

CHAPTER 3 ACCESSIBILITY

This Chapter examines and discusses the various factors that **influence accessibility to drug treatment, care and support services**, both in Scotland and elsewhere. These factors will affect (and even determine) the extent to which integrated care can be delivered in any area.

The key sources of evidence that have been drawn on for this Chapter are the research literature, service users' focus groups undertaken by the Scottish Drugs Forum (SDF), the EIU consultation workshops and the EIU Working Group on Accessibility. The Working Group undertook to review the issues that affect the accessibility of services (specifically in the Scottish context) and to identify key principles and elements of effective practice.

This Chapter sets out in more detail:

- the definition of accessibility, its rationale and wider context
- the evidence on factors that influence accessibility
- key principles and elements of effective practice

What is accessibility?

A service is accessible when it is **available to all potential users** at a time and place suitable to meet their assessed needs and delivered in a user-friendly way. To make services accessible, it is essential to remove the barriers, real or perceived, that individuals experience. These barriers can lead to a lack of engagement and non-attendance. Key issues to be addressed include:

- equity of access for all potential users
- the location and opening hours of services
- the length of time to wait to be seen by a service or to get into treatment
- ensuring an initial (and subsequent) positive experience, as perceived by the user

Above all, a service is accessible when it is designed to meet the needs and aspirations of the individual. In other words, the organisational arrangements should be flexible enough to offer a service that is as **person-centred** as possible.

The Rationale: why is accessibility important?

Accessibility of services is important to ensure that users get access to the services and interventions most likely to help them, at times when they need them (EIU Working Group 2002, Type 5). This will help ensure that individual users:

- reduce harm to themselves and others
- reduce their drug use
- address other health and social problems
- have an opportunity to rebuild their lives

Ensuring access to effective services will also have an impact on the lives of those who care for drug users, those who are cared for by drug users and the wider community within which they live. Recent survey work on family support needs in Scotland shows that the mental and physical health of those caring for drug users can be seriously affected (EIU 2002, Type 3).

There is a growing evidence base on the range and combinations of interventions that can work with drug users (Simeons 2002, Type 1). Research shows that a **range of treatment interventions** (with a range of philosophies) may work, but the outcome depends on the individual getting the right treatment at the right time (Department of Health 2002). Ensuring access to a range of interventions and matching interventions to client needs can help promote the effectiveness of treatment (Gossop 1998, Type 3). This relies upon systematic and effective assessment procedures.

As outlined in Chapter 2, it is widely recognised that people who have a drug problem will have a range of other needs. These need to be resolved before that individual can make a full recovery. Interventions which help people to deal with **wider problems** in their lives and to move on after stabilisation or recovery also show promise and should also be accessible to all users. This highlights the importance of an **integrated approach** to the treatment, care and support of users.

The assessment process may identify needs for better and more stable housing, help with addressing difficult family relationships, help with addressing debt problems and the need to improve employment prospects. Conversely, a referral may be made to a drug service because there has been a problem in another area of the individual's life, for example, because a tenancy is under threat and a drug problem has been identified.

Overall, the available evidence suggests that (ideally) a **broad range of user-friendly interventions** that tackle the plethora of health and social needs of drug users should be accessible to those who need them at appropriate junctures. This includes being sensitive to the needs of individuals based on their socio-demographic characteristics. However, service users in Scotland and across the UK appear to have difficulties accessing co-ordinated drug treatment for a number of reasons including: the uneven availability of health and social care services and interventions, poor assessment procedures and lengthy waiting lists (EIU Working Group 2001, Type 5; Audit Commission 2002)

The Wider Context

Accessibility of services is a cause for concern across a number of settings, including primary care. For example, The Scottish Consumer Council Report 'Access to Primary Care Services in Scotland' (SCC 2001, Type 2) demonstrates that accessibility is a key issue for the patient population of Scotland. It stresses that however effective a service may be, it is only of value if those who need it are easily able to access it. Access can be **limited in a number of ways**:

- where services are provided
- when services are provided
- how services are provided

Groups in the population who may potentially be disadvantaged in seeking access to primary care services include:

- homeless people
- travelling people
- people from minority ethnic groups
- disabled people
- those with mental health problems

Drug users are also a marginalised group and are **disproportionately represented** in some of the groups listed above. For example, there appear to be high rates of mental health problems in the drug treatment population. In a prevalence study of co-morbidity among substance misuse and adult mental health treatment populations in England, 40% of the drug treatment population were assessed as suffering from minor depression, 37% with a personality disorder, 27% with severe depression and 19% with severe anxiety (Weaver 2002, Type 3)

It is important that service providers consider the individual needs of service users. There are a number of legislative and good practice initiatives that help to ensure this. In Chapters 1 and 2 we have outlined the **Joint Future** agenda. This should be a key driver in promoting integrated care in the broader community care field and the drugs field specifically. However, there are other key legislative and practice initiatives.

For example, there are new **National Care Standards** in Scotland for care homes for people with drug and alcohol misuse problems (Scottish Executive 2001). Responsibility for these standards lies with the new **Scottish Commission for the Regulation of Care** (SCRC). These standards have been developed with the needs of the client in mind, and set out what they can expect from service providers in a residential setting. However, the standards also clearly articulate what is expected from providers of support and care services.

The National Care Standards in Scotland for care homes for people with drug and alcohol misuse problems are based on seven key principles:

- Dignity
- Privacy
- Choice
- Safety
- Realising Potential
- Equality
- Diversity

From April 2003, under the Government's **Supporting People initiative**, a new funding and policy framework for the provision of housing support services, will come into operation. Under this initiative local authorities will become responsible for the funding, planning and provision of housing support services in their area. The purpose is to make housing support services more accessible to everyone (regardless of tenure), to have services which are more attuned to people's needs and to enable direct payments to be made. The aim is also to improve the quality of services through the registration of providers of housing support services with the SCRC mentioned above. All new service users will be required to undergo an assessment of their housing support needs under the **single shared assessment procedure** outlined in Joint Future.

A further example is **disability legislation**. Service providers will need to comply with the Disability Discrimination Act 1995. The Act makes it unlawful for service providers to treat disabled people less favourably than they would treat other people, for a reason related to their disability, when offering or providing goods, facilities, or services. This clearly applies to health service providers, and extends not only to the physical, accessibility of premises, but also to how information is produced and how communication is made.

Similarly, the **Race Relations Act 1976** (amended by the Race Relations Amendment Act 2000), makes it unlawful to discriminate against anyone on grounds of race, colour, nationality (including citizenship), or ethnic or national origin. The amended Act also imposes general duties on many public authorities to promote racial equality.

Finally, the **National Treatment Agency** (NTA) in England is set up as a special health authority to lead the development and monitoring of drug service standards. One of the key concerns for the NTA is the accessibility of drug services for individuals across all DATs in England. The NTA emphasise that a constellation of different services will be required in each area to manage and address the complex needs of drug users, and that these services will need to work in partnership to maximise the use of available resources. For further information about the NTA please see: www.nta.org.uk.

Factors that affect accessibility

We have identified a number of service and individual client characteristics that potentially have an impact on accessibility. These include the needs of specific groups of drug users whose circumstances require additional consideration if services are to be accessible to them:

Service characteristics

- the range of available treatment and care services
- client awareness and perception of services
- location of services / distance to travel
- opening times of services
- waiting times
- staff attitudes
- assessment procedures
- referral arrangements

Individual characteristics

- gender
- ethnicity
- rural and remote residents
- homelessness
- non-opiate users

Service Characteristics

1. The range of treatment and care services

As stated earlier, a fundamental feature of accessibility is the provision of an adequate range and capacity of treatment, care and support services to support the changing needs of the client. An effective range of services will be best designed and delivered when they meet **identified local needs**.

A recent survey of NHS treatment services across the UK showed that a wide range of harm reduction and abstinence oriented interventions is acceptable and available across the UK. However, their availability was limited by a combination of practical, economic, safety and theoretical considerations (Rosenberg 2002, Type 3). There is often a mismatch between what is appropriate and what is available.

A survey of NHS treatment services for opiate users carried out by Aberdeen University in 2001/2002 shows that the availability of different types of pharmacological treatments for drug users varies across Scotland (Cameron 2002, Type 3). This may, at least in part, reflect the different needs of local populations. Psychological approaches, psychosocial approaches and alternative therapies were also available in some areas, usually provided opportunistically by a member of the addictions team who was trained in a specific therapy. A summary of the results from this survey is available in Appendix 5.

Research shows that a **range of health and social interventions** may work, but the outcome often depends on the individual getting **the right treatment at the right time**. Most drug users will require treatment, care and support from more than one type of service depending upon their drug of choice and their other health and social needs. For example, detoxification followed by relapse prevention, methadone maintenance accompanied by counselling, or symptomatic relief with cognitive behavioural therapy (CBT).

