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Dear Colleague

CARE AND SUPPORT FOR PEOPLE WITH CO-OCCURRING SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS

The 2006 Advisory Group established to review and update available guidance on care and support for people with co-occurring substance misuse and mental health problems has now produced their outcome report (and recommendations) which is attached. In particular I would like to thank Dr Peter Rice for chairing the group and for working so closely with us to produce this publication.

There are 6 practical recommendations which focus on deliverables for change and improvement in the prevention, care and recovery services for this care group, their carers and their families. We will ensure that these are picked up and monitored through the Implementation Review work plan.

The overall report builds on the principles and recommendations of the previously published *Mind the Gaps* and *A Fuller Life* reports and is designed to move this joint agenda forward and support joined-up local delivery to improve the awareness, support and service provision for people who have both mental health and substance misuse problems.

I would be grateful if you could copy this letter and report to all with an interest particularly those who are currently or will be delivering the changes recommended and set out. Finally I look forward to working with you in the coming months on progress with implementation which fits of course with the published objectives for mental health in Scotland.

An electronic copy is available on: http://www.scotland.gov.uk/Publications.

Yours sincerely

A. McMahon

ALEX McMAHON

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"

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Introduction

In 2006 an Advisory Group was established to review and update available guidance on care and support for people with co-occurring substance misuse and mental health problems and to make practical recommendations for improvement in the prevention, care and recovery services for this care group, their carers and their families.

Membership of the Group was drawn from both mental health and substance misuse backgrounds and services and placed the interests of service users and carers at the centre and whose interests were particularly represented through the Voices of Experience (VOX) and Al Anon representation on the Group. The full membership is at Annex A.

The Group remit was to translate the principles and recommendations of *Mind the Gaps* and *A Fuller Life* reports into practical advice on action needed to move the joint agenda forward and support joined-up local delivery to improve the awareness, support and service provision for people who have both mental health and substance misuse problems by the end of 2007. This undertaking addresses the 2006 published commitment 13 for mental health.

This work is now complete and it has been used to inform the development of this publication.

The aims of this publication are:

- to improve the awareness of co-occurring mental health and substance misuse problems;

- to improve support and service provision for people who have both mental health and substance misuse problems (and their carers); and

- to reduce stigma and influence positively attitudes towards this care group.

Policy Context

The previously published *Mind The Gaps - Meeting the Needs of People with Co-occurring Substance Misuse and Mental Health Problems*, was commissioned by the Ministerial Advisory Committees on Alcohol and Drug Misuse in 2003, and *A Fuller Life – Report of the Expert Group on Alcohol Related Brain Damage*, was co-ordinated by the Dementia Services Development Centre in 2004. The policy context of *A Fuller Life* was part of the forward Plan for Action on Alcohol Problems.

Both reports were well received, but there is little evidence (2007) of their recommendations being implemented. The Centre for Addiction Research and Education Scotland (CARES) report on Co-morbid Mental Health and Substance Misuse in Scotland showed individuals still falling through the gaps in services.

This research and other UK work (Department of Health 2004, McNeill 2007) have helped to explain the nature of the gap in services, suggesting that these reflected generic issues in the nature of substance misuse and mental health services.

During consultation for this report, service users said that:

- Stigma is a major issue in the area of co-occurring problems. This stigma is also seen in staff whose attitudes are sometimes perceived to be negative;
- Care needs to be person centred and to be recovery orientated;
- There are inconsistencies round Scotland in treatment approaches;
- Agencies need to work together better; and
- General Practitioners and Primary Health Care have an important role to play.

The diversity of this client group and their carers must be recognised. The Group took the approach that the needs of all age groups, all types of mental health problems and all types of substance misuse should be considered, specifically:

- 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.

Carers of those with co-occurring mental health and substance misuse problems can experience similar difficulties in having their needs recognised and in accessing appropriate support. Unpaid carers play a vital role in the treatment and recovery of those with co-occurring substance misuse and mental health problems, providing emotional and practical support and supporting treatment at home where possible.

Under the Community Care and Health (Scotland) Act 2002, NHS Boards have an obligation to develop and implement a Carer Information Strategy. These Strategies will improve carer identification, information and training, including those caring for people with co-occurring mental health and substance misuse problems. GPs also have a register of carers within their population.

Just how big is the problem?

The UK Psychiatric Morbidity Study on adults living in private households showed that 12% of males and 6% of females had some form of substance dependence combined with a current psychiatric illness.

The Continuous Morbidity Register, supplied with data by a representative group of GPs nationwide, found that half of the consultations for alcohol problems were found to relate to either mood or anxiety disorders (as opposed to one-fifth of those patients not misusing alcohol).

Over 40% of patients in Scotland seeking treatment for their drug-related problem between April 2001 and March 2002 for the first time or after a period of 6 months absence did so due to mental health reasons. The UK wide National Treatment Outcome Research Study (NTORS) found that a fifth of clients received treatment for a psychiatric illness prior to seeking treatment for their drug misuse problems.

About 50% of suicides since 1997 have had a history of alcohol misuse and about 37% a history of drug misuse, while 20% had a primary diagnosis of alcohol dependence and 10% a primary diagnosis of drug dependence.

In 1997, The Office for National Statistics undertook a survey of psychiatric morbidity among 3000 remand and sentenced prisoners aged 16-64 in

England and Wales. Of those on remand 81% of males and 13% of females had two or more of the five mental disorders considered (personality disorder, psychosis, neurosis, alcohol misuse, and drug dependence); the proportions for sentenced prisoners were 72% and 71% respectively for males and females. Those with anti-social personality disorder were more than six times more likely than others to report drug dependence in the year before coming to prison.

A study of female drug users attending a crisis centre, a drop in and a methadone clinic in Glasgow found that 71% had a lifetime experience of emotional abuse and 65% had been physically abused, with 20% having a history of sexual abuse. (Gilchrist, Gruer and Atkinson 2005).

