Healthcare Improvement Scotland

Mental Health and Substance Use Protocol Programme: National Learning Event

Primary Care & ‘Missingness’

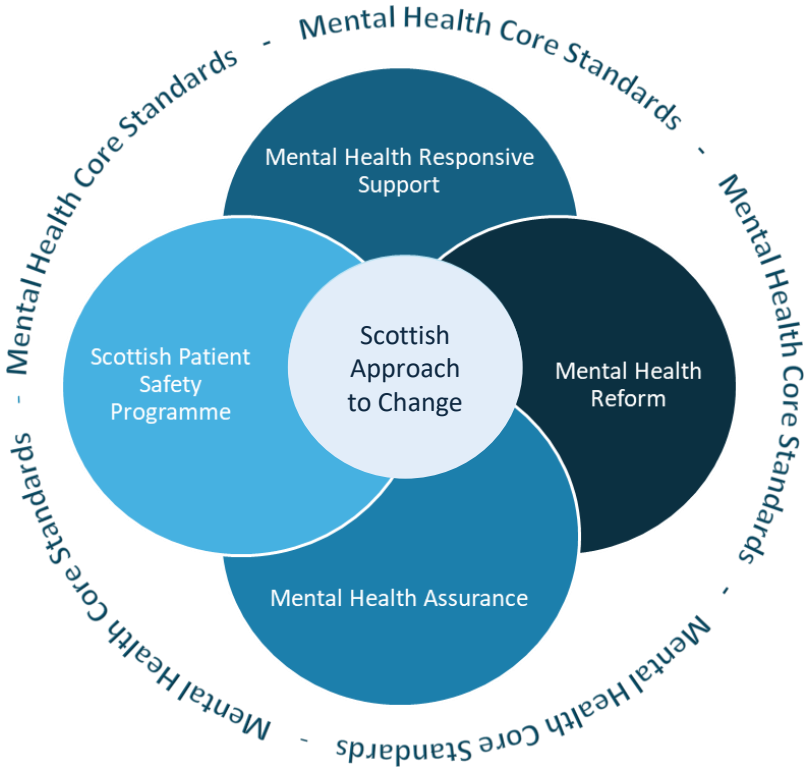
Leading quality health and care for Scotland

NHS SCOTLAND

Agenda

Time	Topic	Lead
1pm	Welcome and introductions	Benjamin McElwee, Senior Improvement Advisor; Dr Robin Moore, Clinical Lead; Mental Health and Substance Use Programme, Healthcare Improvement Scotland
1:10	Models of drug treatment care in general practice and community pharmacy and evidence review findings	Elinor Dickie, Organisational Lead, Drugs Team, Place & Wellbeing Directorate, Public Health Scotland
1:20	Managing substance use in primary care	Julia Martineau, Primary Care Programme Manager, Dundee HSCP
1:35	Pharmacy: Mental health and substance use support in your neighbourhood	Adrian Mackenzie, Pharmacy Clinical Lead, MAT Standards, Healthcare Improvement Scotland & Duncan Hill, Specialist Pharmacist in Substance use Management, NHS Lanarkshire
1:50	Applying a missingness lens to healthcare	Professor Andrea Williamson, Professor of General Practice and Inclusion Health, University of Glasgow
2.10pm	Q & A / Panel discussion	All
2.25pm	Closing remarks	

Mental Health across Healthcare Improvement Scotland



The Five Components of a system of care for mental health and substance use

To develop more joined up approaches in relation to assessment, understanding needs and access to services, roles and responsibilities across services, and how communication should be used to ensure seamless care.

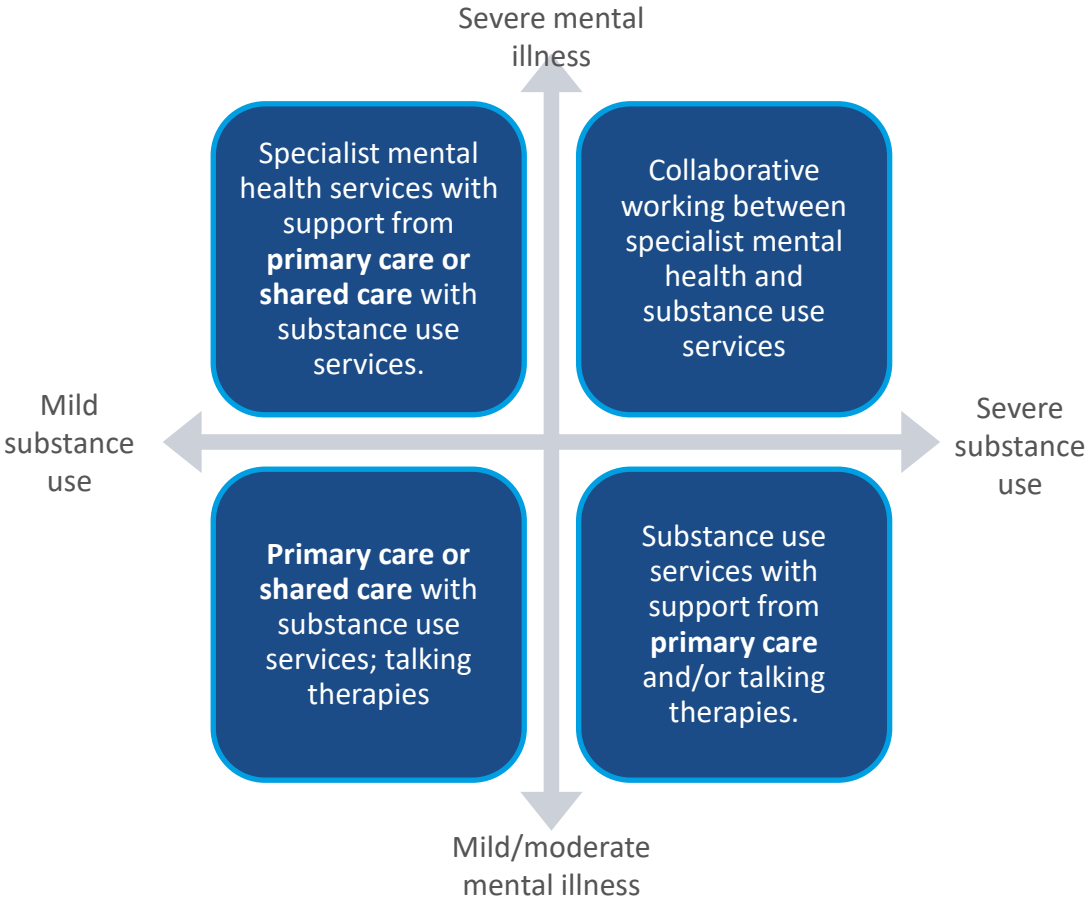
To create strong leadership that supports ongoing implementation and improvement across services, and a collaborative and enabling culture is actively fostered.

