



Mental Health and Substance: Protocol

Evidence Scan

March 2024

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Published March 2024

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Short Read

Key Points

- We explored evidence and knowledge relating to questions contextual issues in the development, implementation and use of protocols in services working jointly for clients with co-occurring conditions.
- Protocols can be understood as supporting a defined episode of care and/or broader treatment approaches.
- Service barriers, enablers and improvement suggestions from the perspective of individuals and families which may be relevant have been documented in qualitative research and reports, though this appears to be an underdeveloped area of inquiry.
- Specific UK guidance relevant to developing collaborative care protocols between mental health and substance use services (and potentially other services) exists.
- A common document can be read in conjunction with this document which explores 'Interface Documents' outlining how mental health and substance use services need to collaborate where there is concurrent need. Common features across them include processes for feedback around referrals, ensuring an identified lead professional and the development of shared care plans.
- A detailed 346 page Treatment Improvement Protocol for Substance use disorder treatment for people with co-occurring disorders¹ exists (based on US context).
- In the literature that we explored for this scan, we noticed repeated considerations related to the importance of communication and leadership, involvement of individuals and families, peer support, recovery focus, individual care plans, clarity (or lack of clarity) in screening, treatment and service processes and procedures (including information sharing), workforce development and training, local needs analysis, and joint expectations and agreement of approach between services. There was a recognition that integrated working requires ongoing commitment and good working relationships.

Background

- The Evidence and Evaluation for Improvement Team were asked to explore evidence and knowledge relating to questions contextual issues in the development, implementation and use of protocols in services working jointly for clients with co-occurring conditions.
- This document does not represent a comprehensive review of evidence but aims to present a pragmatic summary of a rapid scan of selected evidence relevant to the following questions posed by the Mental Health and Substance Use team:

- What does existing literature say about existing practice of good protocols – both enablers and barriers?
- What evidence is there of current protocols operating well and what were the factors that contributed to this?
- What factors that work in conjunction with successful protocols can be demonstrated to support their development and implementation?
- What are the possibilities and limitations of what protocols can achieve?

Examples of enablers and barriers

- **Cross sector collaboration may fail to address factors important to mental health** and alcohol and other **drug service delivery** such as recovery and individual and carer participation².
- There may be limited **specific assessment or treatment recommendations** for people with co-occurring conditions in relevant guidelines³.
- Good services have been suggested to be **flexible** to the individual **care plan, developed with involvement from the person/ family/carers**⁴.
- Good services have been suggested to have **explicit policies and procedures** related to intake and comorbidity screening and discharge planning⁴.

Examples of factors contributing to successful use

- Implementation of relevant guidelines for older people has been shown to be cost neutral and underpinned by demonstrating **local need, workforce development and training, engagement with multiple agencies and individuals** (including family and carers)⁵.
- The creation of clinical protocols may represent one of many factors which could foster integrated practice and challenges may arise because professionals from each sector have different cultures and ways of managing patients. In order to bridge this, for each cohort of patients **a common treatment approach** may be **developed jointly** by professionals as a foundation for building teams and shared practices⁶.

Examples of factors that support development and implementation

- Public Health England (2017) has outlined specific guidance⁷ for developing a collaborative care protocol between mental health and substance use services (and potentially other services).
- Older (general) guidance⁸ from the Royal College of Nursing suggested that protocols have been widely used in health care for many years and can accommodate individualised care, if agreed broad principles are respected.

- A recent realist synthesis⁹ of services and models found three broad contextual factors shaped services:
 1. **committed leadership**
 2. **clear expectations from both workforces**
 3. **clear care-coordination processes**
- These factors led to increased **staff empathy, confidence, legitimisation**, and **multidisciplinary ethos**, which improved care **coordination** and increased the **motivation** of people with co-occurring conditions to work towards their goals.

