonly thought to be relatively innocuous often did not qualify for eligibility to substance misuse services. These concentrated largely on opiates and other
injectable drugs. This service configuration created obvious gaps in provision for people who needed help for both substance use and mental health issues.

**Particular tensions:**

**Accommodation:** Positive experiences were reported in relation to supported accommodation, though the availability of such living arrangements was scarce and often restricted to those who did not use substances.

**Contentions between drugs misuse and alcohol:** Many of the respondents, commissioners and providers included, expressed dismay and frustration over the ways in which generally more money and other resources were made available for drug misuse compared to alcohol.

**Specialist provision:** Frustrations were expressed at the difficulty experienced in accessing specialist help in a crisis. The responsiveness of the ‘system’ to the needs of a group of people with multiple needs was challenging for all concerned.

**Service characteristics**

**The need for flexibility and consistency:** The research highlighted the contrast between the inflexibility of services and the chaotic characteristics of co-morbid service users’ lives. The narratives described how people living with mental health and substance use problems had ordinary life goals such as obtaining work, forming meaningful relationships, and generally improving the quality of their lives. The services set up to support their recovery, however, were heavily medicalised and not sufficiently flexible or appropriate to their needs, concentrating largely on ‘diagnosis’ and ignoring the wider picture.

**The need for responsiveness and continuity:** Providers and users alike reported that when service users asked for help they needed it immediately. They did not want to be placed on a waiting list and told to come back later. Equally, throughout the research project, it was generally felt that service users were often isolated and cut off from appropriate services after formal treatment had ended. A particular example cited was of a service user leaving a hospital environment, where no-one appeared to be ‘in charge’ of that person to help them access further support services to address their total need. There was a clear need for case managers or co-ordinators.

**The need for strengthening psychotherapeutic approaches:** Participants agreed that the most effective interventions took the form of warm, friendly, empowering services usually provided by one individual on a continuous basis. Concern was expressed at the relative lack of psychotherapeutic interventions available and the consequent lack of opportunity to develop trusting, therapeutic relationships with one person.

**The need for holistic care:** While there were examples of good practice and many positive experiences of different therapeutic relations, service users, commissioners and providers alike commented with regret that several services did not treat problems holistically and in a joined-up manner. They continued to consider mental health and substance misuse issues in relative isolation from one another and deal with them sequentially.

**Service organisation**

**The need for specialists:** There was a lack of dedicated co-morbidity specialists who appreciated the interaction of substance misuse and mental health problems and had the expertise and the resources to undertake this work. Both service users and providers
identified the potential benefits of such specialists, either embedded within mainstream substance misuse or mental health teams or in specialist units.

**The need for training to underpin provision:** Service providers stated that they needed specific training and support that would help them deal with the complexities co-morbid individuals brought to the services. A minimum requirement would be to have access to workers who did have the knowledge and expertise of supporting people with co-morbid issues.

**Multi-agency partnerships:** In many parts of Scotland, health services and local authorities were working together and shared funds, yet evidence of joint working remained patchy. Where it did exist, experiences were positive. There was evidence to suggest that putting joint working into operation was envisaged differently across the researched localities. Although multiple engagements were considered to be inevitable, limits to the number and complexity of arrangements needed to be put in place. For some, more informal intersectoral agreements remained a realistic option. For others, change in infrastructure, in terms of coterminous partnerships between health, social and non-statutory sectors, was viewed more favourably than implementing service change per se.

**Shared assessment protocols and development of care pathways:** As a result of patchy joint working arrangements, shared assessments and the creation of care pathways for co-morbid individuals were lacking or under-developed in several locations. Again, there was some controversy regarding the usefulness of uniform integrated care pathways for such a heterogeneous group of people with quickly changing but ongoing needs. Discussions with commissioners indicated that the requirement for joint-funding approval in creating a care package could help to bring about closer collaborative efforts between health and social care.

**Bureaucratic quagmire:** Providers and commissioners voiced concern over the expediency of policy and directional changes and associated changes in remit, despite the consistency of the joint planning, joint commissioning and joint delivery messages for mental health and other needs over the past decade. These structural and procedural modifications were believed to act as barriers to developing functional and successful collaborative efforts and providing consistency in care and support. The volume of information and guidelines to wade through were also a cause of concern and their relevance to local contexts was questioned, especially in relation to rural areas.

**Exclusion:** Service users felt excluded from decisions about their care and wanted greater involvement and empowerment. Many providers and commissioners thought that only lip service was paid to service users during formal meetings. Their opinions were not taken into account and were not followed through by action at the planning level. Although user involvement was acknowledged by some to be important, others considered that service users were not necessarily best placed or informed to direct and advise on service provision and practice. Service users interviewed also stressed their need for peer support groups.

**Stigma and inclusion:** All participants spoke of aspects of wider cultural and social problems that needed addressing. Stigma was an enduring feature of mental health and substance misuse problems alike. Since the late 1990s, a marked policy shift towards recognising the importance of social inclusion had taken place and good progress was being made in Scotland on challenging stigma around mental ill-health. Although the structures within which care and support are provided had changed for many, the language of the various professional silos and the theory that underpinned them frequently remained the same.
Concerns about the medicalisation of co-morbid issues and neglect of social factors did not imply that providers and commissioners were ignorant of their professional limitations or the need for a holistic outlook. Most practitioners appeared to value their relationships with users as individuals with wider needs. Nonetheless, tension continued to exist between the real needs of co-morbid service users and the resources to provide ‘holistic care’ and the treatment interventions currently available and administered. As social and health care workers operated as members of a wider collective social culture, understanding this culture offered insights into some of the social forces that shaped their work and in turn could allow attitudinal change to take place at the societal, professional and individual level.

**Conclusions and implications**

The picture that emerged from this study was one of a group of people who struggle daily with the realities of living with co-morbid mental health and substance misuse problems and for whom existing support services have often been inappropriate, inadequate and which may further undermine their already fragile self esteem and coping strategies. The lives of service users were characterised by a series of loss: loss of a routine life, loss of social networks, including loss of friends and family, loss or inability to obtain employment and loss of financial security. Service users were generally considered by providers to lead ‘chaotic’ lives with a multiplicity of problems jostling for attention.

Services for co-morbidity varied in number and quality across the different research localities. With notable exceptions, the care that services provided was unsatisfactory and inadequate. Exceptionally, key individuals established a therapeutic relationship with service users within a holistic framework, regardless of the primary ‘diagnosis’ or ‘diagnoses’. This applied to both statutory and non-statutory service provision.

There were examples of good practice. However, the themes identified were lack of awareness of available help, lack of clarity about pathways for help, and a lack of ongoing support. How professional roles and responsibilities within a particular socio-cultural context impinged on responses to the co-morbid client were still poorly understood, as were the reasons, causes, consequences and evidence-based treatment interventions for this group. What was clear is that there were considerable training needs across all professional groups and agencies.

Some commissioners remained undecided whether following the national guidance to implement services was ideal. Together with service providers they were, however, unanimously agreed that specialist staff should be based within mainstream mental health and/or substance misuse services and not necessarily reside in stand alone specialist co-morbidity teams. The demand was for specialist mental health and substance misuse competencies provided by a number of practitioners and greater general awareness for all staff working in these services.

Training, information and awareness raising are required for service users, carers, service providers, commissioners and the general public in order to contribute to a greater understanding of combined mental health and substance misuse issues and to engender attitude change.

The human and economic cost to people with substance problems and mental health difficulties, to the wider community and to health and social services is difficult to quantify. A planned prioritised response, however, can augment clinical, service, training and research agenda.
Chapter 1: Introduction

Overview

The research described in this report investigated the nature, extent and impact of existing service provision across Scotland for people with co-morbid mental health and substance use problems. It was commissioned by the Effective Interventions Unit (EIU) at the Scottish Executive to address perceived gaps in information on the nature and provision of care for this client group and help inform the development of the co-morbidity agenda in Scotland.

The study aimed to:

- identify the broad range of health and social care needs of people with co-morbid mental health and substance use issues in Scotland
- explore service users’ experiences of accessing and receiving services from health, social care and independent organisations
- review the quality of current provision and organisation of health, social care and the independent sectors in meeting the needs of co-morbid individuals
- identify common factors that impede provision and organisation of health, social care and independent services for people with co-morbidity
- examine how different services relate to one another through informal and formal arrangements or protocols
- identify examples of good practice.

The researchers interviewed three groups of people, commissioners, service providers and service users to obtain a range of perspectives on these key issues. As decision makers and future planners, the commissioners helped to establish local strategic and bureaucratic contexts. Providers from the independent and statutory sectors gave the research an operational perspective. The views of service users on the services they utilised, their expectations and experiences, provided valuable new insights and made a unique contribution to the project.

The research fits within the wider strategic context in the UK, complementing other initiatives or strategies, such as the National Service Framework recommendations for people with dual diagnosis, the Mind the Gaps report of the SACAM/SACDM Working Group, the Health Advisory Service publication on Standards for Mental Health Services, the Royal College of Psychiatrists information manual on co-morbidity and the Department of Health Mental Health Policy Implementation Guide for Dual Diagnosis.

Research and policy context

Chapter 1 defines co-morbidity and looks at the consequences for those with the condition and for society at large. It covers current models of service delivery and treatment interventions and examines the policy framework and measures being taken in Scotland to manage co-morbidity more effectively.
Defining co-morbidity

Co-morbidity is a complex phenomenon with a range of definitions.

In the field of mental health the term may be used narrowly or broadly. For example, it can be used to describe the co-occurrence of two (or more) different disorders such as the presence of substance misuse disorders (e.g. alcohol or other drug abuse or dependence) and psychotic disorders (e.g. bipolar disorders or schizophrenia).

A distinction is often made between concurrent and successive co-morbidity. Concurrent means two (or more) disorders are present at the same time. Successive co-morbidity is when disorders occur at different times during a person’s life. It is unfortunate that the term co-morbidity sometimes blurs rather than clarifies the complicated diagnostic problems that clinicians have to understand and treat.

Another term used extensively is dual diagnosis. The World Health Organisation (WHO 1994) and the United Nations Office on Drugs and Crime (UNODC) define dual diagnosis as a ‘person diagnosed as having an alcohol or drug abuse problem in addition to some other diagnosis, usually psychiatric such as mood disorder or schizophrenia’. The European Monitoring Centre in Drug Dependence and Alcohol (EMCDDA 2004) refers to co-morbidity or dual diagnosis as a situation when there is a ‘temporal co-existence of two or more psychiatric or personality disorders as defined by the International Classification Diagnostic System (ICD), one of which is problematic substance use.

Since the interrelationship is complex, it is important to appreciate that co-morbidity can present in several ways (Crome 1999). Psychiatric syndromes or symptoms may result from substance use, and psychiatric or psychological symptoms may be triggered by harmful use, dependence, intoxication or withdrawal. Psychological morbidity not amounting to a disorder may precipitate substance use, and primary psychiatric disorder may lead to or precipitate a substance use disorder which may, in turn, lead to psychiatric syndromes.

This report uses the broader definition of co-morbidity/dual diagnosis as that of a co-existing mental health and substance misuse problem as defined by its bio-psycho-social context.

Brief historical background

Mental health and substance misuse problems are a major public health issue (World Development Report 1993). Increased pressures on providers of mental health services have resulted in attempts to limit the remit of different providers and the development of case-mix to determine the resources made available for interventions (Farrell et al 2003). These developments have given rise to a greater focus on diagnostic groupings in some health care settings. There has been a tendency in some specialist services to disown the problems of these different groupings (i.e. the seriously mentally ill with problematic substance misuse within general psychiatric services and those with personality and other psychiatric disorders within addiction services). This has been further complicated by an assumption that each population belongs to the counterpart service. The result is that people with co-morbidity are left in ‘No Man’s Land’ or fall ‘between the cracks’ (Abou-Saleh 2004).

Prevalence

International research points to co-morbidity being not only an issue among clinical populations but also in the general population in many countries (Regier et al 1990; Hall
et al 2002; Frisher et al 2004; Abou-Saleh and Samet et al 2004). One population-based co-morbidity study, *The Netherlands Mental Health Survey and Incidence Study* (Bijl et al 1998), found that one percent of both males and females in the Netherlands met criteria for combined 12 month mood, anxiety and substance use disorder. Another study, The UK Psychiatric Morbidity Study on adults living in private households (Singleton et al 2002), showed that 12% of males and 6% of females had some form of drug dependence combined with a current neurotic disorder.

**Consequences of co-morbidity**

**Poor prognosis**

Patients with co-morbidity have a poorer prognosis. The most consistent predictor of a poor treatment outcome for clients in treatment for substance misuse is the presence of psychopathology (McLellan et al 1983; Rounsaville et al 1987). Similarly, substance misuse is a predictor of poor treatment outcome for mentally ill patients (Drake and Wallach 1989; Carey et al 1991). Research evidence suggests that drug treatment outcomes improve if mental disorders are treated (e.g. Woody et al 1985).

**Self harm, suicide and early mortality**

Self-destructive and antisocial behaviours may develop in extreme situations, leading to homelessness, disengagement from family and community, and the presentation of high-risk behaviours such as offending, intravenous drug use, needle-sharing, suicide attempts, unsafe sex, and binge consumption (Murray et al 1999). There is also an increased risk of early mortality (Evans and Willey 2000).

**Psychological problems**

Increases in impulsive, aggressive and uninhibited behaviours, as well as increases in anxiety, depression and self-harms have been associated with the co-existence of substance use and mental health problems (Evans and Willey 2000).

**General consequences**

Co-morbidity is associated with a range of negative factors. These include higher rates of relapse (Swofford et al 1996) and rehospitalisation (Linszen et al 1994); hospitalisation (Haywood et al 1995); violence (Cuffell et al 1994); arrest and imprisonment (Clark et al 1999); homelessness (Caton et al 1994) and poorer housing stability (Osher et al 1994); and serious infections such as HIV and hepatitis (Rosenburgh et al 2001).

**Social and economic cost**

Those with a co-morbid condition place a heavy burden on a range of public services (Hall 1996). Severe psychotic disorder and substance misuse may be accompanied by a range of social issues, such as homelessness, poverty, criminality, unemployment and marginalisation. A particular strain is placed on acute psychiatric services (Regier et al 1990; Kivlahan et al 1991). The costs of providing treatment for those with co-morbidity are disproportionately higher than for those with psychiatric disorders that do not misuse substances; this is also true of those with substance use disorder (SUD) alone (Hoff and Rosenheck 1998).
Models of service delivery

The international literature describes three service delivery models for the treatment of co-morbidity (Drake et al 1998):

- **Sequential or serial treatment**: Psychiatric/mental health and substance disorders are treated consecutively and there is little communication between the services. Follow up studies underline low success rate (Cuffel and Chase 1994; Bartels et al 1995 and Drake et al 1998)

- **Parallel treatment**: Treatment of the two different disorders is undertaken at the same time, with drug and mental health services liaising to provide concurrent services. In this model the medical model of psychiatry may conflict with the psychosocial approach to drug-related issues.

- **Integrated treatment**: Treatment is provided within a mental health or a substance misuse service or in a special co-morbidity programme or service. This is seen as the model of excellence (SAMSHA 1997, 1998; DH 2002).

In practice the different models of care (sequential, parallel and integrated) often co-exist with little being known about what actually works and for whom (Drake et al 1998). No standard instrument exists for describing social and health care systems and pathways through care for people with co-morbidities. Comparing systems in different areas or in different national contexts is consequently difficult.

Service delivery infrastructures often cannot respond to geographical dispersal of the client group. In addition, the lack of specialised training opportunities for staff, problems in continuity of care with other health providers and stigmatisation issues in the wider community further challenge already fragmented service provision to this population (Larson et al 1993)

Treatment interventions and best practice

The UK Good Practice Guidance to Dual Diagnosis (DoH, 2002) provides the ingredients to help identify and develop an effective and efficient treatment approach individuals with co-morbid mental health and substance misuse problems.

*Integrated Care for Drug Users: Principles and Practice* (EIU 2001) sets out the evidence base for integrated care. Part of this programme includes a fact sheet and guidance on the management of the co-morbid treatment-seeking population (EIU 2004).

The European wide project on co-morbidity (ISADORA Project) is designed to describe service provision for individuals with dual diagnosis in seven European psychiatric settings (including Scotland). The forthcoming publication of the European Monograph on *Co-morbidity: policy and practice* will provide the framework to identify not only the population but also the interventions provided in a European context to individuals with co-morbidity accessing treatment at all levels of the health and social care continuum.

Policy framework

There has been growing public and governmental concern about the consequences of mental and substance misuse disorders – both for the individuals concerned, their families and carers and for the impact on wider society.

Such concerns have been evident since the early 1990s, e.g. the introduction in 1991 of the Care Programme Approach to provide a framework for the care of mentally ill people (HMSO 1994); the Department of Health’s Confidential Inquiry into homicides and
suicides by mentally ill people (Appleby et al 2001); the development in 1995 of a national drugs strategy and subsequent updates (HMSO 1995; Home Office 2002).

Other countries have also developed similar approaches. In Australia, for example, the issue of co-morbidity is included in both the National Drug Strategic Framework (1998/9 – 2002/3) and the Second National Mental Health Plan (1998-2003) (McCabe and Holmwood 2003). The European Monitoring Centre for Drugs and Drug Addiction included a special section on co-morbidity in its annual report for 2004 and issued a policy briefing on the subject in the 20 official EU languages and Norwegian (EMCDDA 2004, 2005).

The report from the joint working group between the Scottish Advisory Committee on Drug Misuse (SACDM) and the Scottish Advisory Committee on Alcohol Misuse (SACAM), Mind the Gaps: Meeting the Needs of People with Co-occurring Substance Misuse and Mental Health Problems, was published by the Scottish Executive in 2003. It makes a number of recommendations aimed at improving the well-being, support and general outlook of people with co-occurring substance misuse and mental health problems (SACDM/SACAM 2002).

This is part of a wider Scottish public health initiative to improve the mental health of the population. The current policy on the organisation of mental health services is set out in A Framework for Mental Health Services in Scotland (Scottish Office 1997), Our National Health (Scottish Executive 2000(1)), Partnership in Care (Scottish Executive 2003 (1)) and Delivering for Health (Scottish Executive 2000 (1)).