There is also good evidence for the **cost effectiveness** of treatment interventions. The National Treatment Outcome Study (NTORs) in

An international systematic review examining the effectiveness of drug treatment suggests (Simeons 2002, Type 1):

- the effectiveness of methadone, buprenorphine and LAAM for community maintenance has been well established
- methadone, clonidine, lofexidine, and naltrexone can all be effective in the management of opiate withdrawal
- retention in treatment and length of treatment are associated with positive outcomes.
- programmes that include psychological and psychosocial interventions are most effective

A summary of the results is in Appendix 6.

England estimates that for every £1 spent on treatment, there is a £3 saving on criminal justice costs (NTORS, Type 3). In particular, NTORS clearly demonstrates the high levels of criminal involvement by drug users before entering treatment. Further information and results from NTORS can be downloaded at www.ntors.org.uk. However, such economic analyses in the drugs field are often partial. They do not account for the increased quality of life for the users and their carers, nor the wider social benefits for the community. As well as 'cost effectiveness' the NTORS study has demonstrated a range of positive outcomes for drug users.

The Outcomes Pilot Study, conducted at five drug treatment services across Scotland in 1998/1999, demonstrated a range of positive outcomes for those retained in treatment after just three months (Galbraith 2001, Type 3). These included: a movement away from illicit to prescribed drug use, reduced injecting and sharing, improvements in physical and mental health, reduced criminal activity and improvements in relationships. The study also found:

- 60% of clients were no longer in contact with services three months after initial contact
- 84% of those who were no longer in contact were defaults (i.e. not turning up for appointments)
- 40% of all clients made only one contact with services, highlighting the importance of a positive first contact at drug services.

It is worth noting, however, that loss of contact after one visit may not necessarily be negative. A one-off contact can be sufficient to resolve the client's problems. A follow-up to this study is now looking at reasons for presenting for treatment, expectations of agencies and motivations in relation to drug use in order to better understand reasons for retention in or drop out from treatment.

Research shows, however, that **more than one treatment episode** is frequently required. Services must be able to meet different types and levels of need that an individual may have as he/she progresses through treatment. This is an important consideration when planning and delivering services.

There are a **number of predictors** that highlight when long-term, or multiple, treatment episodes may be required (Brewer 1998, Type 1). Some of these predictors should be evident at the assessment stage and considered when planning treatment for an individual:

- high levels of pre-treatment drug use
- prior treatment for opiate addiction
- no prior abstinence from opiates
- abstinence or light use of alcohol
- depression
- high levels of stress
- unemployment or employment problems
- association with drug misusing peers
- short length of treatment
- leaving treatment prior to completion

As stated earlier, at initial assessment and when steps have been made towards recovery or stabilisation, a **whole range of other needs** may become apparent.

The range of services also needs to offer the possibility for individuals to move on to another, appropriate service when they have made progress. Further, the possibility of relapse is a concern. Users commonly feel that support is weighted towards the beginning of the recovery process, jeopardising this process in the long-term (McIntosh 2001, Type 3). The EIU Moving On review highlighted that clients who have moved on to employment needed on-going support to cope with the transition in their lives (EIU 2001, Type 2/3).

The Effective Interventions Unit 'Moving On' report (2001) highlights that employment and training can aid the **process of recovery** from substance misuse.

Qualitative research in Scotland (McIntosh 2001) emphasised the role that employment and other social activities can play in **helping fill the 'void'** left by drug use, and help break away from drug using peers.

Delivering this range of health and social interventions commonly requires **effective joint working** across agencies including specialist drug services, generic health, mental health, social work, criminal justice and housing services among others. There is evidence of good practice in partnership building across Scotland. For example, the New Futures Fund projects appear to have played a pivotal role in building partnerships between drug services and education, training and employment services (LRDP 2002, Type 3)

2. Client awareness and perceptions of services

One of the barriers to accessing services is **lack of knowledge** among potential clients of the services available to them and how to access them (EIU Working Group 2001, Type 5). Some drug users will have limited knowledge about the types and range of services available in their area. A number of drug users refer themselves to services and, if they have unrealistic or false expectations of what those services can provide for them, it could lead to a future reluctance to attend any service and potentially treatment failure.

Word of mouth appears to be an important way in which **opiate users** hear about services and make decisions about whether to approach them (EIU consultation workshops 2001, Type 5). However, qualitative research conducted with **stimulant users** in Scotland suggests that this may not be a key source of information for them (SDF 2002, Type 4). In general, primary stimulant users have a different profile. In particular, they are more likely to be employed and have social networks outwith other stimulant users.

Services need to consider **how best to target information** at the groups their service is designed for. In particular services need to be clear to their target audiences about key aspects of their provision. There are examples of how this has been achieved in Scotland. For example, in Argyll and Clyde a handbook has been prepared which includes details of the range of treatment, care and support services and prevention interventions in the area. It also includes information on the local drugs strategy and the list of priorities in the area. This is available at: www.show.scot.nhs.uk/achb/NHSA&C/adat/handbook%20sections.htm

Most of all, services need to be clear about **how the service can be accessed** (EIU Working Group 2001, Type 5). For example, they need to be clear about whether individuals can refer themselves to the service, or whether they need to access the service through someone else e.g. primary care.

The **perceptions** clients hold about services will also influence the extent to which they are accessed and when they are accessed. The credibility and knowledge of support agencies and their associated 'image' were highlighted as key factors in engaging with users in the EIU Moving On review and by the EIU Working Group (EIU 2001 Type 2/3; EIU Working Group Type 5).

3. Location of services

Research carried out to obtain the views of clients about the barriers to accessing services in England shows that the location of services is a **major barrier** (Audit Commission 2002). Public transport can be a real difficulty, particularly in more rural areas. Further, the cost of transport may exacerbate these difficulties. In the research conducted by the Audit Commission, one study area issued transport passes to their clients. The service users' focus groups suggested that once participants knew where the nearest specialist addiction service was located, they would approach this service first (SDF 2002, Type 4). However, this did pose problems in rural areas because services were sometimes difficult and expensive to get to.

In some areas **mobile services and outreach work** have been organised to tackle some of the difficulties posed by locating a service centrally. For example, there are a variety of ways in which needle exchange facilities are provided, including static services, mobile units and backpacking. This range of methods of distributing injecting equipment may reach injectors early in their injecting careers as well as users who would not normally access traditional needle exchange facilities.

A number of areas in Scotland offer outreach needle exchange services. Some of these services are targeted specifically at hard to reach drug users groups; for example drug users living in rural areas and homeless drug users.

The extent to which **out of area referrals** for residential rehabilitation are made is variable across Scotland (Cameron 2002, Type 3). This survey of NHS services for opiate users suggests that there are about 250 NHS out of area referrals for substance misuse each year in Scotland, mostly for residential detoxification. It should be noted that these figures also include alcohol misuse in some areas. Out of area referrals were commonly made when local services had been exhausted and the referral had the support of the clinician responsible for addictions. It is worth noting that the evidence base on the effectiveness of residential rehabilitation is not as strong as for community based interventions for opiate use (Simeons 2002, Type 1). Further research on the effectiveness of residential rehabilitation approaches is required.

4. Opening times of services

For many people it is difficult, if not impossible, to organise attendance at a service at a set time. **Individuals who have children** may have particular problems because of school hours or childcare responsibilities. Services need to be flexible in their opening times to allow these individuals to access services at times convenient to them.

It is also important to consider when **specific groups** of users can best attend. There is evidence to suggest that the majority of primary stimulant users are in employment and would find it hard to attend during normal office hours. This is also the case with steroid users. So, services to cater for these groups should be accessible out-with standard working hours.

Further, as an individual makes **progress towards recovery** it may be appropriate and useful for them to attend an employability project, attend training, undertake voluntary work or indeed enter employment. If individuals still require support from a treatment provider (e.g. for methadone) opening times need to be flexible enough to accommodate the needs of the client at that stage in their recovery.

Some services across Scotland offer evening sessions and a small number offer 24 hour access to maximise their contact with drug users. For example, a service for steroid users in Dundee operates in the evening to accommodate the majority of their clients who work during the day. The Glasgow Drug Crisis Centre offers a 24 hour drop-in service that includes a needle exchange, a one stop service and residential rehabilitation.

5. Waiting times

One of the keys to a successful outcome from treatment is a **prompt and appropriate response** when an individual seeks help. Lengthy waits are demotivating and discourage entry into treatment. (National Treatment Agency 2002, Type 3; EIU Working Group 2001, Type 5).

Waiting times for **access to drug services** is a problem across Scotland and the wider UK for both drug users and for service providers across health, social work and voluntary agencies. (EIU Working Group 2001 Type 5; SDF 2002, Type 4). Information from DAT Corporate Action Plans indicates that there are **wide variations** in waiting times for clients seeking help with drug problems, from a matter of days to several months. For drug users, long delays for and during assessment, delays following the initial assessment, and delays in referral cause frustration and may lead to reduced motivation. For services, lengthy waiting times have a demoralising effect on staff who can feel constantly under pressure. They may also feel that their performance is judged solely in this one area.

