

# Mental Health and Substance use: Protocol Programme

## Initial Self-Reflection Tool



### Introduction

The self-reflection tool has been developed to help you think about and discuss your current position in relation to the [mental health and substance use protocol](#), and what further developments may be required. The tool was designed to **generate discussion, identify opportunities for improvement**, and assist with the prioritisation of these opportunities to **agree areas of focus**. It can support the development of a **shared understanding** of current practice and **consensus** around how to move forward.

As a first step into long-term change, the conversations generated as part of this self-reflection can **identify early actions and build momentum** for activity.

*This tool can support you to build relationships that will drive change*

Through identifying any related ongoing work that is meeting the requirements of a protocol, the conversations sparked by this tool can help identify key people involved in aligned work and supportive colleagues.

It can also show where there are gaps in activity, highlighting where key people within other sectors need to be brought into the process.

*This tool can help provide a focus*

Through seeing where there are gaps between current practice and the good practice highlighted in the National Mental Health and Substance Use Protocol, there can be constructive conversations about where to prioritise efforts, what needs to be focussed on and, ultimately, where to start.

## How to use the tool

The self-reflection tool is NOT an assessment, it is a tool to aid discussions about where you feel you are currently and consider how to progress.

**Ratings Scale:** Reflect on each area of the protocol and rate yourself on a scale from 1 to 5 – where 1 indicates a need for significant development and 5 indicates high system-level competence.

- 1=Not implemented
- 2=Minimal implementation
- 3=Some implementation
- 4=Well implemented
- 5=Fully implemented

**Evidence to support ratings:** Describe why you have selected your self-assessment ratings. This could include specific experiences, new processes or feedback from staff, services or people with lived experience. Examples of what evidence could be used within each section can be found in the [Appendix](#).

**Further development opportunities identified:** Based on your self-assessment, identify areas that need further development. Outline specific actions, resources or developments that can help you improve, such as (but not limited to) developing interface guidance, additional process work, integration of co-occurring conditions agenda into system redesign opportunities, improving relationships and networks, staff engagement, training and development, leadership and strategic support, or commissioning practices.

**Who should be involved:** Different sections can be discussed by different stakeholder groups depending on relevance. For example, bringing together clinical and operational staff to reflect on current practice in relation to ‘Joint decision making, joint working and transitions’ or ‘Enabling better care’; and discussing ‘Commissioning’ with Health Board and Health and Social Care Partnership planning teams and Alcohol and Drug Partnerships.

It will be important to include operational staff within these conversations to understand current practice, rather than looking only at current policy. This can be an important distinction when thinking about where to start (it might be that a starting point is in understanding why existing policy might not be implemented).

However, it will be important for senior, cross system leaders to review the self-reflection, to understand and establish a consensus view around current practice.

## Mental Health and Substance Use Protocol: Initial Self-Reflection Tool

Before delving into the detail of the protocol, discuss some broad reflections on where you think your services are with regards to the overarching ethos and approach of a Mental Health and Substance Use Protocol. The responses to this can be revisited periodically to see how people feel these key areas are changing in the context of ongoing work.

Ethos and Approach			
Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
Co-occurring conditions are supported concurrently.	1 2 3 4 5		
Services and pathways are responsive to changing needs across the spectrum of co-occurring mental health and substance use.	1 2 3 4 5		
Services can provide 'in-house' support for co-occurring conditions.	1 2 3 4 5		
There are planning pathways for sustainable transitions into communities and recovery-oriented systems of care.	1 2 3 4 5		

The below table shows the competency areas within the Five Components of a system of care for mental health and substance use that comprise the core elements of the National Mental Health and Substance Use Protocol.