Taken together, these documents describe how the Scottish Executive, working with statutory agencies, the voluntary and independent sectors and others, have and plan to introduce and develop a range of policies and initiatives to identify the population in need, improve the planning and delivery of accessible and meaningful services, improve outcomes and provide a governance structure which upholds ethical and accountable frameworks of good quality mental health and addiction services. Multi-agency working and communication of good quality and meaningful information is the core driver in the current Scottish Drug/Alcohol misuse and mental health agendas. Several Scottish based agencies have either been set up (Mental Health and Wellbeing Support Groups and Mental Health Services Improvement Network) and others reorganised (NHS Quality Improvement Scotland, Chief Scientist Office, NES Scotland) to maximise resources and respond in a clinically meaningful and responsive manner.

A number of Action Plans and other documents have been published by the Scottish Executive, aimed at tackling various aspects of alcohol and drug-related problems. These include:

- Drug Action Plan: Protecting our Future (2000) which sets out the strategic framework for meeting the needs of drug misusers in Scotland. The drug strategy has been updated more recently with the Treatment and Rehabilitation review (2004), the Criminal Justice Plan (2004) and Hidden Harm (Scottish Executive 2003) which examines the Executive’s action to help children and young people in families affected by drug misuse.
Closely-related Scottish policy initiatives that impact on the Scottish response to co-morbidity include the *Health and Homelessness Guidance* aimed at improving the health of homeless people (Scottish Executive 2001), *Joint Future Agenda* aimed at better outcomes through an integrated approach (Scottish Executive 2000(3)), *Beyond Trauma* (Nelson 2001), aimed at understanding the views and experiences of survivors of trauma (including childhood sexual abuse) and *Choose Life: A National Strategy and Action Plan* (Scottish Executive 2002(2)) aimed at addressing the rising rate of suicide in Scotland. The Clinical Standards Board (now part of NHS Quality Improvement Scotland) published its *Standards in Schizophrenia* (CSBS 2001) and subsequent programmes (CSBS 2002) which aim to monitor and identify gaps in services and potential lack of access to specialised services.
Chapter 2: Purpose, Scope and Methodology

Background

The research addressed perceived gaps in information on the nature and scope of existing service provision in Scotland for people with co-morbid mental health and substance use problems.

The study was commissioned by the Effective Interventions Unit (EIU) at the Scottish Executive as the first stage of its work in the field of co-morbidity. It complements the report of the SACAM/SADAM Working Group, Mind the Gaps and a range of other UK-wide related initiatives and strategies. More detailed information on the nature and provision of care currently available will help to contribute to the development of the co-morbidity agenda in Scotland.

Purpose of the research

The study aimed to:

- identify the broad range of health and social care needs of people with co-morbid mental health and substance use issues in Scotland
- explore service users’ experiences of accessing and receiving services from health, social care and independent organisations
- review the quality of current provision and organisation of health, social care and the independent sectors in meeting the needs of co-morbid individuals, identifying significant gaps in, and barriers to existing provision
- identify common factors that impede provision and organisation of health, social care and independent services for people with co-morbidity
- examine how different services relate to one another through informal and formal arrangements or protocols
- identify examples of good practice.

The research focused on the ways in which services were designed and delivered, and how services worked with each other to make sure that the individual needs of people with co-morbid problems were met. It did not examine the effectiveness of specific treatment interventions.

Practical objectives

The research programme was divided into two phases, a pilot phase and a main phase. The pilot phase tested the feasibility of the proposed main study and collected preliminary data. It provided advance warning of possible problem areas and indicated whether proposed methods or instruments were inappropriate or too complicated. It also helped highlight any logistical problems. The main part of the programme was revised to take account of these findings.
Parameters for the research study

Scope of Study

The study investigated the overall availability, nature and impact of service provision for co-morbid mental health and substance misuse across seven geographical locations, throughout Scotland. At each location in-depth interviews and focus group discussions were used to collect data from **commissioners, service providers and service users**.

Raising the profile of the project

Before the start of the main phase of the study, a number of presentations on the project took place at all research locations which were publicised by a combination of flyers, posters, advertisements and word of mouth. Potentially interested parties were invited to attend from a wide variety of backgrounds, including mental health, social work, substance misuse, general health and other social care agencies from the statutory and independent sectors.

The presentations served the dual purpose of recruiting focus group participants, both directly from the audience and indirectly, by members of the audience circulating information among their colleagues. Audience members were invited to place their name on a list of ‘interested parties’.

Identifying the research localities

The study needed to capture a broad spectrum of practice and need across different geographical locations. This had to reflect the overall pattern of need throughout Scotland and cover both rural and urban locations.

Researchers used the Carstairs Deprivation Category (DEPCAT)¹ to identify different socio-demographic profiles within advantaged and disadvantaged geographical areas. They selected specific postcode areas based on a population size of around 100,000 to form the overall research locality boundary and maintain consistency throughout the seven study areas. These were divided by rurality and level of deprivation to create the following locality combinations:

- **Metropolitan sites**: SW Edinburgh (mixed levels of deprivation); NE Glasgow (high index deprivation)
- **Largely urban**: Dundee City in Tayside (largely high deprivation); Aberdeen in Grampian (largely low deprivation)
- **Semi-rural**: Levenmouth in Fife (high index deprivation); Falkirk in Forth Valley (mixed levels index deprivation)
- **Largely rural**: the Borders (low deprivation).

Collecting data

The main methods of data collection included in-depth, semi-structured face-to-face interviews with 26 commissioners and 38 service users. Focus group discussions were held with 90 service providers directly delivering interventions to service users. All interviews during the main stage of the study were either partially or fully transcribed to enable more efficient and consistent analysis.

¹ DEPCAT is an index of deprivation disaggregated by areas in Scotland. See Appendix 1 for a list of postcodes included in each research locality and associated Deprivation Category scores.
The resulting narratives were subjected to Framework Analysis², a form of thematic analysis developed specifically for public sector research.

**Commissioners**

Twenty six commissioners were interviewed for the project. These were core individuals from different public sectors who occupied senior managerial positions and had planning and commissioning responsibilities for their respective service sectors.

**Selecting participants**

The pilot stage of the project showed that identifying appropriate commissioners was not as straightforward as anticipated. Expert colleagues could not always agree on who could be defined as a commissioner, and identified individuals either denied that they occupied such a role or felt too uninformed to talk about aspects of co-morbidity.

Learning from the pilot phase, the research team worked with the EIU advisory group for the project to select and engage suitable commissioner participants. They identified specific positions identifiable by title in each region in order to offer consistency across research localities. The following participants were included in the study:

- Directors of Social Services: Local authority representatives. They oversee all social service departments and have a broad view of how these departments interlink with each other.
- Public health physicians: NHS representatives in field of general health. They are responsible for contributing to health improvement in their localities.
- Drug and Alcohol Action Team (DAAT) co-ordinators: Accountable for the structural and procedural organisation around substance misuse. This includes the synchronising of their work with other relevant service providers.
- Lead Officers in Mental Health: Not necessarily from a mental health or medical background. This professional group brings a broad range of views on current issues in the mental health field.

**Conducting interviews**

The interview guide (see Appendix 2) was designed to enable the interviewer to cover a number of major topics in a systematic fashion while the unstructured nature captured rich accounts of service-related policy and practice. This allowed for an ‘insider account’ of the topic in question. It was important to capture the perspectives of the commissioners themselves, rather than allow researcher-bias to influence and shape the data gathered. The intention was to develop an account of the commissioners’ broad views of issues relating to co-morbidity and to explore in depth specific issues relating to policy and practice. The methodology also had the benefit of being consistent with that used in gathering data for the service providers and service users.

²Framework Analysis (Ritchie and Spencer 1994) is a qualitative thematic indexing and charting system. This method involves creating an index or code frame of substantive themes and charting key findings within each theme, systematically coding transcripts for key points and illustrative verbatim comments. Findings on the key themes are then summarised on a chart incorporating the key quotes. The charting method ensures analysis of the data is rigorous, balanced and accurate, allowing the themes and hypotheses developed initially to be refined following review of the evidence.
Service Providers

Sixteen focus group discussions with service providers were carried out across the 7 locations. Each group was composed of between 8 and 10 people, on the assumption that around half the sample would attend. The actual size of the focus groups ranged between 3 and 14, with 90 service provider staff participating in total.

Identifying specific services

The research team assembled a list of all services available in the research localities, including services based in the social, mental health, and general health sectors as well as relevant agencies based in the independent sector. The objective was to obtain a cohort of participants from diverse backgrounds having either primary contact with co-morbid individuals, for example, addiction services or mental health services, or secondary contact, such as homeless associations and housing agencies.

Identifying individual providers

A multi-pronged approach was employed to recruit focus group participants. Initial presentations on the project served to heighten awareness and encourage participation. Members of the audience were invited to place their name on a list of willing parties and to inform their colleagues of the opportunity to participate. To complete the selection of participant providers, a diverse selection of agencies and organisations, identified via the list of services, were contacted at a later stage to recruit volunteers who had not attended the presentations.

Making initial contact

Following initial contact with a service, researchers liaised with a named member of staff to promote continued exchanges and to help with the final formation of the focus groups. These key contacts acted as ‘champions’ for the project to promote awareness and encourage participation.

Focus group composition

Focus group members were drawn from the following service groups:

- Mental Health services
- Primary Care services
- Addiction services
- Independent sector
- Social Services.

The focus groups were arranged by tier, to ensure a representative spread of participants by service type and by professional background. This structure also helped to discern service users’ pathways through care and levels of interagency working, both formal and informal. The Tiers, as defined by Models of Care, consisted of a Tier 1 group (primary care, general mental health, social services, probation, etc), a Tier 2 group (open access or “street” agencies, info/advice shops, etc) and a group combining Tier 3 and 4 representatives (structured community services or structured day care, inpatient or residential specialist detoxification or rehabilitation services).

Tiers 1 and 2 were combined in the main part of the project, but the research team retained the ability to discern more generic service responses from more specialist service responses.
Conducting the groups

The discussions were conducted in relation to real co-morbid case histories in the form of vignettes. They were driven by a predetermined topic guide (see Appendix 3) based around practice and policy, assessment, treatment interventions and wider organisational issues. The vignettes covered different mental health and substance misuse combinations frequently encountered, including depression/anxiety and alcohol misuse and possible schizophrenia and cannabis use.

Respondents were encouraged to have a genuine discussion, talking between themselves rather than addressing all their remarks to the moderator. The moderator intervened, where appropriate, to probe and move the discussion on when necessary and to minimise interruptions and instances of more than one person talking at any given time. To ensure consistency of approach and to limit individual biases, the researchers met regularly both before and during fieldwork to reflect on the format of the topic guide, the emerging findings and to suggest changes in emphasis for future discussions.

Service users

Thirty eight service users were interviewed. Difficulties encountered during the pilot stage of the project included identifying potential interviewees who would be able to contribute successfully in an in-depth interview situation via liaisons in the identified agencies and services. The unreliability of service users at times i.e. failure to attend interview appointments or attending intoxicated resulted in the need for re-scheduling. As a result of these obstacles volunteer Specialist Registrars in Addiction Psychiatry were recruited as interviewers across all localities as part of their research remit and one experienced Addictions Community Psychiatric Nurse in the Borders also offered their services. Each interviewer was briefed regarding the research protocol and the format for the interviews was explained.

Selecting participants

Purposive sampling was used to select a particular cohort of participants to reflect a range of experience and demographic variations, rather than random selection of a large sample which is statistically representative of the general population. The decision was to select the sample in order to reflect three main features (see Appendix 4):

- Different co-morbid combinations.
- Different age-bands (excluding those under 18 or over 65).
- Different demographic backgrounds in terms of the emphasised entity of the co-morbid situation (addiction services, mental health services, voluntary services).

In order to ensure representation of different co-morbid combinations, the sample included people with no formal diagnosis as well as those who had received a formal psychiatric diagnosis. The research team felt that it was important that some people with seemingly less marked mental health problems should be included because these cases often lead both to exclusion from studies of this kind and to being overlooked in policy development.

Problem severity proved difficult to judge. Due to the subjective nature of such judgments, severity of problem was determined in terms of the difficulties which significantly affected the person's ability to take part in the interview process. The final sample of 38 respondents included more males (30) than females (8), similar numbers across different age-bands, a spread of co-morbid combinations, some people with complex personal and social situations and some respondents with less severe
issues. While the co-morbid combinations are not exhaustive, the final sample does cover a wide range of experiences and reflects the most typical cases seen by professionals within the relevant services.

Conducting the interviews

Potential respondents were given information about the project and details of what would be involved. If they agreed to take part, a time and place for the interview was arranged. In most cases, the interviews took place in a community setting conducted by volunteer Specialist Registrars interested in the field.

The interview guide (see Appendix 4) was designed to enable the interviewer to cover a number of major topics in a systematic fashion. Interviews were based around service users’ experiences and perceptions of service provision in relation to their mental health and/or substance misuse problems. The interviews provided insight to the different ways of accessing services, the types of treatment received, helpful and limiting experiences and what might be better provided in the future.

It was particularly testing to undertake interviews with people who exhibited cognitive impairments. Often these interviews remained focused on very concrete issues, on the here and now and on immediate concerns. They elicited very brief, limited responses. They did not yield the rich insights and reflections of the other interviews. It was nevertheless felt that these interviews, despite being somewhat 'thin', constituted valuable additions to the data. Their inclusion ensured that a range of experience was being sampled and helped to indicate the main concerns and preoccupations of the participants.

Ethical approval

Multi-site Research Ethical Approval was obtained before commencing the project. This included confirmation of participant confidentiality and anonymity where appropriate. For further details, please see MREC03/0/123 on the relevant website. The research project was also registered with the local research and development office in Tayside (the base for the project) and information to this effect circulated to all participating NHS boards.
Chapter 3: Regional Variations in Experiences of Co-morbid Mental Health and Substance Misuse

Introduction

The structure and resources of current mental health and substance misuse services is a consequence of historic service configurations, funding patterns and past planning approaches by local health and social care commissioners working with other partners. The effectiveness of commissioners’ decisions relies on their awareness of clinical realities, their capacity to predict future needs and demands and their ability to integrate these demands with Government policy. Understanding local commissioners’ perspectives on co-morbidity is a vital part of predicting how local services are likely to develop or need to change.

The first part of this chapter summarises service commissioners’ observations on co-morbidity service provision in their respective areas. Factors common to all localities are covered in subsequent sections. These cover the debate on providing integrated and specialist services to those with co-morbid mental health and substance misuse issues, service user consultation and involvement in decision-making and planning and views on what might constitute an ideal service for this cohort of people.

Commissioner profiles

A total of 26 commissioners were invited for interview. Six were interviewed during the pilot stage and 20 during the main phase. In total 29 people were interviewed with some interviews involving more than one interviewee.

The commissioners in the pilot phase included representatives of Local Authorities and NHS services. In the main phase, the range of commissioners was expanded to include Directors of Social Services (or equivalent), Public Health Physicians, Drug and Alcohol Team (DAAT) Co-ordinators and Lead Officers for Mental Health across the identified regions.

The professional histories of the commissioners were reflective of their respective posts and included a mixture of social work, nursing, medicine, psychiatry, psychology, sociology and criminology. Commissioners’ current remits varied across research localities, inter- and intra-professionally, with considerable overlaps at the inter-professional level. The nature of direct experience of co-morbid mental health and substance use also varied between commissioners. Many had informal experience either working with co-morbid individuals or working at a more strategic level, with some indicating no direct experience. Few referred to any formal training in the theoretical frameworks of co-morbidity.
### Summary findings from interviews with Commissioners

#### Table 1 Tayside

<table>
<thead>
<tr>
<th>Co-morbidity Service Provision</th>
<th>TAYSIDE: Dundee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No specific services were in place. Those with co-morbid mental health and substance misuse problems might find it difficult to establish which service (addiction or mental health) had primary responsibility for care and treatment.</td>
</tr>
<tr>
<td></td>
<td>There were no plans for specific service provision in the Corporate Action Plans from the three Drug and Alcohol Teams (DAATs) and the Health Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients with addictions had difficulty in accessing mental health services. General Adult Psychiatry (GAP) was reluctant to deal with patients who had drug or alcohol issues and might discharge them from their caseloads, even when an on-going and severe mental health problem existed.</td>
</tr>
<tr>
<td></td>
<td>Specific psychological services were essentially non-existent for patients with addictions. GAP did not display a consistent approach in dealing with co-morbidity and there was a lack of uniformity in terms of service response and procedures. For example, there were few case conferences and these patients were often not included in the Care Programme Approach (CPA).</td>
</tr>
<tr>
<td></td>
<td>There was little attention paid to the care pathways of patients with co-morbidity. Although the NHS general psychiatry service and substance misuse services were nominally part of the same directorate, they had traditionally been run as separate services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Developments and Changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In response to the Clinical Standards Board for Scotland, <em>Standards for Schizophrenia, (Standard 11)</em>, NHS Tayside had initiated work on co-morbidity through the Primary Care Division.</td>
</tr>
<tr>
<td></td>
<td>GAP and substance use service managers together with the independent sector had started work to address issues of liaison and joint working.</td>
</tr>
</tbody>
</table>
### Table 2 Fife

| **Co-morbidity Service Provision** | The Fife Intensive Outreach Team was a specialist resource working with people with co-morbid conditions. The team carried an active caseload of 60+ clients and provided support to all ‘sectorised’ mental health teams in Fife. Finding information on the existence of services and how to access them was difficult. Existing care pathways between services were informal and depended on the working relationships of the professionals involved. |
| **Key Issues** | All services were perceived as being overstretched and community care and addiction services were under-funded. No focused attention was paid to the care pathways of co-morbid patients. General psychiatry and addiction services were traditionally viewed as distinct and separate services. Agencies viewed each other as competitors for finite resources and were reluctant to ‘lose’ their clients by referring them on. Although co-morbidity issues were well recognised, there was no focused attention on care pathways for co-morbid individuals. The main perceived problem was keeping people in treatment. |
| **Planned Developments and Changes** | Co-morbidity was expected to become part of the mainstream within service provision. The establishment of locality mental health teams was expected to address co-morbid issues more specifically. Work had already begun on increasing integration between drug treatment agencies in the region and between general psychiatric services and the addiction services. The Health Service-based treatment services dealing with drug and alcohol problems in Fife, Tayside and Forth Valley had been supporting one another informally for some years with the aim of improving services to patients. Lead clinicians and managers from Tayside, Fife and Forth Valley (East Central Scotland Addiction Services – ECSAS) had begun formally to develop a Managed Care Network (MCN) in addictions. |
Table 3 Borders

<table>
<thead>
<tr>
<th>Co-morbidity Service Provision</th>
<th>BORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was no specific integrated care pathway for co-morbid service users and situations arose where neither substance misuse nor mental health sectors took responsibility for these service users. Since inpatient services were limited and access unpredictable, co-morbid service users were often referred via extra-contractual arrangements to residential services outside the region, most notably Edinburgh. This had forced providers in the Borders to consider a wide variety of treatment options such as services available within a primary care setting, in the voluntary sector and in generic social services. Some progress had been made in terms of co-referral where generic mental health teams liaised with the Borders Community Addictions Team to decide on the most appropriate action, and vice versa. This had sometimes resulted in joint working. The adapted DAAT structure with its new commissioning group was thought to be linked to improvements in collaborative efforts.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a perceived discrepancy between National directives and recommendations, such as the use of a joint assessment tool, and local need and ability to implement these changes. Differences in practice criteria and professional cultures, especially between mental health and substance misuse services, required to be overcome. Attention needed to be paid to the wider health and psych-social needs of the individual, the need for increased training for staff and the further development of voluntary services. There was a dearth of diploma-qualified social workers, particularly in the core substance misuse and mental health teams. Limited resources and new responsibilities and initiatives, such as adherence to the Agenda for Change and out-of-hours services, had forced the prioritisation of essential services and slowed down the achievement of national priorities and objectives.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Developments and Changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Some of the recent developments across the Borders included addressing joint services, joint management of services and joint resourcing, the introduction of a new IT system for information sharing about service users and investment in advocacy services for people with mental health problems.</td>
<td></td>
</tr>
</tbody>
</table>
| **Co-morbidity Service Provision** | There were no specific services or provisions in existence for the co-morbid service user. The Community Drugs Problems Service in Edinburgh and the Lothians, in light of the Joint Futures agenda, were beginning to prioritise people who had co-morbid mental health and substance misuse issues.

