Charter 12.8 Increase Uptake of Drug Treatment

Improvement Project Title
Enhance early intervention and preventative treatment for those at greatest risk of harm from drugs and alcohol

Executive Sponsor
Supt. Richard Craig, Police Scotland, ADP Chair

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Aim statement
Increase uptake of drug treatment and specifically within Locality Areas by 10% each year by 2021.

Link to Local Outcome Improvement Plan
12. Rate of harmful levels of alcohol consumption reduced by 4% and drug related deaths lower than Scotland by 2026

Why this is important

Ten cases that were classified as drug related deaths from 2018 through toxicology reporting were reviewed to identify opportunities for earlier intervention to support individuals. Whilst drug use was a factor in the lifestyle of the individual it wasn't necessarily the dominant feature and none of the cases were currently open to substance use services.

The panel involved in reviewing the cases comprised of:

- NHS Grampian
- Social Work
- Police Scotland
- ACC Housing Access and Support
- ACC Information Governance

For each case a timeline of data was created that identified contact points prior to and up to the point of death to examine what opportunities there were for intervention. Data was drawn from the following systems:

- Carefirst – Social Work
- Vulnerable Person Database (VPD) Police Scotland
- Recorded Offences (Crimefile) – Police Scotland
- Custody Record – Police Scotland
- Death Record – Police Scotland
- NPS Housing – Housing / Homelessness Contacts
- NHS Systems: Trak, Vision/EMis, Ambulance

Data was analysed against an emergent profile of risk factors emergent from local reviews and national reports.

KEY FINDINGS

1) Frequency of data points

Information was held on 10 people reviewed representing 100% of the cases reviewed on all systems with the exception of Police Scotland systems. When the number of data points is included the most frequently held information was on housing and vulnerable people recording systems.

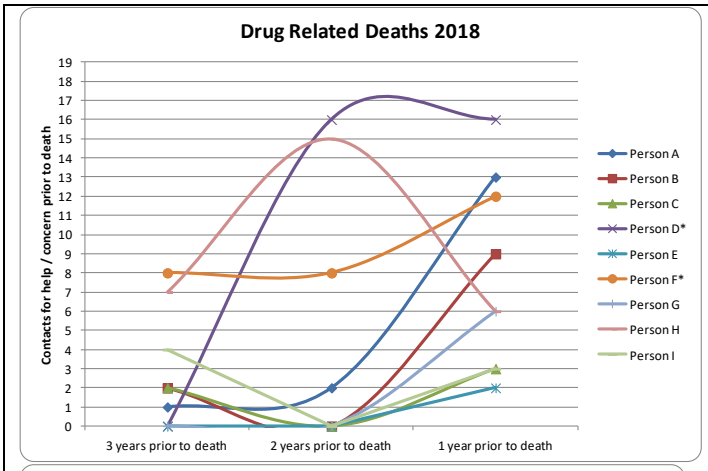
	NHS	VPD	Custody	Crimefile	Carefirst	NPS Housing	Death Report
Person A	Yes	Yes	No	No	Yes	Yes	Yes
Person B	Yes	No	No	No	Yes	Yes	Yes
Person C	Yes	*Yes	No	No	Yes	Yes	Yes
Person D	Yes	47	Yes	Yes	Yes	Yes	Yes
Person E	Yes	*Yes	No	No	*Yes	Yes	Yes
Person F	Yes	43	Yes	Yes	Yes	No	Yes
Person G	Yes	*Yes	No	No	Yes	Yes	Yes
Person H	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Person I	Yes	Yes	Yes	No	No	No	Yes
*Not Recent							