I was made to go for weeks...one day a week for assessment. You just became despondent. They were trying to see if you were motivated. But you saw people come and go in the time you were there and you were just like – when do I get my turn?.....It was murder

SDF Focus Group Respondent 2002

The length of waiting times can be due to a **number of factors**. Work on waiting times by the National Treatment Agency (NTA) and by the EIU Working Group in Scotland suggest that the following factors are the main causes of the problem with waiting times:

- availability of services does not meet demand
- capacity within and across services does not meet demand
- assessment procedures are numerous and variable, leading to delays
- treatment regimes are not flexible enough
- workforce constraints (in particular too few skilled staff)
- joint working arrangements could be better developed (referral / discharge procedures)
- criminal justice initiatives (e.g. DTOs, drug courts) increase demand on services
- there is an increase in client demand at services with good outcome records

Sustaining the client's motivation to enter a service can be difficult when there is a waiting time. A number of interventions have been tried to **minimise drop-out** from waiting lists. However, evidence of their effectiveness is scarce. A randomised controlled trial to evaluate the effectiveness of a motivational intervention to reduce drop out from publicly funded treatment waiting lists in the United States did not enhance treatment entry, completion or outcome among treatment-seeking client (Donovan 2001, Type 3). The authors suggested that alternative strategies such as contingency management and case management may help. However, this is unlikely to be as effective as providing direct access to services.

A study which examined the relationship between waiting times and outcomes of over 2000 clients in Warwickshire between 1983 and 1998 clearly demonstrated that those who completed treatment **waited less time** (on average) between assessment and admission than those who did not complete treatment (Georgakis 1999, Type 3).

The Warwickshire Study showed that those who completed treatment waited 15.6 days on average for treatment between assessment and admission compared to non-completers who averaged 19.4 days on the waiting list. (Georgakis 1999)

There are some management processes that (while put in place for good reason) may contribute to increased waiting times. For example, some substitute prescribing services require that the majority of their clients are on supervised consumption regimes. There can be requirements for weekly drug tests or regular meetings with key workers. For some clients and for a period of time, these conditions are entirely appropriate. However, **universal application** may be costly and will reduce the number of clients who can be treated by that service. Further, if regular reviews are not carried out, the continuation of the practice for individuals whose needs are largely met may prevent others from entering the service. This can lead to long waiting lists, increased waiting times and high priority clients struggling to get the support that they need. It may also have a negative impact on clients who are ready to move on to another stage in the rehabilitation process.

The NTA Guidelines 'Making the System Work' (NTA 2002) highlight that **working practices and joint working arrangements** are particularly important in tackling waiting lists. Some services in Scotland operate a duty system so clients do not have to wait for a first appointment. Other services have learnt through experience that referral to another provider may be more appropriate than further care in their service after stabilisation has occurred. Research conducted for the EIU Moving On report suggested that many treatment services were reluctant to 'let go' of their clients, even when they had been stabilised and were (at least in some cases) ready to progress to the next stage of rehabilitation (EIU 2001, Type 2/3).

There may also be problems with **managing non-attendance**. This will in turn increase the waiting times for others if the appointment cannot be allocated to another client. In some cases, the appointment systems are not designed to reflect the needs and lifestyle of the clients who have serious drug problems. To overcome this difficulty, some services operate on a drop-in or a one-stop model.

The EIU Working Groups and SDF focus groups highlight the problems associated with allocating priority to those on waiting lists. In particular, **users' perceptions** of what they need to do, or be assessed as, to be prioritised for treatment and care. There is a general consensus among users that you need to be referred through the criminal justice system, or be injecting to stand any chance of prioritisation.

A study was commissioned by NTA in 2002 to examine waiting time strategies in 4 DAT areas with zero to low waiting times. They shared a number of similarities:

- spread existing resources further
- use new approaches and interventions
- utilise new information systems and technology
- improve the integration of local services
- manage the movement of clients through the drug treatment system and minimize unnecessary delays
- keep services open for longer and later
- increase performance in the key area of assessment, dosing, and care management procedures.

Annex 3A sets out a three-stage approach to addressing waiting times.

6. Staff

Staff will play a **crucial role** in attracting and retaining drug users in services. For drug users, staff members are the 'face' of the service. Staff members have a clear role in promoting the credibility and image of the service. Further, their attitude at first contact is likely to have a significant influence on whether the drug user will continue to attend (EIU Working Group, Type 5).

Currently there seems to be a national problem with recruiting and retaining staff in the substance misuse field in Scotland and the wider UK. A UK wide mapping exercise of the drug and alcohol sector conducted by Healthworks UK found that many staff working with users were well qualified, but their qualifications were not specific to the work they were undertaking (Healthworks 2001, Type 3). Recent developments in the criminal justice sector (e.g. DTOs) offering offenders referral to treatment services have increased demand for services and, consequently, on staffing. The Executive is working with Drug Action Teams to identify and resolve staffing issues.

When qualified staff are in post, they need **support networks and supervision** to help them to reflect on their professional practice and provide support in dealing with difficult situations. Staff also need effective management support to help them manage their case loads and to help them access and undertake continuing professional development (EIU consultation workshops 2001, Type 5). Finally, administrative support is crucial to support the work of professional staff to ensure they are able to spend their time on the professional tasks they are qualified to practice.

Training is the key to ensuring that staff members have the opportunity to maintain and improve their skills and gain new competencies. In the context of an integrated care service, there is a particular value in multi-agency training to promote and encourage mutual understanding of the role and working practices of other service providers. Access to appropriate services can be reduced because staff members do not know where to direct clients when they might benefit from another service or be ready to progress.

STRADA now provides training in a number of aspects of drug misuse and treatment for staff in a range of agencies. More detail is set out in Appendix 7.

7. Assessment

The assessment process is a **key factor** in making services accessible. Effective assessment practice can help ensure access to appropriate treatment within a time period that will allow the provider to capitalise on the individual's motivation. The judgement on what is the right treatment approach for an individual will be made largely as a result of the quality of information gained at the initial assessment. This is discussed further in Chapter 4. This Chapter provides information that supports the **design and delivery of effective assessment processes** including examples of assessment tools.

8. Referral arrangements

Strengthening referral and discharge arrangements is key to the provision of integrated care. Referrals to drug services are frequently made by a **wide range of agencies and by drug users themselves**. This reflects the diverse needs of the client group. Arrangements at a local level should ensure that referrals can be easily made by a wide range of care providers including health, housing, employment and criminal justice services.

In some cases, drug users simultaneously attend a number of services either through self-referral or through referral with no apparent co-ordination (Audit Commission 2002, EIU workshops 2001, Type 5). Sometimes service providers will not know that the individual is

being seen by other services in the area, or indeed within the same service. The result is **uncoordinated and potentially ineffective** treatment, care and support.

Another problem is reluctance by some service providers to refer their clients onwards. This was one of the **barriers** to helping recovering drug users to move on to training and employment provision identified in the EIU Review "Moving On" (EIU 2002, Type 2 and 4; EIU Working Group Type 5). It can arise from lack of knowledge and confidence among staff about the role of other providers and the services that they can offer.

There must be **effective and efficient referral arrangements** to ensure that individuals get access to services when they need them and their motivation is high. The referral arrangements also need to take into account the individual's need for support to make the transition.

Individual Characteristics

1. Gender

Women make up one third (32%) of the drug treatment population in Scotland (Scottish Drugs Misuse Database 2000/01). Difficulties in accessing services may mean, however, that women are **under-represented** in treatment. The experience of drug addiction appears to be different for men and women. For example, women who have problems with drug use are more likely than men to have a substance misusing partner and to have experienced domestic violence (Gilbert 2000, Type 3; Powis 2000, Type 3). Other difficulties may include: a history of sexual abuse (Wallen 1992, Type 3); low self-esteem and poor emotional health (Swift 1996, Type 3; Gilchrist 2002, Type 3); and the greater stigma attached to drug use among women.

Strategies to improve accessibility of services must take into account the **particular experiences and circumstances of women**. Barriers to entering treatment may be real or they may be perceived. Services may be perceived as being male orientated (if more men than women attend), or women may simply be unaware of the services that exist. In response, active recruitment and outreach can encourage women into treatment. Even when women do engage with treatment services, they may not sustain attendance, thereby reducing the chance of a successful outcome. Further, the design and delivery of services needs to take account of women's roles and responsibilities as mothers. While having children can be an important influence in the decision to seek treatment, child care or family commitments can act as a barrier to accessing services. A lack of **child care provision within services** can be a very real barrier to accessing treatment services. Providing child care facilities can increase attendance (Marsh 2000, Type 3). Whilst women are more likely to have child care responsibilities, it should be recognised that child care may also be an issue for male drug users.

For drug using mothers, the fear of their children being taken into care can present a psychological barrier to approaching services (Allen 1995, Type 3). Providing women with information can assist in overcoming their fears and drawing them into services. Explaining the confidentiality regulations of the agency and the reporting requirements for child abuse and neglect in a way that demonstrates that the worker has the women's welfare in mind can assist in establishing trust (Kumpfer 1991, Type 3).