A medical training position had been developed to provide some provision for co-morbid people who were also homeless. The development of direct links between psychology provisions and homeless services had helped to reduce waiting times and service bottlenecks.

Locality clinics, led by community mental health services, provided a one-stop shop for multi-professional advice, assessment and referral. These were helping to reduce waiting times and provide access to appropriate support and treatment interventions.

The locality teams were able to maximise economies of scale and scarce professional resources including clinical psychology services. The additional cognitive behavioural therapy training provided for nursing and occupational therapy staff meant that psychologists’ time could be freed up for more complex issues.

| **Key Issues** | More resources needed to be assigned to catering for those with less severe needs.

The law was seen as interfering with the flexibility needed to deal with complex co-morbid problems. Substance misuse often prevented people from gaining access to mental health provision, especially residential or inpatient facilities.

The voluntary sector had limited capacity to cope with alcohol-related problems. Different statutory services tended to concentrate on uniform problems which had led to an inefficient and disparate way of dealing with service users. Investment in the non-statutory sector was considered to be essential for the development of specific projects and services that the statutory sector was not able to provide on its own.

| **Planned Developments and Changes** | Although it was recognised that services needed to adapt and provide more appropriate support and interventions, the real issue was that of meeting current structural and organisational requirements and recommendations. It was proposed that growth and change should be organic and emergent rather than being superimposed.

Co-terminous partnerships between health, social care and the non-statutory sectors were helping to deliver more integrated working. Although this development was welcome, doubt was expressed on the extent to which specialist services catering across local authority boundaries could interface with localised general services. |
Table 5 North East Glasgow

<table>
<thead>
<tr>
<th>Co-morbidity Service Provision</th>
<th>NORTH EAST GLASGOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontline service provision was provided by:</td>
<td><strong>Community Addiction Teams</strong> (CATs), 9 new specialist teams bringing health and social work staff together and linking with education and employment services. They assessed the needs of patients with drug and alcohol problems and provided a range of individualised managed system of care and treatment programmes. They acted as the principal referrers to residential and hospital services and operated a single shared assessment scheme ensuring that both mental health and substance misuse issues were dealt with appropriately.</td>
</tr>
<tr>
<td>The <strong>Homeless Addiction Team</strong> (HAT) was a specialist team for homeless service users.</td>
<td></td>
</tr>
<tr>
<td>The <strong>Drug Crisis Centre</strong> consulted and involved the service user and worked in partnership with the Social Work Department, the Housing Department, Greater Glasgow Health Board and with the voluntary sector housing and drug services.</td>
<td></td>
</tr>
<tr>
<td>The independent sector largely addressed the needs of those presenting with less severe problems and those who found themselves in a crisis situation. It was substantially involved with the statutory sector in providing services to those with mental health and substance misuse issues and the homeless.</td>
<td></td>
</tr>
<tr>
<td>Key Issues</td>
<td>Service users tended to be passed between services and inter-agency working did not always function efficiently.</td>
</tr>
<tr>
<td></td>
<td>The current Tier four service in Glasgow was not well enough developed to handle complex problems.</td>
</tr>
<tr>
<td></td>
<td>There was an urgent requirement for liaison psychiatry for patients with drug and alcohol addictions to be provided on all acute hospital sites.</td>
</tr>
<tr>
<td></td>
<td>The independent sector needed to be more actively involved in strategic planning and activities.</td>
</tr>
<tr>
<td></td>
<td>Financial constraints were seen as a potential barrier to appropriate service provision.</td>
</tr>
<tr>
<td>Planned Developments and Changes</td>
<td>A complete medical service review was being undertaken to provide a comprehensive needs assessment for Greater Glasgow.</td>
</tr>
<tr>
<td></td>
<td>A key priority for Glasgow was to increase skills training and employability for everyone, particularly for the socially disadvantaged and the unemployed. Equal Access Teams were based in all 9 of the local authority’s sectors to offer direct support and guidance. These initiatives would benefit co-morbid service users.</td>
</tr>
</tbody>
</table>
Co-morbidity Service Provision

Care pathways in Aberdeen were often designed and managed by community psychiatric nurses (CPNs) who drew on other providers, including the voluntary sector, to complete a comprehensive care package with relevancy over time. Receiving funding for a care package was dependent on a certain level of inter-agency cooperation.

Mental health services were the primary providers for complex problems involving psychological and psychiatric difficulties. This had resulted in mental health leading on addiction provision.

Aberdeen’s Joint Alcohol and Addiction Team had made the development of integration of services to drug users a strategic priority. This service combined the expertise of key voluntary sector organisations to provide a comprehensive package of support to drug users. There were some perceived inconsistencies between proposed strategy and reality on the ground because the service was funded by the Scottish Executive’s New Opportunities Fund. The challenge was to join up services horizontally as well as implement corporate plans from above.

Key Issues

Grampian’s rural nature made the delivery and integration of certain services demanding, particularly services to prison inmates.

Carer support was identified as a gap in service provision. Specific examples included children who informally care for one or both of their parents with either a substance misuse or mental health problem(s) or both.

Inpatient facilities were viewed in need of revision with specific reference to the co-morbid service user. There was a perceived over-concentration on the diagnosed mental health issue to the exclusion of addressing other needs, including issues associated with the person’s substance misuse.

Planned Developments and Changes

Work to increase user involvement was on-going, though still in need of attention. The current focus was on substance misusers rather than on individuals with mental health problems or a combination of the former and latter.
<table>
<thead>
<tr>
<th><strong>Table 7 Forth Valley</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Co-morbidity Service Provision</strong></th>
<th>FORTH VALLEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Despite the existence of new referral protocols and the collation of epidemiological and demographic data, current collaborative and integrative efforts remained inadequate to deal effectively with co-morbid individuals.</td>
<td></td>
</tr>
<tr>
<td>There was an expressed need for service role clarity regarding responsibilities and boundaries. Coterminal access points were seen to give proximity between services and provided a starting block for them to work together more effectively.</td>
<td></td>
</tr>
<tr>
<td>Key providers from the independent sector, particularly in substance misuse, had helped to develop partnership working between the statutory and non-statutory sectors. The non-statutory sector was able to offer a more flexible approach, provide a more holistic care package and address more generic issues since they were less constrained by professional boundaries.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key Issues</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Although partnership working was viewed positively, there were still outstanding cultural and attitudinal barriers, which were not helped by current financial strictures on health budgets.</td>
<td></td>
</tr>
<tr>
<td>Prioritisation had resulted in the diminution of substance misuse and mental health services, because these services were not ranked highly among service providers.</td>
<td></td>
</tr>
<tr>
<td>Traditional ways of working coupled with a lack of knowledge regarding co-morbid mental health and substance misuse issues further constrained the degree to which people receive or are referred to appropriate services.</td>
<td></td>
</tr>
<tr>
<td>The statutory and non-statutory sectors found working together challenging, especially when it involved sharing of budgets or contributions from different budgets. This was highlighted as a significant barrier to working out an appropriate strategy that actually targeted people’s needs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Planned Developments and Changes</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioners in Forth Valley had explored the idea of developing a specialist service for co-morbid service users but concluded that such a service might be too restrictive in its eligibility criteria to provide effectively for this group of people. Ineffective management was cited as a potential barrier to providing appropriate and consistent service delivery.</td>
<td></td>
</tr>
<tr>
<td>Utilising the Unified NHS Board with people from the local authority on board along with the Joint Futures agenda was suggested as a possible pathway to dealing with co-morbidity in a pragmatic and systematic fashion.</td>
<td></td>
</tr>
</tbody>
</table>
Common views on issues relating to co-morbid mental health and substance misuse

Commissioners were in broad agreement on a number of topics relating to:

- the management of co-morbid service users
- user consultation and involvement
- ways of improving integration of services and delivery of care.

Integrated versus specialist service provision

This section discusses the relative merits of integrated care and specialist service provision, outlining commissioners’ views on their respective usefulness and feasibility.

Partnership working has been described in several ways:

- **Partnership work:** organisations with “differing goals and traditions, linking to work together” (Home Office, 1992)

- **Joint working:** [drug] services developing working relationships with other drug-related organisations or services to “help establish the broadest range of seamless service delivery” (NTA, 2002)

- **Shared care:** the joint participation of specialists and primary care, especially GPs and pharmacists, in the planned delivery of care for patients with a drug misuse problem, “informed by an enhanced information exchange beyond routine discharge and referral letters” (Department of Health, 1995)

- **Integrated care:** an approach that “seeks to combine and co-ordinate all the services required to meet the assessed needs of the individual” (Effective Interventions Unit, 2002).

Drake et al. (2000) support integrated treatment or integrated care pathways as set out in *Dual Diagnosis Good Practice Guide* (Department of Health, 2002) rather than parallel or consecutive approaches. Integrated treatments are based on the notion that a single tailored programme caters for both mental health and substance misuse issues by the same specialist clinicians.

Supporting integration

Integration as a concept, at the very least at a structural level, was viewed by the majority of commissioners as essential to effective and efficient service delivery, not only to co-morbid service users but to all service users with complex needs. Some commissioners spoke of the difficulty in overcoming the unintentional barriers, titles and terms created when attempting to develop sound team work.

Others explored the idea that sharing budgets on a needs-led and consumer-focused basis might lead to lowered conflict between services that currently have very different remits and might ring-fence resources to satisfy those responsibilities.

Interviews also highlighted the lack of an evidence-base relating to how a joined-up multi-disciplinary work force might be created. Current guidance was not viewed as sufficiently informative to answer this question adequately. Several commissioners seemed unsure about what an integrated service might look like. The expressed opinion was that the outcome of any service configuration should result in a complete package of
care and support at the user’s level and that it might not be necessary to have a truly integrated service to enable that to happen.

Although there were examples of effective collaboration and good partnership working between different service sectors and agencies, the arrangements could be much improved. The commissioners felt that integrated services would be admirable as long as the service user and his or her main needs remained the focus but queried how this might be achieved. This aspiration reflected the principles set out in Our National Health and Partnership for Care of putting the patient at the centre. They sought a better understanding of the underlying antecedents that brought co-morbid service users to the point where specialist service involvement was necessary.

**Querying integration**

A note of caution was expressed by commissioners who understood ‘integrated’ as ‘holistic’ care with all services coming together to address pertinent and wider needs. One commissioner raised the possibility that such an approach might have the unintended consequence of service users falling through the net because of a perceived threat to their daily life, such as the fear of child protection involvement. This showed a lack of awareness of the availability of published guidance and advice on Integrated Care Pathways and Managed Care Networks.

Other views centred on the notion that a ‘one size fits all’ approach would be unlikely to favour all service users and might be unsuitable in certain areas, resulting in either limited benefits or no benefits at all. Commissioners with a wide remit of services were concerned about the complexity of integrated service provision and the potential for chaos and confusion as opposed to smooth and seamless functioning.

**Supporting specialist provision**

Only one commissioner viewed a specialist service positively. Most commissioners preferred to focus on developing current services rather than create new ones and risk further divisions across the services. Funding restrictions were likely to be a significant barrier in creating effective care pathways and joined-up planning and practice.

**Querying specialist provision**

The majority of commissioners were not in favour of a specialist co-morbidity service for a variety of reasons. Those in rural localities felt there was no demand for a specialist service, in spite of the need for service improvement and possible reconfiguration. Their preferred approach was to address need via existing services by enhancing levels of inter-agency working.

Many commissioners felt that the creation of a specialist service was potentially risky. It could become remote from more mainstream services, resulting in a ‘dumping ground’ for ‘difficult’ service users and creating an overall less skilled and knowledgeable staff base. This view was also expressed by providers in Chapter 4 of this report.

The isolation could also result in little movement between services and service sectors and create lengthier waiting lists due to case overload.

The consensus was that co-morbid service users would be better served by increased joint planning and working rather than by specialist services focusing on co-morbidity.
User consultation and involvement

The NHS in Scotland has a statutory duty to involve service users, but users and professionals have experienced problems in interpreting this and putting it into practice. In recognition of this NHS Boards are therefore required to have a Designated Director for Patient Focus and Public Involvement (PFPI) with responsibility for supporting and coordinating this work across the organisation. Boards are expected to develop a variety of approaches to meet the requirements of specific groups of service users. In this context it is worth noting that in 2004 the National Institute for Mental Health in England (NIMHE) commissioned the Health and Social Care Advisory Service to consult with service users, carers and other stakeholders to establish what the main issues were and how service user involvement might be improved. Their conclusions centred on the importance of reaching out to diverse communities and groups, involving users more informally rather than formally at meetings, making routes to involvement more equitable, and monitoring and evaluating these strategies in terms of good practice.

Advocating involvement

The majority of commissioners and service providers in both the statutory and non-statutory sectors agreed that routine consultation with service users (and carers) was important, even if some of that consultation was tokenistic in gesture.

Issues highlighted by those with experience of widening the scope of consultation and involvement included how to approach service users linguistically at a level comprehensible to them without being condescending or demeaning.

Perceived challenges

The commissioners emphasised the importance of mutual respect and understanding. Some questioned the belief that the views of service users were inevitably sacrosanct and better-qualified than those of providers.

During the interviews, it became clear that a key factor in involving users was the need to ensure that this involvement was real, meaningful and representative. The overriding concern was that user consultation and involvement was not adequately supported. There was little or no training given on how to approach users, no clear brief on their roles and little thought given to incentives for their involvement.

The ideal and the reality of user involvement were thus frequently viewed to be at odds. Rising expectations among users, an inability of many organisations to understand user involvement and tokenistic implementation of user consultation was viewed by many to lead to frustration, mistrust and a questioning of the basis of its foundation.

Despite an overall consensus regarding the challenges of engaging service users there was also overarching agreement that their experiences and perceptions were as important as those emanating from the service sector.

In an ideal world

Toward the end of the interviews, all commissioners were asked to imagine an ideal world in the context of co-morbid mental health and substance misuse. Many responses centred on current recommendations (e.g. Models of care, NTA 2002) and emphasised the importance of providing treatment through integrated care pathways across all four treatment tiers that were as seamless as possible. Joint commissioning and robust
service level agreements were viewed as essential to enhance seamlessness and counter unnecessary duplication of services.

Commissioners essentially concentrated on three core areas for improvement to allow integrated care pathways to come to fruition. These included a holistic or person-centred approach to treatment, improved access and the need for wholesale change in cultural values and attitudes toward mental health and substance misuse.

The Care Programme Approach, advocated here, promotes a level of integrated practice and takes a holistic approach to treatment, care and support. A key element of this 'whole system' approach is effective care co-ordination for individuals with complex needs. Links need to be made across social work or care services, health, education and employment, housing, criminal justice and voluntary agencies to facilitate access for individuals to the range of services required to meet their needs.

Accessibility of services is a key element of integrated care. Improved pathways to access also mean that service users should be able to engage with a range of services depending on need and different services over time as their needs change. The responses of commissioners suggested that this was not currently happening but that that it was an ideal to strive for.

A cultural shift in attitudes toward people with mental health and substance misuse issues presented possibly the greatest problem. Unhelpful and pessimistic attitudes towards substance misusers were noted elsewhere in the Effective Intervention Unit publication *Rural and Remote Areas: Effective Approaches to Delivering Integrated Care for Drug Users* (2004). Increased joint-training was advocated as a possible solution in overcoming these barriers.

**Person-centred and needs-led**

The complexity of co-morbid mental health and substance misuse made it difficult to treat. This was compounded by the continued debate surrounding the aetiology of co-morbid manifestations. One of the commissioners’ main aspirations was to align need and provision. This would need a much better knowledge and understanding of the causes of different co-morbidities.

Interviewed commissioners from rural areas particularly emphasised the need for improved localised interventions and support structures so that people could reside in and benefit from their own known environment and cultural norms rather than having to travel to the major towns and cities.

**Simplified and easy access**

Commissioners were unanimous in advocating easier and simpler access to treatment and support provisions. This ideally would involve the removal of barriers such as opening times as these were seen to lead to a lack of engagement and non-attendance. In addition commissioners felt that organisational arrangements should be flexible enough to offer a service that was as person-centred as possible.
The view was that traditional cultures continued to prevent individuals with dual mental health and substance misuse problems from accessing psychiatric care.

Although it was acknowledged that there were ongoing debates about who should take ownership of co-morbid individuals, this was not necessarily seen as affecting the service user’s right to support and treatment.