Rates of substance use were found to be low in minority ethnic populations in a Glasgow study (Heim et al 2004.). However culture and attitudes are changing and substance use, misuse and mental health may change too. There was no consensus among participants about whether service provision should be specialist or mainstream.

There are high rates of homelessness and unemployment in people with either substance dependence or a psychiatric illness. For those with co-occurring problems these factors present even bigger barriers to recovery.

In 2006, a survey of 4,200 Scottish carers for the Care 21 Report found 24% of carers saying the person they looked suffered from a mental illness, with only 2% of carers giving their primary reason for looking after someone as addiction to drugs or alcohol.

There is evidence that carers of people with unpredictable behaviour, such as those with co-occurring mental illness and substance misuse, are particularly vulnerable to stress and poor health.

The overall intention behind this guidance is to improve and refine the approaches made individually and collectively by all agencies, (NHS, local authority, voluntary sector and others) in designing and ensuring better, more responsive, timely and accessible prevention, care, and recovery services and approaches for those with a mental illness and substance misuse issues.

Connection to published targets for Mental Health

The targets and commitments for Mental Health published in 2006 set a vision for mental health services in Scotland and also underpinned the Scottish Government's vision for a healthier, more successful Scotland. They reinforced the need to undertake this work and made a commitment to –

> "….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".

This commitment is consistent with the Plan for Action on Alcohol Problems' intention to strengthen links between the alcohol and mental health fields, and the commitment to partnership working in the National Quality Standards for Substance Misuse Services.

It is important to achieve a balance and to have clear links between health promotion, illness prevention, care, treatment and rehabilitation/recovery. Each complements and supports the other.

The promotion of good mental health will have direct and indirect benefits on the prevention of mental illness and on substance misuse. With this in mind an emphasis on substance misuse in mental health promotion activities should be supported. It is also important to advance health promotion and illness prevention action aimed at populations and not just at individuals.

We have attempted to focus on recommendations which we think will help to deliver better outcomes for this population through the structure of services that need to be in place to deliver good outcomes. Rigid structures can lead to a reduction in innovation and are not always appropriate for the changing population they service. It is designed to inform change, focusing on the key aspects that need to be in place at each point in a journey of care so that agencies, staff, service users and carers can be clear about what needs to be delivered, how it is to be delivered, where, when and by whom.

As with responses to other identified service needs, delivery requires a clear view and agreement on what is in place, on what is required and local and wider discussion and agreement on how any identified gaps in provision are to be addressed, and by what timetable.
Delivery on many of the mental health targets published in 2006 will particularly benefit those with co-occurring mental health and substance

misuse and we need to build on them and the performance management arrangements around them to help to deliver this agenda. An example of such a commitment is "to improve the physical health of those with severe and enduring mental health problems by ensuring a physical health assessment every 15 months where possible and appropriate (published Commitment 5).

Health Improvement, Efficiency, Access and Treatment targets (HEAT)

There are currently (2007) three identified HEAT targets for mental health. HEAT targets form the basis of the performance management of the NHS. The associated 2006 published targets focus on antidepressant prescribing; reducing suicide; and reducing hospital readmissions. Co-occurring problems are relevant to all of these issues.

- There are high rates of **anti-depressant prescribing** in alcohol dependence. In some locations more than 30% of males and more than 60% of females with alcohol dependence were prescribed anti-depressants on referral from general practice.

- The relationship between substance misuse, mental health problems and **suicide** is also highlighted in this guidance.

- Substance misuse (alcohol and drugs) is the main diagnosis in 14% (2512/18115) of **psychiatric hospital readmissions** and is the most common admission diagnosis for men. 28% (943/3309) of people admitted with an alcohol main diagnosis had a secondary psychiatric diagnosis. (Alcohol Statistics Scotland 2007).

The intention of these targets in improving access to psychological therapies, preventing suicide and developing alternatives to hospital admission will be of value to those with co-occurring problems. The aim is not to prevent the use of anti-depressants or hospital admission where this is the best treatment option.

In this and other aspects the Scottish Government recognise the need and interdependency of agencies in delivering change. The same consideration and priority attaches to the Scottish Government's own approach on the cross cutting action required for cohesion of policy and direction.

Performance Management/Delivery

The agenda set for agencies within the recommendations will now form part of the performance management function being taken forward through the process established to oversee the delivery and implementation of the published targets and commitments for Mental Health. A relevant section on local joint progress, plans, timetable and outcomes for this agenda will be added to the *Implementation Review* process from 2008 onwards. NHS Boards and partner agencies will be expected to evidence progress against the recommendations within the report. The documentation exchanges and outcome report from all *Implementation Review* visits and discussions that take place will be published to allow all with an interest to monitor progress locally, regionally and nationally.

As part of this process the current (2007) Benchmarking project will monitor progress and develop a set of core definitions to allow information to be collected more uniformly across Scotland in order that services and outcomes can be measured for effectively in the future.

Other areas of work

Promotion, Prevention and Communications

The promotion of good mental health (mental well-being) will have direct and indirect benefits on the prevention of mental illness and on helping to address some of the challenges in addressing substance misuse, its care, treatment and rehabilitation. With this in mind an emphasis on substance misuse in mental health promotion activities and wider health promotion and prevention work should be supported. Similarly the promotion of safe use, including abstinence, from alcohol and other drugs will have a beneficial effect on mental health.

These promotion and prevention strategies will involve a range of actions from those delivered to individuals in care and treatment settings such as health advice to heavy drinkers or advice on the impact of cannabis to people with schizophrenia, as well as advice and information to carers, to broad population approaches such as media campaigns, tackling inequalities and alcohol licensing. Wherever possible these health promotion and prevention messages should be delivered in an integrated and co-ordinated way across a range of health campaigns and be based on good evidence of what works in social and public marketing in supporting changes in people's behaviour and attitudes.

There are opportunities within the higher education sector for targeted health promotion and prevention action on substance misuse and mental health at an important transitional stage of young people's lives.

