Improving Our Response to People with Mental Health and Substance Use Support Needs in Scotland

Improvement Hub
Enabling health and social care improvement
Mental Health and Substance Use: Improving our Response Programme Overview

This programme aims to create integrated and more effective and efficient care and pathways of care for people with concurrent mental health and substance use needs.

Objectives

- To enable people to have their mental health and substance use needs supported simultaneously, without facing challenges in accessing services due to their concurrent needs.

- To support local areas to develop pathways for people with concurrent mental health and substance use needs.

- To support staff and services to work better together, ensuring effective care coordination.

- To deliver improvements against national and local recommendations (e.g. MAT Standards, Drug Deaths Taskforce recommendations, The Mission and ADP and Homeless Programme: Reducing Harm, Improving Care recommendations).
Aims to design and formalise a clear pathway between MHSU services that incorporates low support needs, medium support needs and complex support needs services.

Continues to redesign care pathways to improve quality of care, access to treatment and health outcomes.

Interested in further exploring a Human Learning Systems approach to supporting collaborating and better meeting the needs of persons with both a MHSU needs.

Focusing on working alongside the North Lanarkshire ADP to build on ‘discovery’ work undertaken as part of the Reducing Harm Improving Care (RHIC) programme.

Exploring improvements in the interface between MH and SU services and will build upon a service review and learnings from adverse event reporting and service user feedback.

Inverclyde: Aims to develop a supportive, connected system that ensures people are able to easily navigate through services, the whole system supports recovery and services offering short term, low intensity support collaborate to prevent escalation.
The Learning System

Components of a National Learning System

- Healthcare Improvement Scotland
- Pathfinder Sites
- MHSU National Learning Events

Communication

- Flash Reports
- Newsletter
- Updates to website

Sessions within Pathfinder Sites

- Pathfinder Site Learnings
- People with Lived Experience Expertise
- Workshops

MHSU National Learning Events

- National Learning Events
- Clinical Network
Time, Space, Compassion

Nigel Henderson
National Lead on Suicidal Crisis Intervention
Scottish Government
Time Space Compassion

Three simple words – one big difference
Timeline

• NSPLG publish SPAP Action 5 report (Time Space Compassion) – October 2021
• Government approves report October 2021
• NH appointed by Minister, 2 days per week November 2021- March 2023
• Suicidal Crisis Action Group set up to advise on the work – January 2022
• Linda Hunter appointed full time – February 2022
Defining the principles

**TIME**
- being heard/listened to
- feeling validated
- no judgement

**SPACE**
- feeling safe - physically and emotionally
- accessible spaces
- welcoming

**COMPASSION**
- the desire to assist
- sensitivity/trauma informed
- kindness/respect
Informed from multiple perspectives

We want to generate and share stories that demonstrate time space compassion in practice. We want to understand what people do, feel and see when it’s in place and what it took to get there from multiple perspectives.

people experiencing support

people providing support

people designing & commissioning support
The Time, Space, Compassion Approach is...

- **Person centred** – demonstrating inclusion, doing this work together and putting people and their experience of crisis and support at the heart of everything we do

- **Relational** – seeing and working with suicidal crisis response as a human reaction, not a service model

- **Hopeful** – taking an asset based approach of starting with what’s strong not what’s wrong to build confidence and engagement

- **Action orientated** – using our resources and relationships to deliver on what we know how to do, as well as working out what we don’t know how to do yet

- **Trauma informed** - realising how common experiences of trauma, adversity and ACEs are, recognising the different ways that trauma can affect people, responding to support recovery, resisting re-traumatisation and recognising the central importance of relationships

- **Always learning** – actively learning and sharing what we discover as we do the work
Target Populations

People and Communities

Public services

Mental Health services
Framing the work based on our conversations so far...

1. **Supporting integration** of time space compassion into strategy, commissioning and service design

2. **Growing capacity and capability** to offer time space compassion

3. Building and sharing our understanding of **what’s in place and what works**

4. Building understanding of what that means for **targeted communities**

5. Making **time space compassion everyone’s business**, working with the suicide prevention movement

(source: drawn from the latest version of the time space compassion logic model)
Providing support and greater clarity in...