To develop an accountable governance structure focused on learning with robust oversight and auditing, that includes governance systems and processes which are people-led and promote shared decision-making.

To ensure that processes and changes are embedded and sustained through the development of positive relationships across services and a strong, skilled workforce.

To align activity and priorities with strategies and change occurring within the health and care system.

Appropriate treatment by severity - RCPsych



Provocation

"There is no such thing as a hard-to-reach individual"

Statement from the floor at a Dundee Protecting People event in 2023

What is missingness?

Bing Search: **Persistent and troubling pattern**

Missingness is a term that encapsulates a **persistent and troubling pattern –** when individuals repeatedly miss healthcare opportunities, which can lead to adverse health outcomes

- Professor Andrea Williamson's blog…

- Not engaged
- Off the radar

Some numbers – A sample of OST prescribed patients

26% or approx. ¼ (70 out of 274) of patients had not had contact with a clinician at the specialist service between November 2022 and April 2023

Lack of contact between patient and service is a barrier to progress. It is multifactorial in nature and responsibilities lie on both sides, but it should be recognised that there is potential for improvement and given cyclical nature of barriers small changes have potential to realise large shifts.

Drug treatment in primary care
MAT7 national developments

Elinor Dickie
Organisational Lead, Drugs Team

Public Health Scotland

MAT7: People who choose to will be able to receive medication or support through primary care providers. These may include GPs and community pharmacy. Care provided would depend on the GP or community pharmacist as well as the specialist treatment service.

Rationale

The Orange Guidelines identify joint working across health and social care and between hospital, prison, primary care and community drug services as a key feature of effective treatment partnerships (p13). There is an ageing population of people who use drugs and many people have underlying conditions and so would benefit from MAT delivered in General Practice, due to the possibility of wider health problems being met. MAT offered in primary care can help to address issues around access to drug treatment services in rural areas. Community pharmacists are well placed to deliver scheduled or opportunistic care because they can have very frequent contact with people picking up prescriptions or attending for other reasons.

MAT 7 criteria

All people have the option of MAT shared with primary care.

7.1 Primary care and substance use service partners have in place:

a) **practice models** that support people on MAT to remain in primary care
b) **shared care protocols** between specialist services, GP and community pharmacies, that may include prescribing where competent practitioners are in place;
c) **clinical and governance structures** that enable people working in primary care to fully support people, alongside care for physical, emotional, and social needs;
d) **contractual arrangements reflect the requirements of MAT standards;**
e) **pathways** between specialist services, local mental health services, GP and pharmacy;
f) **information governance** - between specialist services, GP and community pharmacy, including child and adult protection procedures;
g) effective recording and review systems for **recovery care planning**
h) **training** on problem drug use and on awareness of local drug services, including non-statutory providers and peer support services for all staff
i) **auditing, monitoring, reporting and reviewing practice** through a 'primary care facilitation team' or equivalent, and for support with workforce development.

This standard will be further developed in collaboration with partners.

Rapid Evidence Review (RER)
Integrated models of drug treatment in primary care

Shared care

- describes a way of working together between primary care, specialist services and social care services where the patient journey crosses interfaces.
- at times the organisation with overall responsibility for drug treatment may be specialist services and at other times primary care will have overall responsibility.
- these models are based on the recognition that a limited specialist resource focuses on complex individuals.

Integrated care

- describes a way of working between primary care, specialist services and social care where the patient journey remains with the primary healthcare provider at all times.
- these models build on primary care as expert medical generalists with a community-based multi-disciplinary team which can be adapted to the patient's needs over time.

RER findings – components of care

M

Coordinated multi-disciplinary care planning and regular multi-agency review meetings were widely described.