A tiered approach to health promotion and ill health prevention should be considered by all partners. For example coordinated approaches should include:

- general health promotion and practical advice on alcohol/ drug use for everyone as part of a broader health promotion tackling inequalities campaign;
- brief intervention and support for people whose current use is such that it could lead to future health problems;
- harm minimisation approaches and abstinence programmes;
- assertive follow up services
- crisis resolution; and
- residential services.

Suicide Prevention

The five year report of the National Confidential Inquiry (NCI) into suicide and homicide by people with mental illness in England and Wales (University of Manchester 2006) gave detailed clinical information on current or recent mental health patients who die by suicide, defined as those who have been in contact with mental health services in the preceding 12 months. The NCI reported that 27% of patients who died had a "dual diagnosis" of severe mental illness (schizophrenia or affective disorder) and substance dependence/misuse.

Most of these suicides were mainly young, single, unemployed males living alone. The NCI also found that 8% of all the Inquiry cases had alcohol dependence as a primary diagnosis and 3% had drug dependency as a primary diagnosis. A further 44% had a history of alcohol abuse and 30% had a history of drug misuse.

The study found that 49% percent of the patients who died had been in contact with mental health services in the previous week, 19% in the previous 24 hours. Of those (dual diagnosis) patients who died while living in the community, 32% had missed their last appointment with services. Recent studies also show an increased risk in mortality (between 30 and 50 times) within a fortnight for those leaving prison, the chief cause being drug-related death and suicide.

At final contact, immediate suicide risk was estimated to be low or absent in 86% of cases, highlighting that suicide risk can change rapidly. These findings are based on all Inquiry cases (ie all those who died by suicide and had been in contact with mental health services in the year preceding death). The NCI report on Scottish data is scheduled for 2008.

The National Investigation into Drug Related Deaths in 2003 estimated that 13% such deaths were intentional overdoses (Scottish Government, 2005). Those dependent on alcohol have a lifetime suicide risk 8 times that of the general population (Foster 2001).

The *Choose Life* evaluation; research findings from 2006 stated that at a national level, key steps to promote mainstreaming in the next stages of implementation should recognise the importance of intervention where key suicide prevention actions are not taken at the local level including failure to integrate substance misuse treatment services into delivery plans. Community Planning Partnerships were also invited to review progress and put in place steps to establish or build on effective links with clinical drug and alcohol services.

Alcohol and Drug Action teams and Suicide Prevention groups should agree joint working arrangements to ensure that local actions reflect the close linkages between their work. In line with this NHS Boards should establish a mechanism to monitor alcohol related suicide trends.

Recommendation

1. **Substance misuse staff identified as providing frontline services should be trained in suicide risk assessment and prevention. This will be an extension to the published 2006 commitment 7.**

Screening, identification and service planning

It is considered best practice for mental health and substance misuse agencies to have assessment procedures which identify co-occurring disorders. Service operational policies should *not* exclude those with substance misuse and mental health problems, although it may be appropriate to direct referrals to another service as part of an agreed pathway.

Recommendation

2. **All services including all substance misuse and mental health agencies should have assessment processes which use an agreed assessment tool to identify co-morbidity systematically and which will help to match care appropriate to level and type of need.**

This can be taken forward through the commitments and work streams that have been developed to implement the published 2006 commitments on mental health around integrated care pathways and the work in relation to access to a range of psychological therapies.

The Group identified a number of screening and identification tools for use in a range of situations by staff, at all levels and in all settings. There will be training needs on the application of the tools in each case:

- Identification of Alcohol Misuse. AUDIT;
- Identification of Drug Misuse. DAST-10;
- Mental Health Screening. GHQ-12 or HADS; and
- Alcohol Related Brain Damage. ARBIAS/SAMH checklist and indicators.

These identification tools are reliable and have been validated in detecting the presence of substance misuse or mental health problems. Properly applied these instruments identify when further specialist assessment is required by appropriately qualified and trained staff. “Referral on” policies will vary between different types of agency. A core principle should be that the client should remain in contact with the original agency until clear transfer arrangements are in place.

While many agencies will have responsibilities, Primary Health Care teams will have a central role in identification, care co-ordination and treatment. The development of this role requires engagement with and support for Primary Care. Doing Well by People with Depression provides a good model of how to achieve this.

Mind the Gaps and *A Fuller Life* both make recommendations to planners and commissioners to ensure that services are co-ordinated between a wide range of potential agencies. The responsibilities of services must be made explicit and monitored. A whole person needs approach should be adopted including attention to any sensory issues - NHS - HDL (2005) 27 refers.

Primary Health Care has a central role in identification and provision of care. The anticipatory care approach is a promising one in the field of co-morbidity, with its focus on a proactive approach, targeting those most at risk. The role of the Nursing profession in designing, training and delivering brief interventions in Primary Care and other settings, such as Accident and Emergency (A&E) has been valuable and requires continued support and development. The evidence for the effectiveness of primary care interventions for alcohol misuse has been summarised by SIGN but the development of these services has been limited until now.