Examples of the possibilities and limitations of what protocols can achieve

- It's been suggested integration strategies (and their implementation) operate across multiple levels: **funding, organisational, service delivery and clinical**¹⁰, with protocols operating at both the clinical and service delivery levels.
- **Staff training, information sharing, case-management, referral and staff inter-professional networks** are key strategies at the service delivery level, with inter-agency relationships potentially influencing these¹⁰.
- **Screening, routine informed consent practices, joint care planning and supervision** were identified as key strategies to improving integrated care at a clinical level, enabled by service delivery and organisational level factors¹⁰.
- Previous learning from Scotland concluded **that operational procedures alone are not sufficient to support integrated working** in mental health. Wider organisational barriers included fragmentation, different priorities and lack of integration at senior management levels of organisations¹¹.
- **Trust, commitment and time** have been historically suggested as **essential** ingredients in Scotland in all aspects of partnership working, evidenced by joint initiatives being more effective where local relationships already exist¹².

Long Read

Context

A 2022 [recommendations paper](#) linked to a Scottish Government review of evidence and literature outlined seven recommendations for Scottish Government, one specifically regarding **development** and **ownership** of an **agreed protocol** in relation to the **operational interfaces** between mental health services and substance use services, plus further recommendations relating to principles and agreements for local protocols.

The Mental Welfare Commission Scotland has also made several recommendations regarding priorities for local protocol development in its 2022 report [Ending the exclusion](#).

The HIS Evidence and Evaluation for Improvement Team were asked to support the Mental Health and Substance Use (MHSU) Programme by exploring evidence and knowledge related to the following key questions (posed by the MHSU Programme):

1. What does existing literature say about **existing practice** of good protocols – both **enablers** and **barriers**?
2. What **evidence** is there of current protocols operating well and what were the **factors** that contributed to this?
3. What factors that work in conjunction with successful protocols can be demonstrated to support their **development** and **implementation**?
4. What are the **possibilities** and **limitations** of what protocols can achieve?

What we did

In this context there doesn't appear to be a widely used definition of 'a protocol'.

In 1993 the Royal College of Nursing reported "a protocol can be described as an agreement to a particular sequence of activities that assist health care workers to respond consistently in complex areas of clinical practice. Protocols may be established on a unidisciplinary or multidisciplinary basis"⁸.

In 2009 Rycroft-Malone and colleagues reported with reference to general protocol-based care: "In reality, there are many terms related to protocol-based care, such as care pathways, guidelines and algorithms, which tend to be used interchangeably."¹³

We carried out a rapid search for selected relevant evidence using the search strategy detailed in Appendix 1. We additionally browsed a search engine for any studies of service-user and carer experiences and staff experiences in Scotland which might provide relevant insights.

We focused on finding existing reviews of evidence in research databases relating to ‘joined-up’ working between separate mental health and substance use services¹ and any additional reports from key organisational websites. We summarised reported findings and we did not formally assess quality. Whilst analysis of the content of clinical guidelines and guidance were outside scope, examples of these and other relevant reports or guidance are shown in Appendix 2.

What we Found

Insights about potential gaps /operational interfaces from people and families using services

A 2011 qualitative study¹⁴ aimed to explore service experience (barriers and improvement suggestions) for individuals with high prevalence mental health (HPMH) and concurrent alcohol and/or drug disorders. Barriers related to

- **not knowing that services existed,**
- breakdowns in **referrals** (particularly from primary care into specialist services),
- **delays** in response or dismissal during a crisis, and
- **inflexibility** of the system and inability of services **to adapt to individual circumstances** such as employment commitments or other issues outside the given specialty.

Improvement suggestions were described as ‘holistic’ and included:

- **worker and community education about dual diagnosis and stigma reduction,**
- addressing issues beyond **illness**, and
- the importance of **relationships** involving worker–client, worker–worker, and client–client.

A 2010 qualitative study¹⁵ of dual diagnosis (drug/alcohol and mental health) health service user experiences in the UK found that:

- experiences of people with dual diagnosis have been relatively neglected in research,
- treatment was experienced in parallel,
- **peer support** was highlighted as **particularly helpful** with a suggestion that an informal ‘drop in’ would provide **social support**, and
- **Staff training** to encourage a stigma-free environment and **develop skills to support integration** was suggested.

¹ We note the limits of our search does not align with consideration of physical health and other needs and recognise we likely miss other relevant evidence available about joint working within or between other services or agencies.