The patient experience appeared similar across the models:

Individuals were seen by a GP or key worker, with support provided by specialist and multi-

Individualised treatment, care plans and goals are agreed with the patient,

with an emphasis on recovery and harm reduction.

R
R **s**

A range of roles and responsibilities were defined – prescribing, case management, priority referrals, third sector leadership

Evaluation: Due to the limited outcomes data, evaluation is needed to assess the effectiveness of different components of care

MAT7 Thematic Group – learning & opportunities

- Importance of patient choice
- Need to be realistic, different for different areas
- Role and ways of working with specialist services to be explicit
- Focus on the need for general medical services for this population, & wider health needs
- Responsibility to ensure unmet need of people not currently in treatment (approx. 50% in Scotland) and where they would like to receive their care?

- Need to look at different ways of recognising and achieving GP involvement
- Focus on 'joined up' *experience* of care for people
- Clearer focus on ways of working
  - how different components of care can be met by different services
  - ensuring practitioners working to their highest competence
  - Connections between services to align best patient care, with clear roles & responsibilities
- GP interest in supporting general health and mental health for this patient group
- Need to consider flexibility, and tailor expectations to local contexts and settings
- Great GP advocates – how can we learn from their models of care, and encourage engagement by others?
- Collaborative model between primary care and specialist services more achievable, including role for community pharmacy

MAT7: People who choose to will be able to receive medication or support through primary care providers. These may include GPs and community pharmacy. Care provided would depend on the GP or community pharmacist as well as the specialist treatment service.

Rationale

The Orange Guidelines identify joint working across health and social care and between hospital, prison, primary care and community drug services as a key feature of effective treatment partnerships (p13). There is an ageing population of people who use drugs and many people have underlying conditions and so would benefit from MAT delivered in General Practice, due to the possibility of wider health problems being met. MAT offered in primary care can help to address issues around access to drug treatment services in rural areas. Community pharmacists are well placed to deliver scheduled or opportunistic care because they can have very frequent contact with people picking up prescriptions or attending for other reasons.

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MAT7 Frameworks

Public Health Scotland NHS Tayside

Drug treatment in primary care:
current practice example (2 of 7)

Dundee

August 2025

Background

The Medication Assisted Treatment (MA
enable the consistent delivery of safe, acce
treatment and care across Scotland. The s
risk of death. They are relevant to people a
well as health and social care staff respons

There are 10 MAT standards and these p
people have the option of MAT shared w

People who choose to will be able to receiv

Public Health Scotland Healthcare Improvement Scotland NHS Lanarkshire

Drug treatment in primary care:
current practice example (7 of 7)

Community Pharmacy

August 2025

Background

The Medication Assisted Treatment (MAT) standards are evidence-based standards to enable the consistent delivery of safe, acceptable, accessible and high-quality drug treatment and care across Scotland. The standards aim to reduce drug-related harms and risk of death for people experiencing problems with their drug use. They are relevant to people and families accessing or in need of services, as well as health and social care staff responsible for delivery of recovery-oriented care.

There are 10 MAT standards and these practice examples focus on MAT standard 7: All people have the option of MAT shared with primary care:

Existing models of care:

- Aberdeen City
- Aberdeenshire
- North Ayrshire
- Dundee
- East Lothian
- Glasgow City
- Pharmacy

Thank you

elinor.dickie@phs.scot

Happy to share the frameworks: phs.drugsteam@phs.scot

Healthcare Improvement Scotland

Dundee Primary Care Drug Redesign Project

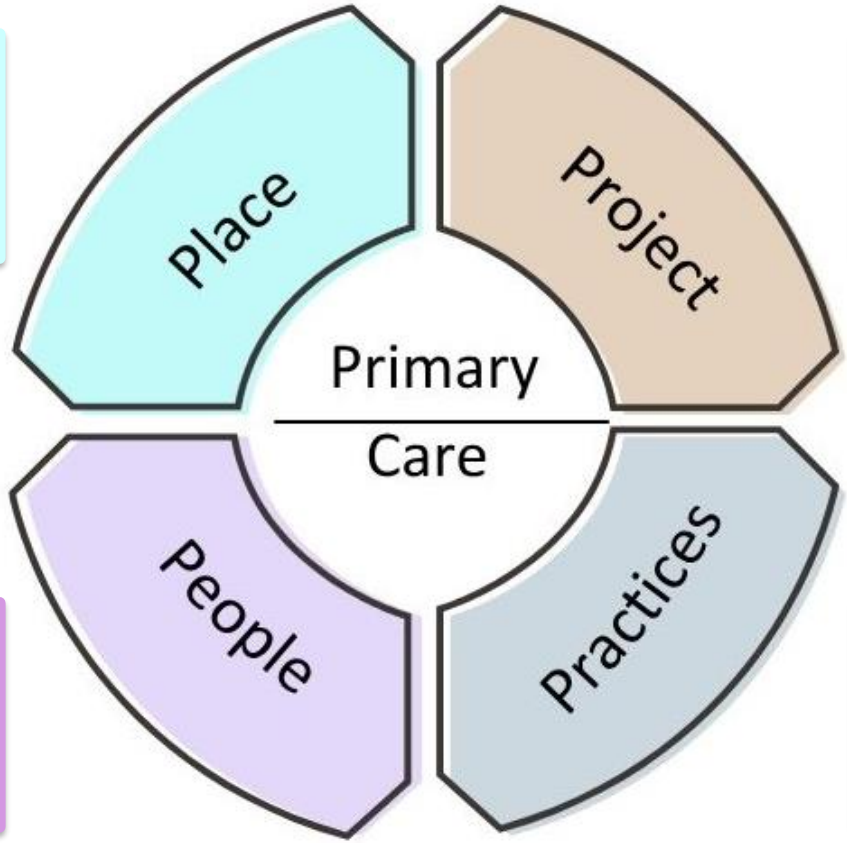
Leading quality health and care for Scotland