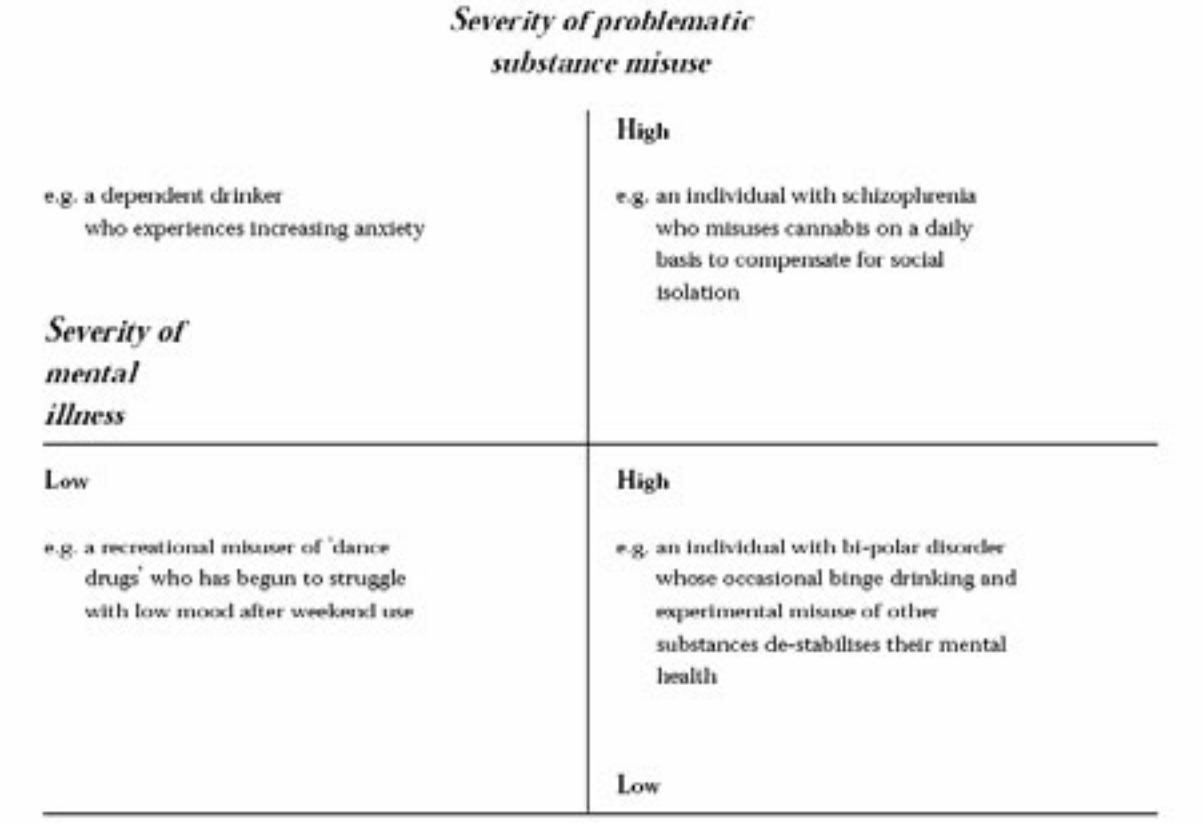
Where evidence has shown that the uptake of the Enhanced Services for Alcohol Misuse in Primary Care has been effective and delivered tangible change, other Boards and Community Health Partnerships (CHPs) in discussion with GP practices should consider developing such a service. This would also fit with the principles of SIGN guideline 74 - *Management of harmful drinking in and alcohol dependence in primary care.*

This anticipatory care approach would be of benefit to those with co-occurring mental health problems and would also link to the work in *Delivering for Mental Health* around early identification of physical health needs through the work on severe and enduring mental health and the Quality and Outcomes Framework (QOF) for offering an annual health check and also the links to the work around identifying those with diabetes and coronary heart disease (CHD) who might be depressed, and in turn matching need with appropriate interventions.

The Group supports the conclusion of *Mind the Gaps* that a model of identifying lead agency responsibility depending on problem severity is the preferred approach.

The matrix below from the Department of Health *Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide* is a helpful representation.

Figure 1: The scope of co-existent psychiatric and substance misuse disorders



NB: The term "mental illness" includes cognitive impairment such as Alcohol Related Brain Damage (ARBD).

Poor mental health / Low severity substance misuse

The issues highlighted under the section on Promotion, Prevention and Communications are designed to improve public awareness of the relationship between substance use, misuse and mental health. Frontline agencies in all sectors should provide advice and materials on this topic in order to reduce risk and harm.

Mild/moderate mental illness / High severity substance misuse, including dependence

The high rates of mental health problems in those treated for substance misuse are due to high rates of depression, anxiety and personality disorder (Department of Health 2004). There are strong associations between substance misuse and trauma, eating disorders and self-harm.

The mild to moderate forms of these problems, including ARBD, will be common among those with substance misuse and dependence, and substance misuse services should develop the knowledge, skills and capacity in psychological treatments to respond.

The disclosure of trauma and abuse, in particular sexual abuse, is common during assessment and treatment in substance misuse services. Staff should have skills in handling disclosure sensitively and competently. Some of these skills will be part of the core counselling skills necessary for effective substance misuse work and should be supported by a process of practice supervision.

The advocated stepped care model for psychological therapies will improve the range of expertise and services in Scotland. The established evidence for the effectiveness of specific psychological therapies in alcohol dependence has been reviewed by NHS Quality Improvement Scotland (QIS) and there is emerging evidence in other areas of substance misuse (National Treatment Agency (NTA). The stepped care approach, including guided self management, from the Doing Well by People with Depression programme provides valuable principles for the organisation of services by NHS Boards and partner organisations.

The development of evidence based psychological therapies (a further published commitment) will broaden the range of services available to those with mental health and substance misuse problems. Recent reviews have shown the effectiveness of some psychological therapies on substance use behaviour and on broader functioning. (NTA review, Health Technology Board for Scotland, NICE guidelines). In advancing the principles set out for mental health in Scotland it is important to extend access to include those with co-occurring mental health and substance misuse problems where appropriate.

The personal planning process outlined in the National Quality Standards for Substance Misuse Services will help ensure co-ordination of care where a range of services are involved.

Where appropriate, care packages should take account of the Health and Homelessness Standards (Scottish Government, 2005).

Recommendations

3. Substance misuse services should develop knowledge, skills and capacity in psychological treatments to meet the mental health needs of their client group.

4. These training needs should form part of the plan for psychological therapies currently being developed by NHS Education for Scotland and NHS Boards under the 2006 published Commitment 4 to increase the availability of psychological therapies and in line with the 2007 standard for Integrated Care Pathway (ICP) for Personality Disorder.