Joint decision making, joint working and transitions			
Pathways and access to services			
Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
There are agreed referral, assessment and screening processes for mental health and substance use services	1 2 3 4 5		
There are agreed upon standard pathways of support based on outcomes of screening/assessment and the Four Quadrants model	1 2 3 4 5		
There are 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	1 2 3 4 5		
There is formal collaboration with third sector services that support a range of conditions	1 2 3 4 5		
There are established escalation processes from substance use services into higher tier psychological therapies and urgent mental healthcare pathways.	1 2 3 4 5		

Understanding and responding to needs

Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
<p>There are 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.</p>	<p>1 2 3 4 5</p>		
<p>Assessment processes 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.</p>	<p>1 2 3 4 5</p>		
<p>There are 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).</p>	<p>1 2 3 4 5</p>		

Roles and Responsibilities			
Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
Responsibilities and processes are defined 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.	1 2 3 4 5		
There is 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.	1 2 3 4 5		
There is 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 there is a shared understanding of how co-occurring conditions interact to impact a person's wellbeing and behaviour.	1 2 3 4 5		
Services deliver on the legislative responsibilities of the Carers (Scotland) Act 2016 in providing carer support and involving carers and families wherever possible.	1 2 3 4 5		

Communication and Information Sharing

Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
There are plans to develop a minimum shared record for individuals to be shared as part of onward referrals or during transitions, that also include information gathered as part of holistic assessments (i.e. information relating to housing status, informal care)	1 2 3 4 5		
There is a key contact for service users and the family enabling a triangle of care between family, service users and services. <i>(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).</i>	1 2 3 4 5		
There are processes detailing how information about a person’s condition is shared across all services supporting them, especially where there are changes in condition	1 2 3 4 5		
Gaps in data sharing agreements have been identified across services, including third sector services. There is development of new agreements to ensure communication and data sharing across new pathways	1 2 3 4 5		
Learning is being used 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.	1 2 3 4 5		

## Enabling Better Care

Competency	Scale 1-5 <small>(1 = Not implemented – 5 = Fully implemented)</small>	Why have you chosen this rating?	Further Development Required/Opportunities Identified
<ul style="list-style-type: none"> <li>• There is a defined mental health and substance use workforce.</li> <li>• The level of skills and knowledge expected has been outlined, ensuring appropriate skill mixes within services aligned to level of responsibility.</li> </ul>	1 2 3 4 5		
Third sector staff are recognised and included as part of the workforce	1 2 3 4 5		
All mental health and substance use staff are trained on assessing and managing co-occurring conditions.	1 2 3 4 5		
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	1 2 3 4 5		
Incorporating staff relationship building approaches into business-as-usual activities, and activities supporting protocol implementation	1 2 3 4 5		
Explicit commitment to providing more integrated mental health and substance use care	1 2 3 4 5		



## Leadership and Culture Change

Competency	Scale 1-5 <small>(1 = Not implemented – 5 = Fully implemented)</small>	Why have you chosen this rating?	Further Development Required/Opportunities Identified
There is the development of an enabling culture amongst staff, empowering them to make informed decisions and develop in their roles	1 2 3 4 5		
Anti-stigma and trauma informed approaches are embedded as a way of supporting better therapeutic developments and supporting staff wellbeing	1 2 3 4 5		
There is an agreed approach to ensuring statutory and non-statutory services are visible and valued	1 2 3 4 5		
The principle of 'it's everyone's job' is embedded across implementation plans and strategies.	1 2 3 4 5		
Commissioners and providers have agreed a joint duty to meet the needs of individuals with co-occurring conditions together.			
Governance structures across the wider system have been mapped to ensure that change programmes beyond mental health and substance use services will actively collaborate and join up services.	1 2 3 4 5		
Leadership is active and focused on learning and enabling, supporting people delivering services to be empowered to make changes and adapt to improve.	1 2 3 4 5		

Whole System Planning and Delivery

Wider System Interfaces

Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
Where possible, there are 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.	1 2 3 4 5		
Connections are understood with other: <ul style="list-style-type: none"> <li>standards, e.g. Core Mental Health Quality Standards, MAT Standards</li> <li>local priorities e.g. integrated care pathways for particular conditions.</li> <li>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.</li> </ul>	1 2 3 4 5		
There is understanding of 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).	1 2 3 4 5		

