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ADP and Homeless Programme: Reducing Harm Improving Care

Understanding the integration of homelessness and drug and alcohol services

Final Report

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Contents

Executive Summary

In 2021 we sought to understand the experiences of homeless people in addressing their substance use. Recognising recently published statistics showing that over half of deaths of homeless people were drug related, it was critical for us to understand the accessibility of services, the extent of choice and control in care, and how those needs are managed.

During this programme we spoke with over 50 people who experienced homelessness and were also using drug and alcohol services. We also worked with Alcohol and Drug partnerships (ADPs), homeless services and third sector support organisations to understand how services are currently delivered. It was clear there was a shared experience as a result of the way our system is designed and delivered. People told us stories about 'being at the bottom of the barrel before there was help' and having a feeling of desperation in trying to get help at the right time. We also heard 'They're getting to choose over my life, they get to pick what I've to be on', as a common story of people feeling rejected, uncared for and without agency to choose or control their care.

Delivering services in a complex system of care for patients who have multiple health needs is challenging. If we add into this system, patient needs that vary and personal situations that are unstable, it becomes increasingly difficult to ensure we are able to deliver safe and effective care. It is important that we recognise that our system of care faces significant challenges in managing patients with complex health needs. Our programme evidenced the increasing volume of physiological needs of patients, at a very human level, that were essential to be met in order to ensure the safety and wellbeing of people battling substance use.

We found that people with increasingly complex care needs required a system of care with improved flexibility in order to provide an effective response. It was clear no one 'owned' the care planning, or coordination of care, despite it being multi-faceted and complex by nature. People told us about co-occurring conditions that remained untreated as they were forced to prioritise their most critical healthcare need in a constant state of survival. Our findings show that people had to manage their own care, despite personal situations or circumstances that may impact an individual's capacity to do this. Findings from this work evidences the many ways people fall through our safety net, whilst challenging us to think about how to better deliver care in the most difficult of circumstances in order for us to reduce drug harms and improve patient outcomes.

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Introduction

Scotland continues to face significant challenges relating to harms caused by drugs and alcohol, including rising numbers of drug and alcohol related deaths. The National Records of Scotland Drug Related Deaths report identified 1339 drug related deaths in 2020, the highest number ever recorded and 3.5 times higher than our European counterparts. Further analysis undertaken by National Records of Scotland showed that in 2020, 59% of deaths amongst people experiencing homelessness were drug related, a 5% increase from 2019 . In addition, 1190 alcohol specific deaths were recorded in 2020, evidencing a 16% increase from 2019.

These figures highlight the need for a better understanding of the models of care and level of integrated working across these systems.

In response to these challenges, the Scottish Government launched a new national mission in January 2021 to reduce drug and alcohol related deaths and harms.

To support this work, Healthcare Improvement Scotland (HIS) were commissioned by the Scottish Government and the Convention of Scottish Local Authorities (COSLA) to deliver an improvement programme, Reducing Harm, Improving Care, which engages homelessness and drug and alcohol services, alongside the people who use them to:

- Improve access to services
- Develop integrated, joined up services
- Provide greater choice and control