Severe Mental Illness

In the UK, the focus for specialist adult mental health services has been on severe and enduring mental illnesses, in particular schizophrenia and bipolar disorder, though policy statements have signalled an intention to respond to a wider range of disorders. This severe and enduring group have the focus of most attention in the study of co-morbidity in the UK. (Cantwell 2003, Weaver and Tyrer 2004.)

For England, the Department of Health Dual Diagnosis Good Practice Guideline recommends that for people with severe mental illness who misuse drugs, including alcohol, the lead responsibility for care should lie with mental health services. This is described as the mainstreaming model. The rationale for this is that Mental Health services may be better placed to offer services such as assertive outreach, crisis management and long term care. This is supported by the findings of the Scottish Co-morbidity Research Group (Cantwell 2003) which found that those with co-morbidity in contact with mental health services, had levels of health and social functioning similar to other mental health service patients.

Another reason is that the capacity of services for those misusing or dependent on alcohol, stimulants and cannabis, the drugs most often used by those with severe mental illness, is limited. (CARES).

The needs for substance misuse interventions should be met through a consultative and co-working arrangement with substance misuse services. Advice and support from substance misuse services should be developed to meet the needs of mental health services, specifically to help deal with cannabis and stimulant use.

The priority is that that local responsibilities are clear and the service gap for these vulnerable people and their carers, previously identified in Scotland and elsewhere, is closed. There are a number of ways of organising services to achieve this and existing effective services should be supported. For other areas, the "mainstreaming" model is commended as a reliable approach for service development.

Recommendations

5. **NHS mental health services should have the lead responsibility (including lead co-ordinating responsibility) for care of those whose mental health needs are severe and enduring and whose needs are best met within specialist mental health care.**

While a recovery focus should be the predominant model, the Chronic Disease or problem model can be a useful approach for some people with co-morbid disorders. Given the terms of the Mental Health (Care and Treatment) (Scotland) Act 2003 access to Advocacy services should be ensured.

There are many examples of successful self and mutual help approaches to recovery, including for partners, children and others. Alcoholics Anonymous and its fellow organisations have been actively working in this way for over 70 years and groups are accessible throughout Scotland.

Individuals with mental health and substance misuse problems should have the same opportunities and needs assessment as other groups who have chronic disease management as individuals with other chronic disorders, for example to the development of an Integrated Care Plan and single point of contact.

Training

Staff training should address knowledge, skills and attitudes in mental health, substance misuse and co-occurring problems.

Within an overall philosophy of a client centred approach focusing on the service user experience, the development of systematic practice, including the use of screening tools, is a useful method of increasing knowledge of important symptoms and behaviours. This requires support by a Staff Development programme.

Training should focus on screening, assessment and appropriate interventions by mental health and substance misuse agencies for co-occurring problems. It should also focus on identification and appropriate support for carers of those with co-occurring problems. Staff training on carer awareness should be included in NHS Boards' Carer Information Strategies. NHS Boards should incorporate training to tackle negative staff attitudes and to promote understanding of the difficulties faced by carers of those with mental health and substance misuse problems to reduce stigma and improve support.

Substance misuse services should develop and maintain the skills and capacity of staff to deal with a range of mental health issues: including low self esteem; relationship problems; suicide prevention; risk assessment; basic life skills; education; housing. There is a significant need for training and confidence-building of staff in the area of inquiring about sexual abuse, receiving disclosures and consulting clients who have substance misuse and trauma issues about their needs. Staff should have skills in the detection of mental illness and knowledge of appropriate additional services in their own and other agencies.

The Scottish Government funds the Scottish Association for Mental Health (SAMH) *Safe to Say* project - a National Training for Trainers Programme working with both statutory and voluntary agencies to establish a national network of training practitioners equipped to deliver best practice training for staff in all sectors consistently across Scotland. This is a key initiative from the *National Strategy for Adult Survivors of Childhood Sexual Abuse* and will help build capacity and quality of responses to adult survivors of childhood sexual abuse within existing agencies.

Mental health services should develop staff skills to identify substance misuse. Knowledge and skills in Harm Reduction, motivational approaches and relapse prevention should be a priority. More specialist elements of substance misuse treatment, such as substitute prescribing should be provided by Substance Misuse services through a joint working arrangement, and mental health staff should have a familiarity with these interventions.

For Substance Misuse services, Scottish Training on Drugs and Alcohol (STRADA) offers specific modules on substance misuse and mental health. These modules are well developed and accessible and could provide a model for Mental Health agency training. STRADA is currently taking forward work with the University of Dundee to deliver 'Children at the Centre' training to professionally qualified social workers on the identification of child abuse or protection issues and its relationship to substance misuse, mental health and domestic abuse.

Service user input to training programmes is valuable in many ways, including the tackling of negative staff attitudes. Links need to be made to existing training and education strategies in order to ensure that these messages are imbedded into practice.

Alcohol Related Brain Damage (ARBD)/Acquired Brain Injury (ABI)

A Fuller Life reviewed the issue of Alcohol Related Brain Damage. In 2006 the Scottish Association for Mental Health produced *Looking Forward: Recovering from Alcohol Related Brain Damage*, a practical guide to working with people with ARBD.

Recent Scottish studies have shown this group to represent a major proportion of the homeless and hostel population.

A Fuller Life outlined the complexity of brain damage and cognitive impairment related to alcohol. There are often multiple factors contributing to impairment such as head injury, vascular disease and degenerative neurological disease processes as well as the long term neurotoxic effect of alcohol and the specific vitamin deficiency, often associated with heavy drinking, which leads to Korsakoff's syndrome. The term "Alcohol Related Brain Damage" covers a wide range of circumstances. For instance some contributors have suggested that Foetal Alcohol Spectrum Disorder should be regarded as a form of ARBD. In real world practice those affected often have a number of causes for brain damage and cognitive impairment interacting and the consequences of the damage can also be highly variable in terms of behaviour and cognitive deficit. We thus recommend a needs based rather than cause based approach to the care of those classed as having ARBD.

