Healthcare Improvement Scotland

Mental Health and Substance Use Protocols: Integrated Care Models

22 August 2024
10:00 – 16:00

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Meet the team

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Knowledge and Information Skills Specialist

Agenda

Time	Topic	Presenter
10:00	**Welcome and opening remarks**	Clare Morrison, Director of Engagement and Change, Healthcare Improvement Scotland Rachel King, Unit Head, Transformational Change – Mental Health, Healthcare Improvement Scotland
10:10	**How did we get here?** - An overview of the work to date	Rachel King
10:25	**Facilitated networking**	
10:45	**Why do we need a specific response to people with co-occurring mental health and substance use conditions?**	Professor Elizabeth Hughes, Professor of Substance Use Research, Glasgow Caledonian University
11:15	**Table discussions**	
11:45	Lunch	
12:35	**Welcome back**	Diana Hekerem, Associate Director of Transformational Change, Healthcare Improvement Scotland
12:40	**"What works?" - A Realist Case Study Evaluation of models of care for co-occurring mental health and substance use: Learning from the RECO study**	Professor Elizabeth Hughes
13:10	**Table discussions**	
13:40	Comfort break	
13:50	**Peer conversations** (National mental health and substance use protocol)	
14:10	**How do you currently support people with co-occurring conditions?** *(part 1)*	
14:45	Comfort break	
14:55	**How do you currently support people with co-occurring conditions?** *(part 2)*	
15:35	**Where do we go from here?** - Next steps	Benjamin McElwee, Senior Improvement Advisor, Healthcare Improvement Scotland
15:50	**Close**	Diana Hekerem

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Clare Morrison

Director of Community Engagement & System Redesign, Healthcare Improvement Scotland

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Clare Morrison – Director of Engagement and Change

Clare Morrison (NHS Healthcare Improvement Scotland)

Healthcare Improvement Scotland

How did we get here?

Rachel King
Unit Head, Transformational Change – Mental Health
Healthcare Improvement Scotland

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Context

MENTAL HEALTH IN SCOTLAND

CLOSING THE GAPS - MAKING A DIFFERENCE

Commitment 13

"We will translate the principles of Mind the Gaps and A Fuller Life into practical measures and advice on what action needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007"

Closing the Gaps: Foreword (2007)

Context

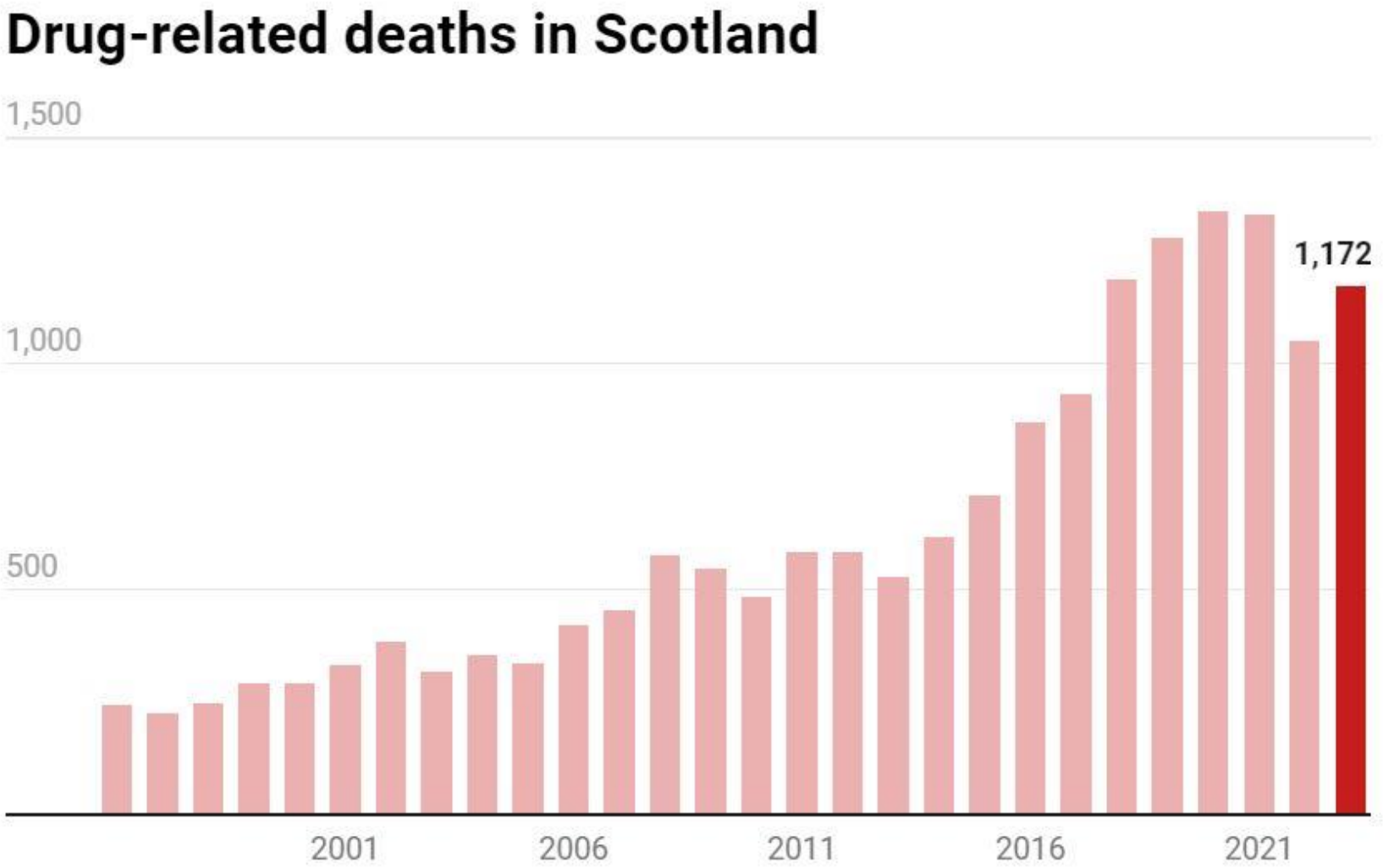
“ During consultation for this report…

“Of the 44% of mental health service users misusing substances, less than 5% satisfied eligibility criteria for drug treatment programmes in their area.

The substance misuse services were set up to deal with opiate dependence, the drugs misused were predominately alcohol, cannabis, sedatives and stimulants.

The majority of the mental health problems among substance misusers were diagnosed as personality disorder, and mild/moderate depression and anxiety which were judged **"low potential for referral" to mental health services.** ”