Purpose of this report

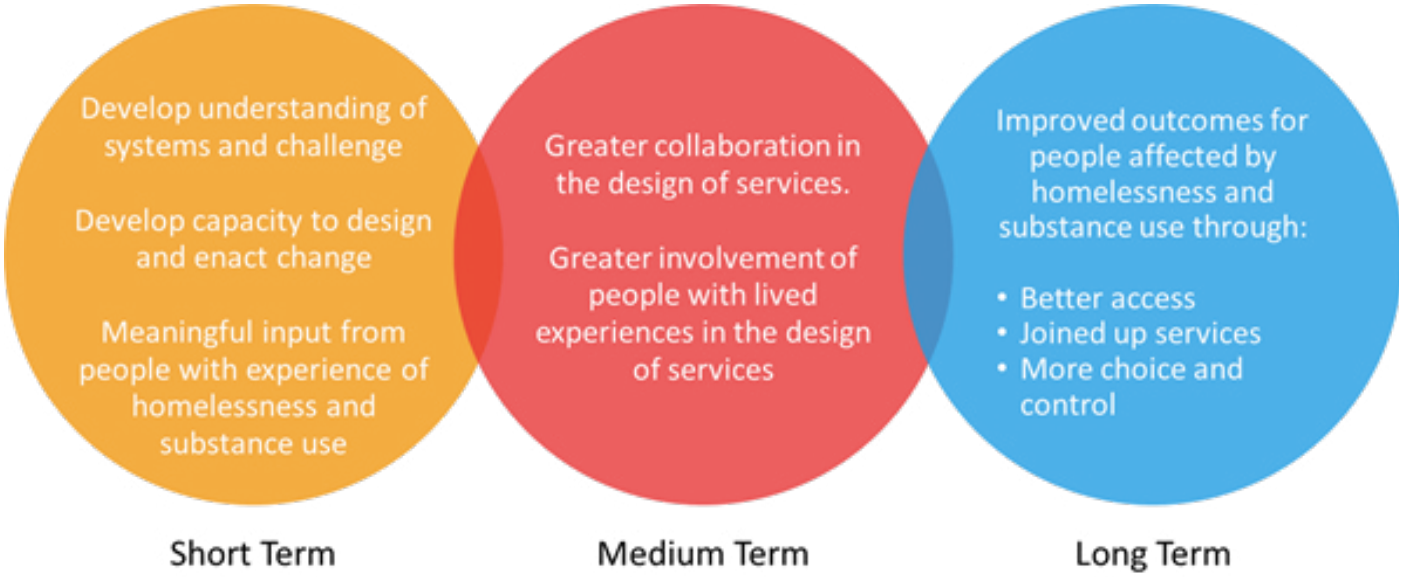
This report provides a summary of the findings from this work and sets out the key areas for consideration at a strategic and operational level that are required to develop services that meet the needs of the people using them.

Who this report is for

- Practitioners and stakeholders in health, social care and housing who are delivering services for people who are homeless that require access to drug and / or alcohol services
- National stakeholders who are responsible for policy, strategy, performance, education and improvement in homelessness and drug and alcohol services

Our approach

The aim of the programme was to develop an understanding of the current levels of integration across homelessness and alcohol and drug services to identify actions required to improve the quality of care and support for people who experience severe and multiple disadvantage:



Our approach blended the methods of strategic planning, service design, and user research and engagement (to understand the problem and design potential solutions/improvements) and quality improvement (to test, refine and evaluate the solutions/improvements identified).
To support a comprehensive understanding of the current system including existing good practice, local delivery models and the experiences of people using services, the Reducing Harm, Improving Care programme was designed around 3 key areas:

1. Evidence and literature:

Healthcare Improvement Scotland's Evidence & Evaluation for Improvement Team (EEvIT) undertook an evidence and literature review which considered good practice, innovation and information about 'what works' in care co-ordination and service provision for people with experience of homelessness, mental health and/or addiction. The full evidence and literature review report can be found here.

2. Understanding the experiences of people with lived and living experience

The programme ensured that the views and experiences of people with lived and living experience of homelessness and alcohol and drug services were embedded throughout the programme.
A full report detailing our involvement approach setting out how we mobilised our engagement ambitions can be found here.

To support this, a range of engagement activities were undertaken:

- 53 peer led interviews were conducted with people experiencing homelessness that require access to alcohol and drug services.
- Engagement with Scottish Families affected by Drugs & Alcohol (SFaD**).** A case study highlighting the experiences of a family member in supporting their loved one can be found here.

- Engagement with Simon Community's Harm Reduction Team and women accessing their service
- An online survey issued to voluntary and third sector organisations

A full report setting out our approach, key findings and areas to consider to ensure that future services are designed around the needs of the people who use them can be found here.

3. Local delivery insights to understand integration of homelessness and drug and alcohol services

A key objective to support the aims of the programme was to create an understanding of the current levels of integration across homelessness and drug and alcohol services. To enable this, we worked with people delivering services across homelessness, drug and alcohol services and third sector support services in the following areas:

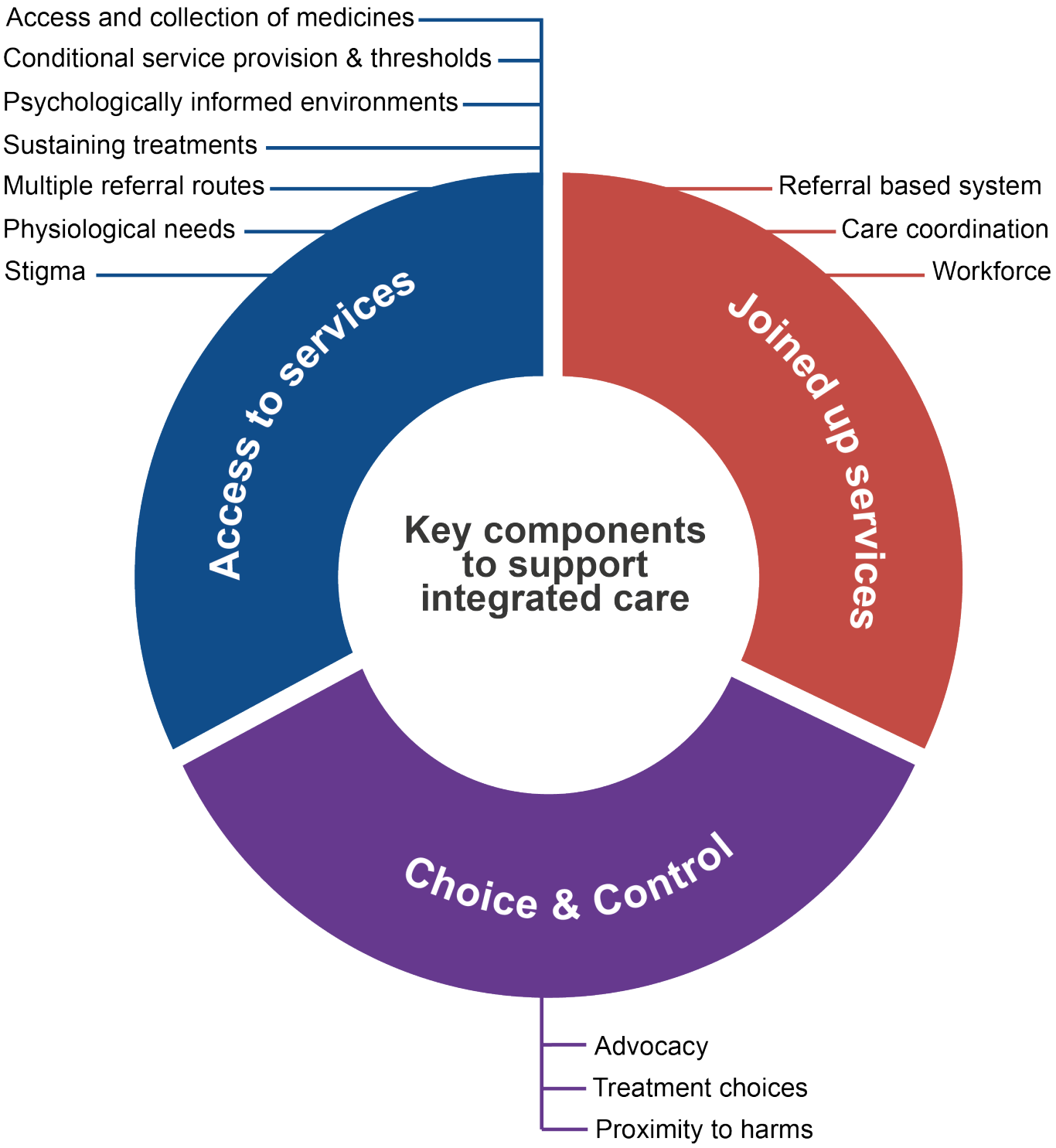
- Edinburgh City
- North Ayrshire
- North Lanarkshire
- South Lanarkshire

Working in collaboration, each area created an Interconnected Systems Map to identify the range of services available in their area.

From this, a demand analysis exercise was undertaken to understand what people were asking of services at the point of contact and how services were able to respond with over 700 demands captured and analysed across 16 key services identified from the Interconnected Systems Mapping exercise.

Findings

Through talking to people, who require drug and alcohol services, and those delivering them, several key themes have been identified that illustrate the current issues people face which require to be addressed to support a more integrated approach to providing care and support.



Access to services

Providing equitable access to services will help support people in their recovery. From speaking to people using and delivering services, a number of key issues were identified that should be considered as we look to design future services.