Adfam carried out a detailed consultation¹⁶ with UK family members of people living with co-occurring mental ill- health and substance use conditions and in 2022 reported:

“Many families spoke about almost ongoing extreme worry and stress about their loved one’s situation. A significant cause of this is the ongoing fear felt by many families of the risk of suicide and self-harm for their loved one, and finding it hard to envisage a future for their loved one where they are able to overcome their substance use problems or manage their mental health.

The biggest cause of stress is the range of difficulties encountered by their loved one in trying to get effective support; people with a dual diagnosis often ‘fall between the gaps’ of mental health and drug and alcohol services and end up not receiving any support at all. Other sources of frustration were the lengthy waiting times and the lack of formal diagnosis.

Furthermore, many families, however, find that once obtained, the presence of a formal diagnosis has little impact on their loved one and doesn’t mean they have greater access to support. In fact, many families find that their loved one’s issues are treated in isolation by mental health, substance use, and other support services that work in siloes and do not communicate with each other or the family.”

The organisation has produced a toolkit for families which provides advice on how to advocate for loved ones in the following service scenarios:

- Where a person is turned away because of ‘being under the influence’ or because their needs are deemed too complex,
- Where a person has not been given a care plan (led by mental health),
- Where the family member/carer has not been included in the care plan (where the person has consented to this),
- Where a person has been discharged automatically as they have not attended an appointment, and
- Where a person has been transitioned/discharged from a service and they are unsure where to go if the person deteriorates.

Selected evidence relevant to: what literature can tell us about existing practice of good protocols and enablers and barriers

A 2021 scoping review² by Minshall and colleagues of principles that inform the implementation of cross-sector initiatives on a workforce level between mental health and alcohol and other drug services found that **existing models of cross-sector collaboration often fail to address factors important to mental health and alcohol and other drug service delivery** (e.g. recovery, individual and carer participation). It was suggested that future models should emphasise workforce development, including the emerging role of the lived experience workforce.

A 2021 systematic review³ by Alsuhaibani and colleagues of the scope, quality and inclusivity of international clinical guidelines on mental health and substance abuse in relation to dual diagnosis, social and community outcomes reported that ‘despite very high co-prevalence, clinical guidelines for substance use disorder or severe mental illness **tend to have limited considerations for coexisting disorders** in diagnosis, treatment and management’.

Key barriers that the authors recommend for future consideration include:

- access barriers to medicines, adherence issues requiring long-acting depot injections, and drug interactions,
- access barriers for people experiencing homelessness in relation to retention, and
- a need to consider perceived stigma and discrimination in the healthcare setting.

Potential enablers include:

- liaison with emergency department, primary care, drug and alcohol services and hospital and specialist treatment centres,
- consideration of cultural and ethnic issues in treatment,
- stakeholder involvement in the development of guidelines,
- consideration of people’s wider social circumstances to support improved outcomes, and
- adaptation of clinical guidelines to enable comprehensive assessment of patients with either single or dual disorders.

A 2010 descriptive study⁴ from Australia by Merkes and colleagues explored key elements of good service models for people with comorbid mental health and alcohol and other drug problems in Australia. The authors found that good practice models shared a range of common characteristics.

‘Good’ services generally reported:

- a range of links with relevant organizations (including networking, coordinating, cooperating, and collaborating relationships)
- well-qualified staff and generous provision of supervision and professional training
- relatively stable staffing
- explicit policies and procedures including those related to **intake, comorbidity screening, treatment guidelines, referral, discharge planning, and client feedback.**

About half of services had treatment guidelines, manuals or protocols. Most of the services reported they had a continuous quality improvement programme.

It was suggested that at a minimum, services would focus on **communication and feedback about joint client diagnosis, treatment provided and progress**, and that a communication mechanism would likely require **agreement on referral feedback protocols between MH and SU organisations** at a local, regional, or broader level, and that this might depend on the type of provider and/or **client consent to share information**. Individual treatment plans (involving

clients, and mostly involving carers and other providers) were used by all but two services. The key finding was that many providers reported they would vary the model depending on client or clinician characteristics.