Context


Drug-related deaths in Scotland
1,500
1,000
500
1,172
2001
2006
2011
2016
2021

Rapid Action Drug Alerts and Response (RADAR) July 2024

Context

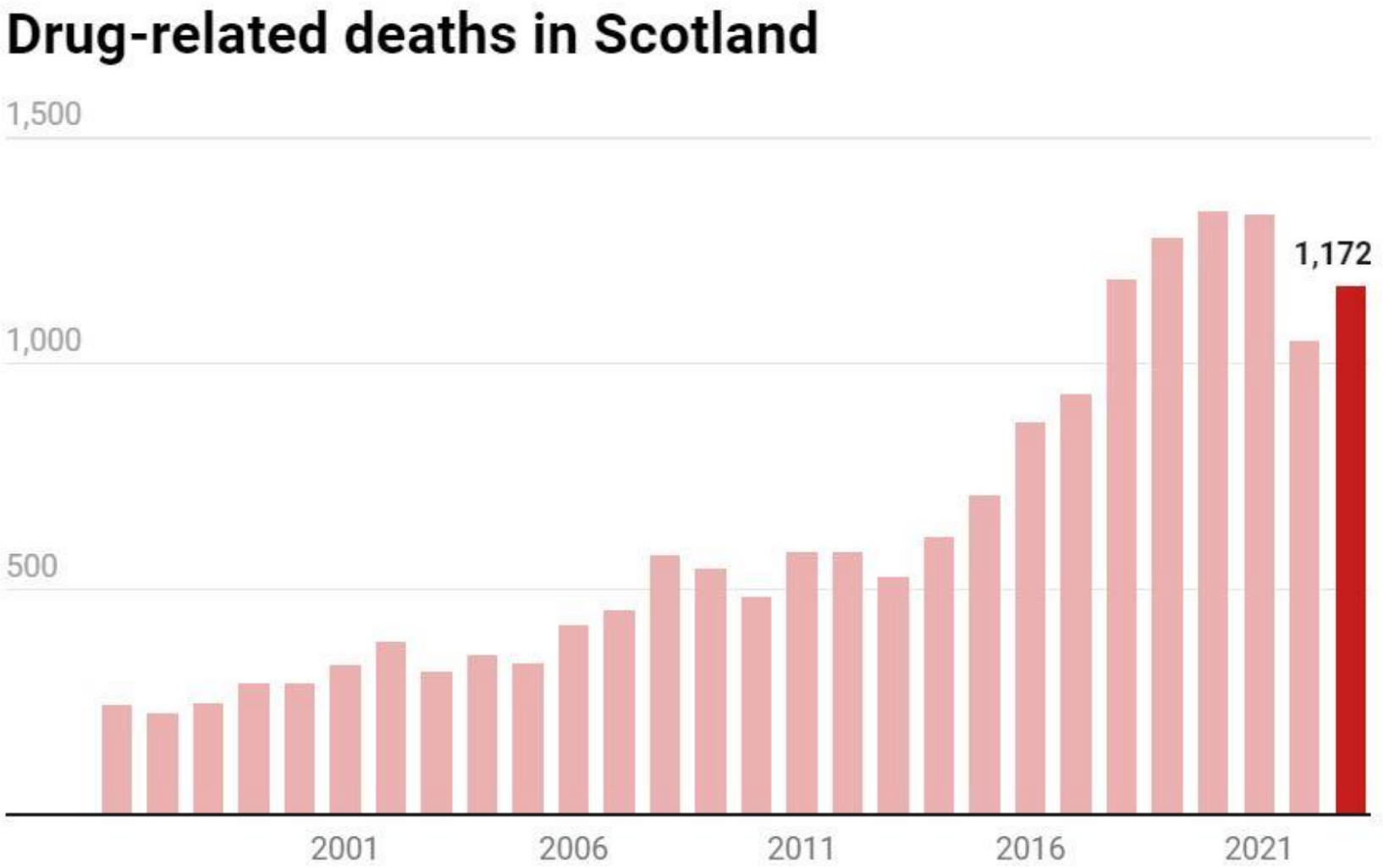
“

The risk of harm and death are increased in the context of polysubstance use, stigma and exclusion.

Prevention, harm reduction and treatment interventions should be adapted to respond to the high prevalence of cocaine and benzodiazepine involvement in drug harms.

”

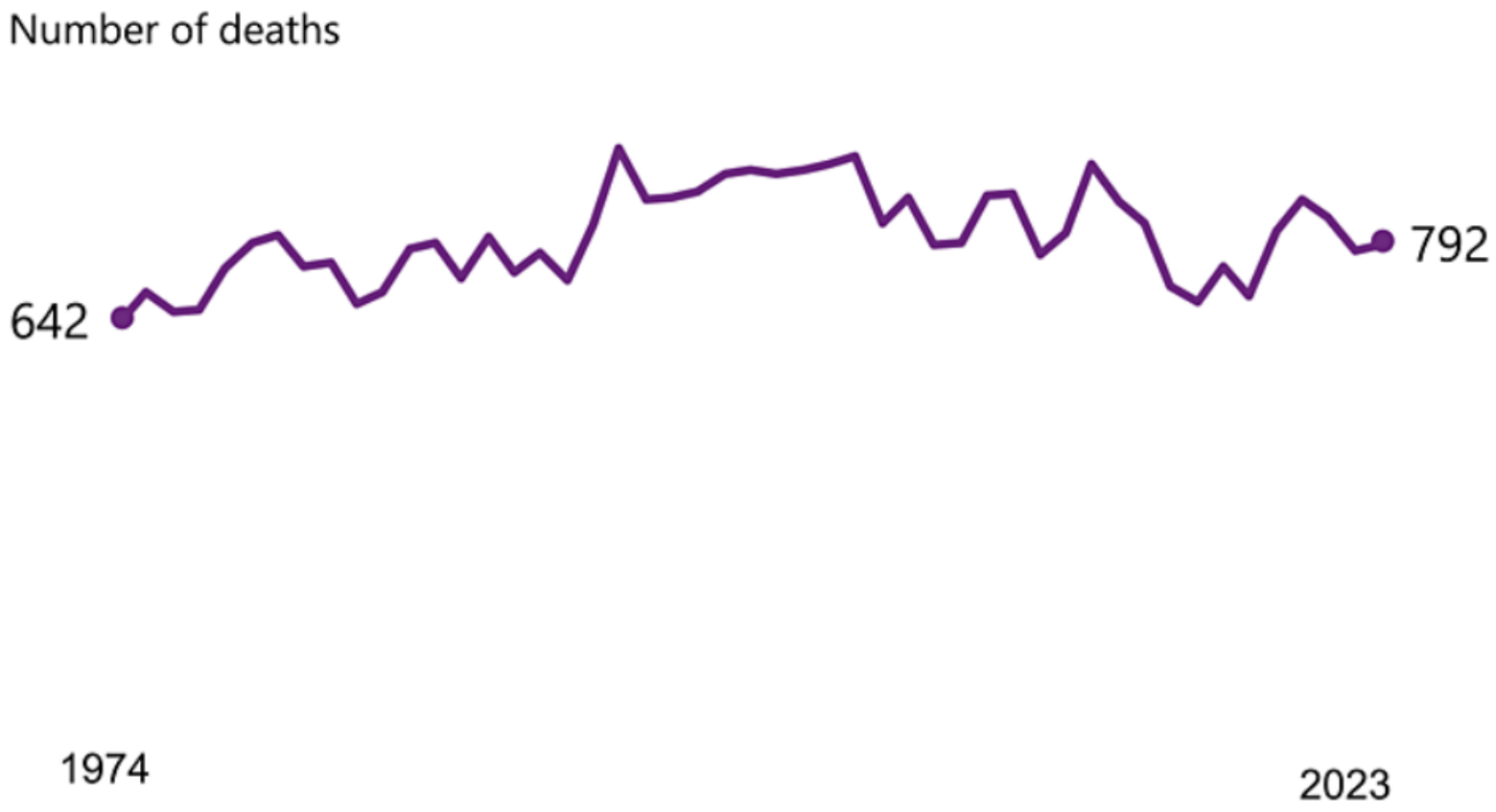
Context


Drug-related deaths in Scotland
1,500
1,000
500
1,172
2001
2006
2011
2016
2021

Probable Suicides in Scotland - NRS

Number of suicides in 2023 increased to 792 deaths

The number of probable suicides has risen from 762 in 2022 to 792 in 2023. This is the second year in a row seeing an increase in suicide numbers after a period of declining numbers in 2020 and 2021.



Context

BBC NEWS

25 July 2024 · 243 Comments

Community health and social care faces "unprecedented pressures" amid funding shortfalls and rising demand for services, according to Scotland's public spending watchdog.

A report by the Accounts Commission said services such as mental health support, drug and alcohol programmes and older people's support face further cuts in provision.

The services are run by Integration Joint Boards (IJBs) that work between local government and health boards to plan many community based health and social care services.

Context

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

November 2022

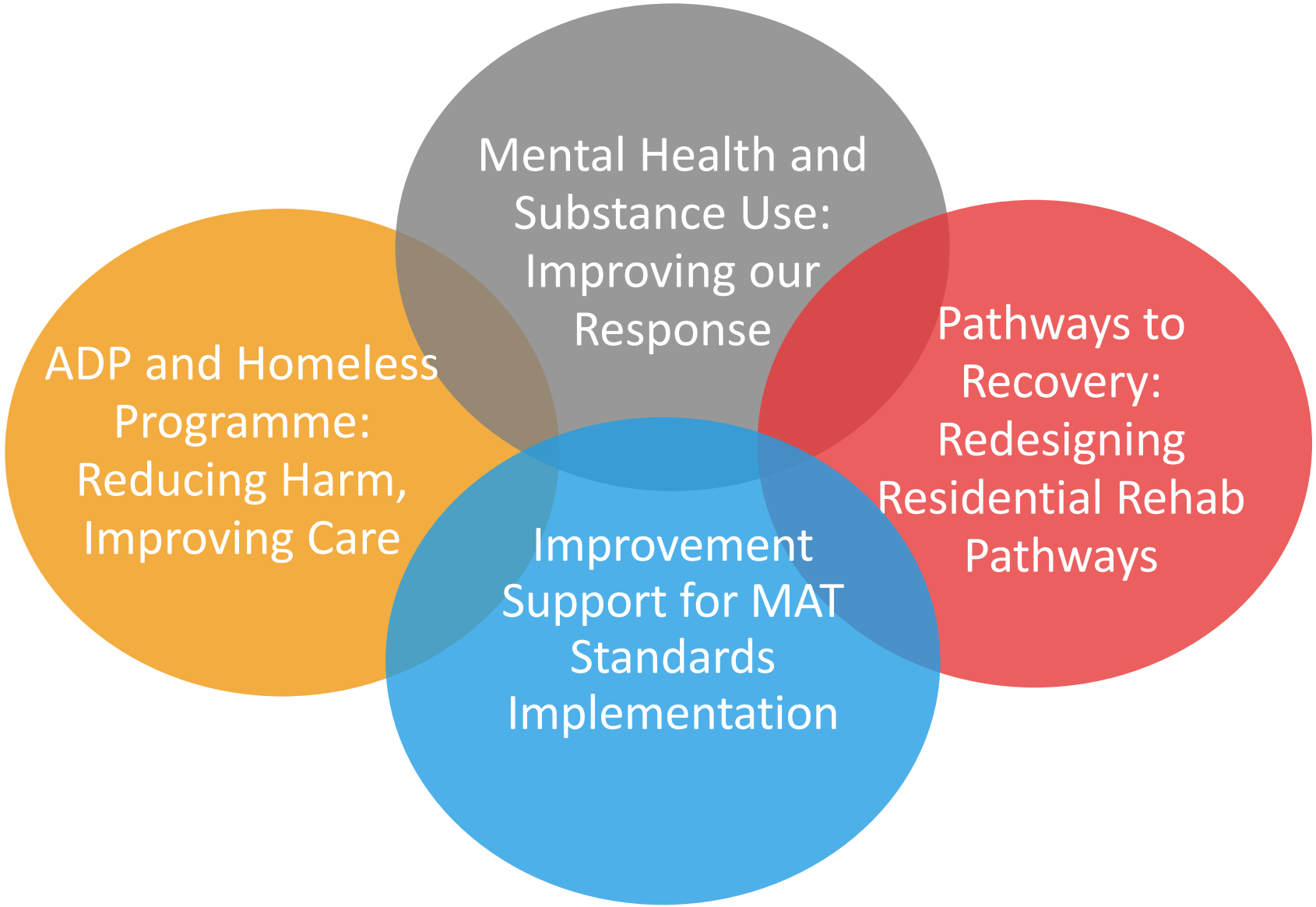
Scottish Government
Riaghaltas na h-Alba