There is understanding of how changes within mental health and substance use might result in access barriers	1 2 3 4 5		
Commissioning			
Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Required/Opportunities identified
Ethical Commissioning principles are incorporated into the planning and commissioning of mental health and substance use services	1 2 3 4 5		
There is shared accountability for outcomes across commissioning bodies	1 2 3 4 5		
There is understanding of how commissioning approaches and mechanisms will be used to support implementation of a local protocol	1 2 3 4 5		
Commissioning practices learn from those who deliver and use services – enabling people to identify what alternatives might be available.	1 2 3 4 5		

Quality Management System

Competency	Scale 1-5 (1 = Not implemented – 5 = Fully implemented)	Why have you chosen this rating?	Further Development Required/Opportunities Identified
<p>There is a clear, transparent, and accountable governance structure with robust oversight and auditing.</p> <p>The responsible individual for mental health and substance use integration has overall responsibility for this and understands their role.</p>	<p>1 2 3 4 5</p>		
<p>What data has to be collected has been clearly defined</p>	<p>1 2 3 4 5</p>		
<p>Services are adapted on an ongoing basis through analysis of relevant data gathered to inform quality planning, quality control, and quality improvement</p>	<p>1 2 3 4 5</p>		
<p>There is an understanding, and receipt, of the data required from third sector providers to support understanding of individual- and population-level needs</p>	<p>1 2 3 4 5</p>		

There are clear processes for listening to and responding to feedback to ensure that all feedback loops are closed	1 2 3 4 5		
There is a joined-up approach to collate feedback and develop insights from a range of sources	1 2 3 4 5		
There are governance and operational mechanisms to ensure that feedback is used to inform improvement of services across the whole system.	1 2 3 4 5		

# Appendix A – a guide to thinking about what evidence can be used to demonstrate progress across the competencies

The below describes the type of activities and processes that would show how you are aligning with the protocol. This is not prescriptive nor exhaustive list and aims to aid in local development and implementation.

Joint decision making, joint working and transitions	
Pathways and access to services	
<p>This area of the protocol will aim to develop pathways and improve access to services for people with co-occurring conditions.</p> <p>Key elements of this are likely to include:</p> <ul style="list-style-type: none"> <li>• Common assessment processes across services and sectors, that includes screening and other decision support tools.</li> <li>• Agreed pathways based on stratification of need across mental health and substance use, and consideration of impact of co-occurring needs on level of support required within services.</li> </ul>	<p>This area can be supported by:</p> <ul style="list-style-type: none"> <li>• Multidisciplinary case allocation meetings or consultant-to-consultant communication to enable agreement on referral acceptance prior to referral generation</li> <li>• Inclusion of third sector services such as community link practitioners, peer workers, mental health, and substance use practitioners, within multidisciplinary case allocation meetings</li> <li>• Guidance on how and when mental health assessments will be carried out for individuals in crisis, who have been using substances</li> <li>• Explicit remits for Harm Reduction Teams that enable either permission to share information in relation to increased risk and/or capability and capacity to do outreach activity to mitigate risk.</li> <li>• Prioritisation processes for clinicians if a situation has been escalated e.g. if an issue is time sensitive or there is increased risk.</li> </ul> <p><a href="#"><i>More examples of what good might look like in this area can be found here.</i></a></p>