Selected evidence relevant to: current protocols operating well and contributory factors

A 2019 shared learning item⁵ from NICE reported that an improvement project over 10 years, based on implementation of three NICE guidelines used in South London to improve care for older people with co-existing mental disorders and alcohol misuse has been used as a national model of best practice by the Royal College of Psychiatrists. Key aspects included **workforce development and training, engagement with multiple agencies and individuals (including family and carers)** and driving **public engagement** by demonstrating evidence of local needs.

A 2010 evaluation⁶ in Canada by Brouselle and colleagues aimed to identify key factors in integrating services for patients with co-occurring disorders with two contrasting models (joint venture and strategic alliance). The authors concluded that integration of services **‘transcends debates on care models and must be focused on the patients’ experience of care’**. They suggested that the process should result in a learning experience that helps to align practices and to integrate teams and care and identify a number of key conditions and levers for success. The creation of clinical protocols represented one of many factors which could foster integrated practice. However they highlighted this as a challenge, because professionals from each sector have different cultures and therefore different ways of managing patients.

In order to bridge this, for each cohort of patients **a common treatment approach was developed jointly by professionals** as a foundation for building teams and shared practices. This process was described by a professional as *“We developed a common philosophy of treatment. We have a precise framework that we call the treatment protocol. It is our manual”*.

Selected evidence relevant to: factors that work in conjunction with successful protocols can be demonstrated to support their development and implementation

A 1993 article⁸ reported *“The Royal College of Nursing recognises that protocols have been widely used in health care for many years, but is concerned to prevent financially motivated misuse of an otherwise acceptable clinical tool. The College believes that protocols need not conflict with individualised care, providing the following guidance is adhered to:*

- *The purpose of the protocol is made explicit,*

- *The protocol is founded on sound research,*
- *The protocol is not presented as a replacement for individualised care planning,*
- *A protocol is devised only when there is a need to assist nurses and other health professionals to deal with a complex operational issue,*
- *All those who are required to follow the protocol should be involved in its production, either directly or through their representatives,*
- *All parties (or representatives) should agree to the contents of the protocol,*
- *Any party to the protocol has the right to seek a review at any time, and*
- *The protocol should be reviewed regularly and whenever there is a change of circumstances”.*

Public Health England (2017) has outlined guidance specifically for developing a collaborative care protocol which states that the protocol should outline how organisations will collaborate, share responsibilities and ensure regular communication when developing or reviewing the person's care plan. The protocol may include mental health and substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.

A 2023 realist synthesis⁹ by Harris and colleagues of service models and systems for co-existing serious mental health and substance use conditions reviewed 132 papers to better understand what works, for whom, in what circumstances. Three broad contextual **factors** shaped COSMHAD services across 11 programme theories: **committed leadership**, clear **expectations** regarding COSMHAD from mental health and substance use workforces, and clear **care-coordination processes**. These contextual factors led to increased **staff empathy, confidence, legitimisation, and multidisciplinary ethos**, which improved **care coordination** and increased the **motivation** of people with COSMHAD to **work towards their goals**.

Selected evidence relevant to: possibilities and limitations of what protocols can achieve

A 2017 systematic review¹⁰ by Savic and colleagues of strategies to facilitate integrated care for people with alcohol and other drug problems categorised 14 integration strategies, across four levels: funding; organisational; service delivery; and clinical. The authors stated that to the interconnected nature of integration it is not possible to isolate the potential effectiveness of a single integration strategy in isolation. Protocols were referenced at both the clinical and service delivery levels. **Staff training, information sharing, case-management, referral and the development of staff inter-professional networks** were identified as key strategies at the service delivery level. **Inter-agency relationships appear to impact on most other strategies**, reinforcing the importance of these relationships to integrated working.

Screening, routine informed consent practices, joint care planning and supervision were identified as key strategies to improving integrated care at a **clinical level**. These were generally enabled by **service delivery and organisational level factors**.

The authors concluded that, in spite of limitations of the currently available evidence, given the interconnectedness of integrated care strategies identified, **implementation of multi-level strategies rather than single strategies is likely to be preferable**. They proposed a stepwise approach and associated toolkit for the implementation of integrated working strategies:

Step 1: Baseline Assessment (agencies map existing relationships to identify needs and priorities).