The Way Ahead: Rapid Review: Recommendation 1

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

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

Drugs and Alcohol Programmes across Healthcare Improvement Scotland



Mental Health and Substance Use Protocol Programme

Sept 2023 – Spring 2024

Discovery

Evidence review of protocols

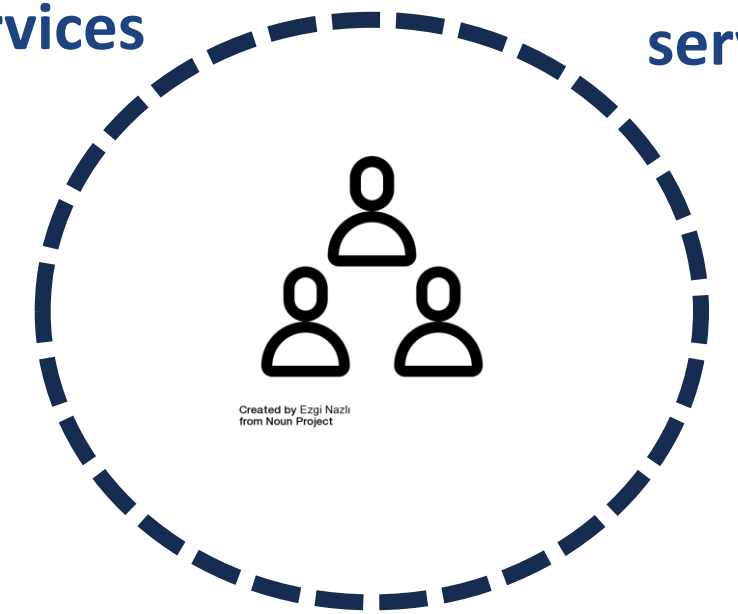
Strategic Gap analysis

Learning from Pathfinders

Engagement with stakeholders

Mental Health and Substance Use Protocol Reference Groups

Where we want to get to



Outcomes
Experiences

Mental Health and Substance Use Protocol Programme

Sept 2023 – Spring 2024

Discovery

Spring 2024 – Autumn 2025

Test. Implement. Iterate.

Autumn 2025 – March 2026

Sustain

Facilitated Networking

What brought you here today?

What led you to do your job and what motivates you to keep doing it?

Healthcare Improvement Scotland

Service models and systems for CO-existing serious mental health and alcohol/drug conditions (COSMHAD).

Prof. Liz Hughes, Chief Investigator (RECO)
Professor of Substance Use Research
Co-Lead Substance Use Research Group
ReaCH, Glasgow Caledonian University

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Disclaimer

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Aims of the Presentation

- Overview of the NIHR funded RECO study
- Rationale for why specific approaches are needed for people with co-occurring mental health and substance use problems
- Focus on RECO data regarding “what works” to improve engagement and better outcomes.

Background to Study

- Co-Occurring alcohol and/or drug use is common amongst people who use mental health services.
- Estimates suggest 30-50% of people with a severe mental illness also have substance use problems (typically alcohol and cannabis) and around 70-80% of those in substance use treatment have a co-occurring mental health problem (depression, anxiety, PTSD etc).
- People with this co-morbidity face significant issues including increased morbidity, suicide and violence (victim/perpetrator), poor physical health, compounded by difficulties accessing the right help.
- Despite policy directives and research over past 30 years, there remains a lack of clarity about “what works”

The RECO Team

- **GCU/University of Leeds**

CI: Professor Liz Hughes

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

The RECO study

Funding: commissioned call (NIHR, HTA; 2018) based on recommendations from PHE Guidance “Better Care” (2017)

AIMS

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

RESEARCH QUESTIONS

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

Inclusion Criteria and focus of RECO

Focus

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

Inclusion Criteria

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

Rationale for Realist Synthesis framework

- Realist approaches attend to the ways interventions (or programmes) may have different effects for different people depending on context. A service for COSMHAD is considered to provide resources that alters context, triggering a change in the reasoning of the recipient, leading to a particular outcome (Context + Mechanism = Outcomes (CMOs).

- CMOs are used as explanatory formulae (realist programme theories), which are then 'tested' either through literature (synthesis) or empirical data (evaluation) and refined. They, in effect, postulate potential causal pathways between interventions and impacts.

- Thus, use of a realist approach intended to help expose the multiple resources delivered as part of services, the ways they were employed with different people, and how they generated different outcomes.

Methods: Series of Interrelated work packages

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

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

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

- Realist synthesis published in Lancet Psychiatry (Harris et al, 2023)

Methods: Series of Interrelated work packages (2)

Work Package 2: Mapping of UK COSMHAD Services

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

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

Methods: Series of Interrelated work packages (3)

Work Package 3: Refining WP1 Programme Theories

- 6 case studies (of 3 types of service models identified in WP2). Staff focus groups, service user and carer focus groups or individual interviews completed. Topic guides developed from 11 PTs developed during realist synthesis used to further test and refine the PTs in different models of COSMHAD care; using data from people who work in those services and people who use and care for those who use services.

- It is important to note whilst distinct phases, the process of conducting realist research is iterative rather than linear, cycling between literature searching and data collection, with constant refinement of, adjudication between, and evidencing of emerging programme theories.

Work Package 2 mapping and audit

- WP2 Phase 1: Identifying and map services existed for people with co-morbid mental health and drugs/alcohol.
- Requests were sent to 793 individual organisations between March and October 2020. A total of 311 response were received (39% response rate). Of these responses, 188 provided information about services (60% of responses)
- The RECO team discussed this information and created a sub-sample of services that had at least one or more elements of a “service model” such as a specific care pathway, a named lead role, training and supervision, champions or link workers etc. This sub-set formed the services that we then sought more information.
- An online survey was developed to collect specific service level information from these services (N=19 responses related to 16 services).

Mapping Results

	Total number of responses	Specific COSMHAD N(%)	No specific COSMHAD service N(%)	Unclear N(%)
Total	190	88 (46%)	78 (41%)	24 (13%)
England	156	73 (47%)	68 (44%)	15 (10%)
Wales	8	6 (75%)	0	2 (25%)
Scotland	19	5 (28%)	7 (39%)	7 (39%)
NI	5	4 (80%)	2 (40%)	0

WP2 Audit Responses

- Audit response were returned from 19 respondents representing 16 services. Multiple returns from the same organisation were merged and deleted when cleaning the data.
- Most services were commissioned by Local Authorities (or equivalent in devolved countries) with only 31% indicating that they were commissioned by the Clinical Commissioning Group, and even fewer were jointly commissioned.
- However, provision and delivery was primarily through NHS Mental Health services (50%), followed by substance use services (38%), and joint services (6%).
- The majority of services were categorised as “lead and link worker” (31%).
- Most services offered a broad range of interventions and modes of delivery.
- Interventions tended to be delivered one-to-one (81%) and over the phone (69%) likely the reflecting the complexity of cases. (NB This data was collected on 2020 when COVID restrictions in place)

Work Package 2: Mapping of UK COSMHAD Services

WP2b:

- Responses thematically grouped , forming 3 types of models:
  - "**Lead and Link**"- typically included lead senior clinician (specialist expertise in COSMHAD), training/supervision programme, additional workers supporting lead.
  - "**Consultancy**" –Specialist team provided training, consultancy, joint working but no direct clinical role
  - "**Network**" - shared group of interested services, some local champions/link workers, not including investment in a specific lead person.