Multiple referral routes

Services should work to understand the various routes to access and develop a standardised pathway that is clearly communicated and understood ensuring relevant consents are gained from the person requiring support. In addition, commissioned services and providers should ensure they balance access by supporting a no-wrong door approach but do not unintentionally make access complex.

Access to services for people came from variety of different entry routes such as via criminal justice, social work, peer support networks or via direct outreach from third sector organisations. People were often unclear how they had been linked with a particular service evidencing the lack of communication or clarity with people at the point of referral. In addition, it was clear that not all services supported people to engage with them directly, requiring a referral from another 'approved' service. This evidence suggests that commissioned services require a 'pre-assessment' of need before acceptance.

Physiological needs

Future services should strategically plan for the absorption of physiological needs within their local area for this population group to support people into and through recovery.

Demand analysis showed that people who are battling the instability of homelessness, addiction and poor mental health also require support with physiological needs. Physiological needs are biological requirements for human survival such as food, clothing and shelter.
People told us that they tend not to see the differences between services and will attend, where they can, to ask for support with this. We found that even if the service did not provide this people would often request it, this further exposed the level of basic human needs that this group of people have. This ranged from basic food requirements to showers and medicines.
Services have clearly adapted to these increasing needs but are often not set up, or funded, to deal with them and this can mean additional referrals and risks needs not being met. People talked about how these needs can be essential to engaging in and fulfilling treatment programmes.

Thresholds

Low threshold services recognised barriers to access and intentionally removed these by ensuring people could get what they needed when they needed it. Supporting services to keep their thresholds low allows for greater access for people who do not trust the system or feel pre-judged.

For many people, the most positive experiences of services were ones that had a low threshold for access with people sharing that they did not need to 'jump through hoops' to get a service. Direct access to services that does not require referral from other services, supported people to exercise choice and control in who they engaged with and when, evidencing a more person-centred approach. Third sector support organisations evidenced great strength in this area, where people felt accepted regardless of their personal circumstances. People told us that the application of criteria for services generated mistrust often leading to people being refused access or being reluctant to engage with the service.

Conditional service provision

Collaboration between addictions, mental health and GP services is required to understand co-occurring conditions in order that care is planned to address all needs simultaneously, together with shared responsibility.

People reported having to be at crisis point before they were able to get the help and support, they needed, often having to meet increasingly high thresholds to be accepted by services.
In addition to increasing thresholds for access, it was clear that people who require support with both mental health and addictions can be excluded from mental health services because of their addiction. People were often referred to mental health services only for this to be rejected and returned to the referring GP (General Practitioner), or addictions service, after being advised that they required to be abstinent to undertake any assessment of mental health condition(s). This conditionality within services leaves the person adrift and unclear who can provide support with both their addiction and mental health issues and so the cycle continues.
People also reported the prevalence of long term physical health conditions alongside mental health and addiction issues. Often, people are prioritising support for addictions and mental health over existing, long standing, physical health issues. As part of a coordinated response to providing care and support, co-existing morbidities should be understood and planned for alongside support with mental health, addictions and housing support.

Sustaining treatments

A deeper understanding of the reasons why people do not attend appointments is required and should be managed to ensure there are no barriers to engaging in treatments, recovery, or wider services. Services should consider advocacy and patient representation to remove any barriers to engagement and explore their ability to adapt.

People reported facing many barriers to attending appointments such as transport, appointments out with their local area, difficulty in attending appointments because of conflicts with supervised medication dispensing, social anxiety and concerns about being judged. People told us that where they do not attend appointments, they can be excluded from services, regardless of the rationale. People should not be excluded from services if they do not attend appointments and the reasons behind non-attendance should be explored.

Access and collection of medicines

Further work should be undertaken to risk assess the range of options for people to obtain their prescriptions, recognising the unique challenges with a central collection point. Exploration of the scale up of a delivery service would help to address some needs of this group and may offer a unique opportunity to keep people engaged and in treatment.