The overall observation regarding points of access was that engagement should occur proactively at varying levels. GP-led services, for example, tended to focus on early intervention and prevention. By the time services were accessed via the criminal justice system, the problems were more complex and corresponding needs were greater, making engagement more difficult. Commissioners highlighted the advantages of a single point of entry with all the necessary staffing to meet the service user’s requirements.

In rural locations, geography, poor transport links, planning and awkward appointment times were all thought to militate against timely access. Service users with complex problems needed additional support to attend appointments and this had to be made as straightforward and realistic as possible.

The nature of co-morbid mental health and substance misuse issues could also create barriers to access. Co-morbid service users often displayed fractious behaviours that were difficult to manage, leading to services or individual staff members being reluctant and apprehensive to deal with them.

The needs of many service users could be met at the primary care stage. The new General Medical Service contract, however, has given GPs the possibility of opting out of dealing with substance misusers. This had resulted in certain specialist services being over-stretched. The lack of a specialist prescribing service discouraged many service users from seeking treatment, as they had to rely on these same GPs.

Access to care and treatment was often only gained at crisis point, leaving a gap in service provision for those service users with less severe or mild to moderate problems.

**Cultural and attitudinal change**

The issue of stigma was another phenomenon frequently alluded to during interviews with commissioners. Either imagined or real prejudice might have the effect of turning people away from seeking advice, support and treatment. An equitable and respectful approach was needed to encourage engagement and disclosure.

There was also a call for more acceptance and understanding of co-morbid issues and a realisation that these complex needs required team working across agencies and sectors.

Information sharing and cross-fertilisation of ideas across Scotland were viewed as important to avoid duplication of effort, helping to discover what actually worked and contributing to an evidence base.

All commissioners stressed that wholesale changes in the way providers and society in general viewed co-morbid mental health and substance misuse issues were essential to create an ideal world for service users and their families.

“I wouldn’t have any stigma or discrimination against people. We need to ensure that people are treated fairly and respected well.”
Summary

The commissioners taking part in the research study were drawn from locations with a wide range of demographic profiles, demands and needs. Although there was considerable overlap between the types of services offered in these areas, the nature of the services and working styles differed considerably. It was not clear to what extent this reflected local service user needs, other requirements or historically grounded ways of working.

There were few co-morbidity-specific provisions in any of the locations; the one that did exist was viewed by the relevant commissioners to be effective only to a minority of service users, because of the strict access criteria, staffing and lack of sound interagency working. It was noteworthy that this view was not echoed either by participating providers or by service users.

Ownership

Commissioner views differed about who should have majority ownership of co-morbid service users. To ensure consistency in care, many commissioners supported the current stipulation that generic mental health should maintain key worker responsibility for an episode of care for clients with co-morbidity or a primary diagnosis of a mental health problem. It was also felt that this arrangement should be complemented by facilitated access to specialist services. This would support generic mental health services more effectively.

Others were sceptical about the value of maintaining consistency where this hindered appropriate service provision. The expressed view was that ideally key responsibility should be dependent on the service user’s needs and should be aligned accordingly. Ownership would then become a collective issue and would help change entrenched cultures and barriers and engender an alternative culture and more positive attitudes toward co-morbid service users.

Clear pathways for co-morbid individuals

Joint policies and shared assessment protocols were widespread although not practised in all the localities. Gaps between national directives and local need and ability to implement the recommendations were highlighted by a number of commissioners.

The support for interagency and joint working was moderated by a degree of scepticism and concern that a policy preoccupation with a ‘quick fix’ had driven the debate. The gap between policy recommendations and local reality was viewed as difficult. It was recognised that assisting recovery for people with co-morbid mental health and substance misuse issues would be a long and often frustrating experience for the service user and their families and for service providers.

Most commissioners did not support a new or separate service for co-morbid service users but did accept the existence of staff with specialist knowledge based within provider services. In rural areas, this lack of support could be attributed to low demand and limited resources. In other areas, it was thought that vast numbers of people with complex needs might present and this would be difficult to manage efficiently. The knowledge and ability to deal with this service group should be available from all services as a matter of course.

Increased involvement of non-statutory sector

Commissioners expressed concern about the underdevelopment of the non-statutory sector. They felt that increased and effective engagement with the non-statutory
services would help to ease some of the pressures experienced in the statutory sector. This issue was compounded by the lack of comprehensive lists of services available and limited awareness of the nature and scope of those services.

**Increased emphasis on prevention and early intervention**

With notable exceptions, the study found that most research locations did not have established protocols and practices addressing prevention, early intervention or focus on recovery. This had implications for training and education of staff, especially staff in generic services that were most likely to come into contact with people when problems were still emerging.

**Crisis and out of hours access**

The service mapping exercise pointed to inadequate out-of-hours access in crisis situations. Coupled with this, commissioners suggested a need for all services within the respective localities to explain what they do, why they work in a particular way, their referral criteria and what to expect from their involvement. This would offer service users and providers a wider choice when support from the mainstream services was not available. It would also help identify service gaps and indicate the best ways to provide crisis support.

**Consultation versus involvement**

The barriers to effective consultation and involvement were thought to be underpinned by historic views resistant to the inclusion of substance misusers as stakeholders. These barriers were intrinsic to the nature of many services and centred around professionalism and power imbalances. One school of thought adopted a tokenistic response, and adhered to the philosophy of filing returns. Another tried to make a real difference in relationships by learning how to engage and empower service users effectively and equitably.

**Professional training**

Commissioners felt that training for mainstream service staff should be introduced to produce specialist co-morbidity workers and increased awareness among all practitioners working with combined aspects of mental health and substance misuse. This included staff in the statutory and non-statutory sectors. The identification of core competencies needed to be clarified in order to develop the right quality of training for the right level of practitioners.

**Potential challenges**

Analysis of the collective views of commissioners has shown where service provision could potentially fail. The list below identifies stages and service gap points where there is a risk that service users could fall by the wayside.

1. **Generic services** appeared to be ill-equipped to identify at risk or vulnerable people. This could prevent them from applying preventative measures or referring these people appropriately at an early stage to prevent escalation of any presenting problems. A lack of focus on prevention and timely intervention could lead to minor problems going undetected and service users falling through the gaps.

2. **Varied assessment time frames and lengthy waiting times** following the recognition of a service user in need could contribute to prolonged distress and the potential for drop-out.
3. At the point of assessment, many mainstream mental health and substance misuse services had continued to screen out on the basis of substance misuse in mental health and mental health in substance misuse. Such territorialism was felt to fail the person-centred approach currently advocated.

4. While some localities had systems in place to pick up those with less severe problems, others relied informally on the non-statutory sector. An over-concentration on severe and enduring problems was seen to highlight the need for preventative actions and timely intervention.

5. The non-statutory sector was seen as under-developed in many regions and was unable to fill service gaps or cope with unmet needs.

6. At the point when service providers were assessed and provided with intervention and support options, individual care plans – the ideal option - were often not put in place.

7. With some exceptions, crisis services and out of hours services were restricted across all localities, with service users having nowhere to turn. As service users often only came to the attention of providers during crisis situations, this had significant service planning implications.

8. Support for informal carers was not well developed in many areas and this compounded the stressors associated with co-morbid problems.
Chapter 4:  Service Provider Perspectives on Co-morbid Mental Health and Substance Misuse

Introduction

This chapter examines the priorities, practices and challenges for service providers in relation to co-morbid mental health and substance misuse. Researchers carried out a series of focus groups with a cross-section of service providers from the seven research localities. The aim of this exercise was to help draw up a contextualised, summative account of the nature of current practice and service provision for co-morbid mental health and substance misuse in Scotland.

Two case vignettes associated with mental health and substance misuse issues were given to each focus group. The vignettes were used to:

- explore actions in context
- let participants define the situation in their own terms
- provide a less personal and less threatening way of exploring potentially challenging topics in a group environment.

The focus groups were organised around topics such as practice and policy, access and assessment, intervention and organisational facets. A summary of the focus groups’ discussions follows each vignette.

Vignette 1: ‘Gordon’

Gordon, a 40-year old white male was initially diagnosed with drug induced psychoses in his early teens, following extensive cannabis misuse. At the age of 21, he was diagnosed with schizophrenia and he refuses to give up smoking cannabis as he ‘likes the voices’ he can hear when he smokes. This is proving to be problematic as he has been neither stable nor clean for a sufficient length of time to establish whether he has underlying mental health problems or whether these are a consequence of his extensive drug misuse. Gordon does not receive much support from his family who are tired of his smoking habits and aggressive behaviour, and think he is doing little to help himself. His uncle gives him some support and a place to live but on the occasions when he cannot cope with his nephew, Gordon is usually hospitalised. Currently he is being treated with Sulpiride and has been hospitalised on several occasions. When he is discharged, however, he stops taking his medication and returns to cannabis use in order to induce the auditory hallucinations he craves. His non-compliance also leads to an attitude problem with the nursing staff who view him as uncooperative and unwilling to help himself.

Summary: ‘Gordon’

The majority of the participants focused on the immediacy of the situation and pointed out the possibility of incorrect hospitalisation. They also discussed the need for alternative contributions, such as anger management or cognitive techniques including motivational interviewing, and the need to have a long-term perspective of the case.

All focus groups were concerned about the diagnosis and some questioned whether the psychoses were actually drug-induced. This issue was considered important because

3 Sulpiride is an antipsychotic medication used for the treatment of schizophrenia.
inappropriate prescriptions could have extremely bad effects especially when taken with other non-prescribed substances. It was also thought that this could partly explain the reason for Gordon's non-compliance with his medication.

Service providers were aware of many pressing accommodation issues which went some way to explain the apparent lack of focus on the needs of Gordon's family in the case study.

Many focus groups expressed concern that a difficult situation had to become a crisis before appropriate support was provided. They examined the possibility of other requirements and asked whether other services had been involved in the past.

This led to discussions regarding a more holistic approach and identifying wider psycho-social issues that might be affecting Gordon. Services that were considered important for inclusion in Gordon's care plan included occupational therapy, community psychiatric nursing, specialist psychiatrist input, voluntary day and residential services. This showed that interagency working was high on the participants' agenda, in principle, if not in practice.

The focus groups suggested that statutory substance misuse services would not engage with Gordon because cannabis use was not seen as a priority. They also agreed that service provision would depend more on Gordon's effect on others rather than on his own requirements.

Many thought it was important to establish Gordon's views on his own goals and ways of reaching them. This focus on self-determination could be part of a method to engage and motivate Gordon into treatment compliance.

More specialist services concentrated on long-term goals. They emphasised the importance of ongoing consistent support and in particular the need for support that went beyond crisis management.

The creation of a support network was believed to be vital in helping Gordon to gain independence and control over his life. Striving for stability was a common theme running throughout the discussions.

Family stability in particular was considered fundamental for Gordon's successful rehabilitation. The focus groups were ambivalent regarding the long-term need for Gordon to be housed elsewhere and the overriding consensus was that this decision depended on the outcome of family meetings and negotiations. The support needs of the family were clearly recognised.

Most participants thought that a multi-agency meeting leading to inter-agency co-ordination would constitute the most obvious initial step toward better care but in reality felt that this was unlikely to happen. They all approved of taking a holistic approach to Gordon's care but were concerned that this practice was not in general use.

Stabilising Gordon, both in regard to his medication and in his cannabis consumption, was thought to be most appropriate move toward a much needed harm reduction strategy.

Other goals identified included the introduction of an advocate to help Gordon with practical issues and find accommodation. Overall, participants recognised that suggesting small bite-size goals to Gordon would be more beneficial than trying to get him to engage in longer-term commitments.
Low motivation and the failure to perceive substance misuse as a significant problem to his health might preclude Gordon from service provision. The focus groups acknowledged that while in principle the development and maintenance of a therapeutic alliance between worker and service user could strengthen a service user's motivation to change, in practice engagement would in all likelihood be halted because of apparent non-compliance and a lack of motivation. This, coupled with lengthy waiting times, was seen as compounding the problem of receiving appropriate and effective service input.

Discussions in many focus groups touched on the issue of staff attitudes and how these might affect entry to treatment. They agreed that Gordon was the type of case that could slip through the net, and few people held out much hope for change.

Throughout the discussions, participants emphasised the need for joined-up working and the identification of a key worker to reduce the number of services who may be involved with someone who already had a chaotic lifestyle.

Vignette 2: ‘Joanna’

Joanna is a 31-year old black female who lives alone and is unemployed. She doesn’t like the flat she currently lives in as she was sexually abused here, but as yet hasn’t been able to find alternative accommodation. She suffers from depression and uses alcohol to blot out reality. Previously she has lain across the railway line at the local station, distressing onlookers but with no intention of killing herself. Joanna wants to change but she feels like she doesn’t have the ability to initiate the change. Her family are supportive of her although they do find it difficult to deal with her drinking habits; alcohol abuse is her biggest problem, which has led to serious liver damage. In the past, Joanna has had some psychological treatment and has had contact with voluntary services but she finds it difficult to engage with others; she is quiet and guarded, has the potential to be violent, and staff find it difficult to work with her. Currently she is taking diazepam, thiamine and haloperidol.

Summary: ‘Joanna’

There was general agreement that Joanna presented as a complex case with many needs. The focus groups acknowledged that dealing with her problems would not be a simple process, either for her or the services she was likely to engage with.

Many queried the possible reasons for Joanna’s extensive alcohol use, and some suggested that she might be using alcohol as a coping mechanism for an underlying problem, such as the sexual abuse she had experienced. All agreed that it would be difficult to unravel Joanna’s problems. It would be particularly hard to determine whether the depression was purely alcohol-related or a separate mental health problem.

All focus groups were concerned about Joanna’s willingness but inability to change. Less specialised services tended to focus on aspects of Joanna’s personality, such as low self-esteem and feelings of insecurity, as a possible explanation for her reluctance or inability to engage with services. In contrast, the more specialist services considered that limitations on Joanna’s intellectual capacity to engage with services and understand the processes were the consequences of her extensive alcohol abuse. External demographic factors, such as her occupation and early life experiences, had also played a part.

A number of participants highlighted the importance of identifying the most appropriate services at each point along Joanna’s care pathway. Given the complexity of her case, they felt this would be a struggle. Many commented that the timing of service involvement was more important than the actual services that were provided.
Participants focused heavily on the consequences of extensive alcohol abuse on Joanna’s physical health. All agreed that the severity of her alcohol problem had a major impact on her physical well-being as well as her mental health, and that this should be a priority issue for her (and services) to address.

Similarly, all participants agreed that Joanna’s ‘cry for help’ or attempted suicide would be another personal issue in need of attention.

Given the complexity of Joanna’s case and corresponding complex needs, most participants suggested that their service would probably be involved with Joanna’s treatment. They recommended joint working with other services across both statutory and voluntary sectors that would address Joanna’s needs concurrently rather than consecutively. In reality, they admitted that this would be unlikely to happen.

The inadequacy of service provision for cases like Joanna was highlighted along with the evident lack of available specialist knowledge. Other issues raised as sources of concern included the limited availability of ethnocentric services, lengthy waiting lists for specialist services and a general reluctance to deal with service users who continue to misuse.

Specialist statutory services discussed the importance of inter-agency involvement. The role of non-statutory services within Joanna’s care plan, however, was unclear. Participants felt that the complexity of this case would require specialist input from competent, trained addictions staff, and did not think that this would be found within the non-statutory sector.

There were some doubts about multi-agency involvement. Participants thought that Joanna might not be able to cope with a possible service overload and suggested a key worker should be allocated to help her deal with her care package. This approach would help to prevent Joanna from slipping through the service gaps, assist in correctly identifying services and reduce the number of appointments to a more manageable level.

The role of a key worker would also help to encourage rapport-building and allow Joanna to engage equitably with services. As with ‘Gordon’, consistency and continuity of care was viewed as crucial to long-term development and positive change.

Participants agreed that a multi-agency approach for treatment would be most favourable, with the primary aim of stopping Joanna’s continued misuse of alcohol. This was primarily dictated by the obvious physical complications Joanna was currently experiencing. Any mental health problems could then be investigated more specifically at a later stage.

All participants agreed that Joanna’s goals should be made manageable and achievable. Her treatment plan needed to be built in steps, so that any accomplishment she made would help to boost her confidence and self-esteem.

Joanna’s accommodation problems could be solved by re-housing. Engaging an ‘advocate’ could help her with practical issues such as identifying suitable accommodation.

Joanna’s continual alcohol abuse was perceived by all as a major barrier. It was felt that services would either have no contact with her while she drank, considering her too uncooperative and non-compliant, or that they would simply grow tired of her presenting to their service.
Joanna’s ethnicity also raised concerns. The focus groups considered that the lack of resources available for ethnic minorities, coupled with ethnicity per se limiting access to existing services, could prevent her from engaging with any services at all.

Conclusions

- Substance misuse services and mental health services held different philosophies. Substance misuse services would mainly treat those willing to be helped, whereas mental health services would have an obligation to try and treat everyone with a mental disorder.

- The types of problems services dealt with were limited in scope. Representatives of most services saw the need to widen their focus, but it was felt most strongly that substance misuse services needed to deal with mental health issues and mental health services needed to identify and tackle substance misuse.

- Lack of communication between services seemed to be a major perceived problem. Some focus group participants felt that meetings between different services were taking place at too low a level. Other participants believed it was more important for there to be good communication between professionals and services at grassroots level where contact with service users actually took place.

- There was a high level of consensus regarding the issue of training need. Staff training was an issue that arose repeatedly. It was viewed as imperative that mental health professionals should be skilled in dealing with substance misuse and that those working in substances services should have knowledge of mental health. Voluntary service providers and non-specialist workers were also viewed to need training in both areas.

- Mental health and substance problems could not be isolated from other disadvantages and hardships such as homelessness and unemployment. Although there was a degree of liaison, not enough communication took place between substance misuse and mental health agencies, the voluntary sector and other services such as housing, criminal justice, leisure and employment. The question of which service would take overall control remained unresolved.

- It was suggested that relevant non-statutory sector services and mental health and substance misuse community services work together. It was also recommended that workers from relevant specialist agencies be seconded to other, different specialist agencies. Training manuals would also prove extremely useful. These would let staff assess clients at any level of intervention as well as understand the effects of different substances and treatment combinations.