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

Underlying complexity

- Adverse childhood events and trauma common factor for people with mental health or substance use issues and especially both
- Socio-economic deprivation
- Inter-generational trauma and abuse
- Lack of early intervention
- Undetected neurodiversity (e.g. ADHD)

Physical health

- People with severe mental illness die 18 years younger than general population and therefore physical health agenda has become important in mental health care – this is especially relevant to people with co-occurring substance use as they are likely to have multiple health risks alongside those common to those with mental illness (Mental Health Strategy 2017-27 Scottish Government)
- Blood borne viruses- people with mental illness have an increased risk of blood borne virus including HIV, hepatitis B and C (Hughes et al 2016) and this is likely to be associated with co-occurring substance use (as well as other factors such as sexual risk behaviours)
- A recent analysis UK HPA data of positive hep C tests performed in mental health services (Hibbert et 2024) showed that only 58% of those who would benefit from hep C treatment were in receipt of it
- Alcohol related- high rates of alcohol consumption amongst people with mental illness. UK HPA data found 16% of mental health inpatients screened by AUDIT were drinking at “increasing or higher risk” and 8% were dependent ((UK general population rate is 1.4%)
- There are no safe levels of drinking alcohol- even so called moderate drinking is associated with long term harm to health including cancer
- Respiratory disease – COPD and lung cancer- smoking cigarettes is highly prevalent in people with severe mental illness
- 31% of people with a long term mental health problem are smoking cigarettes (Ash Scotland 2019 data) half of these people live in the most deprived areas of Scotland.

Risk Issues: Suicide and Violence

- Substance use is associated with increased risk of suicide, violence and homicide
- There are numerous factors at play including disinhibition, increased impulsivity, increased paranoia, craving and withdrawal symptoms
- Alcohol or drug misuse was a factor in between 48% - 56% of all suicides between 2008 and 2018 in Scotland.
- Fazel et al 2013– seminal meta-analysis of violence and mental illness. They found that substance use is a mediating factor between severe mental illness and violence:
  - “a number of dynamic factors were significantly associated with violence risk including: hostile behaviour, poor impulse control, lack of insight, recent alcohol and/or drug misuse, and non-adherence with psychological therapies and medication”
- Dean et al (2024) Danish crime data analysis “Men and women diagnosed with personality disorders, substance use disorders, and schizophrenia-spectrum disorders were at highest risk of violence victimisation and perpetration”
- National Confidential Enquiry into Suicides and Homicides by people with mental illness – consistent message in reports that substance use remains a significant factor in these tragic incidents
  - a third (30%) of people who died by suicide within recent contact with drug and alcohol services also had contact with mental health services in the previous 12 months.
  - These people had high rates of self-harm (76%). A fifth (20%) had missed their last contact with mental health services, and 14% were not adherent with prescribed medication.
  - In a study of impact of service changes on suicide rate (Kapur et al 2016) – one of the important and effective service changes on reducing suicide was having a “dual diagnosis” policy in place
  - NCISH (2018) Review of 20 years of homicides by people with mental illness- “the risk of homicide by mental health patients is strongly linked to other factors …namely the additional use of drugs or alcohol and loss of contact with services”

“Revolving Doors”

- Key finding from suicide and violence case reviews and studies is the disengagement with services prior to the incident (NCISH, Manchester)
- Lack of contact with services often leads to increased use of crisis and emergency services
- Not only is this costly in monetary terms, it is ineffective and likely to be counter-productive
- Involvement with police and emergency department is often traumatic for both the service users, their carers and the staff

Discussion

Consider in your own area what are the key concerns regarding people with co-occurring substance use in terms of:

- Trauma
- Unscheduled care
- Physical health
  - Smoking
  - BBVs
  - other comorbidities
- Risk issues (suicide, self-harm, accidental overdose)
- Transitions into community/primary care
- Revolving doors

Comfort Break

11:30 – 11:45

PART 2: what works?

Case studies

Method

NHS Ethical approval obtained. 6 case studies selected from services identified in the mapping and audit, all participants gave informed consent. At the request of PPI group, Service User and Carer interviews undertaken separately from staff. Video calls on Microsoft Teams were recorded and a transcription generated, then checked for accuracy and annonymisation.

Participants

Service Users

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

Carers

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

Staff

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

Overall programme theory (generated in WP1)

Leadership: Opinion leaders (PT6)

- Context- dedicated respected leaders **with authority** to implement COSMHAD care are required at all levels (from commissioning, strategic leadership and team leaders) to communicate and enact a shared vision, prioritise implementation and make and administrate local policy changes

- Mechanism resource: leaders will sustain awareness and expectations around the needs of COSMHAD

- Mechanism response: an organisational climate where staff will feel supported to implement new practices

- Outcome Individuals will engage with consistent and appropriate support

Leadership

- Organisational commitment to developing a consistent response to COSMHAD is critical – this means both within services as well as in the integrated treatment system more broadly.
- A culture in which the COSMHAD agenda is supported (in terms of workforce development, care pathways and support, and ethos of care) requires leadership.
- The role of the clinical specialist (often a consultant nurse, or allied health professional) serves many purposes- training, role model, support, supervision, care planning, multi-agency working- and is highly valued
- All levels of organisation: Leaders needed to exist at different levels of their organisation including at a senior, strategic level and operating at a more clinical management level.

“clinically credible leaders”

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

Leadership PT6 (2)

“we have got [dual diagnosis service name] worker that…will tend to be the person that we are drawn to, to discuss things. And we see her as a bit of our expert, although I know she likes us to try and do the work as well alongside her - which is right because we've all been trained in it. And I think we naturally just looked to her as our expert in that field, really… And I'm just getting the person involved, you know, because again, they’re the experts in what they're doing and how they're feeling and. So, you know, although she's a bit of the guide clinically, we try and look at our people that are using really. (SP92, Case Study B)

Service Delivery: Formalised network opportunities (PT7)

- Context- formalised, structured and sustained opportunities for practitioners to meet, communicate and take action (local network)
- Mechanism –resource- will lead to an increased awareness of each others service's collective contributions, opportunities for peer support and a multidisciplinary ethos
- Mechanism –response this increases staff motivation confidence and commitment to working with this group
- Outcome- improved care coordination, better provision of appropriate care, coordinated and welcoming services help people with COSMHAD feel more comfortable and engage in a more sustained way

Service Delivery PT 7 (2)

- *“the dual diagnosis network…that I go to, I find that that is more almost like reflective practice. For me anyway, I find that that really helps me emotionally with some you know dealing with challenging the system 'cause it is quite difficult to constantly challenge the system for your clients, so…as a way of. cleansing myself”. (SP2, Case Study C)*

Formalised Care Pathways and Inter-professional/agency working

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

Formalised Care Pathways and Inter-professional/agency working

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

Interagency Working– importance of relationships

“I think relationships with staff within other areas is key with this because you can actually do that joined up working much better if you've got those connections and you can actually sort of just pick up the phone and speak to somebody and say I'm not sure what to do with this person, you know? Can you help?” (SP51, Case Study D)

“A bit too fragmented. They don't have seemed to speak to each other. You know you hear so many times the communication breaks down between people and between services, between the mental health people between the police between the drug worker…you seem to find yourself saying the same thing over and over and over again to different members of the team. Because you lose your confidence that that that's actually going to get passed on…” (P36)

Continuous Professional Development

- Context- if leaders appreciate the importance and need for continuous professional development

- Mechanism resource– by combining didactic and experiential training

- Mechanism response – then staff will internalise compassionate integrated values, skills and confidence to assess need and provide integrated care

- Outcome – this leads to improved therapeutic relationships which in turn lead to improved engagement and motivation to change

Workforce Key Findings

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

Workforce CPD PT5 (2)

- Supervised practice is exemplified in the COSMHAD model delivered in one of the case studies
- In this model, staff receive training the interventions and then the consultant nurse from the specialist team works alongside them to implement into practice.
- This encourages staff "*to try and do the work as well alongside her, which is right because we've all been trained in in it…So you know, although she's a bit of the guide clinically, we try and look at our people"* (SP92, Case Study B). The intention of this model is *"just to give to people that bit of confidence…it's everyone's responsibility…not just say oh, just refer to [specialist service name]. And so, people need that confidence to, you know, to be able to do some of the interventions themselves, really.* (SP84, Case Study B).