Aberlour Childcare Trust provides residential rehabilitation in Glasgow and Edinburgh for women who have a dependency on drugs or alcohol. Their services enable women and their children to stay together during the rehabilitation process.

Being away from their children as a condition of treatment may discourage women from entering residential services (Marsh 1985, Type 3). Allowing women to live with their children during residential drug treatment enhances retention in care, potentially improving the mother/child relationship and post-discharge treatment outcomes (Hughes 1995, Type 3).

An example of this is the Aberlour Childcare Trust residential rehabilitation facilities in Edinburgh and Glasgow. These projects also address the women's personal and social development and provide support to move on to training and employment.

For **women who are pregnant**, access to drug treatment and wider healthcare services, is particularly important. The Women's Reproductive Health Service (WRHS) at Glasgow's Princess Royal Maternity Hospital (formerly based at Glasgow Royal Maternity, Rottenrow) identified a range of barriers to the use of ante-natal services by pregnant drug users (Hepburn 1997, Type 3). Fear of encountering judgmental staff attitudes was often the primary reason for non-attendance. There were other barriers. Women found it difficult to get access to services because of referral procedures. Traditionally access to ante-natal care is by GP referral. There was no opportunity for self-referral. It was difficult to get to services because of distance and time constraints arising from their other responsibilities. Women were also concerned they might be made to have an HIV test and, if positive, be forced to have a termination.

Since 1990 the Women's Reproductive Health Service (WRHS) has provided a city-wide service for women with severe social problems, including drug use. The service's philosophy is one where drug use is recognised as a problem, but women are not condemned for using drugs. Before the service was established, few pregnant women reported drug use and when they did this was commonly late in pregnancy. Now their average booking gestation is the same as the hospital average. Also, the service works alongside social work services.

Women's relationships with their partners also have an impact on their likelihood of approaching services. Research shows that women who have drug problems are more likely to have a substance misusing partner (Lex 1991, Type 3; Powis 2000, Type 3; Pivnick 1994, Type 3). Drug using sexual partners can exert an important influence over women's drug misuse, with most female injectors having been given their first injection by a male sexual partner (Powis 1996, Type 3). As noted previously, they may also have experienced physical violence or sexual abuse. Having a partner who uses drugs decreases readiness to enter treatment (Riehmman 2000, Type 3). Similarly, there is research evidence that women who engage in treatment with, rather than without, their partner have better outcomes (Kim 1994, Type 3).

Base 75 in Glasgow is a drop-in centre for female street workers. They offer harm reduction and other services to women drug users involved in prostitution.

Turnaround project in Glasgow works with female drug users involved in the criminal justice system. Their main areas of work are: arrest referral/court support; prison drug work; and diversion from prosecution.

Some female drug users are involved in criminal activities. **Prostitution** and its associated dangers are of particular concern. This may be another barrier to accessing services. However, there have been some services specifically set up to address the health and social care needs of this group of women, such as Base 75 in Glasgow (see example).

Finally, for those working in drugs services and other agencies, improved inter-agency collaboration and a co-ordinated approach to service delivery should help assist in meeting the diverse and complex needs of women problem drug users (Becker 2002, Type 3).

2. Ethnicity

In 2000/01, only 27 people (0.3%) reported to the Scottish Drug Misuse Database were of ethnic origin other than White. The comparable figure for 1999/00 was 15 (0.2%). This is a lower proportion than the proportion of ethnic minorities in the total Scottish population. Surveillance and surveys suggest that drug use in the UK is more prevalent among white people overall. While this may be the case, there are likely to be substantial numbers of minority ethnic drug users, with geographical variations and differences in the type of drugs used.

Minority ethnic drug users have traditionally been reluctant to access existing services. Service providers must be more sensitive to the needs of minority ethnic groups. This involves providing materials and support in languages other than English, providing services to address the drug of use (e.g. not just opiates) and working with families with different cultural backgrounds and values.

ESHARA is a black and ethnic minorities drug project based at the Gorbals Addiction project in Glasgow. It offers counselling, detoxification, substitute prescribing and access to rehabilitation. The project aims to offer a culturally sensitive approach to dealing with minority ethnic drug users.

Different models of service have been developed and tried across the UK. Some of these are mainstream services with an attached worker to address the specific problems faced by minority ethnic users. In other areas (usually with a high prevalence of use among minority ethnic groups) dedicated services have been developed. Local needs assessment will help to guide decisions about the most appropriate service models.

A **national scoping study** of drug prevention and drug service delivery to minority ethnic communities conducted in 6 DAT areas in England in 2000/2001 (Sheikh 2001, Type 3) showed that 'symbols of accessibility' were important. This means showing explicitly that minority ethnic groups are welcomed by a service, e.g. posters, leaflets, cultural-specific newspapers and magazines (Sangster 2002, Type 3).

However, it was emphasised this was only one aspect of what was required to ensure access to culturally sensitive services. Others include a shift away from delivering services for opiate injectors to the development of services with a holistic, therapeutic and social focus, the importance of 'cultural competence' and gearing mainstream service towards meeting the needs of diverse minority ethnic groups. The full report is available from the Drug Prevention Advisory Service (DPAS Paper 16), or at:

www.drugs.gov.uk/ReportsandPublications/Communities/Blackminorityethniccommunities

3. Residents in rural and remote areas

Drug users who live in rural and remote areas encounter a **number of problems**, some of which are covered in the earlier section on the location of services. In recent years, the increasing problem of rural deprivation and the associated problems of drug use have been recognised (Scottish Executive 2001). Inadequate and expensive public transport, lack of training and employment opportunities and limited childcare provision are all features of rural deprivation. People with substance misuse problems were identified as one of the groups most affected by poverty and social exclusion in the 2001 report. In particular, there is a problem for people with substance misuse problems in reintegrating into the community.

There are a number of factors that affect accessibility for people in rural areas. The **range of accessible and available services** is often a problem. Very few rural areas seem to have carried out an adequate or accurate assessment to establish the real scale of the problem. National databases record activity of existing services that are largely urban based. Opiate use may not be the main problem. There is some anecdotal evidence that there is more opportunistic drug use (e.g. of manufactured substances such as amphetamines or readily "found" substances such as veterinary preparations).

There has also been an assumption in the past that people from rural areas would travel to the nearest town (as a 'hub'). This may happen in 'dormitory' areas, but there is evidence that many people will not travel to get services (EIU working group 2001, Type 5). Sparse populations, long distances to travel and in some cases long standing rivalries between towns and villages mean that the characteristics of the services and who provides them may differ from those in urban centres.

There are frequently **problems maintaining anonymity** in small communities (EIU Working Group 2001, Type 5). There is little or no evidence to support the assertion that there is more

mutual support and assistance within rural communities. The difficulties of disproportionately low levels of confidentiality and high levels of stigma require that substantial efforts be made to engage with communities and improve understanding of the nature of drug problems and their impact.

Different service models can be used to tackle the problems specific to rural areas including home visits and mobile units. Outreach workers in particular can be used to good effect to provide services such as needle exchange, methadone maintenance and home detoxification. Alternatively, premises are found that can function as satellites to the central static sites that will inevitably be difficult for rural users to access. Research has shown that even city-based users were unlikely to travel more than a mile to access needle exchanges (Stimson 1988).

In one area of Scotland the home detoxification of opiate and amphetamine users has been very successfully combined with the already well proven home detoxification of people with alcohol problems. The service consists of short-term, high intensity support from Community Psychiatric Nurses with appropriate prescribing from the General Practitioner. Its success appears to be dependent on a high level of communication between themselves, the inpatient detoxification service and the various drug agencies as to what and when is the most appropriate form of after care and support.

4. Homelessness

In 2000/01, 2.7% of all 'new problem drug users' in contact with services reported to the Scottish Drug Misuse Database had a living situation described as of 'no fixed abode'. The comparable figure in 1999/00 was 3.1%. However, this excludes individuals who are living in insecure or temporary accommodation. Further, the homeless population are probably less likely than the drug using population as a whole to access services.

Homelessness and the problems associated with insecure accommodation appear to be very common among the drug using population. A review of the Rough Sleepers Initiative in Glasgow suggests that about half of rough sleepers between the age of 25-34 years and about one third of rough sleepers between the ages of 16-24 years were dependent on heroin (SWSI 2001). Similarly, a study of 200 drug users in Glasgow and Dundee demonstrated that approximately **one third** (32%) were currently homeless and **two-thirds** (68%) had experienced homelessness at some stage (Neale and McKeganey 1999, Type 3).