- The large numbers of co-morbid people who had also experienced sexual and/or physical abuse were not adequately catered for. There were not enough psychology and other specialist services and waiting times were lengthy.

- There was strong demand for more assertive outreach teams made up of people from many sectors. It was also pointed out, however, that these teams would require secure support systems when working in the community with what could be an unpredictable client group.

- While holistic care was seen as important in terms of service user treatment gains, continuity of care and access was considered to be crucial. The focus group participants observed that most services do not provide 24-hour access and many do not operate during evenings or weekends. This finding has been noted elsewhere in this report.
• It was generally recognised that only a very small proportion of people with problems with drug dependency or misuse were actually engaged in treatment or self-help groups. Given the magnitude of the untreated population, finding a way to reach these people was vital. Procedures were needed that could reach substance misusers and facilitate their induction into treatment or self-help groups. Outreach efforts might facilitate the direct engagement of a certain number of substance abusers. These would help to make users more aware of what is available and give them hope of recovery.

• Mental health services placed a strong emphasis on medical treatment whereas substance misuse services tended to favour a more psychotherapeutic approach. As entrance to treatment was often based on the level of motivation displayed by the service user, simply combining the two core treatment options might not be sufficient to address co-morbid problems. Motivation would need to be encouraged, possibly through motivational therapy or interviewing.

• Although some co-morbid people were involved with the criminal justice system, there was no link between services and services in prisons to help these people and to continue the support needed following release. Investment in this area might be on grounds of strengthening community safety.

• Wider family needs could often not be addressed, especially in rural areas where few services exist and were sometimes difficult to reach with public transport.

• Although work would not be appropriate for everybody, many people with longstanding experience of mental health problems retained an ambition to do meaningful work. Opportunities for vocational training were lacking.

• There was a wide range of specialist and mainstream services providing support for adults with mental health and substance misuse problems, but these continued to be ineffectively co-ordinated and/or were not configured around the needs of individuals.

### Lessons learned

- Unilateral approaches to the treatment of co-morbidity remain prevalent
- Interagency working and communication is patchy
- Professional philosophies militate against effective collaboration
- Holistic approaches to complex needs are necessary
- Childhood and adolescent trauma is not adequately catered for
- Longer and more frequent opening times are important
- Vocational opportunities for co-morbid individuals should not be disregarded
- Increased outreach services are needed to engage those not attending services
- There are clear training and educational needs in the area of co-morbidity.
Chapter 5: Co-morbid Service Users’ Views on the Provision of Mental Health, Substance Misuse and other Support Services

User involvement and consultation play an essential part in developing high quality substance misuse and mental health service and treatment provisions at national and local levels. It is high on the Government’s agenda and commissioners and service providers are now encouraging greater user participation in service developments. This good practice has resulted in an increase in both user representation groups and user involvement posts.

In this part of the project, service users were asked for their views on a number of topics and issues related to the provision of treatment and support for co-morbid mental health and substance misuse problems. A semi-structured interview helped to explore their “lived experience” of their journey through substance misuse and mental health services, covering topics such as relationships with staff, helpful and unhelpful aspects of service contacts and possible areas for improvement. The information collected was able to give a valuable service user perspective, which could lead to informed, evidence-based and effective service provision.

Profile of service user group

Service users were recruited from three different sources including mental health services, substance misuse services and other psychosocial services in both the statutory and the voluntary sector. The profile of those included in the study attempted to reflect the general profile of service users within the seven research locations.

Thirty eight service users, aged from 20 to 57, took part in the study. Thirty were male and eight, female. All were Caucasian and two were non-Scots.

Twelve service users lived on their own, mostly in council accommodation, two lived with their parents, five were in homeless accommodation and five lived with their partner or family. Information about accommodation and living arrangements was unavailable for 14 service users.

Ten service users reported severe [sexual] abuse in childhood or adolescence. Over half spoke of negative childhood experiences and childhood adversity.

Social and familial support

Participants commented on the importance of family contact and support, the part this played in their lives and the isolation felt when social contact was withdrawn. Although several service users were either estranged from their families or had troubled relations with them, some relied on a particular family member for refuge and support and often the mother was cited as the key supporter in their lives. Still others found the pub was a source of social contact, despite knowing that this was unhelpful in the long run. Some service users spoke of their sense of loss when previous friendships with other substance misusers did not survive a change in life-style.

"Loneliness has got a big thing to do with it because if you leave your pub you’re no drinking in a pub any more that was where everything was all happening. So that’s out.”
Service user experiences of service provision and treatment

The experiences of the 38 co-morbid people interviewed for this study were extremely varied and no general conclusions could be drawn. Each individual had sought help from a range of mental health, drug/alcohol and allied services for an array of needs, and their reports of these contacts reflected this disparate approach.

Only one service user described being supported by a specialist co-morbidity service. Co-ordinated service delivery, however, was benefiting several service users, and one service user had accessed a non-specialist service developed for homeless individuals with either or both mental health and substance misuse problems.

The remainder of this chapter examines individual service user experiences and perceptions, grouping them under positive experiences and negative experiences. It reports on the wider implications for one service user’s family and summarises comments made about service provision in prison environments.

Table 8 Service users’ positive comments

<table>
<thead>
<tr>
<th>Helpful experiences of services</th>
<th>Type of facility</th>
<th>User comments</th>
</tr>
</thead>
</table>
| In-patient facility            | Tayside         | This offered opportunity to detox with others in similar situation with help and support from specialist staff. It was willing to readmit after relapses.  
   (Tayside)                     |                 | “The 19 day programme took you away from your drink for a while and you got medicated so that you didnae get withdrawal symptoms so that by the time you left you were clear of alcohol and it was just up to you whether you carried on or no. There were groups you could go to after as well.” |
| Self-help group environment    | Tayside         | The contact with other people in similar situations with similar problems helped to lessen the sense of isolation.  
   environment (Tayside)         |                 | |
| Specialist project             | Edinburgh       | The residential detoxification programme offered was appreciated, particularly the administration of methadone. Staff acted in a straightforward and open manner, allaying the service user’s anxieties sufficiently to allow him to feel safe. Ex-user involvement and the knowledge that staff had first-hand experience and knowledge of mental health and substance misuse complications helped this process. Although this project required new service users to undergo a community care assessment prior to admission, this was not seen to be a problem.  
   (Edinburgh)                  |                 | |
| Specialist GP with knowledge   | Fife            | “She had faith in me and she trusted me and it was the first time a doctor had ever given me trust and we worked together.”  
   of substance misuse and mental health issues |                 | |
| Acute adult inpatient facility | Borders         | Staff were responsive in finding a bed as and when needed in crisis situations and provided a positive and non-judgemental stance.  
   facility (Borders)            |                 | |
### Helpful experiences of services

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>User comments</th>
</tr>
</thead>
</table>
| Specialist facility (Borders) | This facility provided a flexible, person-centred and proactive approach that made the service user feel valued and respected. It offered the opportunity to access alternative and complementary therapies and undertake activities with family members.  

“I would say that (this project) is probably the best thing that’s happened to me in a long time. They listen tae ye. If you’ve missed an appointment they will phone you up and ask us up. You get a sense that they care mair aboot ye there. Now I’m gang doon there three times a week to get the Reiki and acupuncture.” |
| Multidisciplinary service providing co-ordinated help for people at risk, specifically addressing both mental health and substance misuse (Glasgow) | This was highly regarded by one service user. He particularly appreciated their persistence and perseverance in trying to engage with him, their proactive stance and the way in which the providers installed a sense of self-worth. Consistently good levels of communication helped different service providers to work well together.  

“I think the co-morbidity team is the best because they get a hold o’ ye and keep pursuing ye until they get ye. Some days I don’t come but they’re persistent tae get a hold o’ ye and they go looking for ye.”  

A second service user also praised this service, which provided him with counselling and a counsellor. The doctor was easy to access, the key worker was supportive and put him at his ease, and the Service team worked collaboratively with him to organise his care plan. Communication between his key worker, counsellor and doctor was good. He felt he was being listened to and could provide active input into his care plan. It included rapid referral and access to a psychologist. When released from prison, he was quickly picked up by the service and rapidly started on treatment. |
| Residential rehabilitation service (Glasgow) | One service user spoke of positive experiences of group work with the alcohol and addictions team. He also saw a counsellor twice a week. The service had stuck by him until he was developmentally ready to deal with his personal and substance misuse issues. He appreciated the provided activities programme and found it helpful to mix with others in the same boat as it helped him to feel he was not alone. He also valued practical expertise and guidance and being involved in goal planning. This service also referred him to other groups and services for more help with unmet needs.  

Other positive comments received concerned the way service users were consulted and engaged in their care planning. A particular bonus was the involvement of ex-substance users in the service who could empathise with service users. An additional benefit was the ability to speak to people and experience some structure to the day. This service was not available at weekends and was missed. |
### Helpful experiences of services

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>User comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(cont.)</td>
<td>&quot;I find the weekends difficult because there’s no structure during the weekends. I get the Friday feeling on a Monday because I know that I can be kept busy. I think if you get one person that's really wanting to change that’s gonna have an effect on others because you always need that one showing that there can be life without alcohol or drugs. A lot of the workers are ex addicts as well so that helps me personally because it’s good to talk to somebody that knows how utterly horrendous and horrific it is to be in the complete grips of alcohol or drugs.”</td>
</tr>
<tr>
<td>Project combining expertise of key voluntary sector organisations (Aberdeen)</td>
<td>One service user appreciated the wide range of support and help this service provided. Support included accompanying him to a doctor's surgery and providing transport. It also included practical help with paperwork. He enjoyed the massages provided and no longer begged as the project had provided him with accommodation and helped him obtain a methadone script. It had given him hope for a better life.</td>
</tr>
<tr>
<td>Inter-agency working (Forth Valley)</td>
<td>Services were seen to inter-link well, with good communication between different support groups. One service user had been involved with the development of support groups and had helped to set up an organisation for people to come and discuss their needs and wishes and to benefit from advice and direction by ex-users. Good inter-agency working had helped one service user obtain the help she needed without a long wait. Another appreciated the highly flexible nature of this service and the ability to access a worker as and when needed. She had felt that her input to her own care was valued and had allowed for a degree of self-determination.</td>
</tr>
<tr>
<td>Project to help recovering substance users move toward reintegration with their community (Forth Valley)</td>
<td>The group environment provided by this service was appreciated as a place of trust where people could talk with confidence about any problem or issue without fear of reprisal or rebuttal. The opportunity to talk to both service providers and other service users was also welcomed. The social activities and outings provided had also been enjoyed by many service users. &quot;I enjoy coming here and usually come about three days a week. I've been canoeing, I've been quad biking. I hated going at first but the help’s been fantastic.”</td>
</tr>
<tr>
<td>Project to support people affected by substance misuse issues mediation (Forth Valley)</td>
<td>This project was viewed by one service user as being particularly good at resolving practical issues and addressing wider needs than simply the diagnosed problems. Staff helped with accommodation issues, clothing and practicalities such as form-filling. The service also welcomed the woman back after relapses, a flexibility greatly appreciated. &quot;They helped me get my flat. They helped me get out the gutter. Being there for me, just talking to me, getting me clothes. I’m dyslexic and any forms I get I come straight here.”</td>
</tr>
</tbody>
</table>
Table 9 Service users’ negative comments

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>User comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General comments – access to services</td>
<td>Long waiting times were a general problem. At one drug problem service facility, a waiting time of up to three years had been reported. Another service user spoke of waiting a year and a half to see a psychiatrist. She received no reminder notification of her appointment and overlooked the date. She subsequently gave up trying to access a psychiatrist.</td>
</tr>
<tr>
<td>General comments – consistency/continuity of care</td>
<td>A service user commented on the lack of consistency and continuity in staff provision which was difficult to cope with. “I got five CPNs in a row. I find it hard enough to trust one person over a long period of time then to be asked to be moved to another person in two weeks, on to another person and then another it’s just impossible.” Another service user described being passed on to five psychiatrists, allocated two social workers and three community psychiatric nurses. This man indicated that he would have benefited from more consistent care.</td>
</tr>
<tr>
<td>General provisions for mental health/substance misuse</td>
<td>Several service users mentioned the lack of joint working between mental health and substance misuse provisions. Some mental health staff were thought to ignore substance misuse problems. One service user described a classical ping-pong effect, already well documented, where mental health providers feel the substance use problem needs to be addressed and addiction service staff turn people away to have their mental health needs attended to.</td>
</tr>
<tr>
<td>Psychiatric inpatient unit (Tayside)</td>
<td>One service user was still affected by his discharge two weeks before the interview took place. While in hospital, he had been stabilised on methadone, but found the levels were brought down too rapidly and to a sub-therapeutic level. He felt he had had no involvement in his own treatment programme, and the antipsychotic prescribed left him feeling ‘dreadful’ due to the many side effects. This service user disliked the medicalised approach and strongly indicated that it left him with a sense that his personal issues and emotional difficulties had not been addressed. He also felt a lack of individual attention which resulted in him feeling like ‘another number in the system’. He also described the environment as too restrictive with not enough daily activities to keep people occupied.</td>
</tr>
</tbody>
</table>
### Limiting experiences of services

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>User comments</th>
</tr>
</thead>
</table>
| Specialist drugs provision, (Fife)       | One service user felt that his relapse after six years of abstinence had been caused by the single-minded approach to his previous addiction, which excluded other issues. He felt the care pathway offered following his relapse was a punishment rather than a support and experienced a sense of betrayal, which added to his vulnerability.  
“I’ve been off heroin for 6 years and they were still on at me every time they seen me. Are you back using heroin? And it got to the point where I didnae like going any more and I did try to kill myself. I tried to take an overdose it didnae work and I was honest with them; I told them that I took heroin for the first time in 6 years and it was like I was being punished for telling the truth. Everything changed from that day on. Instead of once a month I had to see them every week.” |
<p>| Inpatient psychiatric provision (Borders) | Several service users commented on the lack of acute ward beds, especially for detox. One service user described how he had been left to his own devices in a mental health ward and then discharged without a proper assessment or care plan in place.                                                                                                                                                                                                                                    |
| Inpatient psychiatric unit (Edinburgh)   | One service user commented on the weighted representation of female acute psychiatric ward staff. This gender issue was not raised by other service users.                                                                                                                                                                                                                                                                                                    |
| Inpatient acute unit (Glasgow)           | The service user interviewed felt that he had been admitted to the wrong ward. He thought he should be in a psychiatric ward due to his hallucinatory experiences following excessive alcohol consumption. He did not feel the environment or the care received was appropriate for his needs and he perceived the staff as intolerant about his drinking.                                                                                                         |
| Inpatient psychiatric unit (Glasgow)     | The same service user spoke of an earlier experience of detoxification in a mental health ward. While he was clear about his alcohol problem, he felt the precursors to his alcohol use needed addressing and saw his psychological needs as paramount.                                                                                                                                                                                                                                           |
|                                          | “One time I’ve been in for an alcohol detox and I only lasted about 48 hours and signed myself out in the middle of the night because I was left sitting on the end of my bed for 48 hours. I didn’t feel that any one listened and no one really cared anyway so I basically thought I was a pain to the service and signed myself out. I just don’t feel that they’ve looked into why I started drinking in the first place” |</p>
<table>
<thead>
<tr>
<th>Type of facility</th>
<th>User comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient psychiatric unit (Forth Valley)</td>
<td>One service user reported feeling stigmatised and misunderstood during his episode of care. He had been discharged from an acute psychiatric ward for starting a fire. He described being very unwell and confused to the extent that he hadn’t realised what he was doing. He was extremely upset at being discharged in such a state and stated that without a close family friend to hand he would not have known what to do or how to get home.</td>
</tr>
</tbody>
</table>

**Special issues**

**Family provisions**

One male service user spoke of the difficulties associated with bringing up children single-handedly, especially as an ex-substance misuser with mental health problems. The last time he relapsed and was hospitalised, his children were removed from him. It took 10 months to get them back following discharge from an acute psychiatric ward. He never received any follow-up care provision. He also felt strongly that ward staff had little time for him and his personal problems.

**Prison Services**

Three service users reported having had contact with the criminal justice arena. A service user felt positive about his regular contact with probation officers and thought an appropriate maintenance of medication and medical checks was available while in prison.

Other service users reported more negative experiences of prison environments. One service user felt insufficient information and training was provided to help him back into work and thus help him remain crime-free.

Another service user in relation to a non-specified Scottish prison felt service provision provided could be vastly improved with increased information and education about drugs. Having the option of joining a methadone programme was also seen as potentially helpful. This service user also perceived a level of cynicism harboured by mental health professionals working in prisons.

**Summary**

**Positive experiences**

Though effective interagency communication and consultation worked well in some instances and was appreciated by the affected service users, most helpful experiences were reported in relation to supported accommodation and the relationships built with individual providers. These included support workers, community psychiatric nurses and occasionally social workers.
Where this occurred, service users appreciated being consulted and engaged in their care planning. When ex-substance [mis]users form part of the service this was viewed positively. The opportunity simply to talk to people generally and experiencing some structure to the day was perceived to be a particular benefit.

The emerging message appeared to be that providers who were equipped with an appropriate knowledge-base, took time, listened, responded equitably and engaged with the service user, elicited more favourable responses and entries to treatment and care.

**Perceived gaps in services**

Co-morbid service users in many instances experienced received an ad-hoc service response. There was a general lack of awareness concerning available services and routes of access. There were also concerns that the focus was on signs and symptoms rather than looking at needs holistically. The direct involvement of more agency workers with the service user appeared to work well for some but was not necessarily always a better package of care. The lack of dedicated dually trained staff was considered by service users to be hugely problematic.

Service users were particularly critical of mental health services (in particular inpatient facilities) inability to address drugs and alcohol problems alongside presented mental health issues. They related how mental health services did not routinely address drug use. Staff were not interested in it and were therefore not helping service users address the duality of presenting problems.

Related to this complaint, service users also felt excluded from services because of behaviour linked to drinking or drug taking where they actually needed help and support for these behaviours rather than rejection. Some service users were positive about the quality of the help provided by specific individuals within either mental health or substance misuse services.

Other issues of concern related to opening times which did not always coincide with times of need. Service users preferred a more flexible nature of service and the ability to access workers as and when needed.