Members of the lived experience panel have identified three main areas of impact that they'd like to see from this work ....

(source: taken from lived experience panel and action group workshops on defining purposeful outcome statements for time space compassion

Access
to information, support and follow through

Journeys
into and through key transition points in support

Expectation
of what people will experience and what to expect from support
LEP members also described **key attributes** to support that demonstrates **time space compassion** including...

- **Stickability** of services, demonstrating persistence and sticking with the person in crisis over time,
- A **single trusted point of contact** to support and advocate for the person in crisis,
- Growing the **interpretation and working definition of crisis**, to enable more early access to support and intervention. (crisis being self defined)
- Prioritising **time space compassion** for people working to provide support – recognising people need this to offer time space compassion to other
- Taking a **person centred approach** in and between elements of support provided – taking ‘ecosystem’ approach to supporting the person.

(source: lived experience panel workshops on defining purposeful outcome statements)
Moving from discovery to defining & development

- Supporting integration of time space compassion into strategy, commissioning and service design
- Growing capacity and capability to offer time space compassion
- Building and sharing our understanding of what’s in place and what works
Developing the framework – a draft timeline

- **June ’22**: Initial scoping session with action group
- **3 Aug ‘22**: Comms & design session with comms & LEP leads
- **4-15 Aug ‘22**: Drafting prototype for testing
- **wc 15 Aug ‘22**: Initial testing session with Lived Experience Panel
- **Sept ‘22**: Testing sessions with action group and key delivery leads
- **October ‘22**: Live testing / co-design begins
- **Early ‘23**: Formal launch and publication
Testing time space compassion in practice
an updated list of collaborators

Nationwide
- DBI
- Penumbra
- NHS 24 / Mental Health Hub + Breathing Space
- Samaritans
- Scottish Ambulance Service
- Police Scotland

NHS Fife
NHS Greater Glasgow H&SC Partnership
NHS Ayrshire & Arran
NHS Dumfries and Galloway
Drawing on your experience ....

Where do you see and experience time space compassion?

1. How does it show up in practice – what are people doing, saying and feeling?
2. What made that possible/what did it take?
3. What challenges do you see people navigate and overcome along the way?

➢ What learning can we take from that into how/what we do with this programme of work?

➢ How/where might you or those around you take part?
Thanks for Listening

• Contact the Time Space Compassion team

nigel.henderson@gov.scot
or
linda.hunter@gov.scot
Sharing good and promising practice

Janine Gowans
Senior Improvement Advisor
ihub, Mental Health and Substance Use Programme
Complex systems work better with a plan; where everyone knows what they’re doing and who they can rely on for support.
5. CADT Patient with Routine Mental Health Problems

- Any CADT Care Manager who has a patient for whom they are concerned about the development or deterioration of a mental health problem which is not a psychiatric emergency should seek mental health assessment through the CADT Mental Health Professionals.

- Routine referrals to a CMHT from CADT should have had a mental health assessment prior to referral to the CMHT. The CADT referrals should communicate the up to date A&Ds issues for the patient and how they are being managed in the patients care plan. The CADT referral should explain the mental health concern and what the CADT is hoping for.

- If the patient’s mental health issues can be managed within ADS, this should be the preferred option and appropriate supports put in place.

- If CADT staff think that referral to a CMHT is necessary then they will do this directly – the patient’s GP should not be asked to make the referral.
6. **CMHT Patients with Alcohol/ Drug Problems**

- CMHT staff involved with patients who have or develop an addiction problem should consider referral to their local CADT of the patient for advice, assessment or transfer of care.
- Referrals from a CMHT to a CADT should have had an alcohol and drugs assessment prior to referral to the CADT.
- Referrals to a CADT from a CMHT should communicate the up to date mental health assessment, the alcohol and drugs assessment and what the CMHT is hoping for.
Sometimes easier said than done....