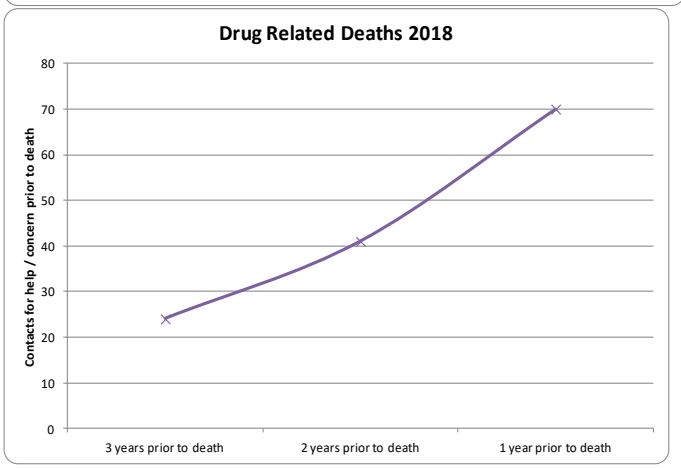
2) Increasing frequency of data points preceding death

For the 10 deaths there were 135 data points were recorded. There was an increase in concerns / requests for help in the months preceding death. Conversely there were cases where there was a drop off in contact prior to death as well.

This illustrated in charts below.

Contacts for help / concern prior to death			
	3 years prior to death	2 years prior to death	1 year prior to death
Person A	1	2	13
Person B	2	0	9
Person C	2	0	3
Person D*	0	16	16
Person E	0	0	2
Person F*	8	8	12
Person G	0	0	6
Person H	7	15	6
Person I	4	0	3
Total	24	41	70





This pattern is also noted in reports such as Health and Homelessness, Scotland 2018.

3) Drug Use not always recorded as a factor

One hundred and thirty five points of information were recorded and concern factors were recorded, primarily in relation to the immediate problem. Drug use, past or present, was not recorded on all systems as a risk factor. The data points represent requests for help or concerns raised.

4) Data sharing

Data was shared on where there was concern of vulnerability but there wasn't always a consistent approach to how information was utilised. There is no concerted vision to consider the risk of or the prevention of drug related death in cases where there is a concern.

5) Multiple Factors indicating risk of drug related death

All of the individuals had multiple factors in relation to risk of death due to drug toxicology / overdose. The risk factors can be used to help profile future potential vulnerabilities in the population and provide a "lens" through which risk of drug related death can be viewed, especially in for raising awareness in the workforce and developing practice.

	Risk Factors	Person A	Person B	Person C	Person D	Person E	Person F	Person G	Person H	Person I
1	Age	Yes	Yes	Yes	Yes		Yes	Yes		Yes
2	Gender	Yes	Yes	Yes	Yes		Yes	Yes		Yes
3	Lived alone	Yes	Yes	Yes	Yes	Yes	Yes			Yes
4	Chronic Pain	Yes			Yes	No	No	Yes		
5	Chronic health	Yes	Yes		Yes	Yes	Yes	Yes		
6	Childhood trauma	Yes		Yes	Yes				Yes	Yes
7	Adult adverse life events	Yes	Yes		Yes	Yes		Yes	Yes	Yes
8	Opiod dependent /use	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes
9	Transitions	No	Yes	Yes	Yes				Yes	Yes
10	Complex / poly medication	Yes	Yes			Yes	No			
11	Previous overdose	Yes	Yes		Yes	No	43	Yes	Yes	
12	Mental health, wellbeing and mood	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
13	Degenerating living conditions	Yes	Yes							
14	Isolated	Yes	Yes	Yes		Yes	Yes	Yes		Yes
15	Current Homelessness	No		No					Yes	Yes
16	Housing difficulties	Yes	Yes	Yes	Yes	Yes		Yes	Yes	
17	Financial Issues		Yes	Yes	Yes					
18	Offending issues	No	No	No	Yes	No	Yes	No	Yes	
19	Protective factors Not engaged	Yes		Yes					Yes	
20	Protective factors engaged				Yes					
21	Not in addiction treatment	Yes	Yes	Yes	Yes	Yes			Yes	Yes
22	Injecting			Yes	Yes	Yes		Yes	Yes	Yes
23	Relapse			Yes	Yes	Yes		Yes	Yes	
29	Custody	No	No	No	Yes	No	No	No	No	No
30	Domestic abuse				Yes				Yes	Yes
31	Historical homeless		Yes		Yes	Yes			Yes	Yes
32	Self harm/suicidal		Yes		x7		Yes		Yes	Yes
33	Alcohol Use	Yes	Yes			Yes			Yes	
34	Illicit poly drug use			Yes		Yes	Yes	Yes	Yes	
35	Mental health diagnosis						Yes			
36	Methadone							Yes	Yes	Yes
37	Child in care									Yes

Not all of these cases would have been picked through other means of concern, such as anti-social behaviour, concerned neighbours, other professional concern, highlighting that there is vulnerable people that are not always “picked up” by existing protection roles.