Positive Outcomes for workforce development

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

Service user and carer perspectives on workforce skills and confidence

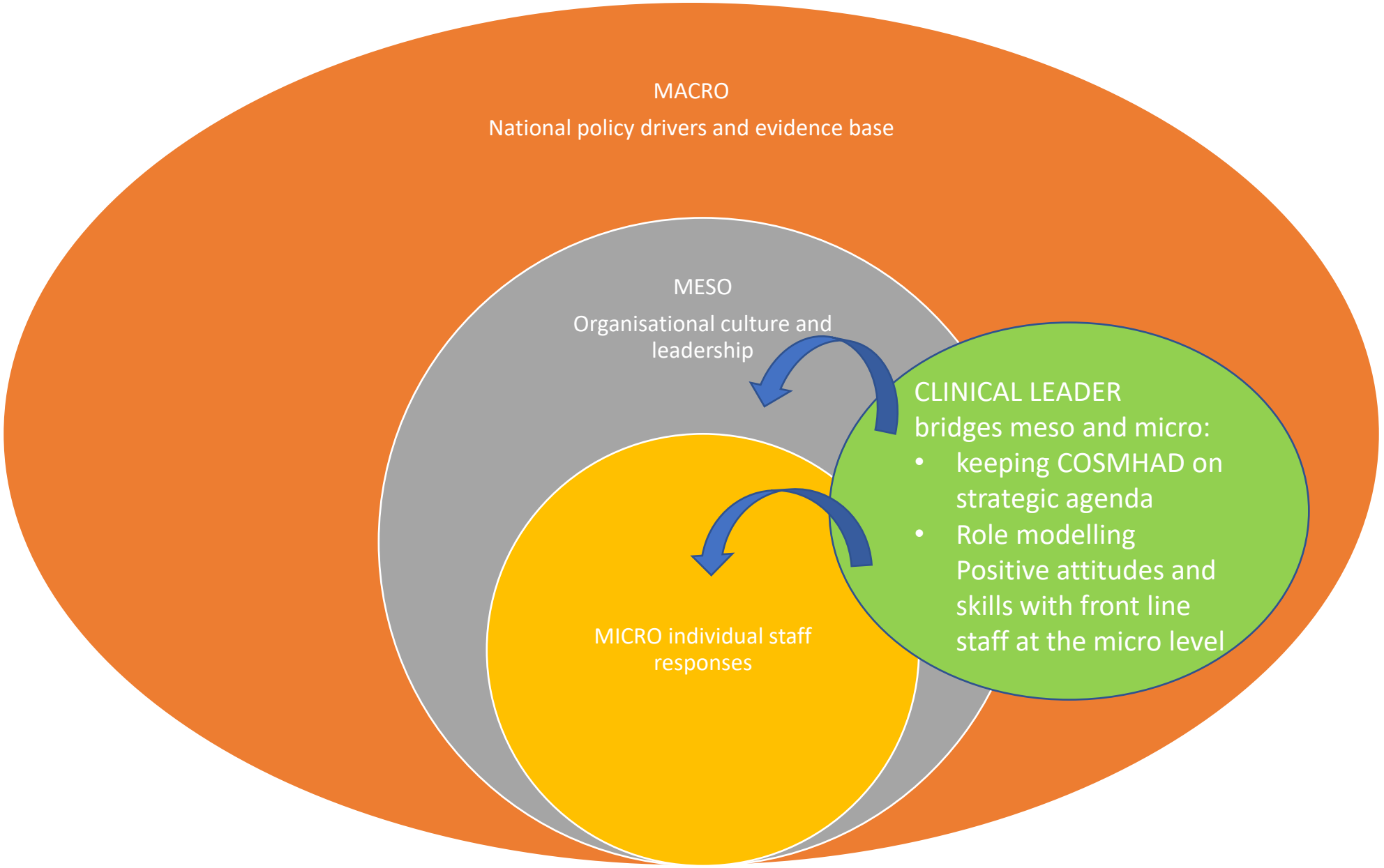
- Trained staff (mechanism – resource) who had confidence in their skills, experience of working with co-occurring disorders, and compassion and empathy towards clients (mechanism – response) lead to better therapeutic relationships with service users and carers (outcome).
- Lack of experience of working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

Carer:

“We have been allocated a key worker… It should have been someone with more experience and not somebody who's literally three weeks ago started working in the service. And that's horrible thing to say because people only get experienced by experience. However, you do have to take into account where people have been, what journey they've been on and where they are going and everything that's happened. And you shouldn't be putting…a fresh faced graduate the job. That, you know, find no objections if that person is there to shadow – shouldn’t be the lead”. (P3, Carer, Male, Case Study 3).

Main findings Summary

- The crucial role of dedicated ”clinically credible leaders” and a skilled confident workforce across all agencies.
- Importance of organizational leadership (including commissioners) in supporting the clinical leaders (funding, aligning strategy to incorporate COSMHAD - suicide prevention, physical health, trauma informed care)
- Ensuring that this group is prioritized as having high needs (and high service use) across the local agencies
- The importance of local multi-agency and multidisciplinary networks
- Continuous professional development – not just classroom; shadowing, access to supervision, networking)


MACRO
National policy drivers and evidence base
MESO
Organisational culture and leadership
MICRO individual staff responses
CLINICAL LEADER
bridges meso and micro:
• keeping COSMHAD on strategic agenda
• Role modelling
Positive attitudes and skills with front line staff at the micro level

Recommendations for Policy and Practice

- Closer integration of Mental Health (MH)/Substance use (SU) policy at government level required, reflected at local (place based) level to ensure services are commissioned to meet needs of COSMHAD. ISCs/ICBs/ICPs able to plan local integrated services addressing population need.

- MH services should take the lead responsibility for people SMHP, irrespective of co-occurring SU issues.

- Make first contacts count- attitudes and values- genuinely “everyone's business”, with mapping of COSMHAD developments as part of Integrated Care agenda.

- Ensure that the issues of COSMHAD are included in the workforce development plans across MH/SU in England and the Devolved Nations of the UK e.g. pre-registration and as part of CPD.

Recommendations for Policy and Practice

- Clear value of investment in leadership, including “expert leader” (e.g. Nurse Consultants/Allied Health Professionals) in driving agenda for more integrated care across agencies. Support from strategic leadership key, as well as e.g. link workers (with protected time) across a range of service settings.

- Given level of disparities of access leading to adverse outcomes, COSMHAD should be a priority in MH services (reflecting LTP/CMHF., 2019). We recommend could/should be embedded as part of service improvement initiatives e.g. trauma informed care and in suicide and violence prevention strategies.

- Service users/carers co-design service pathways (reflecting HSC ACT., 2022).

PART 2 discussion: what works – putting into practice

Consider the key findings of the RECO study (leadership, workforce, integrated care)

- How can this work in your area?
- Who do you need to work with?
- Who are the key leaders?
- What are the quick wins?

Conclusions

- People with COSMHAD are some of the most under-served populations, and experience significant disparities in access to care and treatment.
- This often results in in high acuity service use (police, ED, crisis MH) which is unsatisfactory for them, their carers and the service providers.
- RECO identified <20 UK locations with tangible £ investment to address this need.

Conclusions

- The RECO study has identified 3 main components for success: local leaders; workforce development; joined up service delivery (care provision and pathways).
- A joined up and integrated care between MH/SU (including workforce planning) is required, as well as local leadership at strategic and operational levels
- There is potential to make significant difference to outcomes, but this requires genuine commitment to integration from policy to practice.
- Further research is required to establish the clinical and cost effectiveness of care for COSMHAD.

For further information:

- Chief investigator: Prof Liz Hughes Elizabeth.hughes@gcu.ac.uk

- X @lizhughesDD @OstudyRec

Lunch

12:40 – 13:25

Healthcare Improvement Scotland

Welcome back

NHS SCOTLAND

Turning our work on the protocol into an online learning system

Healthcare Improvement Scotland

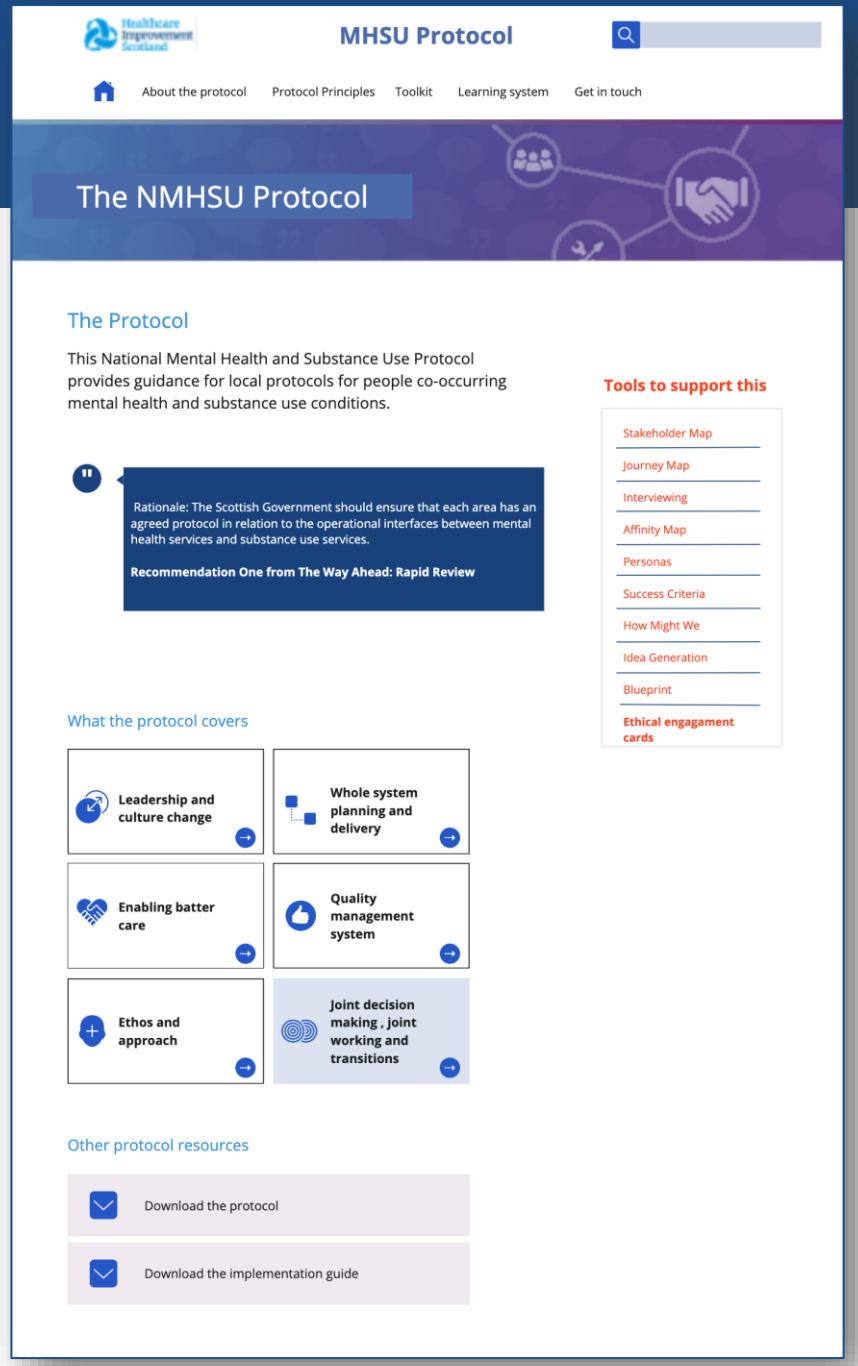
The current Protocol

The Mental Health and Substance Use Protocol outlines expectations on local areas for how their mental health and substance use services, including the third sector, work together and examples of what that might look like.

What if we could take our learning from the protocol and turn it into an online learning system for other health boards?

The Future Protocol

The programme aims to develop a suite of resources to support implementation of local protocols, including case studies/vignettes, outlining the difference that ensuring these expectations have been met, has delivered. Suitable tools to support areas to consider areas of interest will be identified and shared alongside facilitation guidance.



The concept

Main menu

What can a user do?

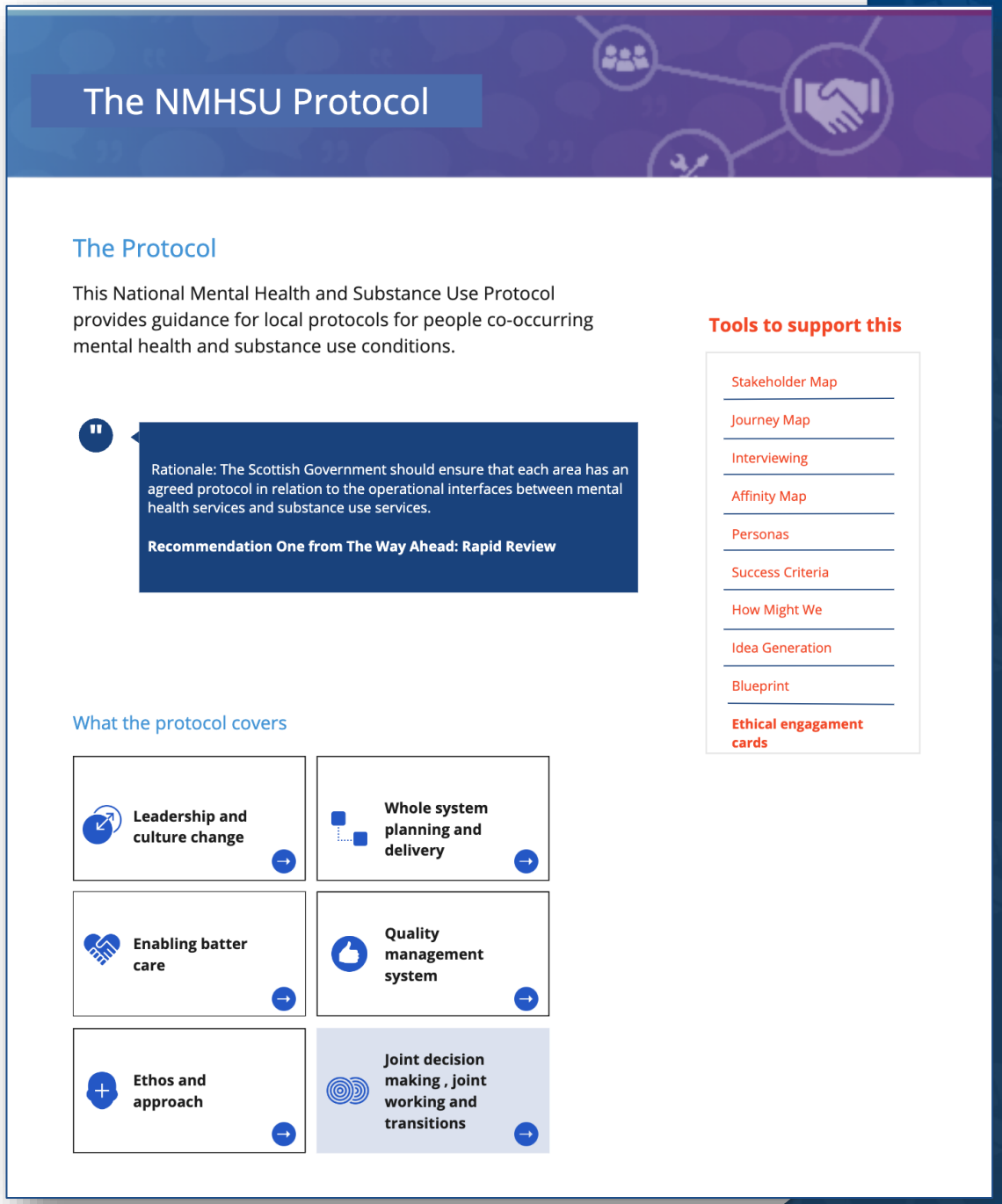
-Understand what the protocol is

-Understand and browse what dimensions underpin the protocol

-Download the protocol

-Download the implementation guide

-Browse tools that can help to implement the protocol

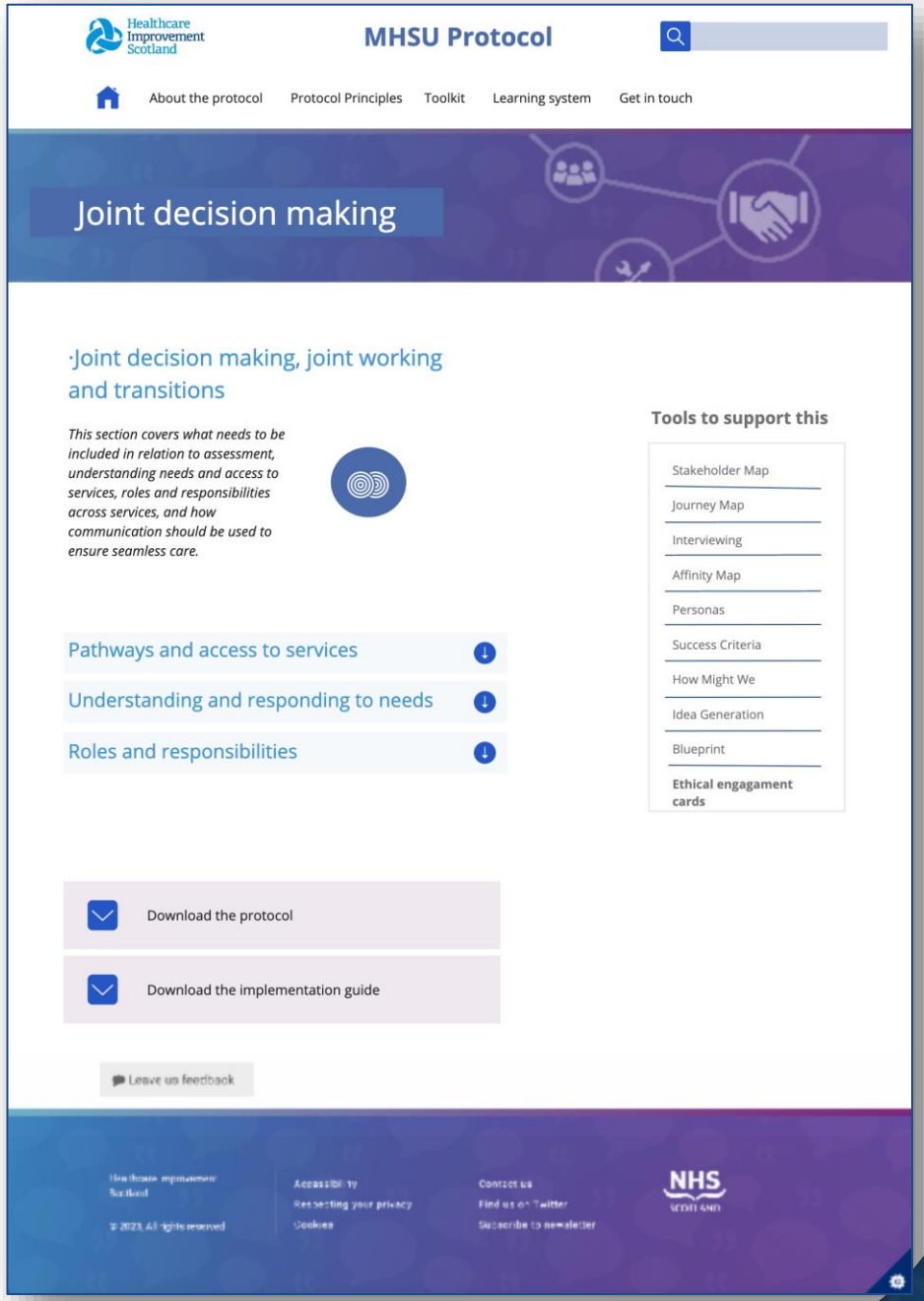


The concept

Protocol dimension

What can a user do?

