Mental Health and Substance Use Protocols – Strategic Gap Analysis

This document includes a Strategic Gap Analysis (SGA) based on the knowledge and evidence gathered during the Mental Health and Substance Use: Improving Our Response programme that finished in March 2024. The SGA is designed to inform the MHSU Protocol's development by providing insight into the current gaps that the protocol needs to seek to address. The SGA explore what good looks like, then describes existing practice, and finally thematically identifies the disparities between existing and good practice to outline the strategic gaps that the protocol can address.

1. What good looks like

In this section we will outline what good looks like across a number of thematic areas in relation to supportive systems for people with mental health and substance use needs. This has been informed by research that has gone into the development of the National Mental Health and Substance Use Protocol, including an evidence review and an evaluation of models that support high-level co-occuring mental health and substance use needs.[1]

There is a high level of complexity in relation to concurrent mental health and substance use. In addition, evidence clearly shows the beneficial impact of social models of support that are able to respond to complex and changing needs. Current models of care need to be able to adapt to meet a range of needs, outside of medical treatment models, and support positive and sustained life outcomes for people. There is no single model of 'good practice' that can be described. Instead, there are various models that include a range of key features that are important to ensure that the services and support provided match what we would consider to be good practice.

The fuller analysis of different models that are appropriate in the context of supporting concurrent mental health and substance use needs can be found within the options appraisal currently under development.

These features of good practice are in relation to leadership and culture within organisations and services, how assessments and access is facilitated, the way that transitions and joint working happens, the communication and information sharing across services, the workforce development, and how lived and living experience is included. These themes are analysed in more detail in the rest of this section.,

1.1 Leadership and culture

Good leadership actively invests in the development of an enabling culture across the various organisations, services and actors relevant to supporting mental health and substance use concurrent

[1] Care models for coexisting serious mental health and alcohol/drug conditions: the RECO realist evidence synthesis and case study evaluation

need. This is required to bring together historically siloed services and develop a whole system response to mental health and substance use. Without this, technical and operational changes made to processes and services will fail to lead to sustained changed and better outcomes. Strong leadership is centred on holding spaces for collaboration, coordinating change across a broad range of services and sectors; and championing the voices of people with lived and living experience of services and staff. From our experience and the evidence we know that the following matters in supporting this to happen:

- Clear reporting mechanisms that supports the development of shared responsibility at a senior strategic level
- Clinical messaging that highlights the importance and benefit of collaboration across mental health and substance use services
- Planned and agreed roles and responsibilities across the whole system that enables flexible responses to mental health and substance use, with a recovery focus
- Consistent messaging from senior leaders in relation to 'Everybody's Job' and 'No Wrong Door' to support the provision of integrated care from mental health and substance use services
- Alignment of key drivers for mental health and substance use integration including National Drugs Mission, Suicide Prevention, Mental Health Core Standards and the improving physical health agenda
- A culture of trust across services that supports relationships between staff

1.2 Assessments and access

There needs to be a clear understanding of a person's needs across both mental health and substance use, and these should be taken into account together when making decisions on access and support. Doing these in relation to each needs in isolation is not sufficient and leads to poorer access to the right support.

- Joint assessments should be carried out involving multiple service providers to comprehensively understand the individual's needs and determine the most suitable lead service provider.
- Clear designation of the main service responsible for coordinating individual's care, along with the development of a shared care plan involving input from all relevant services.
- Agreement on the specific interventions needed for individuals and where care should be most appropriately delivered, based on the level of presenting need and accessibility considerations. There should be flexibility to adjust interventions and support as circumstances change.
- Specific input on decision making, where there is a question about appropriate services, should be sought from specialists to avoid inappropriate and rejected referrals.
- Building patient choice/preference into decision making.
- Service should jointly agree on the most appropriate assessment and screening tools to be used, ensuring they are reliable, valid, and sensitive to the individual's circumstances. Additionally, clarity on who will administer these tools and how often they will be utilised.
- Transparent communication among services and the service user of assessment outcomes and their implications for accessing various systems of care, fostering trust among services and minimising disputes.
- Clearly documented policies and procedures around referrals, screening, care planning, discharge, and supervision to ensure consistency and accountability in service delivery.

- As per the four-quadrant model, substance use services should also be competent to deal with mild to moderate mental health problems of individuals, and the limitations of such care should be agreed in the local interface protocol.