<p>Understanding and responding to need</p>	
<p>This area of the protocol will aim to support professionals to identify where there are co-occurring conditions, what the needs for individuals are, and be supported to respond to presenting conditions.</p> <p>Key elements of this are likely to include:</p> <ul style="list-style-type: none"> <li>• Processes and understanding around when assessments are to take place e.g. on entering service, crisis presentations, or ongoing assessment</li> <li>• Clear communication and sharing as appropriate of outcome of assessment and next steps and who is responsible – including how assessor has defined and interpreted 'mental health' and 'substance use'</li> </ul>	<p>This area can be supported by:</p> <ul style="list-style-type: none"> <li>• Inclusion of families in care and support planning and decision making</li> <li>• Inquiry into and identification of non-clinical outcome goals for individuals as part of screening and assessment processes.</li> <li>• Anticipatory care planning acknowledging the fluctuating needs of someone on a recovery journey</li> </ul> <p><a href="#"><i>More examples of what good might look like in this area can be found here.</i></a></p>
<p>Roles and Responsibilities</p>	
<p>This area of the protocol will aim to establish a shared understanding of the roles of different professionals in the above areas, and their responsibilities in supporting people with co-occurring conditions.</p> <p>Key elements of this are likely to include:</p> <ul style="list-style-type: none"> <li>• Clear processes for when individuals disengage with services, for families to be able to communicate concerns, and responsibility of third sector services to notify statutory services of disengagement</li> </ul>	<p>This area can be supported by:</p> <ul style="list-style-type: none"> <li>• Service specifications and criteria should be written and available</li> <li>• Reference to relevant guidance, such as, <a href="#"><u>The Matrix</u></a></li> <li>• Reference to relevant guidance, such as, <a href="#"><u>NICE Guideline [NG58]</u></a></li> <li>• An explicit role for commissioning to formalise connections, including with non-statutory services and those that deliver care management and social support</li> </ul> <p><a href="#"><i>More examples of what good might look like in this area can be found here.</i></a></p>

<ul style="list-style-type: none"> <li>• An approach to supporting the workforce to understand their roles and responsibility within their speciality, their remit for supporting co-occurring conditions and how to link into other services as appropriate.</li> </ul>	
<b>Communication and Information Sharing</b>	
<p>This area of the protocol will aim to outline how services should communicate with each other regarding individuals, sharing information about changes in circumstances, outcomes of assessments and any onward referrals.</p> <p>Key elements of this are likely to include:</p> <ul style="list-style-type: none"> <li>• Agreed coding for specific conditions and decisions within electronic record keeping systems</li> <li>• Regular review of ways to improve and build on communication across services</li> </ul>	<p>This area can be supported by:</p> <ul style="list-style-type: none"> <li>• Review and improvement of current information sharing processes, with reference to the Mental Welfare Commission’s <u>Carers, consent, and confidentiality: Good Practice Guide</u></li> <li>• Development and use of shared care planning templates across services</li> <li>• Patient information leaflets and informed consent forms to allow for individual’s cases to be discussed at joint meetingsApproval from local information governance teams and Caldicott Guardian around current information sharing agreements/support to modify these where they are proving ineffectual</li> <li>• Thematic analysis of SAERS in relation to communication and information sharing and using key learning points and recommendations to improve processes</li> </ul> <p><a href="#"><u>More examples of what good might look like in this area can be found here.</u></a></p>



## Leadership and Culture Change

This area of the protocol will aim to outline how leadership will support ongoing implementation. Looking at driving improvement across services, as well as actively fostering a collaborative and enabling culture.

Key elements of this are likely to include:

- Supporting implementation of new ways of working by providing sponsorship, removing operational barriers, enabling and empowering staff and bringing together stakeholders.
- Aligning 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.

This area can be supported by:

- Two-way communication to enable problem-solving of operational challenges, awareness of new ways of working and understanding of ongoing challenges or operational barriers.
- Creation of safe spaces that allow staff to develop new ways of working, and the removal of barriers to staff identifying and making improvements. Endorsement of messaging from senior clinicians highlighting the importance and benefit of collaboration across mental health and substance use services.
- Proactive challenge of stigma/myths around co-occurring conditions
- Mapping and aligning relevant work programmes across the wider system, including representation from key stakeholders, including mental health and substance use, within these.

[More examples of what good might look like in this area can be found here.](#)

## Whole system planning and delivery

### Wider system interfaces

This area of the protocol will outline how other sectors and programmes of work will be linked into the Protocol development and new ways of working. Looking at where there needs to be alignment between activity and how that should be planned.

Key elements of this are likely to include:

- 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.
- An understanding of how to ensure that co-occurring conditions are incorporated into other sectors and areas of work, avoiding the replication of service silos.

This area can be supported by:

- 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.
- 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).
- Communications plan for sharing updates across a range of services.
- Identification of how the protocol will impact the work of others.
- 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.