NHS SCOTLAND

Background and components of the project

Dundee - high deprivation, rate of drug misuse deaths

Drug Commission Reports, GP Contract, Scot Gov Funding



Triad – GP, Specialist Nurse & Practice Key Worker

SLAs:
Stable OST, stimulant drugs, holistic health

A view of the project through the missingness lens

Stigma	• GP Practice offers anonymity • Staff workshops on stigma and naloxone
Previous negative experience	• Triad = trusting relationships • Practice key workers with lived experience • Option to have advocacy
Believe services not designed for them	• Personalised patient packs • Recovery workbook • Holistic checks - not just substance use
Access and rigid appointments	• Flexibility in both level of contact and location of appointments
Have non-health priorities	• What matters to you? • Starting point may not be substance use
Families & Carers	• Ripple effect

Question

What is the biggest obstacle you face when caring for patients with substance use in primary care?

Healthcare Improvement Scotland

Pharmacy - Mental health and substance use support in your neighbourhood

Adrian Mackenzie, Pharmacy Clinical Lead – MAT Standards, HIS
Duncan Hill, Specialist Pharmacist in Substance Use Management, NHS Lanarkshire

NHS SCOTLAND

Pharmacy Facts and Figures

1,257 Community Pharmacies in Scotland

1,929 Pharmacists working in Community Pharmacy

Plans underway to train all pharmacists as prescribers.

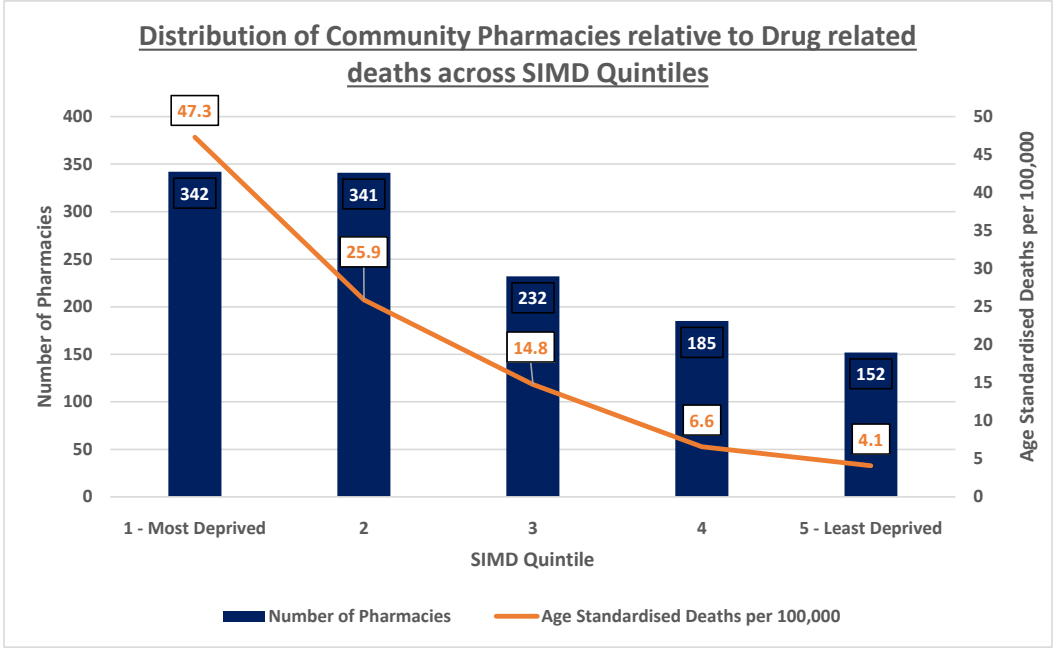
949 Pharmacy Technicians registered in Scotland

Source:
NES Community Pharmacy Report 2024– Accessed 09/10/25
NES Pharmacy Workforce report – Accessed 09/10/25

Location, Location, Location

Pharmacies buck the inverse care

Access to healthcare and advice within their localities wherever they live.



Why engage with community pharmacy?

Primary interface with health services for people impacted by mental health conditions and/or use substances.

No appointment needed

Already have a relationship with patients and have built trust.

80% of the population live within 30 mins walk of a pharmacy

MAT 7 Thematic Examples

All 1,257 pharmacies

- Dispensing prescriptions to people in line with the prescribing directions, – All 1,257 pharmacies
- Holding of Naloxone for emergency use – All 1,257 pharmacies
- Signposting to appropriate services to meet people's needs.