1.3 Transitions and joint working

Being able to be flexible and respond to changes in a person's needs is essential in supporting people with complex needs, including concurrent mental ill health and substance use. Good practice is centred around how transitions are managed in a planned way, with regards to how need for a transition is identified and how services and the person work together to understand ongoing support where there are transitions out of statutory services. Joint working is also key to flexible service delivery, with good practice being enabled by clear lines of communication across services, shared understanding of a person's needs and the joint service role in meeting those needs.

- Mechanisms in place for emerging needs to be identified and supported or transitioned to the appropriate place within the system of care (e.g. screening tools, multidisciplinary case conferences, seamless referral pathways for transitions, single points of access)
- Effective communication and collaboration channels with emergency departments, primary care providers, drug and alcohol services, hospitals, and specialist treatment centres to facilitate seamless transitions and continuity of care.
- Seamless referral pathways to ensure individuals are transitioned to appropriate care smoothly without the risk of rejected referrals leading to uncertainty about where someone can access support.
- Mechanisms in place for emerging needs to be identified and supported or transitioned to the appropriate place within the system of care (e.g. screening tools, multidisciplinary case meetings, seamless referral pathways for transitions, single points of access)
- Allocate protected time for service providers to build relationships and collaborate effectively. Including staff training to develop skills to support integration and collaborative working.
- Adoption of principles such as "everybody's job" and "no wrong door" to promote collective responsibility and accessibility to services. Ensuring that these principles are implemented in their true intention rather than just as a requirement to signpost or refer elsewhere.
- Emphasis on holistic care models that prioritise joined up working and prevent individuals from being bounced between services.
- Interface protocols should outline how services will collaborate, share responsibilities, and ensure regular communication when developing or reviewing the person's care plan.

1.4 Communication across services and information sharing

Good communication across services allows for staff to have a fuller picture of a person and their experiences, than single assessments. Information sharing is a core enabler of collaboration, with evidence showing that rapid information sharing can prevent escalation of crisis episodes and facilitate a more joined up response. Within the context of concurrent need, communication and information sharing is central to good care that is responsive to a persons interlinked needs as a result of substance use and mental ill health.

- Good integration of care needs to be supported by mechanisms that enable effective communication and relationships across services (e.g. joint development days, joint operational meetings at regular intervals, clear points of contact)
- Information governance processes should enable the sharing of information between services (to avoid duplication, to prevent harm and to save people repeating their history again and again)
- Staff should have a clear understanding of when it is appropriate to share information between services, including where they think there might be elevated risks to a person due to specific and emergent circumstances.

1.5 Workforce development

Staff knowledge and skills in support people with concurrent mental health and substance use needs are central to new ways of working that support more joined up, person centred care. Core good practice within workforce development is in supporting staff to have the skills and confidence to address the intersection of both needs, rather than have them in treatment silos. Therefore, underpinning all activity needs to be a focus on staff development that helps develop a workforce with awareness and skills across mental health and substance use, regardless of the service/role in which they sit.

- Opportunities for staff to build awareness, knowledge and skills and relationships across the system (e.g. support and supervision, shadowing, co-occurring conditions networks, multidisciplinary case conferences, single point of access/integrated referral hubs, joint training, reflective practice, joint significant adverse event reviews)
- Staff have awareness, knowledge and skills (to a level appropriate to their role) to care for people with mental health and substance use needs.
- Training is delivered as part of an overall workforce development that emphasises the need for staff to be able to support people with concurrent needs, and not ad hoc.
- Organisational values challenge stigma and promote and expect positive and compassionate attitudes towards those with co-occurring conditions
- There is a demonstrable commitment to staff well-being (including time to access support and supervision, training, career development opportunities)
- Third sector organisations should be included in workforce development plans.

1.6 Lived and living experience

Engaging with people and having the voices of lived and living experience are key to ensuring good practice from a system planning point of view, as well as service delivery point of view. People have better outcomes when they are involved in setting their own outcomes and in decisions on their care.

- Individuals, carers, families and their loved ones, as well as those organisations that advocate for them, should have
    - clear opportunities to inform the development of local protocols
    - ways to provide feedback on their experiences of services that are used to inform service design, delivery and transformation
- As key delivery partners, community organisations should have access to funding to enable them to provide opportunities and services to enhance community and recovery capital

2. Current practice

In this section we will describe existing provision of support for people with concurrent mental health and substance use support needs. This has been informed by the Mental Health and Substance Use: Improving Our Response programme, which offered bespoke support to five health boards.