Prevention

Effective action to reduce rates of alcohol dependence and effective interventions to help behaviour change in alcohol dependent individuals will reduce rates of ARBD. Programmes of vitamin supplementation for people at high risk of ARBD such as those with severe alcohol dependence, poor nutrition, and the socially isolated should be part of substance misuse service provision. (Smith and Hillman 1999, McIntosh and Chick 2004).

It is now established that recovery of memory and other cognitive function in ARBD occurs more frequently than was previously thought (ref Looking

Forward). Recovery rates are improved by early identification and by extended contact with services including re-assessment of cognitive function at regular intervals.

The coming (2008) guidance from NHS Quality Improvement Scotland on Alcohol in the A & E setting will further inform practice, identification and options.

Service commissioners should ensure awareness among services in their area of the risks of ARBD and that services dealing with high risk groups include ARBD prevention in their range of service responses. The separate needs of those with ABI should be considered.

Assessment, identification and relapse prevention

Assessment for any form of brain damage is complex and it there is no single simple test. The Group recommends the checklist developed by SAMH and their partners ARBIAS as a helpful aid for frontline workers in identifying possible indicators. The full assessment and diagnosis of cognitive impairment involves a stepped approach involving generic mental health assessment skills, specialist psychology and psychiatry, highly specialised neuropsychology and neuropsychiatry and imaging approaches such as MRI. Access to specialist practitioners and facilities should be widely available.

There are brief assessments of cognitive function such as the Mini Mental State Assessment (MMSE) and Adenbrooke's Cognitive Assessment (ACE) which can be of value in ARBD assessment. However these are not diagnostic tools for ARBD.

Should the SAMH/ARBIAS checklist and brief assessment tools indicate more fuller assessment is required, a number of standardised assessments have been identified by the group which can be used by specialist clinical psychologists and neuropsychologists.

These assessments should only be carried out following a period of 3-6 weeks abstinence (Ryan and Butters 1986). This ensures the resolution of the effects of intoxication and withdrawal leaving a more stable neuropsychological status which will allow for accurate assessment and facilitate the identification of care and treatment needs.

- WAIS111 - to assess overall profile (eliminate other problems)
- WTAR - to identify previous predicted level of functioning for comparative purposes
- Rey Auditory Verbal Learning Test - a list learning test which provides useful information re individual's capacity to learn. Useful for care planning.
- The Delis-Kaplan Executive Function System Subtests - can be used independently to assess executive functioning.
- Wechsler Memory Scale to assess different aspects of memory.

Alcohol care and treatment services have a key role in detoxification and relapse prevention in those with suspected ARBD in order to allow meaningful assessment of cognitive function to take place. For many with mild ARBD, the most important element of care will be to achieve prevention of relapse back into alcohol use and in these instances alcohol agencies should be the main providers of care.

Care Planning, Treatment and Rehabilitation for more severe ARBD and multi-factorial Cognitive Impairment

The complexity of the contribution of alcohol to brain damage and cognitive impairment, the variability of the impact on individuals and their carers and the regular co-occurrence of a range of causal factors such as head injury, vascular disease and progressive degenerative disease (such as Alzheimer's Disease) alongside high levels of alcohol consumption mean that there is no single approach to the provision of care for those who are diagnosed with Alcohol Related Brain Damage.

One of the guiding principles of our approach is that care should be based on need, not on age or causation.

The issues in providing care and treatment for those diagnosed with moderate to severe ARBD described in *A Fuller Life* have much in common with those faced by people with Huntingdon's Disease, Acquired Brain Injury and Early Onset Dementia (see SEHD summary 2003 of the Scottish Needs Assessment Programme review). The care needs will vary depending on whether the problem is likely to be static or progressive and this will modify the goals of rehabilitation.

The limited capacity of services for younger people with cognitive impairment was commented on by several of the respondents in the consultation process for this report. There appears to be less difficulty in obtaining services for those over 65.

The remit of this report was to cover services in the mental health field, but there are many similarities in issues faced by rehabilitation medicine and physical disability services for a client group with many shared characteristics and contributors suggested exploration of a model of a needs based neuro rehabilitation approach which would build on the evidence base examples of good practice in the statutory and voluntary sector.

Children and Young People

Many of the clients with mental health and dependency problems will live in families with children and young people. There will also be some very young parents. Some may be parents or relatives struggling to retain or regain safe care of their children. In many instances there may be additional and associated difficulties for children affected, for example to do with their needs for nurture, safety, health, and education. The impact of mental health and dependency problems on children should therefore be a priority consideration for all agencies in both the public and voluntary sector which provide services for adults and others with these problems, (Reference National Quality standards statement 10).

When there is effective integration of principles, policies and good practice in the delivery of care and support then affected children and family members will:

- know their assessed needs are being addressed;
- experience a co-ordinated, unified approach, which avoids multiple assessment and multiple meeting processes when this can be avoided;
- believe their views are being heard;
- have confidence in using services; and will
- know about the help available to them.

In all cases and especially when there are complex, long term problems, then clinicians, social workers and other professionals should take an holistic perspective – reflecting that no service will ever have the whole answer. Within the constraints of information sharing, children and their families and those who care for and about the children should usually be regarded as partners, and often as leaders in the shaping and resourcing of

plans to meet children's needs. Children and young people should be appropriately and sensitively involved in decision making processes which affect them.

Integrated development of services for children affected by mental health and dependency problems may be supported by national policy on quality improvement for and evaluation of children's services; and also by national guidance on Integrated Children's Service Plans 2005-2008. This guidance provides advice for local authorities, NHS Boards and other planning partners (the Police, Scottish Children's Reporter Administration, Voluntary organisations, etc.) on preparing integrated Children's Services Plans covering the 3 year period from April 2005 to April 2008. The guidance is issued within the context of the obligations on Scottish Ministers and local agencies to promote and participate in Community Planning, as set out in the Local Government in Scotland Act 2003.