-Dive into individual protocol dimensions
-Understand what is expected
-Browse case studies of implementation
-Browse tools that can help to implement the protocol



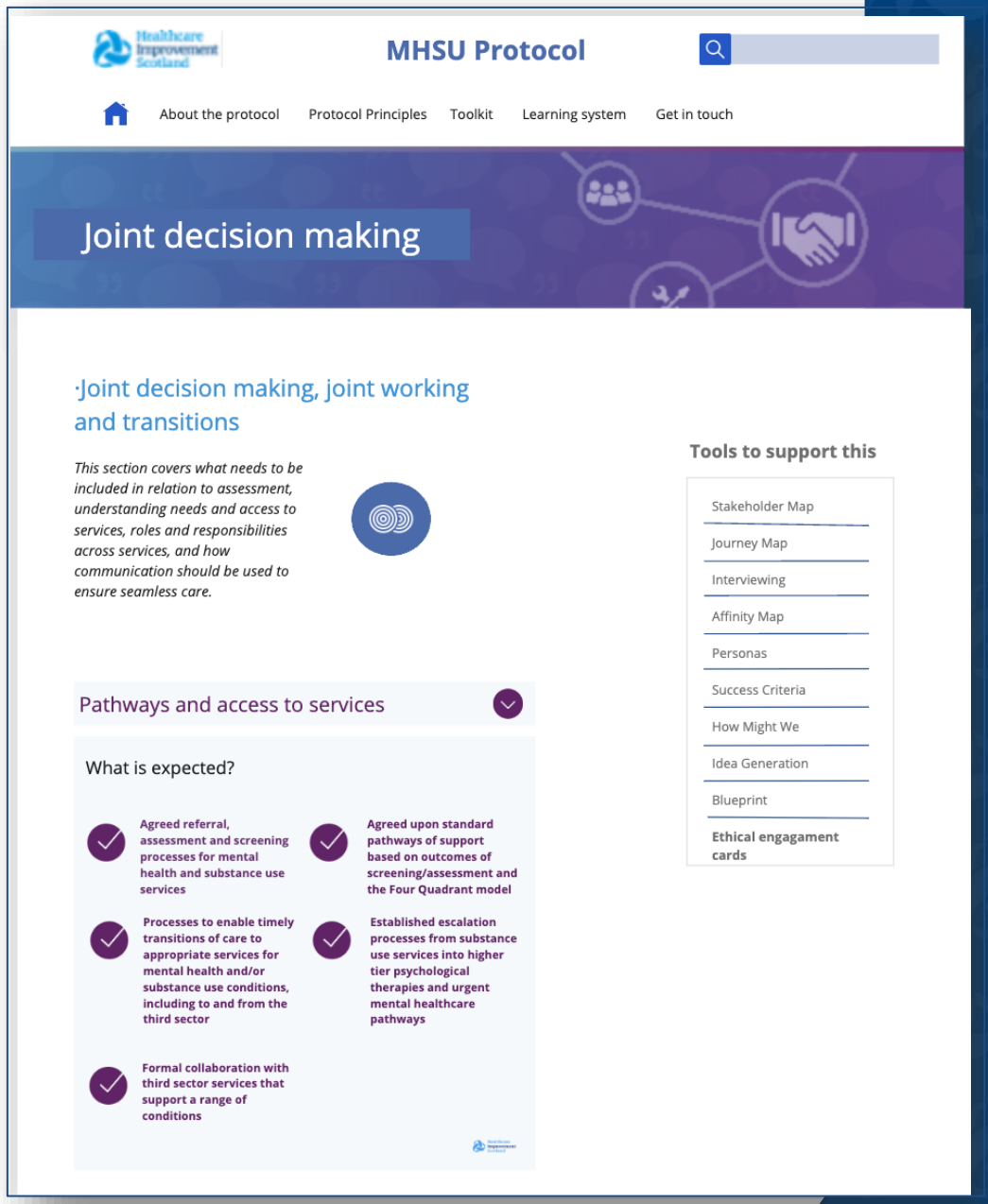
The concept

Dimension info

What can a user do?

-Understand what is expected of each dimension

-Select tools that support implementation of the dimension (still to be defined)



The concept

Dimension info

What can a user do?

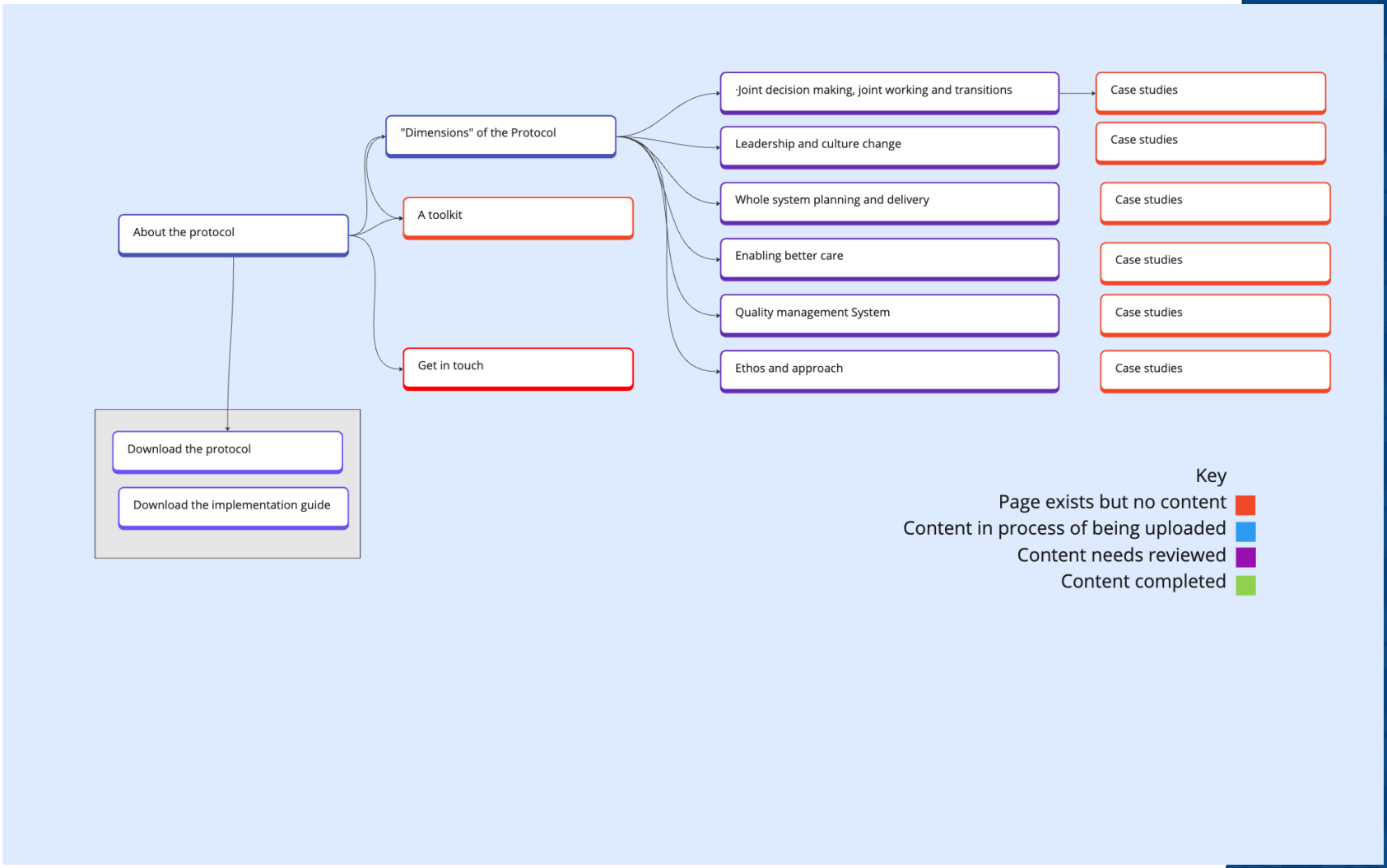
-Dive into sub sections of protocol dimension ideas in practice