There are a range of models of integration that have emerged as a way to better support concurrent need, and there is a lot of ongoing programmes of change looking to improve support. Focal points for improving collaboration are centred on key points of interaction across services such as providing information/ signposting to other services (usually in relation to third sector services); and joint decision making at point of initial referral/identification of joint need. Outside of these formal interactions, a lot of collaboration is driven by peer networks among staff and the provision of additional expertise within a service.

2.1 Leadership and culture

Leadership approaches support the development of high level visions related to whole system support and ensuring holistic responses to needs. However, there is little specificity as to what this means for service delivery and for different cohorts of need. This results in fragmentation of strategy and change, with multiple parallel programmes occurring, that involve similar staff and services. Good leadership is seen in supporting relationship building and providing legitimacy to specific pieces of work, such as the MAT Standards, that are centred on clear clusters of change.

- Mental health and substance use are generally not explicitly noted as a linked issue within local strategies; but are instead addressed individually with mental health sitting within general population wellbeing frames, and substance use being drawn out as a specific are of focus within Alcohol and Drug Partnership leadership and strategy. Where concurrency is noted is mostly under substance use, as a wider consideration around 'holistic' and 'complex' needs.
- In the areas engaged with we have found examples where mental health and substance use were sitting under the same senior manager within the HSCP structure – often accompanied by a range of other responsibilities. This combination has ended up acting as a key facilitator in bringing services around specific programmes of change such as the MAT Standards and the Mental Health and Substance Use Improving Our Response programme.
- As part of the MAT Standards implementation there has been a much stronger focus on operational implementation from leadership around the specific service requirements within the standards, compared to previous change programmes that were built around broader strategic objectives, with leaders taking a more active approach in building relationships and setting direction. This has helped drive improvements, with leaders getting behind operational change and being supportive in overcoming structural barriers around implementation.
- Local clinical leadership still sits within condition specific silos rather than joining up mental health and substance use and centres on risk management and immediate safety with a large focus on medical models and treatments to support recovery. However, in cases of very high risk people with concurrent need there is strong clinical leadership that supports collaboration across service silos.
- While there are strong examples of joint leadership approaches, it is reported that at a whole system level (i.e. beyond mental health and substance use linked services) there remains fragmentation and multiple competing change programmes. This detracts from a singular vision and makes it hard for operational leaders to prioritise their engagement with different strategic change activities.

- There are implementation challenges that arise from competing hierarchies between medical and social models of care. While there is a clear move to develop and support social models of care, many decisions around pathways, appropriate referrals and access are defined by pre-existing processes and culture that emphasises a primarily medical model.

2.2 Assessments and access

Within assessments and determining access to services there is a significant emphasis on managing service risk. Access can therefore be challenging for people with both mental health and substance use needs as thresholds and exclusion criteria in place to support risk in the service can be a barrier to getting joined up support.

- Assessment is clinically led and often single condition specific. Assessments are completed as a way of understanding how a particular service can support an individual rather than the full breadth of need of, and support for, someone.
- Service thresholds act as a barrier to support, as where a person does not meet a service threshold there are few pathways to enable them to find the right level of support.
- There is a significant emphasis on managing service risk within assessments. Within this practice access can be challenging for people with both mental health and substance use needs as thresholds and exclusion criteria in place to support risk in the service can be a barrier to getting joined up support.
- There is a move to integrated referral hubs – such as that seen in Angus. This model is centred on a multi-agency discussion on all incoming referrals through mental health and substance use. Referrals are discussed and allocated to appropriate services, including identifying opportunities where services can work together around concurrent and complex need. This has eliminated rejected referrals in Angus.
    - Dundee have just launched a similar hub, and Perth and Kinross are incorporating the processes and ethos of this into existing multi-disciplinary meetings.
    - In Inverclyde there is a mental health referral hub that supports ensuring people are able to access the right services. Though as it stands, there is limited substance input into these conversations.
- Screening tools are starting to be implemented across services to formalise and standardise conversations – for example, ensuring there are structured conversations to understand levels of substance use within mental health services, and recording these in a way that is easily communicable and understood across all services to inform ongoing decisions and pathways.