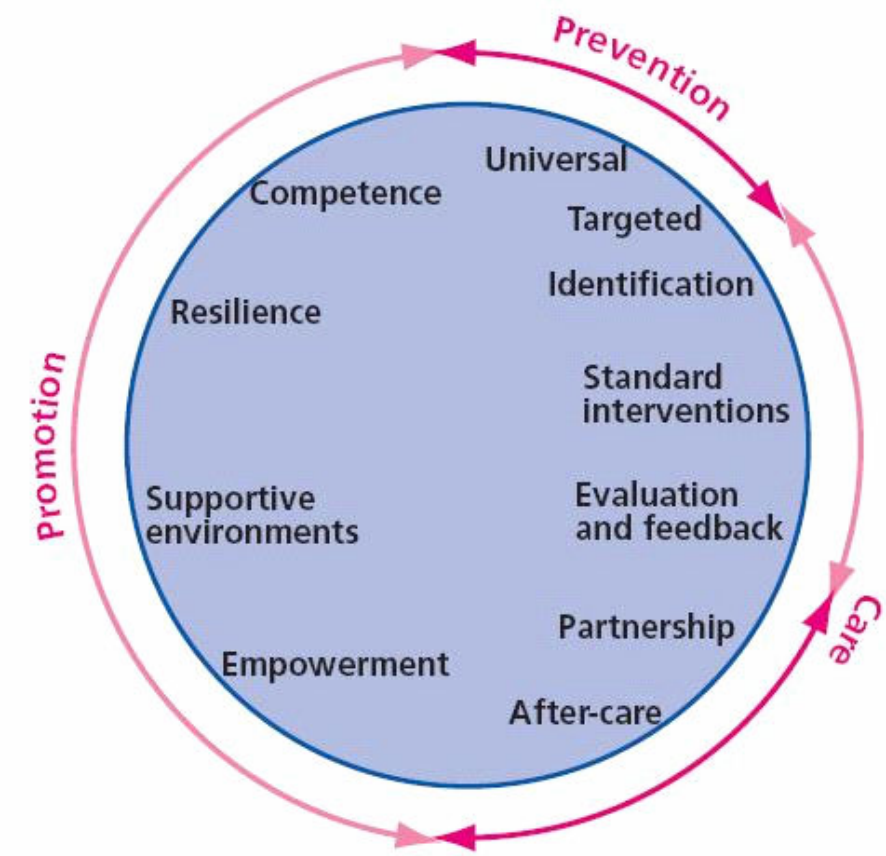
There is a significant training need to be addressed throughout agencies on the combined impact of parental substance use and mental health problems on children particularly given the poorer outcomes associated with some current interventions. *Getting Our Priorities Right* and *Hidden Harm* have led to a considerable development of training and change in attitudes and practice in child protection within substance misuse services working with adults and children. However Aberlour's Think Tank report, *A Matter of Substance'* identified that agencies tend to set higher thresholds in terms of intervening on children's behalf regarding the use of alcohol by parents than they do for drug use.

The Framework for Mental Health of Children and Young People identifies a need for development of specialist Child and Adolescent Mental Health Staff with expertise in substance misuse Training that addresses both needs, that uses common language and approaches, that is inter agency planned, funded, delivered and attended will help engender the joint approach needed for co-occurring mental health and substance misuse problems in young people. Multi-agency training encourages workers to share/compare their respective roles and promote networking and development of local protocols, particularly in respect of how to respond when children are affected.

It is likely that children living in families affected by mental health and dependency problems will have some sort of caring responsibility. NHS Boards are required to include measures to identify and support children and young people with caring responsibilities in their Carer Information Strategies.

There should be recognition of the impact of adult substance misuse on children and of young people's substance use within CAMHS policy and delivery strategies.

The Framework for Mental Health of Children and Young People offers an interesting diagram which is included for reference purposes. The diagram illustrates a continuum of services concerned with prevention, promotion and care.



Recommendation

6. Progress on this agenda will be monitored through the performance management of the published 2006 commitments and targets for mental health and the work strands associated with the commitments on child and adolescent mental health services.

Learning Disability

The combination of learning disability, substance misuse and mental illness was found to have a profound impact on client's well being and was frequently associated with exploitation by others (Taggart 2006). Along with the many benefits of integration of people with a Learning Disability into local communities has come an increased exposure to substance use, in particular alcohol, with the attendant risks of misuse and problems. Therefore we wish to highlight that the recommendations of this report apply to Learning Disability services.

Older People

The principles of this report apply to all age groups, however specific mention of the needs of older people is appropriate.

Health Scotland has drawn attention to the range of potential effects of rising rates of alcohol and drug consumption on older people, including the impact on mental health. Staff attitudes towards identification in older people have been suggested as a barrier to effective help but once identified, the effectiveness of care and treatment is as good as in other age groups.

Alcohol and Drug Action Teams, through their constituent organisations, should ensure services are in place for older people with substance use problems, including those with co morbid mental health problems. There may be opportunities during 2008 to link this work into the work that is to be taken forward under the banner of 'dementia as a national priority'. This will be considered by the Scottish Government Mental Health Division.

Protecting Vulnerable Adults

Some individuals may experience problems making decisions due to the impact of mental illness or disorder, substance misuse or both. As a result they are likely to be vulnerable, and need assistance to engage with appropriate care and support agencies.

The Mental Health (Care and Treatment) (Scotland) Act 2003 includes provisions on access to independent advocacy, the Adults with Incapacity (Scotland) Act 2000 also provides a mechanism to make decisions on behalf of people who lack capacity and provide legal protection for such decisions. The phased implementation of the Adult Support and Protection Bill

commencing in the autumn of 2007 makes a number of changes to existing legislation to support adults in their daily lives. The Act contains amendments to:

- The National Assistance Act 1948;
- the Social Work (Scotland) Act 1968;
- the Adults with Incapacity (Scotland) Act 2000; and
- the Mental Health (Care and Treatment) (Scotland) Act 2003.