What considerations do you think would be important to implement this kind of agreement in your services?
From Consultation to Co-Design

WELCOME
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Session objectives

To explore practical approaches to involving people with lived and living experience in the design of service improvements
Introduce yourself and make new connections in the chatbox.

Q. Why did you choose this breakout session to attend?
Improving outcomes and experience

Image credit: Virpi Oinonen www.businessillustrator.com
How might we routinely involve people in...

Implementing and monitoring

Understanding the system / Discovery

Testing and redesigning

Defining the problem and co-designing improvement ideas
Example approach used to involve people with lived and living experience in Dundee

**Systematic review and evidence scan** from previous lived and living experience engagement activities to create knowledge baseline.

**Interviews** with people who have **lived and living experience** to understand and map their experiences of accessing and receiving services and supports.

**Two community conversations** hosted by third sector organisations with people who have lived experience:
- **Conversation 1**: what do services feel like currently and what does good service experiences look and feel like
- **Conversation 2**: sense check the emerging themes, **identify gaps** and **prioritise** improvement areas that matter most to people.

**Two online surveys** providing alternative ways for people to contribute to the **community conversations** outlined above.

**In-depth interviews** with people who have lived and living experience to **strengthen data and insights**, and

**Focus groups** with third sector community recovery support groups to **share** the emerging themes, **fill gaps**, gain a sense of how people **prioritise** what matters to them.

**Lived and Living Experience Design Group** established where people with mental health and substance use needs explore the insights gathered, then their ideas for improvement using design tools.

**Staff Design group** of statutory and 3rd sector staff developing their ideas for improvement.

**Co-design event** bringing both groups together to review each set of improvement ideas, agree which to work on, and how to continue to work collaboratively.

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*Icon credit: https://thenounproject.com*
Experience journey map

Drug & Alcohol Recovery Service (DARS)

- Assessment and treatment
- Psychiatrist Assessment: (unconfirmed unstable personality disorder)
- Community Mental Health Nurse (CPN) visits commenced
- Prescribed Opioid Replacement Therapy
- Drug & Alcohol Recovery Service
- GP re-referred to Adult Psychiatry for psychiatrist appt.
- Social Work (HSCP)
- 3rd sector Org. (housing & holistic support for vulnerable people)
- Drug & Alcohol Recovery Service
- CMHT

Thoughtpoints/Action

- Discharged (DNA as not been attending)
- Experiencing homelessness so bought around a lot. Did not update court details with GP.
- Waiting to receive an appt. with Psychologist for Cognitive Behavioural Therapy CBT for 2 years.
- Relationship with CPN broke down so asked for replacement and told there wasn’t anyone available at the time.
- Waiting for new CPN to be assigned
- Contacted GP for OT referral to review support for physical injuries and pain
- Modeled content with DARS to review methadone prescription
- Allocated a room in a supported accommodation and receiving holistic support from 3rd sector

Response

- Started on Clozapine
- Started on Methadone 80mg
- Contacted GP for OT referral to review support for physical injuries and pain
- Made attempts to contact Adult Psychiatry Service about referral to Psychologist. Could not speak directly to key worker so left message but no reply.
- Made attempts to contact Adult Psychiatry Service about referral to Psychologist. Could not speak directly to key worker so left message but no reply.

What's being said

- 'I forgot to change my address at the doctor so they thought I wasn’t engaging.'
- 'I waited 2 years for a psychologist and because Covid comes around they cancel my appointment... so have I got to wait another 2 years?’
- 'The CPN, me and her didn't get on and I wasn't allowed another one.'
- 'They're no listening, their no giving appointments. They're here is your methadone and that's it.'
- 'I've been in the psychiatric hospitals so it’s no like they are no notified that I need help. They're treating me like I don’t and I just need my methadone.'
- 'I have a social worker now, but its mental health I'm really struggling to get help with.'
- 'The 50 ml wasn't even covering the drug receptors never mind the pain that I'm in. So they've put it up to 70 now.'
Using the Experience Map in a Workshop

• Prompts discussions around the steps in another person’s journey
• Can maintain a level of detachment and make it easier to advocate
• Tool to identify areas to focus on
Experience eco-map