Step 2: Goal setting and implementation planning (set integrated working goals based on baseline assessment and decide timeline and plan for implementation).

Step 3: Pilot and roll out.

Step 4: Monitoring, evaluation and dissemination (collect data on clinician, client and career perspectives and share learning).

Older studies from Scotland

A 2004 qualitative study¹¹ by Rees and colleagues in Scotland interviewed three community mental health team leaders, two service development managers individually, and carried out group interviews with members of four adult community mental health care teams about the development and implementation of an integrated care pathway for community mental health services in Dumfries and Galloway. All of the teams spoke very positively about joint working and had positive views about the potential benefits of an integrated care pathway for staff and patients. However, in practice implementation was 'patchy' and 'problematic'.

Wider organisational barriers to service integration included **fragmentation, different priorities** and **un-pooled resources** at **senior management levels of organisations**. There appeared to be **a lack of integration at management level** above the community mental health teams. Striking a balance between strategic leadership and practitioner led development of processes was suggested. Some felt the implementation had been 'rushed' and initial enthusiasm had been dashed as a result – inflexible deadlines meant the wider system was not always ready to support the relevant activities so enthusiasm then waned. To maintain momentum, pragmatic support for changes and training on a rolling basis was suggested, but a lack of resources to achieve this was acknowledged. It was suggested **strategic decisions** and **drive** are required for resolution of the issues which are identified by **operational** teams. The authors concluded that **operational procedures alone are not sufficient to support integrated working**.

A 2002 research report¹² by Woods and McCollam examining progress in the development of integrated mental health care in Scotland at that time suggested that there was a lack of clarity about how services designed for people with severe mental illness link with those designed for people with mild or moderate mental health needs, which made promotion of a

whole systems approach challenging. It was suggested **trust, commitment** and **time** are essential ingredients in all aspects of partnership working and that joint initiatives were more effective where **local relationships already exist**.

Summary

We explored evidence and knowledge relating to questions contextual issues in the development, implementation and use of protocols in services working jointly for clients with co-occurring conditions. Protocols can be understood as supporting a defined episode of care and/or broader treatment approaches. General service barriers, enablers and improvement suggestions from the perspective of individuals and families which might be relevant to protocol development have been documented in qualitative research and reports, though this appears to be an underdeveloped area of inquiry. Specific UK guidance relevant to developing collaborative care protocols between mental health and substance use services (and potentially other services) exists.

A number of areas have developed 'Interface Documents' outlining how mental health and substance use services need to collaborate where there is concurrent need. These 'Interface Documents' have been further explored in our companion document. Common features across them include processes for feedback around referrals, ensuring an identified lead professional and the development of shared care plans.

Detailed treatment protocols for the US context – such as the 346 page Treatment Improvement Protocol for Substance use disorder treatment for people with co-occurring disorders (Substance Abuse and Mental Health Administration, 2020) exist. Repeatedly reported considerations related to the importance of relationships, communication and leadership, families and peer support, recovery focus, individual care plans, clarity (or lack of clarity) in screening, treatment and service processes and procedures (including information sharing), workforce development and training, local needs analysis, joint development and expectations of approach between services.

Appendix

Appendix 1: Search Strategy

A knowledge and information skills specialist carried out a search on selected organisational websites and a research database. The full search strategy is available on request.

The search strategy included keywords such as ‘mental health, ‘substance use ’ ‘joint working’, ‘joint care pathways’, ‘protocol’ ‘review’ ‘implementation’

The organisational website search strategy used an existing checklist of key organisations relevant to health and care improvement. The initial search on research database Medline identified over 500 results. These were filtered by year, with the first 100 results considered. The search included publications from January 2013 up to the search date in November 2023. Titles were scanned for relevance and a list of articles was then passed to a researcher for further scanning. The researcher accessed full text articles for immediate relevance to the key questions set out below, and extracted selected conclusions or key information for summary.

