Healthcare Improvement Scotland

The National Mental Health and Substance Use Protocol

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Introduction

The National Mental Health and Substance Use Protocol provides guidance for local interface documents and systems of care for people with co-occurring mental health and substance use conditions.

"The Scottish Government should ensure that each area has an agreed protocol in relation to the operational interfaces between mental health services and substance use services."

- Recommendation One from The Way Ahead: Rapid Review

An outline of what is contained within this protocol is in the graphic below:

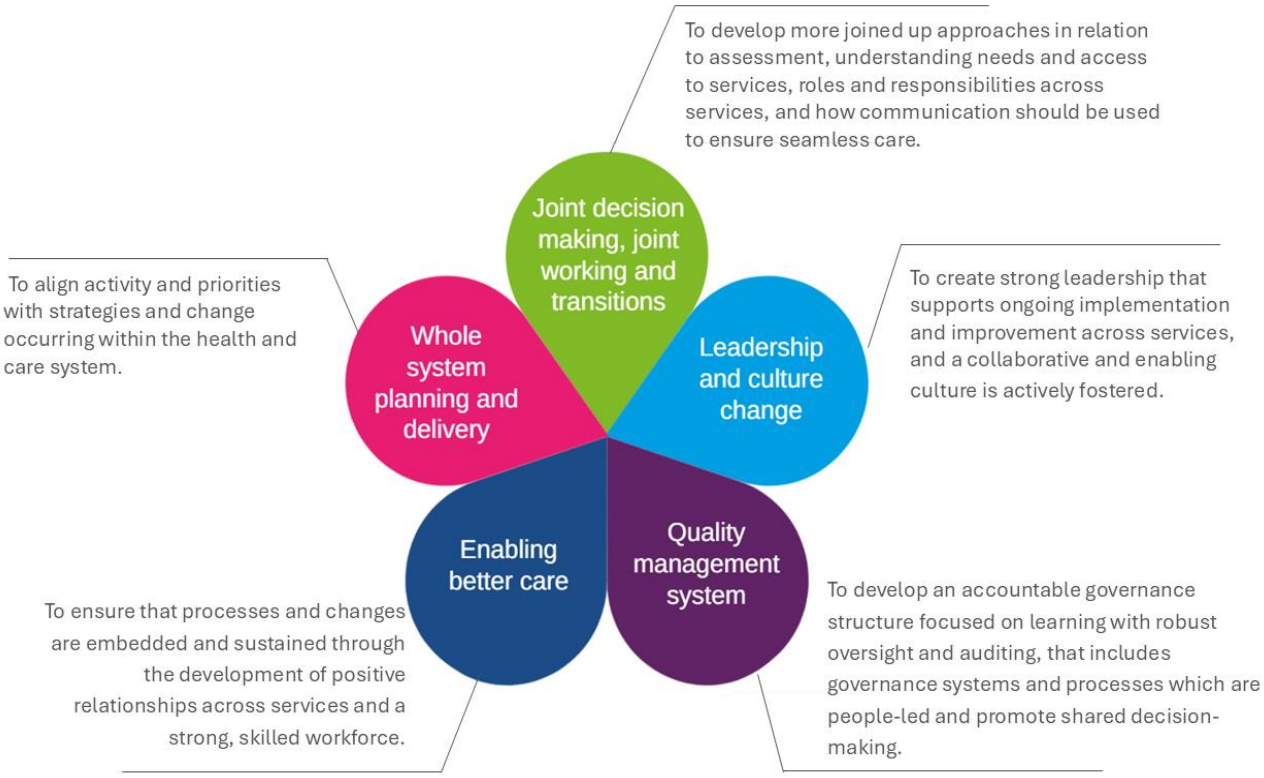

Figure 2: The Five Components of a system of care for mental health and substance use.

Supporting documents and resources:

The protocol can be accessed online: https://www.hisengage.scot/equipping-professionals/national-mental-health-and-substance-use-protocol/

Supporting resources in relation to the protocol can be accessed online:

https://www.hisengage.scot/equipping-professionals/national-mental-health-and-substance-use-protocol/resources-and-case-studies/

These include case studies and examples of interface guidance, as well as a self-reflection tool.