A report on street homelessness in Glasgow by the Homelessness Task Force emphasised the need to deal with drug problems and wider health and social problems alongside homelessness. The report identified the **barriers** faced by homeless people when seeking health care (Scottish Executive 2000):

- a poor reception and inadequate treatment at accident and emergency departments
- difficulty in registering and continuing to access general practitioners
- negative self image and lack of self esteem result in a lack of confidence to access services
- difficulty in tackling health problems when living in poor accommodation and with a lack of social support

Further work to review the causes and nature of homelessness in Scotland, to examine current practice in dealing with cases of homelessness and to make recommendations on how homelessness can best be prevented and tackled is underway. For further information please see their home page at <http://www.scotland.gov.uk/homelessness/>

These and other **barriers** are also highlighted by the Scottish Executive's Health and Homeless Guidance (2001). The purpose of this Guidance is to emphasise the importance of delivering on the target to end the need for people to sleep rough, and on the broader aim of delivering services to people whose life circumstances affect their access to care. A full copy of the

guidance is at: <http://www.scotland.gov.uk/library3/health/hahg-00.asp>. The guidance highlights the following:

- the criteria for accessing a service can be a barrier e.g. requirement to be drug or alcohol free
- unwillingness of some GPs to prescribe for homeless drug users due to fear of overdose and safe storage of substitute medication
- mobility of the homeless population means they may frequently move away from the area where they are registered with a GP

Overall, the research evidence points to the need for an **integrated strategy** of addressing the broader reasons for the homeless situation and drug use (though of course these can sometimes be difficult to disentangle). A study of good practice with homeless drug users suggests that there are a number of key elements that promote good practice (Kennedy 2001, Type 3). These include:

- devoting time and resources to ensuring easy access
- devoting time to establishing trust
- tailoring support to an individual's needs
- incorporating users views into service design and delivery

A number of service models have been developed to address the needs of homeless people, many of whom are drug users. These include one-stop services and outreach work. These services are commonly provided by a partnership of statutory and voluntary providers. Frequently these services offer a range of provision including: community care and supported housing assessments, housing advice, access to primary health care teams and drug and alcohol workers and advice on temporary accommodation.

The Access Point (TAP) in Edinburgh is a one-stop service providing housing, health and social work services for vulnerable homeless people. Some outreach work is also undertaken by the TAP team.

'Under One Roof' in London is a one stop-service run by a partnership of 30 statutory and voluntary agencies. The service delivers interventions to vulnerable young sleepers in two areas.

5. Non-opiate use

Research shows that the socio-demographic profiles of non-opiate users can be different from opiate users, and that a range of support and treatment must be available to address the diverse needs of this group. However, there is likely to be a substantial proportion of stimulant users who are also opiate users. A recent report from the Psychostimulants Working Group in Scotland established by the Scottish Advisory Committee on Drug Misuse (SACDM) in 2001 suggests that there are four main categories of stimulant users, each with their own set of needs (Scottish Executive 2002):

- youthful experimenters
- regular stimulant users
- problematic stimulant users
- opiate / stimulant co-users

It is clear from both the research literature and the service users' focus groups (SDF 2002, Type 4) that stimulant drug users perceive existing drug services to be the **domain of opiate users**. This affects the perceived accessibility of services for non-opiate users. In the case of opiate users who also use stimulants, this can mean that only their opiate use is being

addressed by services. It is clear that decisions on how to re-configure or redesign services to meet the need of stimulant drug users should be based on local needs assessments among non-opiate users and co-users.

Overall, there is limited evidence about the effectiveness of drug services designed to meet the needs of **non-opiate users**, and in particular stimulant users (crack, cocaine, amphetamine, ecstasy). However, a combination of pharmacological (in the main symptomatic relief) and psychological / psychosocial interventions is likely to be appropriate. In particular, evidence on the use of psychological and psychosocial interventions among stimulant users appears promising (Scottish Executive 2002). However, availability of these services and interventions for stimulant users is currently limited.

The full report of the PSWG can be downloaded at:

http://www.drugmisuse.isdsotland.org/publications/abstracts/sac_psycho_report.htm

Remember Harry?

The character of Harry was introduced in Chapter 2. The pathway overleaf shows what happens to Harry when he tries to access services for his problems with drug use, but is unaware of the services available locally.

Accessibility Pathway

Harry is trying to come off drugs, but is unaware what services are available to help him. He is also unemployed and has housing problems. He has a sympathetic GP.

Processes

A range of services is available. Information about local service providers is available.

Outcomes

This outline Integrated Care Pathway is designed to assist all agencies in developing a local multi-agency strategy to maximise the accessibility of services in their area.

Harry picks up a copy of the local directory of service providers for drug users from his local library.

What services/providers are best for me?

Some factors to consider

- Distance to travel
- Opening times
- Who the service is designed for
- Special arrangements

In consultation with his GP, Harry identifies the service(s) he wants and the service provider he feels would best meet his needs at this time.

Service providers should have clear referral protocols and procedures that are available to clients and other agencies.

Harry's GP makes arrangements for him to attend the selected specialist drug service.

Can I just go there or does my doctor have to refer me?

When will I be seen?
Who will I see?
What will happen?

Service providers should supply new clients with information about their first appointment, including the name of the person who will see them and what to expect from the first visit.

Harry attends his first appointment, after receiving information about when to attend, who he will see, what it will involve, and confirmation that he can take his partner along with him.



KEY PRINCIPLES AND ELEMENTS OF EFFECTIVE PRACTICE: ACCESSIBILITY

From our review of the evidence, we have identified the following key principles and elements of practice to help improve accessibility to integrated drug services. These are rarely one-off exercises, but rather they are cyclical, or become an integral part of service development and review. From our consultation work and EIU working groups, it is evident that some of these principles have been, or are being, applied in some areas of Scotland.

1. Establish the need for services in the area.

This is usually achieved by conducting a local needs assessment. The key principles and elements of needs assessment are set out in Annex 3B. Conducting a local needs assessment will help to establish the extent and nature of the drug problem in the area, to describe the socio-demographic profile of users and to examine the common referral routes. This will help build a picture of area population need. The results of the needs assessment should be written up and distributed to all key stakeholders. **A guide on how to conduct needs assessment (specific to the Scottish context) will be produced by the EIU early in 2003.**

2. Review the appropriateness, accessibility and capacity of the existing range of services.

This involves taking a systematic look at the current service profile including both specialist and generic services, and statutory and voluntary agencies. To conduct this review DATs will need to complete a number of activities including a mapping exercise of current provision, (in particular the characteristics and capacity of services) and identifying the relative roles and relationships between services providers. For more information, please see Annex 3B.

3. Establish whether the existing range of services meets the need identified in the assessment exercise.

It is important to examine whether the capacity of both specialist and generic services is sufficient. Further it will be important to assess whether the interventions and services delivered do indeed meet the needs of the local drug using population, and that they are accessible. This is sometimes called a 'gap' analysis. For more information, please see Annex 3B.

4. Ensure that the range and capacity of services and joint working is adequate.

If gaps in service provision are highlighted, DATs need to consider how these gaps can best be addressed. This may be achieved by developing more effective multi-agency working, making adjustments to service characteristics and developing new approaches (such as outreach) to meet the needs of the local drug using population, including the harder to reach groups. For more information, please see Annex 3B.

5. Establish clear arrangements for joint working between agencies to facilitate an integrated approach to providing health and social care services.

This includes working with other specialist services and generic services such as mental health, housing services, employment services and youth services. In rural areas, partnerships with generic service may be particularly important. This will be aided by:

developing shared screening and assessment tools and procedures across partner agencies (also see Chapter 4)

developing referral protocols and procedures for use by all staff.

developing joint training for workers across partnership agencies, both at strategic and operational level.

using other training approaches such as work-shadowing and mini-presentations about the services offered.

6. Develop more effective assessment processes.

Existing knowledge about the client should be used to avoid duplication of effort by agencies and frustration for the client. Key tasks are:

development of single, core assessment information to be shared by relevant agencies to reduce the number of reassessments that are required.

use of a consent statement that allows agencies to share information about the client across their partner agencies (see Chapter 6).

7. Produce and make widely available clear and concise information about services.

It is important for clients to know about the range of service in their area and how to access them. It is equally important that other service providers also know about the range of services available in order to ensure appropriate referrals.

draw together information about services in your area for potential service users, service users, families of drug users and other service providers.

identify the most appropriate techniques for making information available to both clients and service providers. The material should be designed and adapted for each of its target audiences and say clearly:

- who the service is most suitable for (and who it is not suitable for)
- what the service offers (and what it does not offer)
- what clients can expect on arrival at the service
- whether clients can bring someone with them

Service users and service providers should be consulted on the design and content.

8. Provide a variety of access points and times.

It should be possible for service providers to take into account the previous progress of clients who have dropped out or relapsed and for clients to enter or re-enter treatment at an appropriate stage. Going back to the beginning of a care process can be demoralising and counter-productive for both staff and clients.

arrangements should be in place to ensure that individuals do not go back to the beginning of the care process

assessment should build on existing information held on the client, rather than start from the beginning again.

develop more flexible discharge arrangements

9. Employ staff with appropriate skills, attitudes, training and qualifications.

It is clear that staff need (in most cases) to have well developed skills and competencies in their own areas of knowledge and expertise, but also to have knowledge of the range of provision available and how it can be accessed. Further:

staff should be encouraged to build on existing training and qualifications (e.g. through STRADA training modules).

staff members need to be trained in the assessment processes, referral mechanisms and joint working arrangements that characterise integrated care.