**Conclusion**

The picture that emerges from these experiences is one of a group of people who struggle daily with the realities of living with co-morbid mental health and substance misuse problems. Although there are some notable exceptions, they have found existing support services often inappropriate and/or inadequate. The lives of these service users are characterised by a sense of loss: loss of ‘normal’ or ordinary everyday life, loss of social networks, including loss of friends and family, loss or inability to obtain employment and loss of financial security.
Lessons learned:

- The complex needs of this group are highlighted by generations of substance misuse and mental health problems within families, poly-substance misuse, homelessness and unemployment.

- Psychological needs in this group are diverse with common themes of severe and enduring mental illness, sexual abuse, domestic violence and low self worth, all of which require skilful intervention.

- The co-morbid condition is a chronic and relapsing one, and service users value perseverance and continuity with their care.

- There is a need for comprehensive care packages that focus on keeping service users maintained in treatment across several agencies. In mental health services, the Care Programme Approach should be strongly considered and in the substance misuse field Models of Care implemented for the difficult group with co-morbid mental illness.

- The service users’ preferred model of care plan development involves collaboration and joint planning.

- The service user group exhibits a high degree of movement between agencies, highlighting the need for fluid communication systems between statutory and non-statutory agencies.

- A variety of services are necessary including detoxification, self help groups, inpatient setting and rehabilitation.

- Rapid access to services is vital.

- Substance misusers often experience the effects of stigmatisation within services.

- Education and training in substance misuse is required for key health professionals i.e. GPs, mental health units and health staff within prisons.
Chapter 6: The Scottish Picture

This chapter gives a summary of the quality and scope of the services delivered in Scotland to people living with severe mental health and substance misuse problems. The interviews conducted with commissioners, providers and service users identified a number of problems and ‘gaps’ in the provision of these services. Although the focus differed, the problem areas identified and the beneficial aspects of service provision were similar across all groups. The chapter examines the research outcomes where appropriate in the context of current policy arrangements and good practice guidelines.

Many of the reported experiences were common to service users, commissioners and providers alike

- Difficulties accessing services
- Difficulties getting timely and appropriate help
- Lack of crisis support
- Inappropriate level of available services
- Lack of continuity of care
- Insufficient access to talking therapies
- Over-reliance on use of medication
- Lack of service user involvement in care plan decision making
- Lack of holistic focus in services
- Need for quality relationships
- Insufficient employment or work opportunities
- Problems with information sharing and confidentiality
- Variability in service quality and expertise (training needs)
- Patchy development of integrated care
- Need for expertise but not necessarily a specialist service
- Gaps in services for minority ethnic communities
- Gaps in services to address antecedents such as childhood trauma
- The impact of ‘double’ stigma
- Lack of information and understanding of co-morbidity by the general public
- Lack of specific services for carers.

This section is divided into several broad themes based on the issues raised in interviews with the three participant groups:

- Accessibility
- Service Quality
- Holistic Care
- Hearing and Listening
- Opportunity
- Involvement
- Support for informal carers
- Stigma
- Training needs.
Accessibility

Encouraging people to seek early help for mental health problems is a key target for the mental health community (Department of Health 1999 – NHS Plan), but service users still faced problems in accessing the screening and assessment process. People with co-morbid mental health and substance misuse issues ran the risk of being turned away from mental health services if seen to have a drug or alcohol habit, and turned away from drug and alcohol services if seen to be involved with mental health services.

People with co-morbid problems faced particular difficulties accessing treatment services and obtaining the help they need in a timely fashion. They experienced long waiting times for services that were sometimes poorly funded and/or co-ordinated and managed. The complexity of co-morbid issues made such problems inherently challenging to manage and treat, yet there were a number of examples of good practice and many instances of good will.

- Raising awareness

Several discussions indicated that efforts to raise awareness of people at risk of poor mental health and/or substance misuse needed to go hand in hand with better signposting of services and sources of support.

Current services tended to focus on a telephone contact point for information and signposting to a range of other providers. The Internet was thought to offer a better source of up-to-date information than directories which needed continual monitoring and updating.

Although advice lines were useful and addressed a need, the expressed view was that there was still a gap between picking up the phone as an anonymous caller and making the effort to visit a service and accept intervention or support. As people with co-morbid issues were often chaotic and extremely vulnerable, there was a need to fill this gap.

- Basic information

Service users spoke of the need for the distribution of more information regarding mental health and drug misuse problems. It was felt that this would be helpful in accepting certain aspects of care that may be less desirable, such as medication, and enable easier access to services for those in need.

There was a distinct lack of systematic and proactive approaches to the provision of information about alcohol, substance misuse and mental health for users and carers.

Service users reported little consistency in the delivery of information about the availability and appropriateness of treatment and support, commenting on the lack of available information about where to go for help, what services existed, the nature of those services and associated threshold of access.

Some did mention that posters and pamphlets were available, but the general consensus was that this was insufficient and not targeted at the user’s actual needs. Information was mainly communicated between peers and between those who have similar mental health and substance misuse problems. One service user suggested that pamphlets or booklets might cover not just the services available but also the focus and nature of those services.
• **Waiting times**

According to interviewees, many areas struggled to respond in a timely fashion to new referrals, with reported waiting times as long as 18 months. There were also wide differences in the time it took to complete an assessment for referral to detoxification and rehabilitation units. This was in part explained by the dearth of such facilities with the consequent decision to delay assessment until placements were available. Alternative input was not always followed up.

There were also delays involved in obtaining a prescription. For example, in one service, multiple assessments by different staff meant that service users needed to attend several separate appointments before a prescription was issued months later.

While providers and commissioners were largely aware of the difficulties service users faced when trying to gain support from specific workers and professionals, they also expressed frustration about the attitudes that were often displayed by service users. Providers pointed to the diminution of users’ self-worth and sense of self-determination as a barrier in getting them to engage at all, compounded by the inevitable waiting times several services faced. A further factor hampering the planning of care was not knowing how long a service would take to accept a referral.

• **Bureaucracy and policy**

The sequence of events after an initial assessment varied widely across Scotland. In general, when a referral to a residential rehabilitation service was sought, the client’s care plan needed to be ratified or approved by a senior social worker or team leader. In some areas, this individual might be able to authorise release of funding for the placement but in other areas, authorisation would have to be sought from a third individual, such as a service manager or locality manager. A referral for detoxification usually needed to be ratified or approved by a senior medical practitioner or consultant psychiatrist and authorised by the Health Board. Many residential agencies also had their own pre-admission assessment, although the rigour of this process was variable. This level of bureaucracy was felt by many to be a barrier to effective, efficient and equitable treatment and support.

The study suggested that service providers were concerned about an ever-evolving policy scene. While guidance was generally viewed as helpful, the rate of change and the volume of publications were felt to oversimplify the nature of work carried out and have the potential to skew the delivery of services toward politically driven goals and readily measurable outcomes. Statutory services and many non-statutory initiatives attempted to adhere to national policy and agency-specific national guidelines but there was a strong call for local interpretation to meet the specific needs of the locality where initiatives were based.

Research results also highlighted a further concern. An example referred to was the evolution from a focus on Standards for Schizophrenia to the current attention on Integrated Care Pathways. The fact that initiatives took a long time to develop and required a large amount of invested effort has led to disillusionment.

The message was that policy and educational curricula relating to multi-professional and multi-agency working appeared to be formulated by those remote from work contexts. Participants advocated a greater involvement of providers and users and better communication pathways between commissioners and practitioners.
• **Consistency in care**

Service users considered the lack of consistency in service provider staff to be potentially damaging especially when they had developed a particularly good relationship with the provider concerned. People spoke of the crucial importance of developing a rapport with a service provider, be it a psychiatrist, key-worker, CPN, and of their sense of disappointment when that individual was replaced by someone different. Sometimes a rapport was not struck with the new worker, which on occasions had led to a deterioration in the service user’s physical and psychological health.

The changing political landscape and policy directives were also viewed as having an effect on the consistency of care delivered.

• **Continuity of care**

Service users, providers and commissioners all spoke of a general lack of long term support in the aftermath of a crisis situation or relapse. There was a general feeling that more after-care programmes and facilities were needed. Several service users spoke of the despair felt when having to face the ‘real world’ following a period of rehab or detox.

The role of housing support services had evolved in many areas to include support engagers whose job it was to work on a long term basis alongside people with their problems. The view was that simply re-housing evicted service users without dealing with the root cause of their problems would not provide a lasting solution.

Providers spoke of the frustration in trying to engage services during Bank Holidays and the festive period when staffing levels were at their lowest and family responsibilities particularly high. People were often left unattended at a time of year when they were most in need of social support. Both service users and providers gave examples of a lack of continuing care provision following discharge from an inpatient setting. Both the lack of follow-up services and the lack of expertise where these services exist were felt to be a serious problem.

• **Crisis access**

Faster intervention to help in crisis situations was raised as a key issue by service users and providers. This would require that people knew where to go and have enough confidence in the service to allow them to speak about issues that might be painful and highly personal.

Department of Health guidance on the care programme approach and the National Service Framework for Mental Health (DOH, 1999)) stipulate that a crisis management plan where appropriate should be an integral part of the package of care provided for all under the care of secondary mental health services. Despite this guidance, several service users expressed a desire for 24-hour support services and were concerned at the lack of proper crisis plans. Overall, the need for improvements in this area was a priority among service users and providers interviewed. The Delivering for Health initiative has committed to a national standard for crisis services and out of hours working by December 2006.

The lack of crisis team support or the availability of a named individual to contact in an emergency was cited by several service users as a major problem. They also felt they had not been given sufficient instructions about what to do in a crisis.

According to the Department of Health (1996) review of service of the effectiveness of substance misuse services, any service that aims to provide ‘low threshold’ access to treatment must be available when its target population needs it. Yet few service
providers appeared to operate outside normal office hours. Some offered limited evening and weekend opening.

- **Financial complications**

NHS Boards and local authorities tended to rate commissioning substance misuse treatment services as a low priority. Attempts were being made to introduce joint commissioning to increase service effectiveness and maximise economies of scale. Balancing different priorities, however, could prove difficult and have a knock-on effect on service delivery. Many providers were critical of the failure to secure finance to enhance current ‘successful’ activities, such as increasing opening hours for drop-in centres.

Statutory agencies referring an individual to a detoxification or rehabilitation unit usually had to make an application for funding. Only a few areas in Scotland had joint budgets for detoxification and rehabilitation. In most areas of Scotland, funding for detoxification (including detoxification in residential rehabilitation units) was managed by NHS Boards. Local authorities (Social Work) managed the funding for rehabilitation. This could mean that an individual, referred to a single residential unit for both detoxification and rehabilitation, might have to wait to take up the place if either the local authority or NHS Board had exhausted their respective budgets for the current financial year.

Many participants highlighted the lack of funding and service provision for children of co-morbid service users, which needed to cover protective and preventative measures as well as support to enhance resilience and increase coping skills in older children. Reflecting this, many providers were also highly critical of funding regimes that promoted new initiatives but failed to address ongoing difficulties in securing monies for core activities or opening times to help attract new service users and provide vital support during problem periods.

**Service quality**

- ** Appropriateness of service**

Access to different types of treatment and care was an important requirement for people with mental health problems. Service users reported a number of good examples of this throughout Scotland, though they also complained of not always being able to get appropriate help when they did receive treatment. Existing systems did not always have safeguards to prevent mismatches between service user needs and service availability. Validated assessment tools were lacking and eligibility criteria setting out the type of service user most likely to benefit from the service were unclear.

- ** Flexibility**

Service users placed a high priority on knowing there were places they could go during the day that were supportive, friendly and warm. They also felt that there should be more user groups and drop-ins available and that going out socially was hugely beneficial as it counteracted the feelings of isolation that so often experienced by those with co-morbidity issues.

Although there were many encouraging reports relating to contacts with community-based mental health services, especially regular contacts with key workers, for some service users the level of contact was insufficient. Outreach work with more regular contact was also mentioned as a crucial contribution to an enabled existence, especially following discharge from hospital.
• **Respite, detoxification and rehabilitation**

The Department of Health effectiveness review suggests that choice of setting should depend on the degree of motivation and preferences of the patient, the severity of the dependence, the degree of poly-substance use, associated physical and psychological complications and availability and accessibility of local services. Those with more severe problems associated with substance misuse, according to the same document, should ideally be catered for as an inpatient or in another residential unit.

Service users interviewed for this study reported beneficial experiences of inpatient substance misuse services. They had been helped by the respite offered by the treatment, the substance-free, safe and healthy environment and the specialist support, counselling and education.

The study has shown that specialist inpatient services were frequently lacking. Where they did exist, eligibility criteria and bed shortages prevented both timely access and the number of service users that could be helped.

Initial engagement by co-morbid service users was more likely to take place in low threshold facilities, despite the intermittent need for hospitalisation and detoxification. Besides lengthy waiting times for residential and detoxification facilities, there was a clear shortage of supported accommodation, much valued by service users.

• **Over-reliance on medication**

In general, pharmacological interventions played a more significant role in mental health treatment than in substance misuse treatment and were most often used to control symptoms. Though many mental health service users believed medication could be beneficial, they reported concerns over side-effects and the dominance of medication over other forms of treatment. More recently, the benefits and significance of psychosocial intervention has gained prominence with the advent of holistic care (Rethink, 2004).

• **Alternative and complementary therapies**

Evidence to support the effectiveness of alternative and complementary therapies was scarce, yet service users generally reported that such therapies helped alleviate stress, pain and the effects of withdrawal and promoted a feeling of well-being and calmness.

Several service users participating in the study also indicated receiving spiritual and personal support from faith-based services and complementary therapies. Some service users found that meditation helped them to relax and reduced anxiety levels. Others spoke highly of acupuncture and how this alternative therapy soothed the mind and helped them to unwind, remain calm and concentrate better.

• **Group versus one-to-one work**

While many service users perceived one-to-one therapeutic relationships extremely important, for some the sharing of experiences and social contact group work entailed proved a beneficial addition to their treatment.

Some service users felt hearing other people’s stories and volunteering their own was helpful but others found the anxiety the group environment provoked prevented them from becoming involved in discussions and benefiting from the group experience. Others reported that the environment was limiting because group members continued to misuse. One female service user spoke of relocating to find another more appropriate group.
Service providers also expressed concern regarding the disparity between the availability of treatment and support and the suitability for co-morbid individuals presenting with complex problems and a wide range of needs. A beneficial aspect, however, was the consistent emphasis on peer-relations that was integrated into a wider care package or treatment program.

- **Choice and range**

The complex nature of co-morbid mental health and substance misuse problems meant that service users often required different combinations of treatment interventions over time and needed to be supported along a 'treatment pathway'. Many also had multiple needs and some had difficulties with their social networks and accommodation. This meant that treatment options and support had to be carefully matched to different needs but a mismatch between available resources and individual service user preferences was a frequent occurrence. Providers also noted the need for structured day programmes and activities to prevent slippage and engage the user socially.

- **Remit**

The range of interventions offered by the same type of service varied and some services were only provided in a single location. Even when the right service existed, the style of the service might not be appropriate for specific and minority groups. On paper there appeared to be a plethora of appropriate services but the reality was somewhat different, with many services seemingly not being able to cater for the needs of complex clients.

Many people with complex co-morbid problems were involved with the criminal justice system. While the Government’s ‘Updated Drug Strategy’ focused on interventions via the criminal justice system, the cohort of interviewed providers talked of services in prisons being particularly limited with blanket application of inflexible standard treatment regimes that lacked specialist provision. The view was that providers on the whole were reluctant to invest time and effort in obtaining appropriate interventions even when they did exist.

- **Joint working**

Most providers should have been aware of the DoH’s Care Programme Approach in mental health or the Models of Care system in substance misuse. Both systems advocate a range of agencies working together effectively to promote service user wellbeing. In practice, however, collaborative working could be problematic and CPAs were often not implemented.

Service users undergoing a period of inpatient care were often not linked into community services for continued care following discharge. This could have the effect of increasing rates of relapse, especially if the residential unit was not in the service user’s locality. Service users with children had particular problems, and delays in treatment intervention often followed.

The independent sector was less constrained by professional boundaries and traditional remits. One response to ineffective joint working was to have a system based around a key worker, whose responsibility it was to co-ordinate services.

What was accepted across the board was that a single agency acting alone was unlikely to be able to meet the needs of co-morbid service users. Several providers spoke of the difficulty in achieving a seamless pathway of care for their clients. Joint working remained patchy with little routine contact and communication between services to co-
ordinate assessments and care. It was felt that good practice and good will was frequently met with disappointingly little co-operation.

Efforts were being made to improve shared care arrangements and there were signs of overall better alignment between generic and specialist services and primary and community care.

**Holistic care**

Although there were some very positive experiences relating to joint working and integrated care, many of the research participants reported that care planning often concentrated overwhelmingly on substance misuse or mental health issues with little reference to wider social needs including relationships, housing, personal development and employment.

The main focus tended to be on medication, including medical aspects of substance use. Service users frequently complained that psychiatrists tended to put problems down to the substances being misused and exclude mental health problems. The assumption seemed to be that abstention from drug-taking would make the problems go away.

Service users indicated that talking therapies and a wider approach to recovery were beneficial. Several would have preferred to have access to psychiatrists via community addiction services rather than attend an office-based appointment. They added that the one-to-one counselling enabled by such access would be more worthwhile than reaching for the prescription pad. This relates closely to the need for being viewed holistically rather than as a ‘drug user’.

While the need for holistic approaches was widely recognised amongst providers and commissioners alike, some concern was expressed that small services with a specific remit would not be able to cater for all the needs of presenting co-morbid individuals.

Co-morbid persons often required help with basic amenities like assistance with form filling, accommodation and employment. There were clear examples of services striving to meet such basic needs, though these were not widespread.

**Hearing and listening**

Professional values and individual provider attitudes could seriously impede engagement with a service user. Approximately half the service users interviewed complained of not being listened to or taken seriously by some of the providers they encountered. There were notable exceptions, most typically psychiatrists and other doctors.

Having the opportunity to talk to staff, be heard and build meaningful relationships was extremely important for the current cohort of service users and helped to support them through their mental health and substance misuse journeys.

One service user with a highly-critical family indicated that he would have valued a community mental health nurse with a non-critical and non-judgemental understanding of his issues. Another spoke of services not picking up sooner on what might be contributing to his substance use. He described with regret how despite making the effort to report earlier sexual abuse to social services, they appeared to take no notice of this information.