2.3 Transitions and joint working

Within the context of concurrent mental health and substance use, transitions and joint working play a significant role in a person's outcomes. Joint working remains either a consequence of multiple crises or ad hoc reactions to specific episodes. In the case of the latter this is reliant on informal relations between staff. Current practice around transitions across services are centred on referral relationships and 'warm handovers' in cases of transitions between statutory services. Where a person is requiring third sector support transitions are done through signposting, often with the help of an advocacy or link worker.

- There are examples of joint working where people have experienced multiple crises. This is done through the Care Programme Approach or where areas have developed specific complex case teams.

    - North Lanarkshire have developed a High Resource User team that supports frequent Emergency Department attendees (a significant proportion of whom have mental health and substance use support needs) and provides interventions with an emphasis on re-direction to, and liaison with, more appropriate services. These services are located within health and social care settings, or in the community, and are tailored to meet the particular needs of the person.
    - Inverclyde have a Community Response Service within the Community Mental Health Team (CMHT) and an Addiction Liaison Team within the Alcohol and Drugs Recovery Service (ADRS) that provide outreach and urgent care services for people, they formulate joint risk assessments and relapse prevention plans
- Where people are open to both CMHT and ADRS services, without a history of multiple crises, there is a generally a lack of joint working, with people getting what can be described as 'parallel care' where people are receiving support from both services, but there is little coordination and communication between the services.
- Where there is a 'mild to moderate' need (in mental health or substance use) in conjunction with a more severe need (in substance use or mental health), there is a focus on the 'primary diagnosis' and people having to find their own support for other 'secondary' needs (and they are often only provided information and signposting to other sources of support)
- There are good pathways and planned transitions where there is a changing need within mental health or substance use that needs escalating or de-escalating. For example, in the form of no-discharge agreements with third sector services that allows for 'step-down' type transitions that can enable re-engagement if necessary. This allows people to progress into community based recovery but with the confidence that they can still access statutory services if required.
- Joint working is often initiated by an individual staff member as a response to a specific need they encounter. This joint working is often enabled through informal, interpersonal relationships with staff from other services rather than as a systematic change in the way the system operates.

2.4 Communication across services and information sharing

Communication and information sharing is regularly highlighted as a barrier to collaboration. The multiple electronic systems means that it is hard to get a full picture of a person. There are few routes of communication that allows third sector staff, seeing a person regularly, can update staff in statutory services. There are increasing instances of joint meetings across services that facilitates information sharing in a way that feeds into decision making.

- Communication tends to be done asynchronously through electronic systems which slows down response times to changes in a person's condition.
- Recording of information is inconsistent; with reliance on free text that results in services not getting the required information to make a decision, and exacerbating issues relating to people having to repeat their stories.
- We have seen many examples of good professional relationships facilitating good joint working. Examples of good practice include informal routes of communication, which tend to be based on interpersonal and individual factors of staff. This approach is subject to risk when people move roles and leads to variation in the care someone receives (dependent on the quality of the professional

relationships held by the staff supporting them) as relationships do not exist consistently across services.

- There is very little information sharing with the third sector beyond initial referral (where this is in place)
- There are instances where service level agreements are in place with third sector organisations that allows for accessing and updating of electronic records
- Where there are examples of joint meetings, participants have noted the ease of information sharing through these forums, including third sector organisations.

2.5 Workforce development

There are significant areas of focus regarding working development such as improving trauma informed practice and reducing stigma. There is also a move to include more awareness around mental health and substance use across services, and how concurrent need might impact the required support. However, these are yet to be fully implemented, and there is only early discussions regarding the need to clinical support and supervision across specialisms (e.g. supervision from a substance use specialist for mental health staff).

- Workforce development plans largely centre on the provision of training that can support staff to understand and respond in a person-centred way. Key areas of focus for this are around trauma informed and anti-stigma training. The National Trauma Training Framework offers the key resources underpinning this training, though work is done locally to make it locality and service relevant.
- There is also inclusion of specific training that can be described as 'cross-specialism' where staff within mental health services are training in substance use specific interventions, and vis versa. This has been supported by recent national initiatives around brief interventions and the MAT Standards that specify a need for this.
- Early work is emerging around developing workforce development plans that move beyond formalised training sessions and starts to look at how this is embedded within practice, with space/opportunities for reflective practice. A 2023 *Mental Health Training Needs Assessment* in Tayside noted that:
    - *"For many participants the skill aspect of mental health training may be more important and challenging as they believed rather than only focussing efforts on awareness and knowledge areas, skill development should be supported well to raise worker's confidence in more sensitive topic areas."*
    - A participant said "[we need to be] learning more actively and reflectively with a guide there to help over a period of time."
- The culture around workforce development from service managers and leads is driven by awareness of staffing shortages and anxieties around freeing up staff for training (though there is a recognition that this is important to do), therefore, plans often focus on mandatory training driven by legislation and local policies.