6) Demand

All forms of demand were recognised with the review with specific examples of where demand was a result of service design failure, cases of demand that could have been avoided and prevented through earlier proactive engagement and a systems approach to risk and management.

7) Comments, Observations And Assessment By Participants

Participants in the process discussed the following points throughout the process

- Data didn’t always exist, despite involvement but we weren’t sure why.
- There was discussion about statutory thresholds perhaps being too high for intervention plans to be implemented eg duty team triage/assessments
- Data sharing between departments where one or the other doesn’t share, won’t get involved due to thresholds not being hit, lack of resource,
- In some cases there were unsatisfactory processes ie sending a letter by post asking for client to call office to make appointment, asking person to attend for appointment when person is housebound
- Lack of insight that one service might have a good relationship with person that provides access to individuals who are isolated and at risk of harm – i.e. key resource in intervention plans
- VPD often to one individual in other organisation and not known if acted on
- VPD – very few because of drug related issues
- Departments not the same as organisations – VPD might go to “health” but not recognised that within NHS there are many departments
- Primary care potentially key to intervention
- Nobody currently has the ability to look at all the data and formulate a safety plan
- Lot of task oriented activity without looking holistically at the risk of death / vulnerability

- Analysis needs to have a "human" aspect – there were anomalies that meant some individuals could have not be picked up by a rigid criteria / algorithm
- Transitions and people falling between services
- Data map, measures for target alerts how, who

8) Conclusion

This study has confirmed that individuals at risk of drug related deaths, who are not engaged in substance use services, have multiple other life problems that are apparent to other public service partners.

There are multiple points of information held on a number of systems but no single agency has an oversight of the whole set of information or the circumstances, vulnerabilities or risks faced by individuals.

Concerns are being raised and shared but there is no concerted action taken to reduce risk and preserve life.

There is no pro-active "forum" into which agencies can pool intelligence and work to reduce risk and ultimately reduce demand on our services. The way we organise ourselves and work (currently) separately makes it harder to reduce risk and demand.

Services already can and do share information as evidenced from this review – the issue is what is then done with this in practical application e.g. multi-agency discussion to pull threads together and co-ordinate action.

Measures

- **Outcome measures**
- Increase the number of people contacted
- Number of people engaged in treatment from each locality, by age, gender

- **Process measures**
- Increase the number of people identified by partners as at risk
- Number of people in each locality made contact with
- No. of FTE outreach support workers recruited
- % of partners with established points of contact

Change ideas

1. **Improving direct access into service for those not utilising existing access processes**
    - Staff going to rough sleepers and offering services, in partnership with Police and Homeless service
    - Identification of people at high risk by partner organisations and developing pilot direct access pathways for drug treatment
    - Outreach service and direct access for those known to have non fatal overdose and supporting engagement with services

2. **Ensuring partners are aware of risks of drug use and how to access most appropriate service by**
    - Establishing a concern forum/hub to discuss high risk cases and task / co-ordinate actions for agencies involved and ensure appropriate information shared for individuals best interest and safety
    - Providing an assertive outreach service for those at risk not engaging or managing to be retained in services

3. **New access and engagement models for those most at risk**
    - Ensuring illicit drug use is considered as part of the assessment of vulnerable people and that Drug services are also part of the notification process by GPs and Social Work
    - Ensuring points of contact established for all partners to support retention and access to support
    - Recruitment and resourcing of new Outreach support for people assessed as vulnerable and support provided to access appropriate services. This is a new partnership approach which aims -