Where commissioned

- Providing supervised self-administration of medicines where required.
- Administration of long-acting injectable buprenorphine
- Deliver training and supply of take-home naloxone
- Supply of injecting equipment -10%-25% of pharmacies in a HB area.
- Blood Borne Virus (BBV) testing - where commissioned
- Dispensing of Hepatitis C medications – where commissioned

Community Pharmacy Links

- Strong in most areas
  - GP Practices and pharmacotherapy teams
  - Substance Use Teams
  - Acute pharmacy colleagues
- Variable in most areas
  - Community Mental Health teams
  - Acute care medical, nursing and AHP colleagues
  - Third sector providers

Summary - Why Pharmacy?

- Experts in medicines
- Extensive hours of operations
- Close to people's home, particularly deprived communities
- Trusted location and profession
- Good links with communities
- See patients more frequently than any other healthcare professional.

Contacts

- If you would like to discuss more how community pharmacy can support service delivery.
  - Speak to your local Specialist Pharmacist or Community Pharmacy Lead
  - Meet with your Local Pharmacy Contractors Committee to discuss services.


University of Glasgow
Applying a missingness lens to healthcare
Prof Andrea Williamson on behalf of the missingness research team, HIS substance use and mental health, October 2025
WORLD CHANGING GLASGOW
THE TIMES THE SUNDAY TIMES
GOOD UNIVERSITY GUIDE 2022
SCOTTISH UNIVERSITY OF THE YEAR

Presentation Outline

- Epidemiology of multiple missed appointments
- Causes of missingness
- Applying a missingness lens & interventions

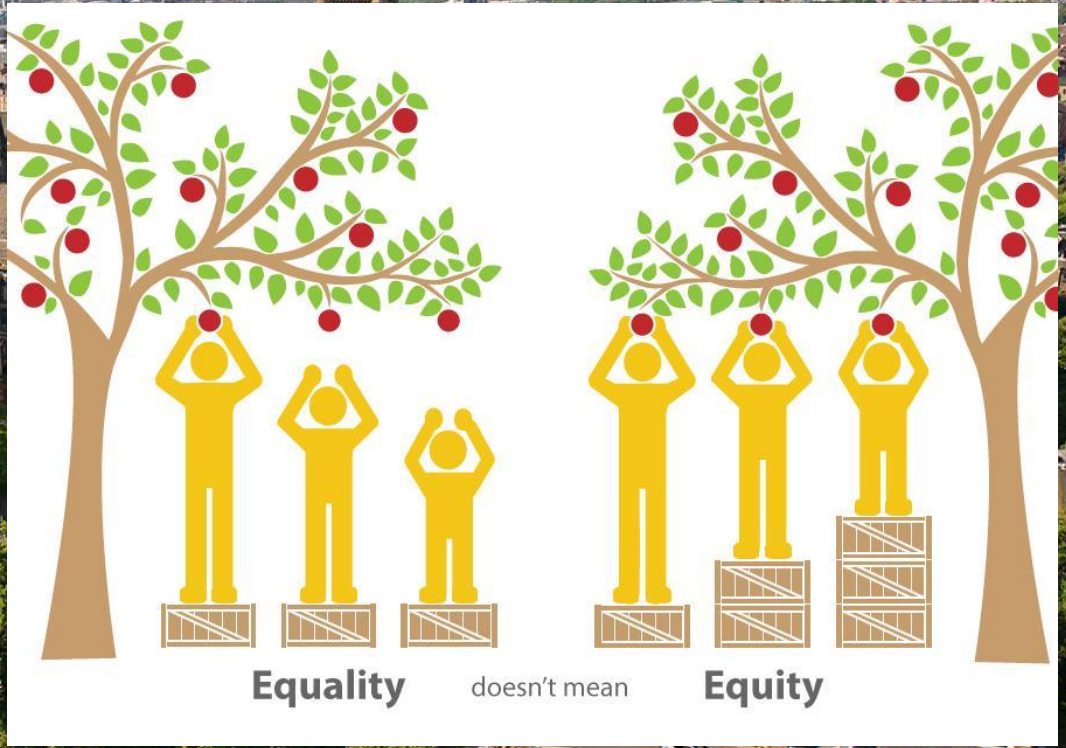
University of Glasgow

Acknowledgement

We acknowledge the survivorship of the people who are in Inclusion Health groups and who we meet and represent in our work. They continue to be an inspiration to us through their resilience and strength in the face of adversity.

University of Glasgow

The importance of equity 1



Defining ‘Missingness’

*“The **repeated tendency** not to take up opportunities for care, such that it has a **negative impact on the person** and their life chances”*

(Lindsay et al, 2023)

- Not one or two, but multiple missed appointments over an extended period of time
- Signifies **significant and enduring challenges** in accessing and engaging in healthcare

SMA Research Acknowledgements

PI: Andrea E Williamson
Co-investigators: David A Ellis, Alex McConnachie & Phil Wilson
Researcher: Ross McQueenie
Collaborator: Mike Fleming
Trusted Third Party: Dave Kelly Albasoft
Participating GP practices
Colleagues at Scot Gov and eDRIS