2.6 Lived experience engagement

Engagement with people with lived and living experience takes place mostly at a strategic level, identifying what people's priorities are and where they would like to see improvements. Engagement centred on the

specific design of services, or feedback from experiences is not routinely sought and used to improve or inform service delivery.

- Ongoing engagement also takes place to support strategy reviews or to provide input into particular initiatives. Such engagement is instigated by leadership within the HSCP or ADP but is usually led by Third Sector Interfaces.
- The third sector play a role in elevating voices of lived experience in the forums they attend by relaying the conversations that they have had with people
- There are examples of good outreach engagement around a specific change, for example, in Dundee, the development of an out of hours crisis service was developed with significant input from people with lived experience. A key outcome of this was the development of a service in an open, community and non-clinical setting with few doctors. This was a challenging model to accept by some staff, but the lived experience engagement helped make the case.

3. Gap analysis

- Improvements in supporting concurrent mental health and substance use should be explicitly linked to whole system improvement as highlighted in strategic documents, to ensure there is sufficient prioritisation and enable clear links to leadership driving HCSP wide change.
- There is a system-wide lack of clarity over the roles and responsibilities of staff and services in supporting concurrent need, resulting in debates about where a person's care should sit and people falling between services or not having their whole needs met.
- There are few early intervention or prevention services that can support identified mental health and/or substance needs that don't necessarily meet the thresholds of core services. Such services are required to provide lower level need, but have the capability and connections to identify risk of escalating need and get more support. This should also include links across other services such as housing and social work. Currently third sector provision sits too separately from statutory provision to provide an adequate response to people with concurrent mental health and substance use need. There needs to be better coordination with third sector services that people with mental health and substance use needs rely on. This will enable sustainable transitions out of statutory services and into communities.
- Statutory service staff highlight a lack of knowledge around the third sector service provision, especially outside of commissioned, case holding third sector services (such as recovery cafes), as well as sometimes not feeling confident to signpost due to uncertainty over the quality of services
- There is a lack of coordinated referral assessment when Primary Care are making a referral for someone with concurrent need. This can lead to rejected referrals in cases where mental health services redirect referrals on the basis of substance use, but the identified substance use doesn't meet thresholds for substance use services. This judgement and decision is made without input from substance use staff and can result in another rejected referral and people falling through this gap
- Mild to moderate mental health and substance use tend to be managed within Primary Care and the Third Sector. A significant challenge within this is a lack of agreed definition of 'mild to moderate' and the ability for services to 'hold the risk' of someone with needs outside of their specialism, especially with regards to substance use. This results in a focus on the 'primary diagnosis' and people having to find their own support for other needs. People are provided with information and signposting, but this still leaves a gap with regard to collaboration across services to coordinate care.

- While there is an increase the level of joint decision making, for example, the hubs in Tayside and the outreach services in Inverclyde, there remains a gap around how services support people jointly on an ongoing basis.
- Limited understanding of the way that mental health affects someone's substance use and how someone's substance use affects their mental health. These interplays between mental health and substance use are not currently sufficiently incorporated into care planning.
- There are few mechanisms for phased and flexible transitions between services, in the form of step-up/step-down services where people are able to transition at their own pace
- People with high substance use but moderate mental health needs are not seen as high risk by mental health services due to service specific (risk) assessments and so are often not considered eligible for mental health support that would have a material impact on the high risk nature of their substance use. This is despite strong evidence that suggests that people in this situation are likely to benefit from mental health support, and people with experience of recovery note the increase in mental health needs as drug use decreases.
- Few opportunities for staff networking and relationship building across mental health and substance use, which could work to create staff peer support networks, breakdown clinical silos and build awareness of different service offerings.
- Lack of infrastructure to support information sharing across third sector services means that they are excluded from the information and intelligence required to conduct their services.
- Engagement with people with lived experience needs to be specific and planned, being clear on what the role of the feedback will be, understanding the different roles of engagement, and having agreed mechanisms for influencing change.