[More examples of what good might look like in this area can be found here.](#)

### Commissioning

This area looks at how commissioning can be used to bring together services and develop a more holistic system of care. It looks at how different approaches to commissioning can

This area can be supported by:

- Using different commissioning approaches such as Alliance Contracting and Collaborative Commissioning, that move away from a competition driven system.

ensure a more adaptive and sustainable model of support for people with co-occurring conditions.

Key elements of this are likely to include:

- Outlining a clear commissioning strategy for mental health and substance use services that emphasise collaboration across different sectors
- Commissioning services based on local intelligence regarding what type up support is needed, and what can make best use of local resources.

- Reviewing IRISS recommendations for ethical commissioning in drug and alcohol services.
- Making informed decisions using 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.
- Developing a methodology for understanding local needs for specific interventions/services such as trauma counselling, residential rehabilitation, and recovery cafes.

[More examples of what good might look like in this area can be found here.](#)

## Enabling Better Care

This area looks at 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.

Key elements of this is likely to include:

- A workforce development plan that is explicit around how all staff will be supported to recognise and respond to co-occurring needs.
- Support and supervision approaches that allows for clinical input into workforce development, along with opportunities for peer support across specialisms.

This area can be supported by:

- Shadowing opportunities, secondments, and opportunities for staff to rotate between services.
- Regular networking opportunities through routine activity such as joint meetings, training and case discussions.
- A training needs assessment, including levels of current staff capacity to deliver training, support and supervision, and coaching.
- 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.

[More examples of what good might look like in this area can be found here.](#)

## Quality Management System

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

Key elements of this is likely to include:

- Clear roles and responsibility for the oversight of the protocol's implementation by appropriate governance structures
- Mechanisms of feedback that support decision making and learning regarding implementation and impact of the protocol. With a clear emphasis on understanding what is happening within the system.

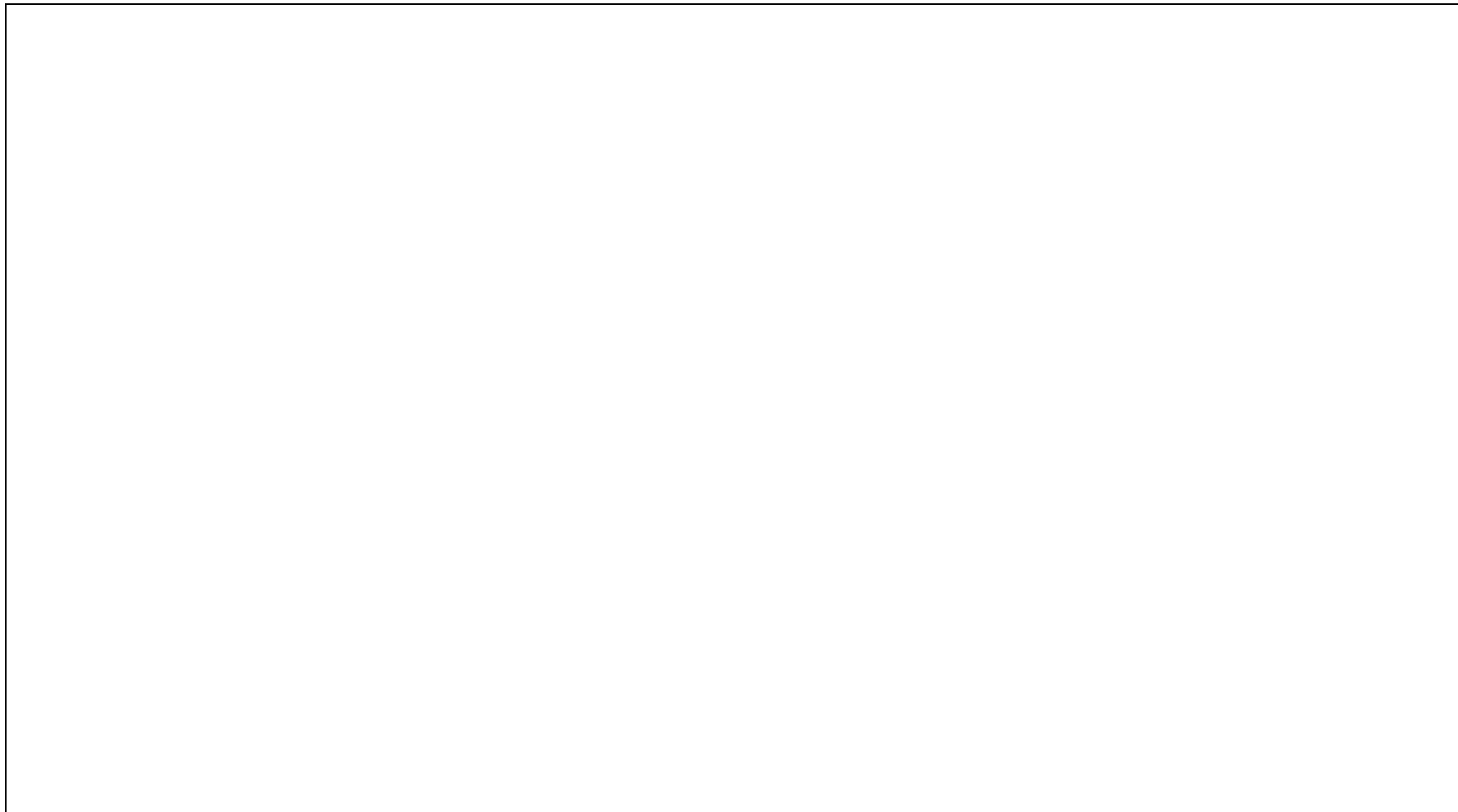
This area can be supported by:

- Development of data collection methods to measure staff awareness, understanding and use of local protocols.
- A holistic approach to setting measures that are based on outcomes for people and other relational factors (e.g. organisational culture).
- Identification of appropriate clinical and care governance, patient safety and quality improvement forums, for data to be discussed.
- Generation of insights from sources such as local outcome measures, Significant Adverse Event Reviews, complaints, third sector organisations, engagement activities and informal mechanisms.
- 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.

[More examples of what good might look like in this area can be found here.](#)

# Appendix B – Additional Evidence or Further System Development Opportunities

Please use this section to elaborate on the above. For example, what work has already been done, and what is there still to do.

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# Appendix C – suggestion for using the self-reflection tool with operational staff

Completing the self-reflection tool with operational staff can:

- allow leaders and managers to develop a true understanding of current practice and see any gaps between policy and practice
- develop a consensus around current practice, to support action focussed conversation going forward
- highlight any particularly interested or engaged staff members
- support networking between mental health and substance use staff

## Before the session

It is important that there is a working group of people from across mental health and substance use, including the Senior Responsible Officer, to hold the insights and actions that emerge from the workshop. See Implementation Guide.

Decide which component of the Protocol you would like to explore. It is suggested that with staff, they look at:

- Joint decision making, joint working and transitions
- Enabling better care

## During the session

Split the participants into groups of up to 6, with a blend of staff from different services.

*Discussion One:* Go through the self-reflection for the Ethos and Approach – then feedback to the group – highlighting any key points and noting similarities across the feedback, and any noticeable differences in views.

*Discussion Two:* Assign each group a different section of the chosen component for discussion – feedback to the group

*Whole room discussion:* As the chair, through the feedback, note any areas you see where there is a large gap, and where there is a lot of good practice. Lead the discussion around identifying where there are any high impact areas.

## Outputs/Actions

From this session you will be able to:

- Start work around formalising ongoing good practice
- Build an approach to address any larger gaps
- Develop key communications highlighting the importance of joint working to support outcomes for people (and help staff)

## Suggestions for follow up

After this session it could be useful to:

- Engage with third sector staff and discuss their role in improvements in care for co-occurring conditions, including bringing together all staff using the 'Matchmaking Care' tool
- Undertake Journey/Case Mapping to focus in on where changes can be made.