Scheduled care

unscheduled care
Lived Experience Involvement

• Listen to what people want to say, not what you are looking to hear
• More than surveys!
• Communicate with everyone on their terms
• Make sure people are supported to engage
• Make sure people feel safe
Final questions and thoughts
Sooze Gallagher
Development Officer/Naloxone Lead

Email – Suzanne@sfad.org.uk
Twitter - @SuzanneSFAD
Families are key to recovery

- Background of Scottish Families
  - Service provision
- Impact on families
- Family interventions
- Ask the Family Survey
- Family Support Principles
- Family feedback
- What can you do?
Grassroots Organisation
Established 2003 SNFAD

Scottish Families

Incorporated Alcohol in 2013

NCO for Families & Communities from 2017

Who are we?

Families are a movement for change

Families are connected to communities

Families are recognised

Families are included

Families are supported
What do we do?

- Connecting communities and families
- Recognition of families’ affected by someone else’s substance use.
- Supporting CSO’s in their own right
- Supporting and delivering training to frontline services

Scottish Families

- Supporting ADPs to address local needs
- Policy
- Conferences and masterclasses

- National helpline
- Online support
- Local services
- Telehealth
- Bereavement
- Naloxone

- Family Recovery College
- FRIF
- Leadership Network
- Exploring Stigma and the Power of Kindness

- Training
- CRAFT & community of practice
Accessing support & information

All supports are confidential, free & accessed through our national helpline

• Freephone - 08080 101011
  – M-F 0900/2300rs Weekend callback service

• Email - helpline@sfad.org.uk

• Webchat - www.sfad.org.uk
  – Referral Portal
  – Enquiry form

• Text – 07908 667551
Who do we signpost to

Signpost to services (most frequent)

- Family Support Groups
- Family Support Services
- Adult Alcohol/Drug Treatment Services
- Young Person Alcohol/Drug Treatment Services
- Young Person Support Services
- Carers Services
- Advocacy Support
- Bereavement Support
- Community/Recovery Groups
- Blood Borne Virus support
- Harm Reduction
- Needle Exchange
- Naloxone Providers
- National/Local Specialist Support Organisations
Impact on families

- Stress, fear and anxiety.
- Anger and betrayal.
- Guilt – ACE’s.
- Shame, stigma, and social isolation.
- Relationship difficulties.
- Problems at work.
- Financial difficulties.
- Domestic abuse (inc coercive).
- Non relationship based physical and verbal abuse.
Rights, Respect & Recovery identifies families need to be supported in their own right.

Evidence for the effectiveness of treatment models and approaches that include families is strong. Families can be influential in:

• Helping initiate treatment.
• Positively affecting the course and outcomes of treatment.
• Supporting long-term maintenance of change or sustained recovery.
• Minimum Estimates*
  – Nearly 1.5 million adults will be significantly affected by a relative’s drug use in UK
    • heroin, crack, powder cocaine and cannabis
  – Cost of harms as a result - £1.8 billion per year.
  – Support they provide would cost the NHS or local authorities about £750 million.

*UKDPC Supporting the Supporters: families of drug misusers
Family interventions

- Working with family members to promote the engagement of PWUD into services
- Providing services directly for family members
- Involving families and others in assessment and treatment plans

(Copello, Velleman & Templeton, 2005)
Ask the Family

Commissioned by SG Dec 2020

- National online survey 2021
  - Over 16
  - Affected by alcohol and/or drug use (their own or someone else’s)
  - Being supported by family support
Who took part?

- Person who previously used substances: 11%
- Person currently using substances: 2%
- Family member: 86%
- Other: 1%
How long did you live with problematic substance use?

On average lived with substance use for 16yrs
On average 8yrs before accessing support
Who had been harmed?

- No one: 1%
- Kinship carers/guardians: 4%
- Other: 5%
- Grandparents: 9%
- Cousins: 12%
- Grandchildren: 13%
- Aunts/Uncles: 16%
- Nephews/Nieces: 17%
- Work Colleagues: 19%
- Neighbours: 21%
- Children (over 18s): 30%
- Children (under 18s): 34%
- Siblings: 43%
- Parents: 47%
- Partner/Spouse/GF/BF: 50%
- Myself: 92%
How many people have been affected?