The importance of being listened to was echoed by the majority of participating service providers. Referring to commissioners, they highlighted the need to listen to what service users and people working at the coalface were saying. Insufficient and
ineffective vertical communication could lead to mismatches between service planning and addressing local need.

The narrow remit of many services, especially in the statutory sector, meant that there was no flexibility to provide holistic care. It seems that despite any effort to listen to the service user’s needs the application of standard interventions left the user with unmet needs. There was a considerable degree of consensus that the non-statutory sector was in a better position to cater for the gaps in statutory service provisions.

A participant acting both as carer and provider told of the struggle to gain the attention of hospital staff to listen to what she and her son needed. Her son was admitted to a psychiatric unit as a voluntary patient because of his alcohol problem. Eight days later he discharged himself because the ward was overcrowded and chaotic. Despite the effort this service user made to redress his problems, staff were unable to attend sufficiently to his needs. This was compounded by no liaison service for his carer being put in place.

**Opportunity**

Employment and the importance of getting work was a key theme and an important priority for over half of the service users interviewed but few were receiving any support to help them achieve their work goals. The goals were also viewed as an access route for returning to a ‘normal life’. Co-morbid individuals faced particular problems in gaining appropriate skills and in obtaining work, especially work that was enjoyed and valued. There is good evidence available about the effective service models required to support people back into paid employment.

**Involvement**

The involvement of service users in care planning (individual and service-wide) is a core part of the National Service Framework for Mental Health, (Department of Health, 1999). Users across the mental health services should be involved in decisions regarding their personal care and be invited to contribute to decisions regarding the planning and running of services. Implementation of these principles, however, was known to be patchy (Wallcraft et al 2003).

The results of the study suggested a general desire on the part of service users to be more involved in decision making about their own care and support. Where this occurred, people felt empowered and important. Service users who described examples of poor user involvement spoke of feeling disempowered and ultimately de-motivated to engage and change.

Feedback indicated that there was limited consultation and involvement in service development and treatment pathways. When service user groups did exist (DAT-based), service users as well as providers felt that these structures were often token gestures and merely paid lip service to the issue of user consultation and involvement.

Service users suggested involving ex-service users in service provision. They were thought to have a better understanding of the specific predicaments of service users and would be able to ‘guide’ others through the system, help to identify appropriate services and aid access.

The issue of user involvement was largely discussed with commissioners and less emphasised during the focus group discussions. Nevertheless, interviews indicated that the opportunity to listen to voices least heard (including carers and those working at the coalface) was often not taken.
Support for informal carers

There was much agreement that support for family members was an important aspect of effective service provision. This is supported by evidence (Clark, 2001) that co-morbid people whose family members continue to support them have better outcomes than those with little or no support.

Families and carers also needed advice and signposting as to where they can receive help and support in the local community. Providers indicated that support for family members and other informal carers, in particular children affected by either or both parental substance misuse and mental health problems, was lacking in many respects.

Many service providers cited the dearth of services for children and adolescents. Only three services in Scotland provided facilities for the children of drug users. This was a major concern, given the level of ‘hidden harm’ caused by parental substance misuse and the higher likelihood that children of parents of drug misuse may go on to misuse substances and have more mental health problems over the long term than children of non-abusing parents.

Stigma

The recent Social Exclusion Unit report (June, 2004, Office of the Deputy Prime Minister) highlighted how stigma is a major barrier to social inclusion for people with mental health problems. Having substance misuse problems in addition to mental health issues provides for ‘double’ stigma.

The stigma attached to being under the care of both mental health and substance misuse services meant that some interviewees were reluctant or unwilling to access these services. Feelings of guilt and shame were prevalent, as was a fear of being criticised and looked down on.

Providers and commissioners were clearly acutely aware of the prejudices people with mental health and/or substance misuse issues often face. National initiatives such as ‘See Me’ were viewed favourably. Providers and commissioners hoped these campaigns would help to ‘destigmatise’ current public attitudes.

• Attitudes

Many service users had both negative and positive experiences of service provider staff. The attitudes of psychiatrists and non-specialist staff such as GPs attracted more negative comments. Variations in staff attitudes and perceptions of helpfulness also differed between the treatment tiers. It was generally felt that low threshold flexible services such as drop-in centres and voluntary services were more appropriate for everyday support. Tier three and four specialist services were viewed as being necessary during crisis situations.

Criticism regarding professionals’ attitudes was largely levied at ward staff. An example was given of one A&E department, staffed by nurses who did not seem to have adequate levels of knowledge and training regarding mental health and substance misuse problems.

What service users perceived as prejudice and intolerance was described somewhat differently by service providers. The frustration of working with a cohort of people who frequently are difficult to engage with and notoriously difficult to manage long-term, manifested itself in terms of a substantial need for support rather than the need to modify ‘wrong’ attitudes.
Further frustration was expressed regarding the use of drugs that were socially ‘acceptable’ but were known to cause significant problems for certain people. Providers reported that motivating people to change their attitude to substance misuse was not helped by the decriminalisation of cannabis.

- **Normalisation**

A recurring underlying theme was the need for service users to normalise their situations. They wanted to feel empowered through leading a normal life, and this was reflected by their expressed desire to live in their own home or in their own council house, to be involved with social activities, have meaningful relationships and to be involved in treatment decisions.

One homeless man waiting for accommodation to be allocated spoke of the value of having his own tenancy and how this might contribute to a more responsible existence. He felt having a tenancy would force him to save money and so give him reason to concentrate on aspects of life other than his substance misuse.

Providers recognised the difficulties people with complex problems not only faced but may have experienced in the past and how these potentially damaging events had contributed to the inability to lead ‘normal’, fulfilling lives.

**Training needs**

The Department of Health’s *Dual Diagnosis Good Practice Guide* recommends that services assess their training needs. Along with this assessment, providers should attain core competencies including knowledge of co-morbidity, substance misuse awareness, assessment skills for both mental health and substance misuse issues and knowledge of how to manage these problems, ability to conduct motivational interviewing to engage service users, relapse prevention work, preventative work and knowledge of the Mental Health Act. Training should also be evidence-based supported by ongoing professional development for the creation of an informed and non-judgemental workforce.

The study showed that there were gaps in service provider knowledge and a lack of confidence and competence to deal with such complex issues. The majority of research participants were unable to identify training opportunities on the issue of co-morbidity, other than those provided by STRADA. This resulted in wide variations in practice and standards of services.

The need for increased knowledge of other professions and disciplines, the services available and the nature of these services were repeatedly mentioned. Suggestions ranged from basic training days to shadowing and secondments to different agencies. Training opportunities for service providers were limited and what was available was poorly attended and too basic to address knowledge gaps adequately. Further issues deemed important for training included basic drug and alcohol awareness, basic mental health awareness and the interactions of substances with prescribed medication.

As reported by the Audit Commission (2004), staff shortages across social and health care professions further limited the ability to meet service demands. This was compounded by the rapid development of service delivery.

In 2004, Rethink and Turning Point produced a dual diagnosis toolkit for staff guidance. The toolkit is based on practical information, supported by good practice examples and underpinned by national policy. This introductory guide is intended for those with little time to wade through research evidence and as such is a valuable contribution to raising the profile and knowledge base of co-morbidity-related issues.
Summary: a Scottish picture

Service users with co-morbid mental health and substance misuse issues were dealt with in an inconsistent and ad-hoc manner. This varied between services and between individual practitioners. Individual levels of confidence and competence in working with particular issues played a vital role, as did individual threshold levels. While the needs of some service users were met, this was clearly not the case for the majority.

At the time this report was written, there was only one reported dedicated team who worked specifically with co-morbid service users. Existing service provision tended to be based on a single issue such as addiction, rather than a plethora of complex issues, such as accommodation, education and legal difficulties. There was, however, evidence of mental health workers working with service users with drug and alcohol problems and of substance misuse workers working with service users with mental health issues.

Many difficulties associated with successfully treating co-morbid problems stemmed from uncertainty regarding what worked and what was good practice. While evidence was growing internationally, there was still no strong research base in Scotland for the treatment of co-presenting mental health and substance misuse problems. This knowledge gap made purchasing, configuring and providing services all the more challenging.

Problems regarding access were particularly acute in times of ‘crisis’ when someone was in need of immediate help and support. Difficulties listed by service users included not knowing where to seek help, time delays in getting help, services not being open and difficulties accessing specific individuals. Providers pointed out that many services did not have the structures in place to provide a timely service, resulting in frustrations when people did seek help.

Many service users interviewed reported positive experiences of individual providers. Providers, however, were aware of a continuing lack of appropriate provisions, in particular, supported accommodation and rehabilitation and detoxification facilities and the absence of appropriate skills. The ‘one size fits all’ model of services was particularly inappropriate for complex problems. A more suitable approach needed to consist of flexible packages of care tailored to meet individual requirements.

While some service users clearly benefited from group work, the form of treatment favoured more than any other was based on one-to-one contact. Service users’ reasons for assessing one-to-one contact as the most helpful form of service were based on their wish to build a trusting, empathetic one-to-one relationship with one person over time. The issue of trust and aspects of behaviour that engender trust, such as retaining confidentiality, pervaded the interviews directly and indirectly.

Key concerns for service providers as well as for service users were difficulties in building therapeutic relationships. Problems relating to staff retention disrupted continuity in care pathways. Developing trust and confidence in professionals was clearly of key importance to service users.

Service users needed the opportunity to be heard and to feel their views mattered. This reflected both their need for recognition as individuals and their wider needs that stretched beyond specific co-morbid mental health and substance misuse problems. These service users had more comprehensive psycho-social needs than others with fewer complex problems.

Prescriptions, especially Methadone and depot injections, were viewed as extremely important aspects of service provision. The reasons mentioned for this mainly rested with the stability medication brought to chaotic and itinerant lives. Sole concentration
on the medical aspect of care, however, was viewed as insufficient for successful recovery and social and psychological aspects of care were deemed extremely important. People spoke of the need to be assessed holistically and for staff to look beyond the ‘diagnosed’ problems.

Similar overtones were notable during the focus group discussions, with providers acknowledging the need to address wider issues over and above the primary problem(s). However, when asked how cases might currently be tackled it became apparent that for many transparently holistic care, partly afforded by sound interagency working, remained in its developmental stages. Providers regularly described a way of working commensurate with consecutive care as opposed to the recommended concurrent approach.

Commissioners expressed concern over the resource implications, in terms of staff time and finance, of new national initiatives. They were also concerned about the impact new arrangements might have to service delivery in a climate of rapid health and social care change. Providers believed a better understanding of local needs together with an improved understanding of the remits and limitations of different services would go some way to redressing the balance between availability and appropriateness. The expressed view was that more effective liaisons between services and increased information sharing and collaboration could be brought about by joint or multidisciplinary training.

Further issues considered ideal by users and providers included better education about substances and alcohol, more structured activities on wards, the opportunity to go away on trips and outings, a more positive attitude and outlook toward people with substance misuse issues coupled with increased support and a more caring response and better communication between different members of staff and between different services.

Well co-ordinated tailored packages of care bringing together appropriate support from a range of services only existed on a limited basis across research sites. Service users’ needs remained unmet, heightening the possibility that users might fall by the wayside and end up re-entering the system on numerous occasions. Pathways through care and aftercare following treatment needed to be managed more effectively.
Chapter 7: Main Findings and Recommendations

Introduction

This qualitative research project has explored the experiences of 26 commissioners of services spanning mental health, social work and substance misuse, 90 staff members across a variety of primary and secondary health and social care services and 38 service users living with severe mental health problems and substance use issues. The interview narratives were analysed to address:

- participants’ understanding of co-morbidity
- the impact of living with co-morbidity
- experiences of support provided through statutory and non-statutory sector services
- the ‘gaps and problems’ that individuals identified which significantly affected their ability to manage complex dual health issues.

Service user and provider responses were compared. The focus of each group differed but there was substantial agreement about the impact of co-morbidity on peoples’ lives and how ideally these complex problems might be tackled.

Accessibility and availability

Signposting: The degree to which services were advertised and the level of knowledge regarding the nature, remit and limitations of services were insufficient to guide the service user either to or through the service maze. Booklets and pamphlets went out of date quickly and often appeared or were available only in a limited number of facilities, most notably in general health facilities. In the absence of a ‘live’ and regularly updated directory of service remit and availability, providers were likely to continue to rely on historical links to services rather than on what was actually available.

Structural obstacles: The structure of existing services and their service philosophies were considered by many as creating barriers for co-morbid service users who might need input from a number of different service providers. Reports suggested that traditional trajectories rather than client-centred thinking often influenced decision-making about approaches to service users. As a result, there were debates between services as to who should take responsibility for service users with different presenting problems.

Management of mild to moderate mental health problems in substance misusers: Individuals with substance misuse-related issues often did not have sufficiently severe mental health problems to be eligible for attention from community mental health teams which prioritised severe and enduring mental illness. The majority with mild to moderate mental health issues were then sometimes inappropriately managed by substance misuse agencies or by primary care services.

Management of mild to moderate substance misuse problems in those with mental health problems: Similarly, individuals who used substances such as cannabis that were commonly thought to be relatively innocuous often did not qualify for eligibility to substance misuse services. These concentrated largely on opiates and other injectable drugs. This service configuration created obvious gaps in provision for people who needed help for both substance use and mental health issues.
Particular tensions:

**Accommodation:** Positive experiences were reported in relation to supported accommodation, though the availability of such living arrangements was scarce and often restricted to those who did not use substances.

**Contentions between drugs misuse and alcohol:** Many of the respondents, commissioners and providers included expressed dismay and frustration over the ways in which generally more money and other resources were made available for drug misuse compared to alcohol.

**Specialist provision:** Frustrations were expressed at the difficulty experienced in accessing specialist help in a crisis. The responsiveness of the ‘system’ to the needs of a group of people with multiple needs was challenging for all concerned.

Service characteristics

The need for flexibility and consistency: The research highlighted the contrast between the inflexibility of services and the chaotic characteristics of co-morbid service users’ lives. The narratives described how people living with mental health and substance use problems had ordinary life goals such as obtaining work, forming meaningful relationships, and generally improving the quality of their lives. The services set up to support their recovery, however, were heavily medicalised and not sufficiently flexible or appropriate to their needs, concentrating largely on ‘diagnosis’ and ignoring the wider picture.

The need for responsiveness and continuity: Providers and users alike reported that when service users asked for help they needed it immediately. They did not want to be placed on a waiting list and told to come back later. Equally, throughout the research project, it was generally felt that service users were often isolated and cut off from appropriate services after formal treatment had ended. A particular example cited was of a service user leaving a hospital environment, where no-one appeared to be ‘in charge’ of that person to help them access further support services to address their total need. There was a clear need for case managers or co-ordinators.

The need for strengthening psychotherapeutic approaches: Participants agreed that the most effective interventions took the form of warm, friendly, empowering services usually provided by one individual on a continuous basis. Concern was expressed at the relative lack of psychotherapeutic interventions available and the consequent lack of opportunity to develop trusting, therapeutic relationships with one person.

The need for holistic care: While there were examples of good practice and many positive experiences of different therapeutic relations, service users, commissioners and providers alike commented with regret that several services did not treat problems holistically and in a joined-up manner. They continued to consider mental health and substance misuse issues in relative isolation from one another and deal with them sequentially.

Service organisation

The need for specialists: There was a lack of dedicated co-morbidity specialists who appreciated the interaction of substance misuse and mental health problems and had the expertise and the resources to undertake this work. Both service users and providers identified the potential benefits of such specialists, either embedded within mainstream substance misuse or mental health teams or in specialist units.
The need for training to underpin provision: Service providers stated that they needed specific training and support that would help them deal with the complexities co-morbid individuals brought to the services. A minimum requirement would be to have access to workers who did have the knowledge and expertise of supporting people with co-morbid issues.

Multi-agency partnerships: In many parts of Scotland, health services and local authorities were working together and shared funds, yet evidence of joint working remained patchy. Where it did exist, experiences were positive. There was evidence to suggest that putting joint working into operation was envisaged differently across the researched localities. Although multiple engagements were considered to be inevitable, limits to the number and complexity of arrangements needed to be put in place. For some, more informal intersectoral agreements remained a realistic option. For others, change in infrastructure, in terms of coterminous partnerships between health, social and non-statutory sectors, was viewed more favourably than implementing service change per se.

Shared assessment protocols and development of care pathways: As a result of patchy joint working arrangements, shared assessments and the creation of care pathways for co-morbid individuals were lacking or under-developed in several locations. Again, there was some controversy regarding the usefulness of uniform integrated care pathways for such a heterogeneous group of people with quickly changing but ongoing needs. Discussions with commissioners indicated that the requirement for joint-funding approval in creating a care package could help to bring about closer collaborative efforts between health and social care.

Bureaucratic quagmire: Providers and commissioners voiced concern over the expediency of policy and directional changes and associated changes in remit. These structural and procedural modifications were believed to act as barriers to developing functional and successful collaborative efforts and providing consistency in care and support. The volume of information and guidelines to wade through were also a cause of concern and their relevance to local contexts was questioned, especially in relation to rural areas.

Exclusion: Service users felt excluded from decisions about their care and wanted greater involvement and empowerment. Many providers and commissioners thought that only lip service was paid to service users during formal meetings. Their opinions were not taken into account and were not followed through by action at the planning level. Although user involvement was acknowledged by some to be important, others considered that service users were not necessarily best placed or informed to direct and advise on service provision and practice. Service users interviewed also stressed their need for peer support groups.

Stigma and inclusion: All participants spoke of aspects of wider cultural and social problems that needed addressing. Stigma was an enduring feature of mental health and substance misuse problems alike. Since the New Labour Government of the late 1990s, a marked policy shift towards recognising the importance of social inclusion had taken place. Although the structures within which care and support is provided had changed for many, the language of the various professional silos and the theory that underpinned them frequently remained the same.

Concerns about the medicalisation of co-morbid issues and neglect of social factors did not imply that providers and commissioners were ignorant of their professional limitations or the need for a holistic approach. Most practitioners appeared to value their relationships with users as individuals with wider needs. Nonetheless, tension continued to exist between the real needs of co-morbid service users and the resources to provide ‘holistic care’ and the treatment interventions currently available and administered. As
social and health care workers operated as members of a wider collective social culture, understanding this culture offered insights into some of the social forces that shaped their work and in turn could allow attitudinal change to take place at the societal, professional and individual level.