10. Clear information sharing protocols.

Clear information sharing protocols should be developed and explained to clients approaching service providers for help. This may be especially important for particular groups, for example female drug users with children who may have concerns regarding child protection issues. Chapter 6 on Information Sharing provides guidance on:

inter-agency information sharing protocols.

provision of information to clients/service users.

informed client consent to the sharing of their personal information.

11. Involve family members.

It is good practice to involve family members and close friends in the care of the user. The research evidence points to the benefits of including significant others in treatment and care. Family members can also be pivotal in securing access to service for drug users.

as part of the assessment process, it will be important to assess the level of potential support the individual is likely to receive from family members.

it will also be important to assess the extent to which family members should be involved in delivering treatment, care and support to the individual.

it will be important to be clear about where family members can get help and advice if they require it. There are a growing number of family support groups developing across Scotland.

12. Address negative community attitudes.

DATs and partner agencies should find ways to engage with communities and improve understanding of the nature of drug problems and their impact. This may ease the stigma associated with drug use, particularly in rural areas and help the development of services in the area. For further information see the EIU Guide to Community Engagement at http://www.drugmisuse.isdscotland.org/goodpractice/EIU_commeng.pdf. Further, the Scottish Drugs Forum have a remit for developing community engagement in the drugs field. For further information please contact them on 0141 221 1175 or go to <http://www.sdf.org.uk>.

DATs should develop a community engagement strategy for their area. This involves being clear about the definition of 'community', the level of engagement they are aiming for and the techniques they may use to achieve this.

the strategy should probably include plans to support user groups and family support groups in the area to help empower these individuals and help reduce community stigma.

as with all strategies, this should be revisited and reviewed periodically.

13. Periodically undertake needs assessments and review the integrated care process and its effect on accessibility.

Regular reviews of these arrangements and procedures will help to identify if improvements can be made and to build on success This will include:

revisiting and updating the needs assessment exercise described earlier in this section and in Annex 3B.

revisiting the analysis of current need compared to the profile of service provision

reviewing the effectiveness of joint working arrangements, assessment processes and referral procedures.

A THREE-STAGE APPROACH TO ADDRESSING WAITING TIMES

This Annex sets out a **three-stage approach to addressing waiting times**:

- **Minimising Waiting Times (Stage 1)** focusses on the development of systems to ensure that clients are directed to the most appropriate services as quickly and effectively as possible. It involves streamlining administrative systems to maximise the use of practitioners' time.
- **Managing Waiting Lists (Stage 2)** comes into effect when clients are having to wait for an unacceptable length of time for care and treatment. This stage requires that cases be prioritised and that steps are taken to ensure that the health and well-being of clients waiting for services is not put at risk.
- **Developing Contingency Plans (Stage 3)** would be initiated when the ability of the service provider(s) to see new referrals is compromised as a result of waiting times.

Included at each Stage are **key action points at client, agency/service provider and integrated services level**, adapted from the National Treatment Agency paper "Making the System Work" (NTA 2002).

This Annex also sets out information on the **monitoring of waiting times** and details of current **waiting times research**

1. Minimising Waiting Times

Traditional approaches to improving access to services and reducing waiting times have focussed on creating additional capacity within agencies. However, there is increasing awareness and acceptance of the role of service planners and referring partners in managing demand for services and improving the overall experience of the integrated care process.

From the information collected we have identified the following approaches to minimising waiting times:

- joint planning
- improve referral patterns
- appointments and bookings
- re-assessment
- triage and re-distribution
- communicating good practice
- managing resources to meet need

Joint planning

It is increasingly clear that effective management of capacity and demand must be carried out as a joint responsibility between services: for example, between primary and secondary care in health and across services such as health, social work and housing. As is often said "If we always do what we've always done we'll always get what we've always got" (NHS

Modernisation Agency, Type 3). In order to reduce delays and improve access, systems need to be re-designed to improve waiting times.

In the health field, there is increasing awareness and acceptance of the role of primary care in managing demand for secondary care services. The work of the National Primary Care Development Team (NHS Modernisation Agency 2002, Type 3) goes one step further and introduces the concept of primary care managing a specified level of capacity of secondary care for their local population. This involves establishing a system of capacity and demand management which forms the central core of a range of activities that can be undertaken jointly between primary care and secondary care, to improve access to routine services.

Improve referral patterns

Statistics from the Scottish Drug Misuse Database, 2000/01, show the most common sources of referral to drug services to be GP and self (41% and 34% respectively).

The recent developments within the criminal justice system: Drug Treatment and Testing Orders, drug courts, arrest referral schemes and the Scottish Prison Service transitional care arrangements will have to be reflected in agreements at local level on the criteria and processes of referral. This should ensure:

- access to the right service
- core information for the assessment process

There are, at present, no specific questions on referrals from arrest referral schemes, DTTOs etc. on the Scottish Drug Misuse Database. It would, however, be possible to adapt the system to pick up this additional detail in future.

Service providers require a shared knowledge of where to refer someone on to, depending on their presenting need(s). Individuals wishing to refer themselves to a particular service will require up-to-date knowledge of what services exist in their locality and what the remit for a service is. This information will assist the individual to identify and approach the most appropriate service provider for them.

The referral process should promote accessibility to services at a time when they are needed. It depends on joined-up working between agencies. The process would be aided by:

- a directory of local services
- a referral form designed around the core data sets outlined in Chapter 4
- clear sign-posting information on services including 'Client Information Leaflets' and active outreach work

Appointments and bookings

Service providers and service users have stated that appointment systems are not always designed to reflect the needs and lifestyle of the clients who have serious drug misuse problems (EIU consultation workshops 2001, Type 5; SDF 2002, Type 4). There may also be problems with managing non-attendance in ways that increase the waiting times for others if the appointment cannot be allocated to another client. Service providers suggested that the provision of a number of community-based satellite points, with opening hours that reflect the needs of the client group rather than the needs of the service, would reduce non-attendance (EIU consultation workshops 2001, Type 5).

Auditing non-attendance patterns at service provider level can help to identify indicators associated with non-attendance. A study by North and East Devon Health Authority, on patient, hospital, and general practitioner characteristics associated with non-attendance examined a cohort of 1972 referrals from 26 general practitioners, with complete follow-up (Hamilton 2000, Type 3). Five factors were found to be significantly associated with non-attendance: male sex; younger age; longer interval between referral and appointment; higher Jarman (Deprivation indicator) score and patients of high-referring GPs. Development of strategies to reduce non-attendance is possible using these results.

Re-assessment

The amount of time involved in re-collecting information when clients re-present at services could be reduced by ensuring that assessment processes allow for an update of information, to build on existing knowledge rather than a new assessment to be carried out (see Chapter 4 Assessment for further information).

Triage and re-distribution

Following assessment it may be beneficial to consider how best the resources of an agency (or agencies) involved in an integrated care network can be employed in delivering the care required for the individual. Rather than "lining clients up" to see a particular person or service provider, the needs of the client may well be met through employing a triage and re-distribution system. Factors to consider in triage and re-distribution include:

- the demand for a service
- the number of service providers who could provide this service
- the current capacity of these service providers
- the preferences of the individual

Communicating good practice

There may be useful approaches to the management of waiting times in other parts of Scotland and from other sectors. In the NHS, later in the year, an on-line good practice guide will showcase examples of good practice (see 'National Waiting Times Initiative', in Section 4. 'Monitoring Waiting Times'). "The database will enable the best possible use of capacity across the NHS in Scotland, help identify and shift bottlenecks and should even out the inconsistencies in waiting times across Scotland" (Mr Malcolm Chisholm MSP, Minister for Health & Community Care).

Managing resources to meet need

Chapter 5 on Planning and Delivery of Care highlights the need for integrated planning of care between service providers in order to ensure that services are in place when the individual needs them. This should ensure that clients waiting to move on to the next phase of their care are not delayed by administrative or resource difficulties. Often this situation has arisen in the past where there has been limited provision of substitute prescribing services outwith the specialist drug services. These service providers become log-jammed and unable to take new referrals.