- 2% None
- 35% 1-5 people
- 32% 6-10 people
- 23% 11-20 people
- 4% 21-30 people
- 5% 31-80 people
What difference has support made to you and your life?

-I feel more connected"

"I was asked - Are you OK?"

"Help making boundaries with my loved one"

"Support stopped me taking my own life"

"Space to bounce ideas of someone else"

"It helps having someone to rant to!"

"I can't talk with friends, I feel judged"
Whole Family Support

• Rights Respect & Recovery Policy
  – “Whole family needs support”

• What does this mean to you?
  – 81% “everyone in the family (adults & children) should be supported but in different ways”
  – 16% “everyone supported in the same way/same time”
  – 1% “only adults”
  – 1% “only children”
Whole Family Approach/FIP

- Scottish Government Framework (Dec 21)
- Framework - Drug & Alcohol services improving holistic family support
  - Whole family approach/family inclusive practice principles
    - Overarching principles
    - Services
    - Workforce
    - Models of whole family support
### Principles

<table>
<thead>
<tr>
<th>What is important? SAME as Draft Principles?</th>
<th>What is important? DIFFERENT than Draft Principles?</th>
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</thead>
<tbody>
<tr>
<td>1. Driven by positive family values and a positive inclusive ethos</td>
<td>1. Connecting with others with the same experience; peer support</td>
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<td>2. Family rights</td>
<td>2. Leads to change in my life; makes me feel better</td>
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<td>3. Focus on people’s individuality, strengths and assets</td>
<td>3. Listen (take time and show interest)</td>
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<td>4. Fosters hope and positivity</td>
<td>4. Love and belonging; feeling valued and worthwhile</td>
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<td>5. Free from stigma and judgement</td>
<td>5. Providing respite/relaxation/escape</td>
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<td>6. Help and support is available to individual family members in their own right</td>
<td>6. Safe space to talk and open up</td>
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<td>7. Holistic approach; “Look at the whole person”</td>
<td>7. Support me to advocate and make decisions for myself</td>
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<td>8. Mutual respect</td>
<td>8. Support outside of the family; independent of the family</td>
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<td>9. Swift and responsive; continually improve accessibility and availability; “There when I need it”; “No postcode lottery”</td>
<td>9. Support to grow knowledge and skills</td>
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<td>10. Trusted relationship</td>
<td>10. Time and Patience (going at our pace); recognise change can be hard work for families</td>
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<td>11. Visible family support and recovery</td>
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Why family support matters?

- As a person in recovery from addiction, I can see the benefits of having a strong family support network around you to get support. This is only possible when the families of addicts are also supported to recover.

- ‘Whole family’ often makes me think of those silly adverts promoting holidays or games - ‘it’s fun for the whole family!’ I think it’s a difficult and confusing phrase. ‘Whole Family Approaches’ really it should just be Family Approaches or The Family Approach. I hate anything that sounds policy and jargony, makes me feel less human and more of a test subject.
I shudder to think what would have happened to my physical and mental health if I had not been given the chance to connect to this group. They have been my saviour. I can never thank them enough.

Our family support comes from my children’s school and is not specifically trained in substance use issues. There is no such service locally and the services supporting my husband through his recovery do not communicate with me nor do they take a family centred approach to his recovery.
Recommendations

• Its everybody's responsibility to highlight support for families
  – Principles are not only applicable to those delivering substance related family support services
  – Relate to all services supporting individuals and families in any communities.
  – Relate to all those services coming into contact with families affected by substance use
• How do we reach families sooner?
  – How do you identify if families are affected by substance use?
  – What do you do in your practice to identify families impacted by substance use?
  – What could you do differently?
Thank you for joining us – please keep in touch!

- Follow us on Twitter @SPSP_MH for latest updates
- Email us at his.mhportfolio@nhs.scot to be added on our mailing list