Our Mental Health and Substance Use Toolkit aims to support services in providing better care to people with both mental health and substance use needs, and can be accessed online: https://www.hisengage.scot/equipping-professionals/national-mental-health-and-substance-use-protocol/mental-health-and-substance-use-toolkit/

Joint Decision Making, Joint Working and Transitions

This section covers what needs to be included in relation to assessment, understanding needs and access to services, roles and responsibilities across services, and how communication should be used to ensure seamless care.

Pathways and access to services:

What is expected?

Local interface guidance should include reference to:

1. Agreed referral, assessment and screening processes for mental health and substance use services.
2. Agreed upon standard pathways of support based on outcomes of screening/assessment and the Four Quadrant model.
3. Processes to enable timely transitions of care to appropriate services for mental health and/or substance use conditions, including to and from the third sector.
4. Formal collaboration with third sector services that support a range of conditions.
5. Established escalation processes from substance use services into higher tier psychological therapies and urgent mental healthcare pathways.

What might this look like?

Examples of what this might involve:

1. Common assessment process across services and sectors, that includes screening and other decision support tools. For example:
    - Agreement on which screening tools to use, such as ASSIST-Lite, AUDIT, GAD-7, PHQ-9, GHQ-12, Mini Mental State.
    - Identification and recognition of trusted referrers to reduce duplication of assessments (e.g. to avoid assessment by a Registered Mental Health Nurse (RMN) in substance use services leading to assessment by a Community Mental Health Team RMN prior to referral acceptance).
2. Agreed pathways based on stratification of needs across mental health and substance use. There should be consideration of the impact of co-occurring needs on the level of support required within services. For example:
    - Understanding/awareness of how to respond to changing needs across all patients facing staff groups.

- Agreed operational definitions of mental health and substance use needs, along a spectrum, with reference to the Four Quadrants model.

3. Use of multidisciplinary case allocation meetings or consultant-to-consultant communication to enable agreement on referral acceptance prior to making a referral.
4. a) Inclusion of third sector services such as community link practitioners, peer workers, mental health, and substance use practitioners, within multidisciplinary case allocation meetings.

   b) Development of services to support early intervention/prevention to reduce the need for transitions into secondary services. For example, low-intensity psychosocial interventions available within primary/community-based care.

   c) Enhanced role of the third sector in providing psychosocial interventions for substance use presentations.
5. a) Clear guidance on how and when mental health assessments will be carried out for individuals in crisis, who have been using substances.

   b) Inclusion of substance use needs within Psychiatric Emergency Plans.

   c) Clear guidance and remits for Harm Reduction Teams that enable permission to share information in relation to increased risk and/or capability and capacity to do outreach activity to mitigate risk.

   d) Clear prioritisation processes for clinicians if a situation has been escalated e.g. if an issue is time sensitive or there is increased risk.

   e) Timely support (advice, joint assessment or joint working) from mental health services for substance use services concerned about suicidality/crisis presentations.

Understanding and responding to needs:

What is expected?

Local interface guidance should include reference to:

1. Processes enabling specific input from multiple specialists on decision making. Especially if there is uncertainty or disagreement about the most appropriate care, to avoid inappropriate and rejected referrals.
2. Assessment processes that gather information that can inform a person-centred, whole system response. These should enable people to be signposted accordingly to different services to support any identified needs. These assessments should not be carried out from the sole perspective of what an individual service can provide and be shared between services where there is consent.
3. Processes for sharing information and insights about a person that can enable anticipation of fluctuating needs on an ongoing basis (e.g. triggers, situational stressors).

What might this look like?

Examples of what this might involve:

1. Multidisciplinary case meeting, consultant-to-consultant, nurse-to-nurse or key-worker-to-key-worker communication, or joint assessment or joint working involving mental health and substance use services.
2. a) Clarity around when assessments are to take place e.g. on entering a service, crisis presentations, or ongoing assessment.
   b) Inclusion of families in care and support planning and decision making.
   c) Inquiry into and identification of non-clinical outcome goals for individuals as part of screening and assessment processes.
3. a) Clear communication and appropriate sharing of the outcome of the assessment, next steps and who is responsible. This should include how the assessor has defined and interpreted 'mental health' and 'substance use' (i.e. acknowledgement of, for example, the experience of complex trauma that has resulted in a psychological need that does not meet the threshold of a severe and enduring mental health condition or is diagnostically overshadowed by substance use).
   b) Anticipatory care planning acknowledging the fluctuating needs of someone on a recovery journey.