People reflected their negative experiences of attending pharmacies to access prescriptions and medicines. People spoke about being targeted by those selling or using drugs in the pharmacy queue as well as being exposed to negative behaviours from peers. Furthermore, people felt stigmatised by having to stand in the ‘methadone queue’ and being treated differently to other people using the pharmacy. These issues were faced, often daily, with people feeling increasingly anxious about attending the pharmacy, this was in the context of other wider barriers such as transport, stigma, and their own social anxieties.
During the early part of the pandemic, a prescription delivery service delivered prescriptions to people where they lived. People reported feeling trusted and empowered to manage their medication and daily living needs. Access to a prescription delivery service has now ceased and people are required to attend pharmacies again to access their prescriptions and medicines. The removal of the service has left people feeling stigmatised with the trust placed on them during the pandemic now removed. This service was widely welcomed by people during the pandemic and helped to address some of the issues people experience when attending pharmacies.

Stigma

Staff working within services should have an awareness of trauma and be supported to access training that helps to develop a greater understanding of the realities of what people are going through to foster more trusting relationships that support continued engagement with services.

Stigma remains a major barrier to people accessing services. Stigma was often felt in lots of separate ways, from attitudes of people to judgements made of a person's circumstances, personal presentation, or situation. People reported not being listened to and feeling judged alongside a feeling of embarrassment because they were experiencing homelessness and alcohol and / or dug issues which can leave people reluctant to engage with some services. Where people were treated with kindness, empathy, and compassion they were able to develop trusting relationships that led to further engagement and satisfaction with services.
The most positive relationships were experienced by engaging with third sector support organisations. People also shared that, alongside services who showed compassion, they valued talking to someone with lived experience of the issues they are facing and an understanding of trauma. This led people to feel more relaxed, trusted and listened to.

Psychologically Informed Services / Environments

Acknowledging the importance of trauma informed practise is critical in this system and services should work to develop psychologically informed services and environments with a focus on relationships; staff training and support and a welcoming environment to build rapport and trust. Trauma informed practise will support the people who use this system and those who work in it.

Staff operating across the system are dealing with people who are vulnerable and may have experienced significant levels of trauma. This can lead to challenges in relationships between services and the people who use them and if not understood can lead to more harm. People told us about the need to repeat some of the most traumatic and emotional situations they have experienced regularly, this was commonplace with little consideration of the impact on the individual sharing this and the individual hearing it.

Joined up services

The complexity of care needs that people experience has highlighted the importance of integrating services to provide a coordinated response to meeting people's needs.

Referral based system

Where a service cannot meet the range of needs and referrals are required, strong working relationships and protocols should be developed with those services to minimise the time taken to have referrals actioned and the right care and support provided.

Interconnected systems mapping showed how the system of care is currently delivered. There is a considerable number of services however, no single service can meet the range of needs that is evident in this group. Services try to support a person with the resources they have available but are often required to refer people onto other services, resulting in a continuous chain of referrals. People experienced lengthy wait times and the passing of time between presentation and support being provided can mean that people disengage with services. For homeless people who are battling addiction, there is an essential immediacy of response necessary and the current referral-based system prohibits this with people feeling that they are being passed from pillar to post, having to retell their traumatic stories at every stage.

Services often require a referral from a GP (General Practitioner), driving demands on Primary Care. GP practices are facing unprecedented demand following COVID-19 and people already find it difficult to get appointments to obtain that critical referral. Consideration of the reliance on GPs for this is important given the impact on the wider system.

The referral-based system also results in duplication of effort across services as people may already be engaged with a service when they present to another. The lack of information and data sharing across services mean that the person requiring support is confused as to who is picking up their care needs.

Complexity of commissioning

Commissioners of services should be mindful of the complex system created from commissioning services by specialism and consider this complexity in their integrated strategic planning. To support this approach, statutory housing and alcohol and drug services should explore opportunities for joint planning and commissioning, ensuring that commissioned services are set up to deal with the range of needs people require.

Services are currently delivered by specialism meaning no single service can meet all a person's needs at the point of contact. Although each service has been set up with a specific purpose, evidence from our peer interviews showed people do not differentiate between services and will attend where they had a previous positive experience. Analysis of demand supported this insight with high numbers of the same demands for support being presented across all services.

The changing mix of providers can also mean that continuity of care where people have existing relationships with services can be lost.

Workforce

Services should be designed that support staff to be able to provide the right care and support for people at the point of contact without the need to turn people away or refer them onto other services where there is less certainty of acceptance.

Caseloads for staff are increasing in complexity and volume. The complexity of needs that people have against a referral-based system, designed by specialism, means it is often not possible to provide the holistic care that people require. The inability to meet the continual range of presenting needs may affect morale and contribute to a sense of frustration from staff.