The researcher additionally carried out a first 50 results web search engine using keywords ‘mental health’ ‘substance use’ ‘joint working’ ‘good practice principles’ (Google Scholar). A separate web browse using the phrase ‘experience service dual diagnosis/mental health/substance use’, was completed with first 100 results considered in each case. A web browse using the phrase ‘what is a protocol in healthcare’ and ‘experience Scotland mental health substance use’ was also completed with first page of results considered.

Appendix 2: Selected Examples

Selected examples of existing co-occurring national mental health and substance use guidelines or guidance

Author(s)	Year	Title	Publication type	Setting
NICE	2022	Integrated health and social care for people experiencing homelessness	NICE Clinical Guideline (Multiple cross-references to the 2016 NICE guidance)	UK
Scottish Government	2021	Medication-assisted Treatment (MAT) standards	Standards	Scotland

Turning Point	2021	The SUMH Resource Pack Working with people with coexisting Substance Use & Mental Health (SUMH) issues A good practice guide for practitioners	Guidance	UK
Substance Abuse and Mental Health Services Administration	2020	Substance Use Disorder Treatment for People With Co-Occurring Disorders: Updated 2020 [Internet].	Treatment Improvement Protocol	USA
NICE	2019	Coexisting severe mental illness and substance misuse	NICE Quality Standard	UK
Public Health England	2017	Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers	Guidance	UK (England)
Clinical Guidelines on Drug Misuse and Dependence Independent Expert Working Group	2017 (update)	Drug misuse and dependence UK guidelines on clinical management p.73	Guidance	UK
NICE	2016	Coexisting severe mental illness and substance misuse: community health and social care services	NICE Clinical Guideline	UK (England & Wales)
Welsh Government	2015	Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem	Guidance	UK (Wales)

Public Health England	2015	Service user involvement: A guide for drug and alcohol commissioners, providers and service users	Guidance	UK
NICE	2011	Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings	NICE Clinical Guideline	UK (England & Wales)
Institute of Medicine	2006	Coordinating Care for Better Mental, Substance-Use, and General Health – Improving the Quality of Health Care for Mental and Substance-Use Conditions – NCBI Bookshelf (nih.gov)	Quality Report	USA
Department of Health	2002	Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide	Guidance	UK

Selected examples of Overviews/Reviews/Reports

Author(s)	Year	Title	Publication type	Setting
Scottish Government (Social Research)	2022	Co-Occurring Substance Use and Mental Health concerns in Scotland - A review of the literature and evidence	Rapid Review	UK
Northern Ireland Assembly Research and Information Service	2021	Mental ill health and substance misuse: Dual Diagnosis	Narrative overview of relevant literature	UK (NI focus)

Wiktorowicz and colleagues	2019	Models of Concurrent Disorder Service: Policy, Coordination, and Access to Care – PubMed (nih.gov)	Scoping Review	Canada
Yule and Kelly	2019	Integrating Treatment for Co-Occurring Mental Health Conditions (nih.gov)	Narrative overview of relevant literature	USA
All Party Parliamentary Group for Complex Needs	2018	People powered recovery (Report researched by Turning Point, which provides secretariat to the APPG for Complex Needs)	Report	UK
Canadian Executive Council on Addictions	2008	On the Integration of Mental Health and Substance Use Services and Systems – Summary Report	Analysis identifying key facilitating factors, challenges and other issues relevant to integration discussions or processes	Canada

Selected examples of UK initiatives

Author(s)	Year	Title	Notes	Setting
Nottingham City Place-based Partnership	2022	Changing futures - information about programme focused on people with complex needs related to at least 3 of the following: homelessness, substance use, mental ill health, contact with criminal justice and domestic abuse. Team includes Lived Experience Ambassadors and paid Peer Mentors.	November 2023 interim report outlines recommendations for frontline delivery and for system change	England

South London and Maudsley NHS Foundation Trust	2019	Improving care for older people with co-existing mental disorders and alcohol misuse	<p>Details a 10 year project to improve care drawing on upon 3 NICE advice products:</p> <p>1) Alcohol Use Disorders: Prevention (PH24) guidance</p> <p>2) Coexisting severe mental illness and substance misuse: community health and social care services (NG58) Guidance</p> <p>3) Alcohol-use disorders: diagnosis and management (QS11) Quality Standard.</p>	England
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Published March 2024

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