Roles and responsibilities:

What is expected?

Local interface guidance should include reference to:

1. Responsibilities and processes for ensuring that individuals are not left without a service or unmet needs. This should include processes that address ‘missingness’ or when individuals disengage with services.
2. Agreement on the specific interventions needed for individuals and where care should be most appropriately delivered. This should be based on the level of presenting need and accessibility considerations. There should be flexibility to adjust interventions and support as circumstances change.
3. An agreed approach to managing co-occurring conditions across multiple services. This should include explicit reference to responsibilities in supporting mild to moderate needs alongside higher needs. Approaches should ensure ‘lesser’ needs are not left unmet and that there is a shared understanding of how co-occurring conditions interact to impact a person’s wellbeing and behaviour.
4. Responding to the legislative responsibilities of the Carers (Scotland) Act 2016 in providing carer support and involving carers and families wherever possible.

What might this look like?

Examples of what this might involve:

1. Clear processes for when individuals disengage with services. These should include opportunities for families to be able to communicate concerns, and a responsibility of third sector services to notify statutory services of disengagement.
2. a) Service specifications and criteria should be written and made available.
   b) Reference to relevant guidance, such as The Matrix.
   c) Supporting the workforce to understand their roles and responsibilities within their speciality, their remit for supporting co-occurring conditions and how to link into other services as appropriate.
   d) Workforce development plans that ensure staff have the awareness, skills and confidence to identify mental health and substance use conditions and manage these as appropriate, including local pathway knowledge.
3. a) Reference to relevant guidance, such as NICE Guideline [NG58].
   b) Commissioning should be used to outline how services should be delivering care and formalise connections. This includes non-statutory services and those that deliver care management and social support.
   c) Inclusion of third sector services (including advocacy) and social supports such as mentors, befrienders, navigators, and peer support.
4. Identification and provision to address carer support needs.

Communication and information sharing

What is expected?

Local systems should enable:

1. Development of minimum shared record for individuals to be shared as part of onward referrals or during transitions. This should include information gathered as part of holistic assessments (i.e. information relating to housing status and informal care).
2. A key contact for service users and the family enabling a triangle of care between family, service users and services. (*This contact does not need to be the same person for the service user and the family, and there may be benefit in separation between individual and carer support)*.
3. Processes detailing how information about a person's condition is shared across all services supporting them, especially where there are changes in condition.
4. Identification of gaps in data sharing agreements across services, including third sector services; and the development of new agreements, to ensure communication and data sharing across new pathways.
5. Learning from Significant Adverse Event Reviews and other relevant reviews around communication and information sharing, including the involvement of families, carers and people who use services.

What might this look like?

Examples of what this might involve:

1. Electronic record keeping systems with agreed coding for specific conditions and decisions.
2. Review and improvement of current information sharing processes, with reference to the Mental Welfare Commission's Carers, consent, and confidentiality: Good Practice Guide.
3. a) Development and use of shared care planning templates across services.
   b) Patient information leaflets and informed consent forms to allow for individual cases to be discussed at joint meetings.
4. a) Review and improvement of current processes and systems to enable shared access to relevant records and improve communication across services.
   b) Approval from local information governance teams and Caldicott Guardian around current information sharing agreements/support to modify these where they are proving ineffectual.
5. a) Thematic analysis of Significant Adverse Event Reviews in relation to communication and information sharing and using key learning points and recommendations to improve processes.

Enabling Better Care

This section covers what needs to be considered to ensure that processes and changes are embedded and sustained through the development of positive relationships across services and a strong, skilled workforce.

What is expected?