Care coordination

Further understanding of how best to provide care coordination for homeless people requiring access to drug and / or alcohol services is required. The recently published NICE guideline: Integrated health and social care for people experiencing homelessness, could be a helpful starting point in understanding how we can coordinate care for homeless people in Scotland. To support a coordinated approach to providing care and support, information sharing limitations must be understood and overcome to support the current system to operate efficiently and help improve visibility of services involved in care.

The interconnected systems map highlighted the complexity of service provision and the vast array of services that someone might require access to. At present, there is a lack of care coordination that means people are left to try and navigate the system on their own despite unstable living conditions and periods of instability.

People spoke of an endless cycle of referrals, appointments and crisis interventions that they are required to manage on their own. Staff acknowledged that even within services they find it difficult to navigate the system despite having knowledge of services and how to access them.

The lack of information sharing across services means that people are required to re-tell their often traumatic stories and without access to the right information services find it difficult to provide the care and support required.

Demand analysis and insights from our peer research has shown how the needs that people have are interconnected and require to be addressed simultaneously. Without a coordinated response to providing the care required, people will continue to find it challenging to navigate such a complex system.

Choice and control

People valued experiences when they were involved in decisions around their care and treatment, including the support of families and carers to understand treatment choices and make informed choices around what is best for the person.

Treatment choices

People should be informed of the available treatment options on offer and be supported to make decisions on what is best for them. This should include the involvement of family members and carers to support decision making and access to services and treatment.

People were often unclear what treatment choices were available to them. Analysis of demand across the 4 HSCP areas showed low numbers of people seeking drug and / or alcohol treatment suggesting that treatment options are not clear, and people are not requesting what they do not know to exist.

People reported having little choice or control over the treatment programme they were engaged in with many people feeling that it was 'methadone or nothing'. This evidenced that people were not aware of the range of recovery-oriented choices available to them. Where people were listened to and involved in their decision making, they felt empowered, respected and listened to.
Through working with local delivery partners and drawing on the experiences of people using services, we were able to identify the range of treatment options available. Notably, of the over 700 demands analysed, only 2 were in relation to either residential rehabilitation or detox services.
Family members and carers reported that they are excluded from being involved in the planning of care and treatment for their loved ones. Navigating the complex system on a loved one's behalf can have a detrimental effect on the mental wellbeing of families and carers given the continual barriers around information sharing or involvement in care planning. Involving family members in decisions around a loved one's care and treatment, working alongside service providers, can support recovery and help re-establish relationships affected by homelessness and or substance use.

Advocacy

Support with advocacy and physiological needs should be seen as part of an integrated approach to meeting people's needs and future services should be designed to ensure adequate resource is available to provide support with their advocacy needs.

Demand analysis highlighted the levels of advocacy people require support with to navigate the complexity of the system. This can range from accompanying people to attend appointments, help with benefits applications, contacting other services on the person's behalf and help with day to day living such as cooking, cleaning and budgeting.

Proximity to harms

**Offers of accommodation need to consider proximity to supports that can aid recovery whilst being mindful of placing people in areas where they can be exposed to harmful behaviours such as violence, drug and alcohol consumption and drug dealing.
While housing options may be limited due to availability, these factors are important considerations especially if someone is returning to the community from a care setting, prison or hospital.**

People spoke about not feeling safe across a range of interactions with services. Hostels and other types of temporary accommodation sites were viewed as unsafe environments that can have a detrimental effect on a person's recovery because of exposure to people selling and / or using drugs within or close to the premises.
Women described not feeling safe when accessing services and spoke of the lack of adequate accommodation in order to maintain access to their children.

Summary

Our system of care across homelessness, drug and alcohol and mental health services is dealing with complex and varying needs at the same time as people requiring access to services are dealing with a complex, difficult to navigate system. This means our referral-based system struggles to adapt to the changes of care that are required to absorb periods of chaos and periods of stability for this population group.

The current system set up is challenged to address the range of needs of people have at the point of access and people are left to coordinate all of their own care across a number of different services, leading to confusion, drop off and missed opportunities. Treatment options are unclear and people reported having little choice or control around they care they receive.

