**Mental Health and Substance Use Learning System: Primary Care & Missingness**

**Q&A**

1. **Q: How are the MAT principles being used with Consumption Rooms?**

A: I'd see these services as a great example of improving access, choice and support for people, which was the ambition of the MAT standards - all the international evidence demonstrates that safer consumption facilities particularly engage people that have experience of the justice system or experience of homelessness, and that as well as harm reduction and overdose prevention, consumption rooms provide a route to other health and social support, as well as providing an opportunity for referral to other specialist drug treatment support to improve people's quality of life.

2. **Q: Do you know how many pharmacies in Scotland are administering Buvidal? Which Health Boards do these include?**

**A:** The number of pharmacies' is not known by the presenters. Boards undertaking services to our knowledge are:

- NHS Ayrshire & Arran
- NHS Dumfries and Galloway
- NHS Grampian
- NHS Greater Glasgow and Clyde
- NHS Lothian
- NHS Tayside

Areas looking to develop services are

- NHS Forth Valley
- NHS Highland
- NHS Lanarkshire (starting pilot in 2026)

3. **Q: How do we ensure that this level of support (triangulation etc) is achievable for those with co-existing mental health and substance use issues – given the logistical differences in the systems (for example, being able to access ORT on the same day, but having a significant wait for mental health support)?**

4. **How do we ensure equity, to ensure individuals and their families/loved ones, can access support across the system? Regardless of where they present.**

**A:** Within alcohol and drug recovery services, because we've had the drug related deaths crisis going on for so long, we've become so sensitised to thinking that someone in treatment is much less likely to die than someone who's not in treatment, and so this push for engagement has been quite strong. Whereas in mental health services, there's still the old idea of where if the patient doesn't turn up that means they're not motivated to engage in care. But when someone's feeling low and anxious, managing to get to their mental health appointment might be too much for them. But within the mental healthcare system there's so much of a focus on waiting lists and other drivers that we have completely lost sight of what it is we're actually trying to do, which is try to provide good care to people so that they thrive in life.

**A:** Mental health presentations sit more on the primary care end. People can't directly access mental health services, but most people do have access to general practice. So mental health presentations come into the primary care side and it's difficult because we don't necessarily get equitable care within primary care and have difficulty around the connections and interfaces with secondary care mental health. The general feeling is that if the substance use is stabilised, then that provides a much better potential to help with mental health. But there's often a kind of dissonance between what patients expect and what patients will say "it was my mental health that's the reason why I'm using this stuff. So, you must fix my mental health before I can stop using substances." I don't think it's an easy answer.

Addictions services, through the MAT standards and the focus on drug related deaths, have developed a greater sense of urgency in getting care to this population to reduce the risks and possibility of deaths due to substance use. This has not been the case in mental health and it is harder for referrals to be made to mental health than for addictions (most addictions services have multiple referral pathways including self-referral) and the waiting times/lists are greater. There is also a much wider spectrum of conditions under the umbrella of mental health, from milder anxiety and depression to more severe and enduring conditions). Above all as has been mentioned services are trying to provide the best treatment and care for all individuals with substance use and mental health issues.

5. **How do we fill the gap that community pharmacists generally have no access to a patient's medical record? (So all they have is a prescription but no shared diagnosis or specific information risks that are individual to that patient, nor will they know if a patient is "open " to a mental health team unless patient on ORT. They may well be the first person to recognise a change in a patient's mental health or receive a patient in distress, but it will not be clear to them what to do or who to contact especially if they have no idea what a patients treatment plan is or which services they are receiving or open to.)**

**A:** A single shared record with read/write access has been called for many times and from many levels and multiple professions. The Care Reform Bill passed in June 2025, will hopefully pave the way for access to records for all health and social care services however, it is not clear on the timeline for implementation.

6. **Do you think, including families and someone's care plan, would help reduce some of that missingness, and why are families not more included as a standard?**

**A:** It depends. It can be positive and helpful to have families involved. Substance use services are trying because of MAT standards, and in mental healthcare services it's variable. But it depends on the person's relationship with their family, some people's families are not actually a safe place. In general, it can be positive but it's back to that whole person-centred approach and now, we're still far too service oriented.

**A:** It is helpful, but it depends on the patient – it's very much patient centred. A lot of patients in substance use, especially, are distant from their family or had fractured relationships and it's not always beneficial. But for some, it's incredibly beneficial and we do encourage having that openness with the family - they are welcome to have family come to appointments, but you've got to get the patient's permission.

**A:** Family can be seen as a wider network as opposed to relation.

**A:** We default to seeing families as a negative too quickly, and that means we miss vital support