Development plans for this workforce should include:

1. a) Defining the mental health and substance use workforce, outlining the level of skills and knowledge expected, ensuring appropriate skill mixes within services which align to the level of responsibility of staff.
   b) Explicit reference to third sector staff as part of the workforce.
   c) A requirement for all mental health and substance use staff to be trained in assessing and managing co-occurring conditions.
   d) Workforce development that goes beyond training, with input across specialisms. For example, ongoing support and supervision, coaching, reflective practice, peer support and co-occurring conditions networks.
2. Incorporating staff relationship building approaches into business-as-usual activities, and activities supporting protocol implementation.
3. Explicit commitment to providing more integrated mental health and substance use care.

What might this look like?

Examples of what this might involve:

1. a & b) A comprehensive workforce development plan.
   c) A training needs assessment, including levels of current staff capacity to deliver training, support and supervision, and coaching.
   d) Protected time for staff to participate in continuous professional development. The formation of teaching and peer support networks for staff from both mental health and substance use services, that allows for discussion of topics relevant to supporting co-occurring conditions.
   e) Shadowing opportunities, secondments, and opportunities for staff to rotate between services.
2. Regular networking opportunities through routine activity such as joint meetings, training and case discussions.
3. Exploration of co-location opportunities (e.g. mental health and substance use services located within one building; third sector service having one day a week within a statutory service).

Leadership and Culture Change

This section covers what needs to be included within local protocols to ensure that strong leadership supports ongoing implementation and improvement across services, and a collaborative and enabling culture is actively fostered.

What is expected?

Local systems should enable:

1. The development of an enabling culture amongst staff, empowering them to make informed decisions and develop in their roles.
2. Embedding of anti-stigma and trauma informed approaches as a way of supporting better therapeutic developments and supporting staff wellbeing.
3. An approach to ensuring statutory and non-statutory services are visible and valued.
4. The principle of 'it's everyone's job' being embedded across implementation plans and strategies; in which commissioners and providers have a joint duty to meet the needs of individuals with co-occurring conditions together.
5. Mapping of governance structures to ensure that change programmes across the wider system will actively collaborate and join up services.
6. Leadership that is active and focused on learning and enabling, supporting people delivering services to be empowered to make changes and adapt to improve.

What might this look like for leaders and managers?

Examples of what this might involve:

1. a) Effective communication with staff, involve them in change processes.
   b) Two-way communication to enable problem-solving of operational challenges, awareness of new ways of working and understanding of ongoing challenges or operational barriers.
2. a) Endorsement of messaging from senior clinicians highlighting the importance and benefit of collaboration across mental health and substance use services.
   b) Proactive challenge of stigma/myths around co-occurring conditions.
3. a) Support implementation of new ways of working by providing sponsorship, removing operational barriers, enabling and empowering staff and bringing together stakeholders.
   b) Align their work with other key drivers for mental health and substance use integration, including National Drugs Mission, Suicide Prevention, Mental Health Core Standards and the improving physical health agenda.
4. Link in with governance structures and ensure accountability.

5. Mapping and aligning relevant work programmes across the wider system, including representation from key stakeholders, including mental health and substance use within these.
6. Courageous and compassionate leadership that provides permissioning, safe spaces that allow staff to develop new ways of working, and the removal of barriers to staff identifying and making improvements.

What might this look like for services, service planning, and workforce development?

Examples of what this might involve:

1. a) Non-specialist training to enable awareness and build knowledge and skills in supporting co-occurring conditions.
   b) Career and training development pathways for those with interest and responsibility to help them promote improvement.
   c) Regular feedback and learning from Significant Adverse Event Reviews in a pro-learning environment that enhances other mechanisms (such as email communication or occasional learning events). This should be embedded in local learning systems with opportunities for staff to present and learn from adverse events, allowing promotion of a non-judgmental culture.
   d) Mechanisms for regular feedback and communication jointly between mental health and substance use services. For example, to identify risks, improvement opportunities, and highlight good practice.
2. a) Training to raise anti-stigma awareness.
   b) Support trauma informed practice.
   c) Foster a culture of trust across services that supports relationships between staff.
   d) Proactive engagement with, and working alongside individuals with lived experience, including to co-deliver training.
   e) Consideration of the role of lived experience leadership.
   f) Broad communication plan with accessible language and narrative so the public and wider society are part of the change.
3. a) Strategic planning to ensure different services are visible and valued across the whole system.
   b) Identification of influential staff who can play a leadership role within change programmes, as either leaders due to their role or champions within services.
   c) Identification and support for champions of care for co-occurring conditions.
4. Link in with governance structures and ensure accountability.