Missed appointments results

136 Scottish representative GP practices

550 083 patient records

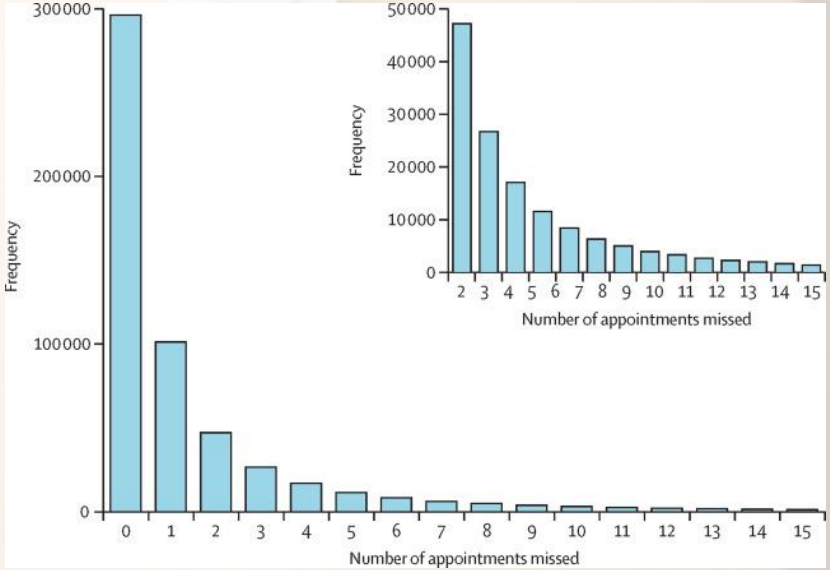
9 177 054 consultations

54·0% (297,002) missed no appointments

46·0% (212,155) missed one or more appointments

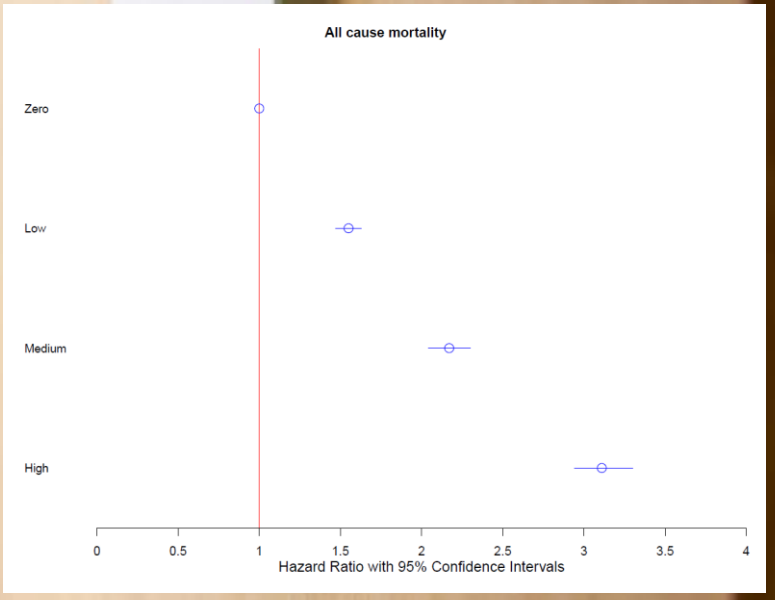
19·0% (104,461) missed more than two appointments

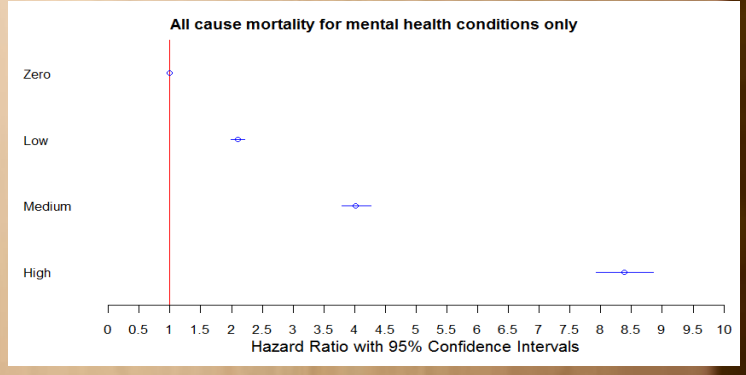
(Ellis, McQueenie et al Lancet Public Health 2017)



Epidemiology

- **Patients** at high risk of missingness are characterized by poor health, higher treatment burden, complex social circumstances and have higher premature mortality (McQueenie et al BMC Medicine, 2019, Williamson et al Plos One 2021, Williamson et al BJGP Open 2020, McQueenie et al BMC Medicine 2021)
- **General practice appointment scheduling** and context is important (Ellis, McQueenie et al Lancet Public Health 2017)
- **Patterns of missingness persist across secondary care** outpatients and inpatient 'irregular discharges'; patients are NOT seen in ED instead (Williamson et al Plos One 2021)
- **Missingness is a strong risk marker for a poor outcome** so needs urgent attention from health service planners and practitioners





Current Realist Research

Dr Calum Lindsay, Dr David Baruffati, Prof. Geoff Wong, Prof Mhairi Mackenzie, Prof Sharon A. Simpson, Prof David E. Ellis, Michelle Major, Prof Kate O'Donnell, Prof Andrea E. Williamson

Acknowledgements: Elspeth Rae research administrator, Jack Brougham illustrator, research interview participants and Stakeholder Advisory Group members.