-Look at case studies for each dimension

The concept

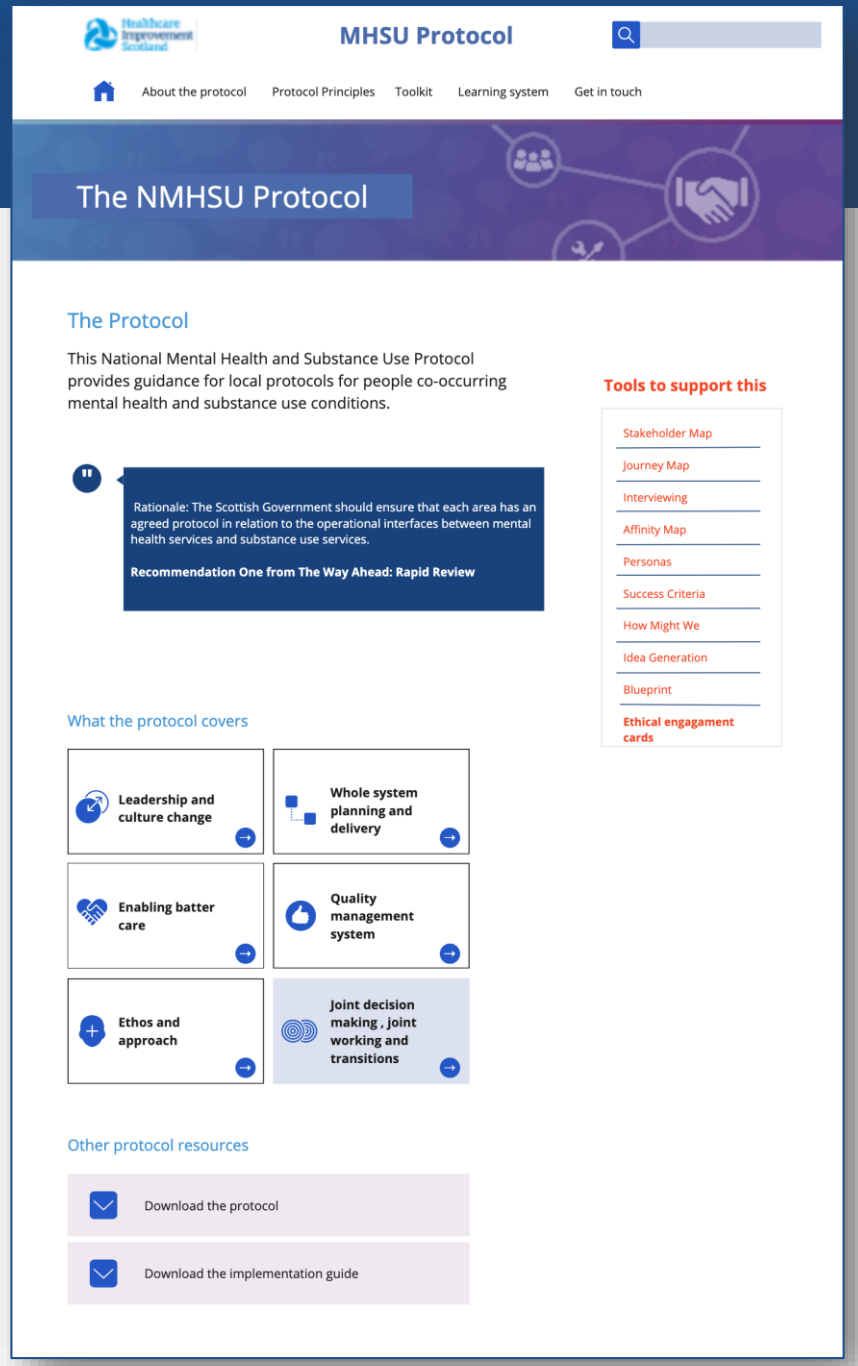
Site map

Behind the concepts we are defining the structure of the site map. Tools and case studies associated with each part of the protocol still to be defined.



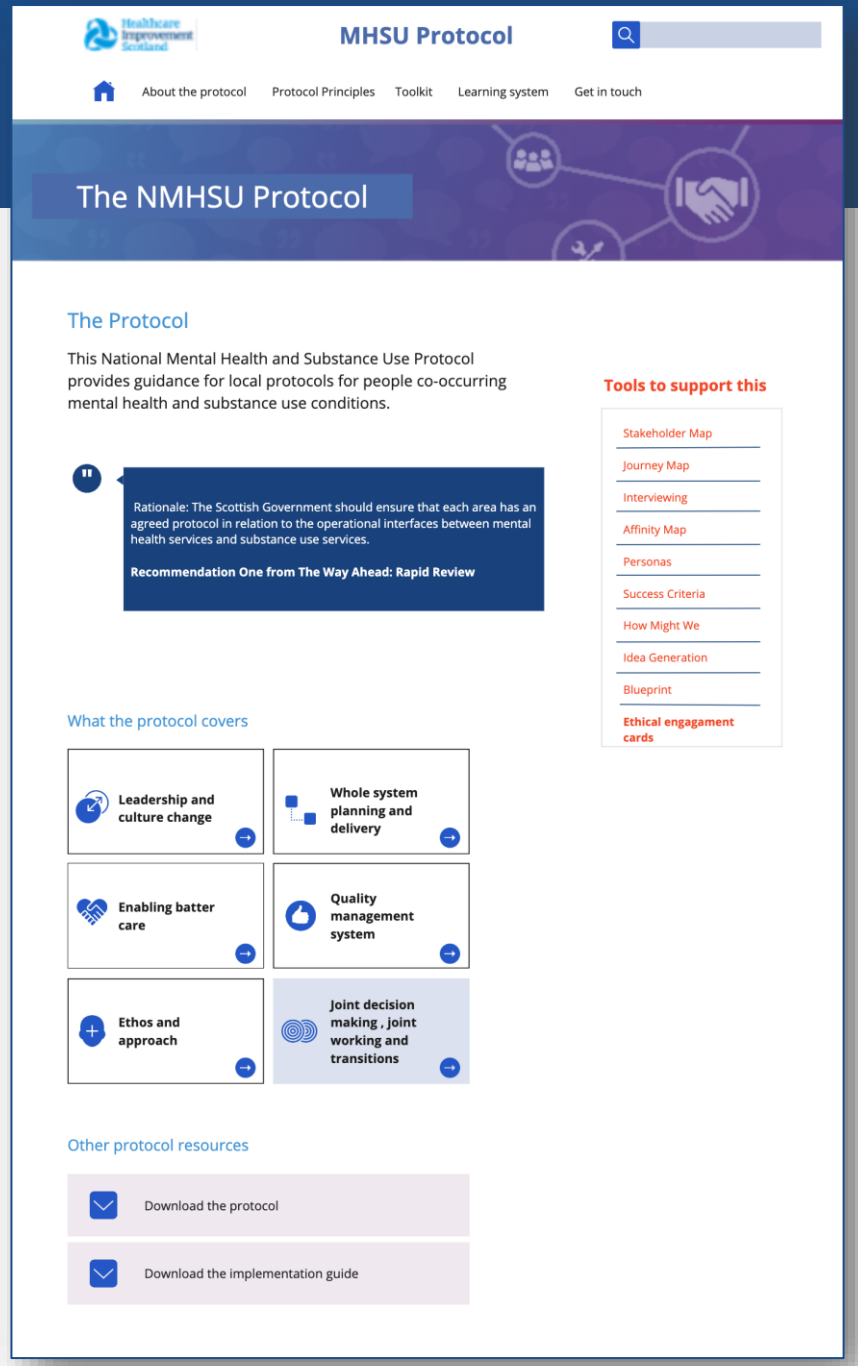
Benefits of an online protocol

- One place for Mental health and substance use practitioners to find information on the protocol
- One place to update and add case studies to as the protocol evolves
- Drives traffic to HIS tools and services.



Next steps

- Develop the case studies for protocol dimensions
- Develop the toolkit
- Engage with HIS Comms team



Healthcare Improvement Scotland

Supporting better quality health and social care for everyone in Scotland

- Advice on new medicines
- Advice on health technologies
- Standards, guidelines and indicators
- Inspections and reviews
- Enabling health and social care improvement
- Death Certification Review Service
- Scottish Patient Safety Programme
- Safeguarding antibiotics
- Community Engagement
- Global quality improvement webinars

Peer Conversations

2 – 4 – All

- Are you doing anything in this area?
- What can you learn?
- What advice do you have for others?
- What would you like to know more about?
- What would help you with this?

5mins – in pairs

5mins – in pairs of pairs

5mins – share your thoughts

Breakout One

Discuss examples of how you currently support people in line with the protocol principles.

Co-occurring conditions are supported concurrently and decisions regarding treatment and support should be made jointly.

There is proactive collaboration and co-ordination between services across the wider system of care, with joint consideration of clinical and social support needs.

Comfort Break

14:45 – 14:55

Breakout Two

Discuss how you might approach developing and implementing a protocol.

Where are you now?	**Enablers of progress so far**	**Any challenges that will need to be addressed**	**What do you need to do next?**

Discuss how you might approach developing and implementing a protocol.

Where are you now?	**Enablers of progress so far**	**Any challenges that will need to be addressed**	**What do you need to do next?**

Feedback

We would be very grateful for your feedback – please spend a couple of minutes to complete the feedback form on the tables. Alternatively you can do this online by following this QR code:

Save the date

25 September 2024

09:00 – 11:00

MS Teams

Keep in touch

Email:his.transformationalchangementalhealth@nhs.scot

Web: healthcareimprovementscotland.org