Where the impairment is to a nature or degree where protection of vulnerable adult problems emerge through formal assessments there may be a need to invoke the above legislation

In the spirit of the legislation any act or decision made on behalf of a person must consider the least restrictive option in terms of the person's rights. The Mental Health (Care and Treatment) (Scotland) Act 2003 does not consider dependence on alcohol or drugs by itself to constitute a mental disorder under the terms of the Act. This does not preclude the use of the Act if there is a co-occurring mental disorder.

Trauma and Abuse Survivors

Agencies which work regularly with people with co-existing mental health and substance misuse problems should also seek sensitive ways to include a childhood trauma history in their assessments, so that they can identify specific needs arising from these experiences. Services need to consider which forms of support they can provide, and which will require referral links to specialist agencies, which may be required for some clients. There will be added considerations here (as for other aspects) to reflect the remote and rural dimensions. The solutions and steps taken in and for other areas of care will inform practice. There will also be particular considerations to apply for offenders who are highly represented within the known condition groups but their needs may be under-recognised in the prison system. All service commissioners should work with the prison and community justice services on integrated care pathways out of offending and offender programmes.

Research

The CARES report - Co morbid Mental Health and Substance Misuse in Scotland informs the following considerations for future research:

- To continuously monitor the epidemiology of co-morbid mental health and substance misuse issues in Scotland. Most of this data will be from community services but should include admissions and re-admissions to psychiatric hospitals in order to measure progress against published targets;

- To evaluate current good practices to support both service users and carers to ascertain efficiency and effectiveness;

- To study the impact of parental co-morbidity on children – many of whom will be young carers - to begin exploring ways to better support families leading to more positive outcomes for children and adolescents; and

- To understand the prevalence, type and impact of co-morbidity present in The State Hospital, Young Offender Institutions, Prison, psychiatric and general practice populations.

Annex A

MENTAL HEALTH AND SUBSTANCE MISUSE GROUP

Dr Peter Rice (Chair): Consultant Psychiatrist, Tayside Alcohol Problems Service, NHS Tayside
Dr Alex Baldacchino: Director, Centre for Addiction Research and Education Scotland, University of Dundee and Consultant Psychiatrist Fife NHS Addiction Services
Dr Seonaid Anderson, Specialist Registrar, NHS Grampian (from December 2006)
Dr Stephen Bell: Consultant Clinical Psychologist and Neuropsychologist, NHS Grampian
Dr David Blaney: Director of Postgraduate GP Education, NHS Education Scotland
Jim Carroll: Clydebank Addiction Team
Dr Fiona Clunie, Consultant Psychiatrist (Rehabilitation), NHS Lothian and Chair of Rehabilitation Sub Group, Scottish Division, Royal College of Psychiatrists (from January 2007
Dr Denise Coia: Psychiatric Adviser, Scottish Government
Frank Fallan: Voices of Experience (VoX) (from January 2007)
Dr Andrew Fraser: Director of Health Care, Scottish Prison Service
Ellen Hair: Planning and Commissioning Officer, Mental Health Services, Edinburgh Council and Association of Directors of Social Work (ADSW) representative
Dr Audrey Hillman: Consultant Psychiatrist (Mental Health and Substance Misuse), Inverclyde Community
Health Partnership, NHS Greater Glasgow and Clyde and Service Clinical Lead, Mental Health Services Inverclyde, NHS Glasgow and Clyde
Dr Charles Lind: Consultant Psychiatrist (Substance Misuse), NHS Ayrshire & Arran
Chris Lock: Voices of Experience mental health service user representation (to November 2006)
Dr Tom MacEwan: Consultant Psychiatrist (Old Age Psychiatry), NHS Grampian
Mike McCarron: Association of Alcohol and Drug Action Teams, National Substance Use Liaison Officer
Lorraine McGrath: Scottish Association for Mental Health
Dr Debbie Mountain: Consultant Psychiatrist (Rehabilitation), NHS Lothian and Chair of Rehabilitation Sub Group, Scottish Division, Royal College of Psychiatrists (to January 2007
Dr Donald Mowat: Consultant and Clinical Director in Old Age Psychiatry, NHS Grampian

Karen Norrie: Addictions Adviser, Scottish Prison Service
Barbara O'Donnell: National Alcohol Liaison Officer, Alcohol Focus Scotland
Chris Park: Acting Service Manager – Alcohol and ARBD, Inverclyde Council
Dougie Paterson: National Operations Manager, Choose Life (from October 2006)
Jacqui Pollock: Carers Scotland and also representing Princess Royal Trust of Carers and Coalition of Carers in Scotland
Eunice Reed: Consultant Clinical Psychologist (Substance Misuse), NHS Lothian
Gail Reid: Secondary Services Manager, Glasgow Addiction Services, NHS Greater Glasgow and Clyde
Linda Reid: Senior Mental Health Liaison Officer, Scottish Government
Marion Shawcross: Mental Welfare Commission for Scotland
Addie Stevenson: Director of Children and Family Services, Aberlour Child Care Trust
Clive Travers: Head of Mental Health, North Community Health Care Partnership, NHS Greater Glasgow and Clyde
Alan Wilson: Al-Anon (from November 2006)

Annex B

The following published material, references and links cover those mentioned in the document and wider

Alcoholics Anonymous – http://www.alcoholics-anonymous.org.uk

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Adult Support and Protection Bill
http://www.scotland.gov.uk/News/Releases/2006/03/31100138

Alcohol statistics Scotland 2007
http://showcc.nhsscotland.com/isd/4602.html

ARBIAS/SAMH checklist and indicators - Contact SAMH - :
Lorraine.McGrath@samh.org.uk

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Drug-related deaths in Scotland 2003
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Dual Diagnosis Good Practice Guide, Mental Health Policy Implementation Guide, (Department of Health 2004)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060435.pdf

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