Methods

I. Realist literature review (254 papers)
II. Interviews (61 participants)
III. Stakeholder Advisory Group (16 participants)

Broad range of clinical, social and inclusion health backgrounds

Missingness caused by interaction between overlapping service- and patient-side drivers, shaped by wider structural context, enduring over time.

"I haven't missed very many NHS appointments, but that's through *vast* amounts of effort. All these factors interplay and […] it's surprising anyone ever gets outside the door because it's all stacked against you." (Sharon, Peer Support Worker, Inverclyde)

What causes missingness? (Lindsay et al 2024)

- Patients not feeling the service is **‘for’ them:** necessary, helpful, appropriate, safe.
- **Past experiences**: mistreatment, poor communication, power imbalances, offers do not help/‘fit.’
- **Getting there:** travel, transport, space and place.

“you see yourself as one of the least deserving people, when somebody reaches their haund… […] because you believe already that you don’t deserve it, you arenae gonnae take the haund…”

(Jim, Glasgow)

What causes missingness(2)? (Lindsay et al 2024)

- **Access rules:** difficult to understand/navigate; gatekeeping; delay; inflexibility; errors/mistakes.
- **Competing demands/limited resources:** appointments, work/money, relationships, survival.
- **Mistrust/distrust:** stigma, trauma, discrimination, mistreatment, misunderstanding, “easier” patients.

“There's a constant dynamic of conflict […] and this is a theme you'll find from anybody you speak to, who has a child or an adult with complex health needs, a constant fight. And some people; they get exhausted, and they give up, and I can't blame them.” (Jodie, Glasgow)

Intervention Development Process

Realist principles

- Synthesising literature, interview and StAG findings.
- Extended stakeholder involvement for insight, contextual relevance and equity.
- “Changing relationships, displacing existing activities and redistributing and transforming resources”. (Wight et al 2016)

The 6SQuID Method

1. Define and understand the problem: from a “one size fits all” model to a missingness lens.
2. Identify factors that can and should be changed.

¾. Identify how to bring about change – the “change mechanism” - and how to deliver it in context.

Redefining the problem – a missingness lens

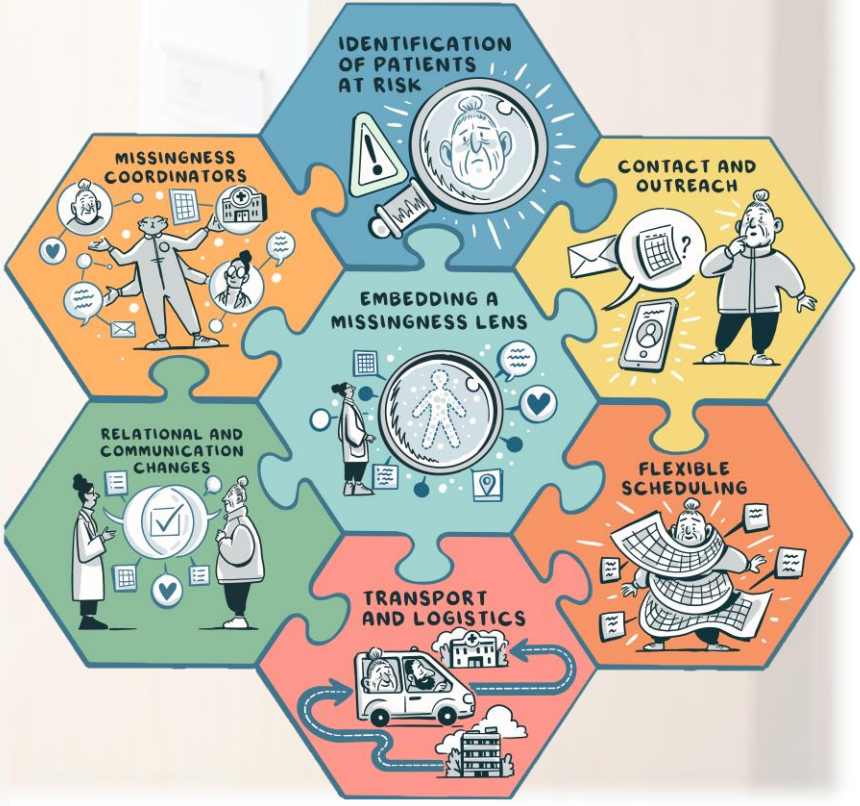
The 'situational' model	A missingness lens
Patient 'responsibilisation'	**Services** committed, resourced, incentivised to identify and address barriers
Shallow, monocausal perspective	**Complex causality** for individuals, in contexts (tailoring)
Technical, practical, logistical	**Safety -** structural, cultural, relational, psychological
Standardised, service-oriented	Proportionate universalism and positive selectivism
Biomedical models of healthcare	**Condition Competency,** addressing SDOH, poverty, & marginalisation
Hierarchical, service-oriented solutions	Person-centred approaches

Missingness Interventions (unpublished)

Designed as a ‘suite’ of activities – “a ‘recyclable’ core set of processes that can be judiciously applied.” (Pearson et al 2015)

Implemented on a needs-led, patient-centred basis, oriented around **embedding a missingness lens.**

A systems perspective – creating conditions to disrupt the system that creates and sustains missingness.