Whole System Planning and Delivery

This section covers what needs to be considered within local areas to align activity and priorities with strategies and change occurring within the health and care system.

Wider system interfaces:

What is expected?

Local systems should consider:

1. Where possible, connections with local public health work programmes, particularly anti-stigma campaigns, social capital projects, and place-based approaches, to support community-level health and care services and Tier 1 supports.
2. a) Connection with other standards, e.g. Core Mental Health Quality Standards, Medication Assisted Treatment (MAT) Standards.
   b) Connection with other local priorities e.g. integrated care pathways for particular conditions.
   c) Connection with other areas of improvement, redesign and transformation in the health and care system. This may include Quality Improvement projects and service development through Significant Adverse Event Review processes.
3. References to how changes, through the implementation of a local protocol, might impact other areas of the health and care system (e.g. primary care, community-level support, third sector commissioning).
4. How changes within mental health and substance use might result in access barriers.

What might this look like?

Examples of what this might involve:

1. a) Use of community planning partnerships, locality planning networks and third sector interfaces to build alignment across the whole system in achieving the principles and outcomes of local protocols.
   b) Ongoing engagement with the distributed mental health, and substance use, leadership across the local area, including those within the Local Authority, NHS Board, Integrated Joint Board and Community Planning Partnership.
   c) Enhancement of the recovery-oriented system of care by linking to community wellbeing resources, third sector services (including advocacy), and social supports such as mentors, befrienders, navigators, and peer support.
   d) Promotion of and support for recovery, social cohesion and community connections as ways of supporting resilience and wellbeing.

e) Awareness raising of the wider recovery-oriented system of care amongst staff, with information on a range of recovery support services.

2. a) Ensuring relevant standards are used by all community-based mental health and substance use services to support all co-occurring conditions.
   b & c) Ensuring inclusion of mental health and substance use perspectives within the governance, improvement and redesign of other services (e.g. primary care, pharmacy, mental health transformation, urgent and elective care, physical health).
   a, b & c) Communications plan for sharing updates across a range of services.
3. a) Identification of how the protocol will impact the work of others.
   b) Staff education on interfaces/wider system of care.
   c) Review of interfaces (and improvement, redesign or transformation if necessary).
   d) Inclusion of other stakeholders in the development of protocols and commissioning, e.g. GPs to develop Primary Care Shared Care Protocols; third sector in development of Tier 1 supports such as community health projects, Community Link Practitioners, peer recovery networkers.
4. Health Impact Assessment to identify how changes may affect access to mental health, substance use, or other services.

Commissioning:

Commissioning approaches should include:

1. Incorporation of Ethical Commissioning principles into the planning and commissioning of mental health and substance use services.
2. Development of shared accountability for outcomes across commissioning bodies.
3. Description of how commissioning approaches and mechanisms will be used to support implementation of a local protocol.
4. Commissioning practices which learn from those who deliver and use services – enabling people to identify what alternatives might be available.

What might this look like?

Examples of what this might involve

1. a) Consideration of the impact of commissioning decisions on choice and control.
   b) Exploration of different commissioning approaches such as Alliance Contracting and Collaborative Commissioning, that move away from a competition driven system.
   c) Reviewing IRISS recommendations for ethical commissioning in drug and alcohol services.
2. a) Commissioning informed by a good understanding of local data, taking into account factors such as demand, capacity, activity and queue, along with alcohol and drug partnership commissioned needs assessments and MAT standards reporting data.
   b) A robust methodology for understanding local needs for specific interventions/services such as trauma counselling, residential rehabilitation, and recovery cafes.
3. a) Review of the current commissioning environment and assessment of suitability to deliver the required system changes for the implementation of a local protocol.
   b) Identification of areas for capacity building around commissioning, including local skills, available data and relationships between commissioning and delivery bodies.
4. Engagement is being built into commissioning practices to ensure continuous learning from those that deliver and receive services.