It is clear that delivering holistic care to patients in a changing and chaotic situation is difficult to plan for. The current approach to providing services in a referral-based system does not meet the range of needs for those requiring significant levels of specialist support and is causing delays in care and placing people in harmful situations. Across this work there is evidence to suggest that the system expects people to be able to identify the care they require and then coordinate that care, regardless of their personal circumstances, presentation and / or ability to understand the system.

As we consider the co-morbidities of this group alongside their evidenced physiological needs at the point of care, we must recognise how these things relate to each other and their role in supporting treatment and recovery.

To improve access, care and treatment for people, we must take a holistic view of the range of needs people have and design services that are coordinated and able to meet the needs of people at different times in their journey, avoiding where possible, the need to refer on to different or more appropriate services.

To support this, standards of care for people with complex and multiple needs should be developed, recognising the current system challenges and the range of varying needs people require support with at different times in their journey.

Considerations for improvement

The findings from this work have highlighted how the current system of delivering care for people experiencing homelessness and drug and / or alcohol issues is struggling to meet people's needs. Change is required at both a strategic and operational level and the following section of the report sets out the key areas that should be considered as we design and deliver future services in recognition of the complexity of drug related harms and homelessness prevention activities.

System considerations to support improvement

1. Reviewing the existing Health and Homeless standards to support a more coordinated approach to providing services, taking into account current system challenges and opportunities within the Scottish Government's Ending Homelessness Together action plan.

2. Scotland would benefit from developing guidelines, tools and resources for the coordination of care for people with experience of severe and multiple disadvantage by:
    a. Using the NICE guideline: Integrated health and social care for people experiencing homelessness, to develop a Scottish approach to improving access to and engagement with health and social care services for people experiencing homelessness;
    b. Undertaking an Equality Impact Assessment to ensure that the needs of protected groups are considered in the design of guidelines, tools and resources.

3. Homelessness and drug and alcohol services would benefit from addressing the stigma people experience by supporting the workforce to understand complexity by:
    a. Developing a national trauma informed training programme that is made available to staff working across services;
    b. Developing support mechanisms to nurture workforce resilience and to deliver safe and effective care.

4. In our strategic planning we must explore the available data to understand demand on drug and alcohol services from people experiencing homelessness and the system capacity to adapt by:
    a. Carrying out an analysis of demand and capacity to identify the gaps in service provision that require to be addressed;
    b. Strategic planners and commissioners being mindful of the complex system created from commissioning services by specialism and consider this complexity in their integrated strategic planning.

5. Services aimed at supporting people with experience of severe and multiple disadvantage would benefit from consideration of proximity to harms, known risks and previous experiences of stigma when determining where services should be delivered.

6. A review of how homeless people access their prescriptions and medicines should be undertaken by:
    a. Evaluating the provision of prescription delivery services provided during COVID-19 and using the lessons learned to support patient choice and control.

7. Scotland should consider how the referral-based system for people with experience of severe and multiple disadvantage drives GP demand and the long-term challenge of this by:
    a. Reviewing the requirement for GPs to make referrals to specialist services.

Operational considerations to support improvement

1. Homelessness and drug and alcohol services should consider designing and delivering services that are low-threshold recognising the barriers of referral-based care by:
    a. Reviewing access criteria for homelessness and drug and alcohol services;
    b. Assessing the appropriateness of referral pathways for people who experience severe and multiple disadvantage.

2. Drug and alcohol services should ensure visibility of treatment choices and support patient led decision making.

3. Services would benefit from understanding the engagement patterns of people who experience severe and multiple disadvantage by:
    a. Not excluding people from services if they do not attend appointments and exploring the reasons for non-attendance with the person to support them to be able to attend;
    b. Ensuring the provision of physiological requirements to support treatment and wellbeing which should be assessed as part of an initial needs assessment.

4. Homelessness and drug and alcohol services should ensure advocacy to support patient views in care planning by:
    a. Ensuring people are supported by relevant services / staff to understand the options available and to support them to make informed decisions around their care and treatment.

5. Homelessness and drug and alcohol services would benefit from embedding psychologically informed environments with a focus on relationships, staff training and support.

6. Homelessness and drug and alcohol services should ensure the workforce are trauma informed and understand how this affects demand and engagement.

7. Homelessness and drug and alcohol services would benefit from developing information sharing arrangements to support the effective coordination of care for people who experience severe and multiple disadvantage.

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