To help better manage the demand on services and to attempt to reduce the numbers of drug related deaths it is proposed to undertake improvement work and tests of change that help us no longer work in data or operational silos as per figure below. The change will be that a forum is created to share information and existing services and / or task an assertive outreach team to work on behalf of NHS, ACC, HSCP, Police to engage and support the most vulnerable people in relation to high risk substance use and who are not currently engaged in substance treatment services as a test of change

The forum will bring information from their respective systems to share. The task group will be supported by the new posts below which will be ADP funded:

- 2 x Assertive Outreach Workers
- 1 x Housing / Domestic Abuse Worker
- 1 x General nurse
- Service capacity for reach out, low threshold, no barriers access

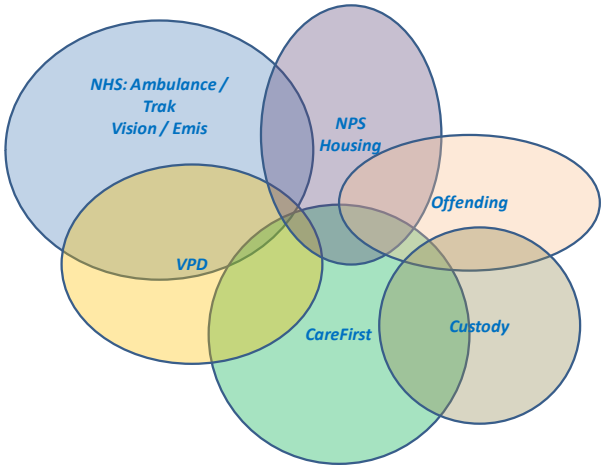


Figure 1

New Operating Environment

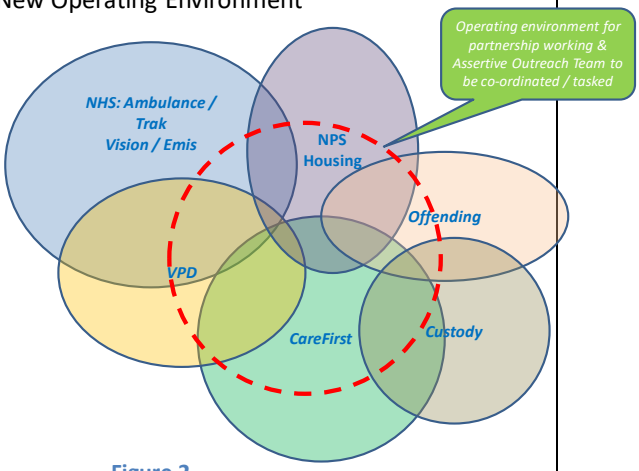


Figure 2

Potential risks and/or barriers to success & actions to address these

Key to the success of the project is enabling safe and effective data sharing. To facilitate this data managers within stakeholder organisations are developing appropriate data sharing protocols.

Project Team

- Simon Rayner, ADP
- Tara Shivaji, Public Health
- Caroline Anderson, ACC Information Governance

- Graeme Gardener, ACC Housing Access and Support
- Rachel Harrison, ACC Housing Access and Support
- Ian McKinnon, Police Scotland
- Jacqui Simpson, SW /Adult Protection Unit
- Martin Smith, Central Locality
- SMS, Staff to be determined

Outline Project Plan		
Project Stage	**Actions**	**Timescale**
Getting Started (Project Score 1-3)	**Information Sharing Protocols are in place**	**May 2020**
	Tasking and Coordinating work begins	**May 2020**
	Operational Team are recruited and in place with project co-ordination **Data gathering and baselines agreed**	**May 2020**
Designing and Testing Changes (Project Score 4-7)	**Initial outreach work is being undertaken** **Direct access process being tested and reviewed** **Adapted VPD notification process being tested** **Feedback from Points of contact and wider services and service users**	**June 2020**
Implementing and sustaining changes that demonstrate improvement (Project Score 7-10)	**Team is established and has been operational for 1 year** **Review capacity and where referrals now coming from** **Identify what can be done as mainstream** **Funding options**	
Spreading Changes (Project Score 9-10)	**Long term sustainability of the project and the team is reviewed**	