Quality Management System

This section covers what local systems need to do to ensure that processes and changes are embedded and sustained through the development of positive relationships across services and a strong, skilled workforce.

What is expected?

This should include:

1. A clear, transparent, and accountable governance structure focused on learning with robust oversight and auditing. The responsible individual for mental health and substance use integration should have overall responsibility for ensuring this. This includes ensuring regular and ongoing analysis of data and information to understand what's happening in the system, and to provide local assurance of quality and outcomes.
2. Governance systems and processes which are people-led and promote shared decision making.
3. Data and measurement used for learning, with variations from quality standards used to identify areas where things could be done differently.
4. How services will be adapted based on analysis of relevant data gathered to inform quality planning, quality control, and quality improvement.
5. Data and information and learning are shared across statutory and third sector providers to support understanding of individual- and population-level needs. This would enable services to adapt and flex based on shared learning and understanding in response to demands and emerging issues.
6. Triangulation of information from multiple sources, including experiential data from people delivering and receiving services, and quantitative data across partners to create insights to inform decision making. Approaches to engagement are based on the meaningful involvement of people who need, access, use and deliver services – this would include involving people in the planning, design and delivery of services.
7. Governance and operational mechanisms to ensure that feedback is used to inform improvement of services across the whole system.

What might this look like?

Examples of what this might involve:

1. a) Oversight of the protocol's implementation by appropriate governance structures such as Mental Health, Learning Disability, and Substance Use steering groups, Patient Safety and Quality Improvement groups.
   b) Development of data collection methods to measure staff awareness, understanding and use of local protocols.
   c) Feedback mechanisms to monitor adherence to local protocol and identify potential improvements or areas of concern. This would include (1) Data for adherence (2) Data for monitoring positive practice (3) Data for performance support (4) Data to inform workforce planning.
2. Governance systems and processes that enable collaboration, mutual respect, shared learning and decision making are based on an authentic understanding of what is happening within systems of care.
3. A holistic approach to setting measures that are based on outcomes for people and other relational factors (e.g. organisational culture). There should also be the use of key data such as readmission rates, crisis team involvement, Mental Health Act assessments and rejected referrals.
4. Identification of appropriate clinical and care governance, patient safety and quality improvement forums, for data to be discussed.
5. Further development of commissioning relationships to build trust and shared understanding, enabling a system of care that is flexible and responsive to emergent needs. Establishing reporting requirements within contracts for commissioned providers.
6. Generation of insights from sources such as local outcome measures, Significant Adverse Event Reviews, complaints, third sector organisations, engagement activities and informal mechanisms.
7. a) Using the Medication Assisted Treatment standards experiential programme to inform the redesign of services as part of a broader landscape of change, not just within those services supporting Medication Assisted Treatment.
   b) Routine follow-up with services to check on the implementation of Significant Adverse Event Review recommendations.

Ethos and Approach

Effective implementation of local interface guidance and attendance to the wider system of care will enable key principles to be embedded within service delivery:

1. Co-occurring conditions are supported concurrently.

2. Services and pathways are responsive to changing needs across the spectrum of co-occurring mental health and substance use.

3. Services can provide 'in-house' support for co-occurring conditions.

4. There are planned pathways for sustainable transitions into communities and recovery-oriented systems of care.

To create the conditions for effective implementation and improve services and outcomes for individuals with co-occurring conditions, the following should be focused on:

1. **Culture change** to enable integrated care, reduce stigma and discrimination, deliver holistic models of care, and increase the visibility and value of services across the recovery-oriented system of care.

2. **Relationships** between staff in different services should be actively fostered to build understanding and awareness of other services, and ensure staff are able to get specialist input as required.

3. **Strong leadership** is required to bring together different services and workstreams, to create a shared vision for services, and to support and enable the workforce.

4. **Workforce development** and support for staff wellbeing to ensure staff feel confident and enabled to respond to and make decisions regarding overlapping needs. Staff should have an understanding of needs and presentations outside of their own specialism. This can be supported by access to protected time, supervision, mentoring, training, continuous professional development and co-occurring conditions networks.

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