**Recommendations**

The recommendations in this report are categorised into 6 main components, with some overlap:

- **Strategic**
- **Operational**
- **Clinical**
- **Training**
- **Workforce considerations**
- **Research suggestions.**

**Overall strategic plan**

- **A national strategy:** National organisations (e.g. Scottish Drugs Forum and Scottish Recovery Network) for service users need to have a joint approach to co-morbidity to help develop national priorities, including increased resources and funding opportunities, best practice models and the identification of research gaps. Such an approach would also benefit organisations, such as Drug and Alcohol Action Teams (DAATs) and Mental Health groupings across Scotland.

There is also a clear need for commissioners to take increased responsibility for developing a national strategy and encourage joined-up working.

- **Agreed definitions and overall model of care:** Within the strategic plan described above there is a need to describe and define the use of the term co-morbidity. The model of care should acknowledge that co-morbidity is a complex, chronic and relapsing condition that needs focused and flexible responses at different service levels/tiers in the health and social care system. A chronic care model such as those in the field of diabetes and coronary care might be a viable policy approach to target this needy population more effectively. The definitions and model of care should be agreed by all key service providers and commissioners and made widely available via agreed channels in order to facilitate communication between services.

- **Joined up provision:** The Scottish Executive Departments responsible for the provision of health and social care need to have a more joined-up approach to co-morbidity. *Mind the Gaps* should act as the catalyst to this end.

- **Greater integration of mental health and substance misuse services:** Overall, mainstream mental health services, both statutory and non-statutory, need to pay greater attention to the issue of co-morbidity when planning and delivering services. Equally substance misuse services need to pay greater attention to mental health. Mainstream mental health and substance misuse services need to work more closely together in order to maximise resources, expertise and skill mix. Effective inter-agency working and better communication are essential to provide an integrated response to the needs of people with co-morbid mental health and substance misuse issues. There should be improved networking and better interagency protocols between different organisations. Information-sharing protocols outlining how information should be shared with different agencies and with providers must be developed. Communication agreements between service users, providers and
commissioners should also be explicitly addressed, with effective communication being evidenced horizontally as well as vertically.

- **Development of policies, protocols and procedures:** Organisations should develop specific co-morbidity policies, together with appropriate protocols and guidelines for responding to clients who have these complex problems. Protocols should include practical toolkits for the identification of co-morbid conditions and provision for data collection and the recording of evidence and later evaluation.

- **Commissioning:** Clear identification and responsibilities of service commissioners in relation to their role in the field of co-morbidity are needed. Adequate training for commissioners and managers is also recommended.

**Operational**

- **Stigma and prejudice:** Information about mental health problems and substance use should be available to inform service users, providers and the public in order to attempt to reduce the stigma attached to these problems.

- **Health promotion:** Health promotion activities should be increased to address the negative impact of substance use on mental health. This is consistent with prevention and early intervention strategies to prevent issues escalating with disabling health and social care consequences.

- **Means and mechanisms:** Better information resources should be provided to increase the knowledge-base around co-morbidity and the services available locally and nationally offering help and support. Resources should signpost service users and providers to services including helplines, self-help groups, support groups, NHS facilities, local authority facilities and local non-statutory sector provision.

- **Accessibility:** Greater provision of access to out of office hours and drop-in facilities are required to support service users who are having difficulties with substance use or mental health problems, both on a day-to-day basis and in a crisis. Staggered and co-ordinated opening times might also be a consideration in certain localities.

- **Education, training, employment:** There is a need for provision of information and advice on vocational training and employment opportunities, and support in obtaining and retaining work, where possible. Establishing links between employers and employability services and developing local agreements may go some way to removing the multiple barriers co-morbid individuals face when trying to access employment.

- **Ethnic minorities:** Since there is insufficient knowledge about the nature and extent of the needs of minority groups, consideration needs to be given as to how best to address these needs. It is clear that a culturally sensitive approach is recommended.

- **Carer support:** There should be further development of services for carers supporting people with co-morbidity problems and specific support groups for carers and users living with combined mental health problems and substance use. Children and adolescents living with family members with co-morbid issues in particular need increased support.
Training and education

- **Defining the objective:** All those working within mental health and substance misuse organisations should receive training in relation to the complexities of co-morbid mental health and substance misuse to support this group and their families. A range of training opportunities are required.

- **Training needs analysis:** Appropriate and different levels of training are required to skill providers and support staff. In recognition that there will be providers with high-level skills and experience of working with co-morbid service users, a training needs analysis of providers should be undertaken.

- **Education:** There is a need to address co-morbidity as part of an educational component at undergraduate, post graduate, CPD levels in medicine, nursing, social work, psychology, pharmacy, etc. Drugs and Alcohol National Occupational Standards (DANOS) courses may be appropriate for other workers.

- **Training resources:** New methods of training delivery and knowledge building need to be developed to maximise access and increase skill-mix. New methods may include the use of DVDs, CDs, e-learning, manuals and toolkits.

- **Face-to-face:** New opportunities are needed for staff to experience alternate ways of working with this complex group of co-morbid people. The possibility of in-house training, access to accredited courses, shadowing and secondments should be enhanced.

- **Special groups:** Advanced training and educational requirements are likely to be necessary for tailored provisions for special groups of service users, including for example adolescents, older people and learning disabled.

- **Childhood trauma:** Specialist co-morbidity services should have one or more workers trained in sexual abuse and childhood trauma. Increased resources should be allocated to provide opportunities for service users to access validated and effective psychological therapies in the field of co-morbidity.

- **Other relevant organisations:** Where specialist training is not deemed sufficiently necessary, guides (*Mind the Gaps*, not yet widely circulated or read) or toolkits (such as the Rethink and Turning Point toolkit for dual diagnosis) should be available. A dedicated worker or ‘champion’ may help to communicate and publicise the most significant messages.

Clinical

- **Inclusivity rather than exclusivity:** The research team noted the importance of adopting an inclusive approach to supporting people in distress. Service users report the benefit of providing approaches that are non-judgemental and supportive for dealing with their mental health and substance misuse issues (also supported by NTORS\(^4\) research findings).

- **Philosophy:** Harm reduction and intermediate goals should be aimed for rather than concentration on abstention and full recovery.

---

\(^4\) NTORS is the National Treatment Outcome Research Study, established to gather information in this country about the treatment outcomes of a large sample of drug misusers who had been treated within the existing national system of treatment services.
• **Needs-led rather than service-led:** There are dangers of labelling service users as having a co-morbidity in the long term because substance misuse and mental health problems are transitional and the severity of the problem often fluctuates. Specialist service provision that concentrates on a narrow definition of co-morbidity may not be appropriate in certain instances. Any provision should be needs-led rather than service-led.

• **Assessment framework:** A comprehensive assessment and information sharing framework should be established to eliminate duplication of effort when conducting interviews.

• **Development of a user-friendly screening and assessment tool:** When developing a screening and assessment tool to be used in routine practice by staff from a wide range of backgrounds, preliminary research should be carried out into the services available for co-morbid problems.

• **Working with childhood trauma:** Childhood trauma is highly prevalent amongst the co-morbid population and screening for this should be implicit and routine. Where they exist, links to appropriate services should be made. Further development of provisions for this subgroup should also be addressed, in particular provisions for minority groups and men.

• **Care planning:** Collaborative working between mental health and substance misuse services (perhaps facilitated by the Joint Futures agenda), led by mental health teams needs to be in line with Models of Care or Integrated Care approaches. Every co-morbid service user should also have a care plan in place.

• **Provision of the range of psychological and pharmacological interventions:** Increased provision of alternatives to medication including effective psychological interventions should be available, to allow service users to address their problems through the development of trusting, therapeutic relationships with providers.

**Workforce considerations**

• **Learning environments:** There should be opportunities to make traditional health and social care environments therapeutic and learning environments for both service users and providers. This should have the effect of reducing burnout within the workforce as a result of dealing with potentially stressful experiences.

**Further research**

Information on co-morbid treatment and service delivery in Scotland is scarce. The following areas of research are suggested as part of a national research strategy, underpinned by funding:
(A) Research into understanding and enhancing the effectiveness of treatment interventions

- Explore biological and psychosocial approaches in the understanding of the development of co-morbidity.
- Commission a meta-analysis if possible or systematic reviews on the best treatment interventions with a view to the development of SIGN guidelines for the treatment of co-morbid conditions.
- Investigate appropriate therapeutic models for engaging effectively with people who have multiple and complex needs. Investigate the impact of these models on person-centred outcomes by conducting simultaneous and comparable localised research projects, exploring which models work where, when and why.

(B) Research into service development models

- Develop a regularly updated, ‘live’ database of services available to the co-morbid population in Scotland.
- Identify effective mechanisms to strengthening joint working and care pathways.
- Interview pairs of related service users and carers to explore the relationships between users and carers and the management of these multiple and complex problems in the context of the family unit.
- Evaluate current good practices to ascertain efficiency and effectiveness and ways of enhancing accessibility and improving availability.
- Understand the relationships between mental health problems and substance misuse and the many neurobiological and pharmacological mechanisms involved.
- Produce a ‘SIGN Guidelines on the Treatment of Co-morbidity in Scotland’. This would help mental health and substance misuse treatment settings identify training and financial resources to let such complex cases be more effectively managed.
- Study the process and outcomes of a newly designed service for co-morbidity with a focus on service discordance/concordance issues.
(C) Research into specific (generally hard to reach) populations

- Recruit participants who are not currently accessing services to better understand coping mechanisms of co-morbid individuals e.g. homeless, black and ethnic minority groups, looked after children, women.
- Explore the potential diversity of co-morbidity experiences: e.g.
  - Criminal justice
  - Rural populations
  - Homeless
  - Black and minority ethnic groups
  - Conduct a gender-focused project to explore gender specific issues and commonalities
  - Lifespan approach: Study the impact of parental co-morbidity on children to begin exploring ways to better support families leading to more positive outcomes for children and adolescents
  - Pregnant substance misusers
  - Children and adolescents
  - Older populations.
Appendix 1: Deprivation Categories

The Carstairs and Morris Index of Deprivation is often used as a measure of quantifying relative socioeconomic deprivation or affluence in different localities across Scotland. Deprivation scores are derived by combining four census variables which best indicate material disadvantage (proportion of households with male unemployment, lack of car ownership, overcrowded housing and the head of household being in social class IV or V) for each postcode sector in Scotland. There are seven deprivation scores (DepCat) with DepCat 1 being the most affluent and DepCat 7 being the most deprived. It should be noted that the Carstairs score for each postcode sector does not refer to the deprivation or affluence of individuals but refers to the proportion of individuals who report particular attributes when the census is taken, and provides a summary measure of the population for each sector relative to the average for Scotland as a whole.

The sectors primarily chosen for the study were EH14, AB11, G21, FK1 and TD1 in Edinburgh, Aberdeen, Glasgow, Forth Valley and the Borders respectively. These geographical areas were chosen to provide a combination of rural/urban and deprived/affluent areas across the study area, using the DepCat scores to determine the socio-economic status of these areas. As the population size varied greatly across all areas it was felt that postcode sectors which were situated immediately next to the chosen areas should be included so that each region should have a sample size of approximately 100,000 population. The list below shows the breakdown of postcode area, population and Carstairs scores for Edinburgh, Aberdeen, Glasgow, Forth Valley and the Borders from the 2001 Census respectively (McCloone 2004).

Grampian/Aberdeen Area
AB11 - Population: 18390, DepCat scores: 5, 3, 1, 6, 5
AB24 - Population: 30376, DepCat Scores: 6, 6, 4, 4, 4
AB25 - Population: 16900, DepCat Scores: 5, 3, 4
AB10 - Population: 21158, DepCat Scores: 4, 2, 4
AB12 - Population: 16021, DepCat Scores: 2, 4
TOTAL POPULATION FOR ABERDEEN AREA: 102845

Edinburgh Area
EH14 - Population: 38108, DepCat Scores: 3, 6, 5, 2, 2, 1, 1
EH11 - Population: 37016, DepCat Scores: 3, 5, 5, 6
EH10 - Population: 32357, DepCat Scores: 3, 2, 1, 1
TOTAL POPULATION FOR EDINBURGH AREA: 107481

Glasgow Area
G21 - Population: 32323, DepCat Scores: 7, 7, 7, 7
G33 - Population: 28220, DepCat Scores: 5, 6, 7, 7
G31 - Population: 23644, DepCat Scores: 7, 6, 7, 7, 7
G4 - Population: 11828, DepCat Scores: 7, 6
TOTAL POPULATION FOR GLASGOW AREA: 96015

Forth Valley/ Falkirk Area
FK1 - Population: 28300, DepCat Scores: 4, 4, 4, 5, 2
FK2 - Population: 42317, DepCat Scores: 2, 4, 3, 5
FK3 - Population: 17906, DepCat Scores: 5, 5, 4
FK5 - Population: 16677, DepCat Scores: 4, 2
TOTAL POPULATION FOR FALKIRK AREA: 105200

Borders Area
TD1 - Population: 16220, DepCat Scores: 4, 4, 3
TD2 - Population: 1898, DepCat Score: 2
TD3- Population: 1002, DepCat Score: 2
TD4- Population: 2076, DepCat Score: 3
TD5- Population: 10295, DepCat Scores: 3, 2
TD6- Population: 6855, DepCat Scores: 3, 1
TD7- Population: 7404, DepCat Scores: 3, 3
TD8- Population: 5998, DepCat Score: 3
TD9- Population: 18797, DepCat Scores: 4, 4, 5, 4
TOTAL POPULATION OF BORDERS AREA: 100766

**Edinburgh Area**
EH26 9 - Population: 140, DepCat Score: 1
EH38 5- Population: 354, DepCat Score: 1
EH43 6- Population: 787, DepCat Score: 5
EH44 6- Population: 2901, DepCat Score: 4
EH45 8/9- Population: 9565, DepCat Scores: 3, 2
EH46 7- Population: 2927, DepCat Score: 1
ML12- Population: 1074, DepCat Score: 2

Reference
http://www.msoc-mrc.gla.ac.uk/
Appendix 2: Commissioner Interview Topic guide

The following is the general topic guide employed to capture commissioners’ views of local service provision for people with co-morbid mental health and substance misuse issues and associated policy.

Rapport-building

- I understand that as a commissioner of ................. services, your main interest lies with ................. Please could you tell me a little more about your interest in this field?

General views

- Please can you tell me more about your general views on service provision and care pathways for people with co-morbid mental health and substance misuse problems?
- Have you any direct experience of such co-morbidity?
- How do you envisage service provision changing over the forthcoming years?

Partnership

- Is there integrated service provision in your area? If so...
- Do you believe integrating other services and professions is working or would work well?
- Do you believe integrated care could be disadvantageous in any way?
- Some people say that integrated care is the only way forward, but other say that it makes little difference. How do you feel about this?
- Do you personally advocate integrated care?
- Could you envisage more effective ways of working together?
- The changing nature of mental health/social care into a more team-based or ‘working together’ model may result in conflict of interests. What is your experience of the extent of conflict or otherwise between workers from different professional backgrounds?

Specialist services

- What are your thoughts about providing a specialist service for co-morbid service users?

Client-centred work

- Do workers focus together on client’s needs?
- How could you make the emphasis/relationship on client needs more effective?
- Does your locality practice user involvement and consultation? What are your views on this?
Policy

- Are you familiar with the document *Mind the Gaps?* If so, what are your views on the guidance?

- How do you believe the revised policies (e.g. Mental Health Act) and structural changes will affect provision and care for people with co-morbid mental health and substance use problems?

The future

- What, in your view, are the criteria for an effective service for people with co-morbid mental health and substance use issues in Scotland?

- What questions or issues do you consider are important to address and should be explored?
Appendix 3: Focus Group Topic Guide

Possible focus group themes

The following topics will be discussed in relation to different case vignettes.

- **Practice and policy**
  Different approaches and priorities of professionals
  Extent of cross-communication
  Extent of engagement with other services
  How evidence-based are the practices/interventions?

- **Assessment**
  Perceived challenges
  Criteria used in screening for psychiatric problems, mental state and substance misuse issues
  Risk assessment and identification of primary needs

- **Intervention**
  Meeting primary needs
  Methods of engagement
  Goals
  Care/treatment pathway (including medication and substitute prescribing)
  Methods of relapse prevention

- **Organisational issues**
  Function
  Structure
  Financial issues
Appendix 4: Service User Interview Topic guide

The following is the general topic guide employed to capture Service users’ perspectives of and feelings about the services they have used. The guide is not comprehensive; it represents the essential information that needs collecting. Most interviews gave rise to much richer information helping to further contextualise the responses specifically regarding aspects of service provision.

1. Preamble

- purpose of study
- focus of study on communication
- outline of key issues
- likely length of time for interview but stop if need to
- use any form of communication
- minidisk recorder
- confidentiality

2. Rapport building

- Information about the study. Explain to client the main theme of the case studies, the main objective of this interview and why we want to do these interviews

- Consent to take part in the research (if not completed earlier).

- Tell me about yourself. Why have you come to this service (the service where the interview is taking place)?

- Tell me more about your family and friends; what is your family situation /close relationships?

- What do you believe are your main problems? What do you think that they are about? Problems in life in general? Problems related to your mental health? Your substance use? What do you know about your illness? What information have you been given?

- Experiences of help received: Who do you contact when you are not feeling well? And if your life situation is changing for the worse?

3. Experiences and perceptions of service provision

- What are your views about this service (the service where the interview is taking place)?

- Which other centres or services have you attended or been in contact with? Why? What help did you receive? How did it help you?

- Have you ever had problems with service provision? What happened? How did you feel about it?

- Do you have a key-worker/ carer? (From which professional group?) How do you work together? (Examples of good collaboration/support. Examples of support/treatment which does not seem to be helpful)
• What kind of experiences do you have with relationships with staff? (doctors, nurses, social workers, psychologists...)? Have you perceived anything in their way of working with each other, which has affected your care?

• What other experiences do you have of attending different services? What works/does not work?

• How do you get access to care? Does the system seem to work well to get access to care? Please describe your experiences.

• Have you ever had difficulties in accessing services? Have you ever given up or decided to interrupt seeking help? Why? What happened?

• What help do you feel you most need?

• Before we conclude this interview, in an ideal World what would you do to change service provision?

4. Concluding questions

• Any other issues not raised in this interview?

• What advice would you give to someone in a similar situation?
References