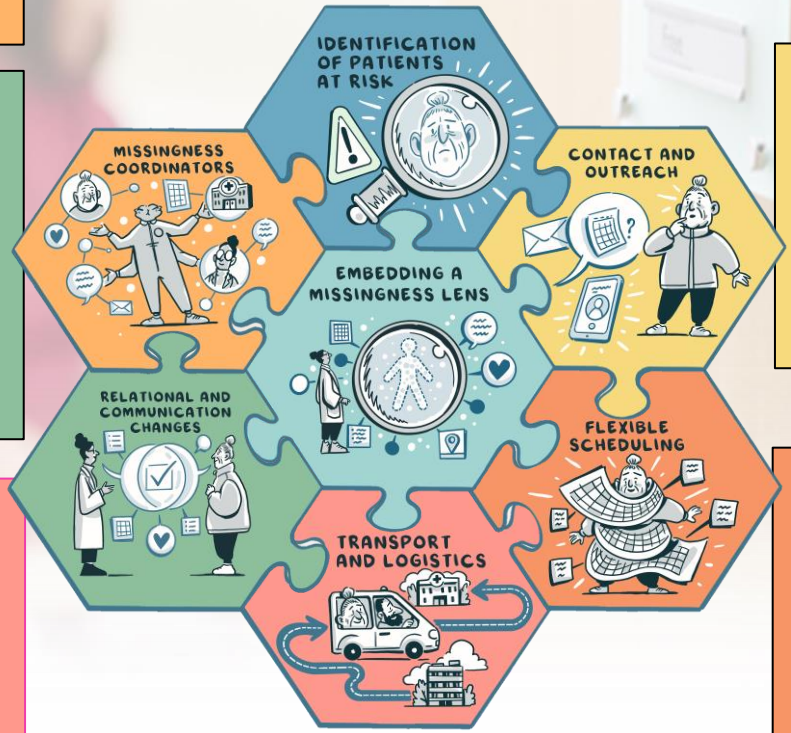


Coordination: Open-ended, flexible, relational; bridging work; address SDOH and patient priorities, advocacy and promoting system change.

Resourcing a change in perspectives, practices, systems; staff development and support; build in localised perspectives; means for monitoring and accountability

Identifying and tracking local patterns and trends.
Exploring barriers while building relationships.
Building a picture – individual + collective.

Person-centred, trauma-informed practices.
Choice/continuity of staff; addressing comms needs and power dynamics; advocacy work.



Contact before/after appts – reminders; orientation; explore immediate barriers; offers of support or care; check-ins; points of contact for patients.

A stepped, needs-led approach:
Tickets/reimbursement > taxis > accompaniment > outreach/inreach.

Prioritising for tailored forms of access: choice of how, when, who, where; longer appts/opening hours; allowances/accommodations.

Scottish Health Policy developments

Glasgow ADRS missingness guidance

Staff Guidance

Glasgow Alcohol and Drug Recovery Services:

Addressing Missingness in Community ADRS

https://www.gla.ac.uk/media/Media_1217492_smxx.pdf

Conclusions

- **Missingness** is a strong risk factor for negative outcomes BUT has clear causes that can be addressed.
- Requires a perspective shift towards a ‘missingness’ lens, with a suite of interventions guided by these strong principles.
- Provides a **purposeful organising framework for Inclusion Health and mainstream services**.

Thank you!

Addressing missingness already? email us
missingness@glasgow.ac.uk
Direct email address for Andrea Williamson
andrea.williamson@glasgow.ac.uk
Further information about the research (papers, presentations, what we are doing now) can be found here on the Missingness Interventions, University of Glasgow webpage

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Open discussion and Q&A

Feedback

Please click this link or the one in the chat box.

Alternatively, you can scan the QR code

Peer Network workshop

Join the Mental Heath and Substance Use Peer Network….

- To build knowledge and accelerate improved outcomes,
- Connect with people to share learning, successes and challenges,
- Develop an understanding of co-occurring mental health and substance use needs within the health and social care system.

Our next workshop is taking place on **27 November at 14:00** to continue the discussions held today, join the network to take part:

https://tinyurl.com/mpt3hnh6

Mental Health and Substance Use: Toolkit

- We have launched a new Mental Health and Substance Use Toolkit
- It shares tools that can help staff with the process of designing and delivering services.
- Using the framework of the Scottish Approach to Change, it can support and guide teams on how to approach and make changes, from initial planning through to implementation and sustainment.

Register for upcoming event

Mental Health and Substance Use: National Learning Event - Care, Recovery, and Suicide Prevention

3 December, 1-2.30pm

This event will explore:

- good practice for involving families and carers in clinical assessment and care planning, when self-harm, suicidality and/or substance use are active factors for the person seeking clinical support and treatment
- the importance of supporting and involving families, carers and nominated persons in improving outcomes and supporting social relationships

Next steps

Use this link to sign up to our distribution list to ensure you receive all communication around future mental health and substance use events, including how to register.

Alternatively, you can scan the QR code above or press the link in the chat

Keep in touch

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Email: his.transformationalchangementalhealth@nhs.scot

Web: healthcareimprovementscotland.scot

Find out more:
https://ihub.testing.nhsscotland.net/ihub.scot/improvement-programmes/mental-health-portfolio/mental-health-and-substance-use-protocol-programme/