DATs and partner agencies should develop local protocols aimed at ensuring a seamless transfer of care between service providers. At a service or locality level this will require agreement on:

- referral procedures of participating service providers
- discharge protocols, including those for non-attendance, which recognise the implications for other agencies
- joint transfer planning arrangements

Key Action Points for Minimising Waiting Times – at Client, Agency/service provider and Integrated services level

Level	Action Point
Client	<p>Produce individual care plans with goals Service providers should:</p> <ul style="list-style-type: none"> ▪ produce individual care plans for, and with, each client. Plans should include and be based on clear and achievable short, medium and longer term goals ▪ review care plans in partnership with clients on a regular basis ▪ develop joint care plans with shared care providers, where involved. All providers should agree and review the care plan with the client
	<p>Develop discharge plans Providers should include a provisional discharge date in the initial care plan, which reflects the client's goals</p>
	<p>Develop clear protocols for clients who have defaulted Service providers should:</p> <ul style="list-style-type: none"> ▪ develop clear protocols for early discharge. These should contain possible interim steps to help clients resolve difficulties where possible, and be implemented fairly and consistently ▪ involve any other agency, which is sharing the client's care, in the decision making process e.g. a specialist mental health service sharing the care of a client with dual diagnosis ▪ liaise with the probation officer of clients on a DTTO ▪ involve the key worker and at least one other colleague in making any decision to discharge a client early ▪ allow clients the opportunity to present their case against early discharge ▪ provide clients with information on the service's complaints procedure ▪ provide clients with onward referral to advice, support and harm reduction services and advise clients about when and how they might seek readmission ▪ tell all clients what the discharge protocol is when they are admitted and remind them of it, when and if necessary ▪ carry out an audit of clients who are discharged early

Level	Action Point
Agency /Service Provider	<p>Streamline re-assessments</p> <p>Providers should ensure that when a client is re-referred or returns to a service with a view to re-admission, the re-assessment process builds on existing knowledge about the client and does not duplicate information which is already available</p>
	<p>Keep case review focused</p> <p>Providers should:</p> <ul style="list-style-type: none"> ▪ routinely incorporate case reviews into care planning and care management ▪ meet requests for case reviews as quickly as possible - particularly from GPs involved in shared care ▪ focus case reviews on the issue in hand and not involve unnecessary further detailed re-assessment
	<p>Conduct an appointments audit</p> <p>Service providers should:</p> <ul style="list-style-type: none"> ▪ conduct an appointments audit to identify patterns in unattended appointments and to gather client's suggestions on how systems might be improved. The audit should identify how often and why clinical sessions or booked appointments are cancelled by services ▪ review and redesign the appointment system, if required ▪ operate a range of appointment options, if possible. This could include partial and double booking to minimise time loss; drop-in and 'turn-up by' dates for stable clients; evening and weekend sessions for people in work; and appointments at peripatetic sites for clients who have to travel long distances, or who find travel difficult ▪ develop guidelines on what to do when a client fails to attend. Where possible, this should proactively seek to determine why the client did not attend. This, and the client's level of risk, should determine the course of action to be taken
	<p>Manage workforce constraints</p> <p>Service providers, in consultation with joint commissioners, should:</p> <ul style="list-style-type: none"> ▪ assess the administrative workload of practitioners and clinical staff and, where necessary, appoint additional administrative cover. Practitioners and clinicians should not spend time on administrative tasks ▪ ensure that service managers do not carry a clinical caseload. Clinical time lost as a result is likely to be offset by a more efficiently managed service ▪ consider the benefits of new initiatives such as the role of nurse consultants and patient groups directives
	<p>Develop evidence-based practice</p> <p>Providers should:</p> <ul style="list-style-type: none"> ▪ develop mechanisms for remaining up-to-date with new and emerging evidence and approved standards of practice – clinical and managerial ▪ provide staff with access to relevant professional journals. Services could consider developing a local 'journal club', possibly in partnership with a relevant research organisation ▪ develop internal systems for monitoring practice against approved standards ▪ implement strategies to raise practice standards to approved levels where indicated
	<p>Establish and maintain clinical governance systems</p> <p>NHS service providers should:</p> <ul style="list-style-type: none"> ▪ have in place a governance system for ensuring standards are set and met. This should promote accountable and responsible practice and support continuing quality improvement ▪ ensure that their clinical governance systems interface with those of other health and social care organisations, including Community Mental Health and Primary Care Trusts

Level	Action Point
Integrated Services	<p>Map local services Whilst DATs, in accordance with existing guidance, should already be aware of the range of local services, this might be complemented by comprehensively mapping the full range, scope, role and client groups served by all local providers</p>
	<p>Provide information on available services to reduce inappropriate Referrals In accordance with existing guidance, providers should ensure that clear, up-to-date information about services:</p> <ul style="list-style-type: none"> ▪ is widely available ▪ is produced in the first languages of key local communities ▪ is delivered through a range of techniques, including help lines (with 24 hour recordings), the internet and printed materials ▪ is designed and adapted for professional and service user audiences. Service users should be consulted on design and content ▪ provides advice on estimated waiting times but encourages clients to attend so that they start to link into the drug treatment system
	<p>Develop local common assessment criteria Assessment should serve a clear and common purpose. Providers should:</p> <ul style="list-style-type: none"> ▪ develop common screening and assessment criteria and aim to harmonise their assessment protocols ▪ reach common agreement on the key elements of screening and assessment ▪ implement triage assessment. By receiving referrals from generic providers, standardised triage assessment should ensure only appropriate onward referral to specialist services
	<p>Work with general hospitals to develop local protocol [Action on Waiting Groups¹] and local general hospitals should work together to develop a local protocol for managing drug users admitted to general medical and surgical wards which:</p> <ul style="list-style-type: none"> ▪ reduces the risk of avoidable self-discharge due to ineffective drug treatment prescribing ▪ ensures planned discharge so that specialist drug treatment is maintained
	<p>Develop shared care arrangements with GPs DATs should:</p> <ul style="list-style-type: none"> ▪ work in partnership with LHCCs, and lead the development of shared care arrangements within their localities. This should include responsibility for funding the provision of shared care and ensuring its underpinning in accordance with approved standards
	<p>Develop integrated care for through and aftercare</p> <ul style="list-style-type: none"> ▪ DATs should reflect the importance of through and aftercare services in commissioning plans ▪ Drug treatment specialists should regard generic providers as members of the extended treatment and care team

Source: adapted from the National Treatment Agency (NTA) paper "Making the System Work" (NTA 2002)

¹ There is no equivalent in Scotland at present

2. Managing Waiting Lists

Once a client is placed on a waiting list the service provider has a duty of care to ensure that they will receive treatment (Council of Europe 1999).

Allocating priority

For services where there are waiting lists, there may be a case for allocating priority. The EIU Working Groups and the service users' focus groups highlighted the problems associated with allocating priority to those on waiting lists, in particular users' perceptions of what they need to do, or be assessed as doing, to be prioritised for treatment and care. There is a general consensus among service users that you need to be referred through the criminal justice system, or be injecting to stand any chance of prioritisation.

A tool for prioritising waiting lists

If it proves necessary or desirable to allocate priority, agencies should develop clear criteria for allocating such priority and make those criteria known to other partner agencies. Partner agencies should also agree a local protocol for assessing risk where priority is being allocated.

Client perception

Clients should be actively involved in decisions about their own treatment, care and support. This means that, when they are added to a waiting list, they should be told:

- whether any priority ratings have been applied, and the implications that these have for waiting times guarantees
- how long the waiting list is and what the expected waiting time is likely to be
- what happens if they cannot attend for an offered appointment and they let the service provider know in advance
- what happens if they do not attend an appointment without letting the service provider know in advance
- what happens if they attend for an appointment but are unable to fully participate due to problems with withdrawal or over-sedation

Individuals, in discussion with their keyworker or care co-ordinator, should be able to make informed choices about where they are referred for treatment. There are a number of factors which should be taken into account, including the preferences of the individual, the size of waiting lists for services and the likely waiting times for treatment (accepting that waiting times will be largely determined by priority cases).

The development of such policies may be helped by national standards of what is an acceptable length of wait for each service. Although these policies would then need to be locally determined, depending on the service and the circumstances, as a minimum they should:

- provide for effective risk management by reviewing clinical priorities for clients on the list
- include ways of keeping patients and referrers informed of the current waiting times for specific agencies and services
- if possible, identify alternative treatment options, including the use of different locations and service providers

Maintaining contact

Agencies and service providers will need to ensure that they have strategies in place that will monitor the situation of each person waiting for treatment. The key objectives of this function are:

- monitor the risk of harm from self or other person
- prevent loss of motivation and where possible enhance motivation as a precursor to entering treatment
- ensure the retention of the individual on the waiting list
- provide alternatives as needs change

Key features of a well managed list:

- clear managerial ownership and control
- senior practitioner and managerial leadership
- clear lines of accountability for the management of the list, and clarity in the roles and responsibilities of everyone involved
- integrated IT systems so all waiting lists within a DAT area can be accessed, interpreted and audited consistently
- consistent application of definitions for national reporting and comparisons to ensure equity for all clients
- early warning system in place to identify unacceptably long waiting lists or times
- data protection of clients' information guaranteed
- information provided to clients on position on list and expected waiting time
- information for the public on waiting lists and waiting times

Key Action Points for Managing Waiting Lists – at Client, Agency/service provider and Integrated services level

Level	Action Point
Client	<p>Enhance motivation of clients on waiting lists Providers should work with clients who are waiting for treatment in order to enhance motivation, prevent loss of motivation due to waiting, and improve retention and the effectiveness of treatment</p>
Agency /Service Provider	<p>Maintain contact with clients on waiting lists Service providers should maintain contact with clients on waiting lists in order to:</p> <ul style="list-style-type: none"> ▪ identify changing need ▪ continue to assess and provide interim support and advice to enable clients to reduce drug related risks whilst waiting for treatment ▪ actively follow-up clients on long waiting lists who have not been in contact for up to two months <p>Providers should not use waiting times to test a client's motivation. It is the responsibility of service providers to help clients remain motivated whilst waiting for treatment.</p>
Integrated Services	<p>Establish clear criteria for prioritising clients DATs should:</p> <ul style="list-style-type: none"> ▪ establish clear local criteria for prioritising clients who need treatment. Criteria should be based on a locally agreed protocol for assessing risk to reduce harm, both to self and others. Protocols should state: <ul style="list-style-type: none"> • the possible <i>outcomes of risk</i> which the protocol aims to reduce or avoid (e.g. overdose, acquisition or transmission of blood borne infections) • <i>who</i> is a priority (e.g. pregnant women and their using partners, prisoners due for release) • which <i>behaviors</i> are priorities (e.g. chaotic drug use, criminal activity) • <i>circumstances</i> that are priorities (e.g. soon to be discharged from hospital) ▪ advise generic services who refer to drug services of the criteria for prioritising clients for assessment

Source: adapted from the National Treatment Agency (NTA) paper "Making the System Work" (NTA 2002)

3. Developing Contingency Plans

The report on waiting times in Scotland by the Auditor General (Audit Scotland 2002) states that it is not acceptable to simply leave a list to grow ever larger; management action is required to ensure that clients do not suffer as a result. Problems such as this need to be actively monitored, and all service providers need to ensure that they have early warning systems and contingency plans in place to identify and manage potential waiting list problems.

Anticipating new demands

Increasing the resource capacity of service providers as a means of reducing waiting times may not necessarily provide the 'breathing space' that workers and service planners may be seeking.

For example, expansion of methadone maintenance treatment (MMT) at Ontario's Centre for Addiction and Mental Health did not result in a drop in demand for the clinic-based MMT treatment programme. In fact the patient population was able to continue to grow. There was a broadening of the patient profile in the programme including patients who were better educated, more likely to be employed and less likely to be currently injecting (although with a significant history of past injection drug use). The expansion in treatment availability did not impact negatively on the existing programme, but rather enabled access for a group of higher functioning opioid dependent patients who were previously being deterred from treatment entry by the large waiting lists and the need for priority access for pregnant and HIV positive heroin users (Brands 2002, Type 3).

Examples of where such new demands and expectations may come from include:

- new developments in criminal justice services, such as DTTOs and arrest referral schemes
- an increase in the prevalence of drug misuse locally
- changes in patterns of drug using behaviour, for example greater use of stimulants such as cocaine
- difficulties in recruiting and retaining suitably qualified staff
- changes within other service providers

Monitoring demand activity

Potential sources of information for monitoring demand activity include: service provider's own process information; the views of service users; data from partner agencies; statistics from the Scottish Drug Misuse Database on numbers of new individuals in contact with services; and national prevalence information.

The monitoring of waiting times is discussed in more detail below.

Key Action Points for Developing Contingency Plans– at Agency/service provider and Integrated services level

Level	Action Point
Agency/ Service Provider	<p>Consider subcontracting elements of service Service providers, in consultation with joint commissioners, should:</p> <ul style="list-style-type: none"> ▪ consider subcontracting elements of their service, if they are experiencing staff shortages or space constraints. For example, a community service with a prescribing function could sub-contract a partner service to run its waiting times support group. By working with its partners and using funds creatively, services should consider extending outwards rather than expanding inwards ▪ consider joint appointments or inter-service arrangements for seconding staff when shortfalls arise due to staff sickness or annual leave. By reimbursing locum costs, GP specialists could be recruited to provide temporary clinical cover ▪ review the caseload and casemix of their staff. Regular team meetings should ensure that a service's total workload is evenly distributed, care plans regularly reviewed, and plans in place to enable appropriate and timely discharge
Integrated Services	<p>Develop a local contingency plan [Action on Waiting Groups²] should:</p> <ul style="list-style-type: none"> ▪ develop a local contingency plan to manage sudden change in the nature and size of demand for specialist drug treatment services ▪ consider scope, and develop protocols for interim services, including prescribing services provided by GPs or local independent contractors ▪ involve primary care and Accident and Emergency services in developing contingency plans <p>DATs should:</p> <ul style="list-style-type: none"> ▪ monitor local trends ▪ aim to gain prior knowledge of plans to disrupt local drug markets
	<p>Forecast demand and supply In accordance with existing guidance, DATs should develop their abilities to forecast new demand as part of the needs assessment process. This information should be considered against current waiting times and existing capacity, in order to identify the possible impact of new demand on the drug treatment system and inform investment decisions</p>

Source: adapted from the National Treatment Agency (NTA) paper "Making the System Work" (NTA 2002)

² There is no equivalent in Scotland at present

4. Monitoring Waiting Times

Consistency in data recording

Consistency in the recording of waiting times information at a local level is required if waiting lists are to be successfully managed. Data received from Drug Action Team Corporate Action Plans suggest that a number of different recording procedures are in place across service providers, statutory and voluntary, both within local areas and across Scotland. Audit Scotland's review of drug services also found different practices operating in the recording of waiting lists.

Monitoring systems

It has been suggested that waiting times for first treatment episodes should only be measured once comprehensive assessment has been completed and a referral for treatment made. While that information may be helpful to the planning and delivery of services, it is a reality that a person's perceived need for treatment prompts referral and that, for this reason, **waiting times should be measured from the date of first referral (or self referral) to the date an individual begins a programme of treatment and care.**

Whilst information systems need not necessarily be the same across agencies and service providers, the data collected, the way it is validated and the way it is interpreted needs to be consistent. A core data set should include at least the following items:

- client details (age, gender etc)
- priority of client
- date of referral
- date of first contact
- date of assessment (if different to first contact)
- date the programme of treatment commenced. In a sophisticated system it may be possible to include the dates that subsequent programmes commenced (e.g. aftercare, rehabilitation)
- date of discharge/referral to other service
- information on 'did not attend' rates

To ensure consistent returns agreed definitions of "waiting time" should be used e.g. maximum length of wait, average length of wait or number of people waiting. A standardised approach to prioritisation and an understanding of the impact of this approach should also be agreed.

Information sharing

Waiting lists contain confidential client-based information and so should be subject to high levels of security access. Only those with a demonstrable need to access the waiting list should be able to do so. Audit Scotland found that not all computerised systems had password protection or an audit reporting facility.

Case study: Good practice in developing waiting list procedures and monitoring waiting lists and times in primary care trusts

Renfrewshire & Inverclyde Primary Care Trust uses a procedures manual, which is given to all those involved in waiting list management. This is also available electronically.

Lanarkshire Primary Care Trust has implemented a comprehensive and effective monitoring system across all its services to manage the time that patients wait according to clinical need. A template has been developed to help clinical teams structure clinical information, helping it ensure consistency in data collection and simplifying reporting mechanisms.

Greater Glasgow Primary Care Trust has developed a comprehensive waiting times reporting mechanism with a standardised approach to all the services it provides.

National Waiting Times Initiative

National work to tackle waiting times in the NHS is currently underway through the National Waiting Times Unit. There are targets in place for inpatient/day case treatment and for the clinical priorities of cancer and heart disease. These national initiatives are being supplemented with local waiting times targets, set by NHS Boards, which reflect local priorities, and which should be identified in Local Health Plans.

A national Waiting Times Database is due to come on-line at the end of 2002. This will contain useful approaches to the management of waiting times in all sectors. It will showcase examples of good practice, some of which may be applicable in a drugs services setting.

There is no waiting time initiative currently operating for drug misuse treatment services. However, ISD Scotland, on behalf of the Executive, has recently gathered detailed information across Scotland on waiting times for drug services to see how this might be improved and monitored in the future. Following analysis of this information it is intended that work be taken forward with the Waiting Times Unit to look at options for the routine monitoring of waiting times, including what national standards might sensibly be set. The options will include the following:

- continue to collect waiting times information through the annual DAT planning arrangements
- monitor waiting times directly from treatment services on a more frequent basis, possibly through surveys on a quarterly basis
- introduce a patient based monitoring system, possibly expanding the existing Scottish Drug Misuse Database dataset

Decisions on how the work will be taken forward will be made later in the year, in consultation with DATs and local agencies.

5. Current Research on Waiting Times – Drug Misuse Research Initiative

The Drug Misuse Research Initiative (DMRI) is a £2.4 million programme of research over the years 2000-2003. It is located within the Department of Health Policy Research Programme and currently comprises 13 studies in the areas of drug treatment and prevention. This includes two studies focussing on waiting times.

Waiting for Drug Treatment - Effects on Up-take and Immediate Outcome (OWL)

This project is headed by Dr Michael Donmall, Director of the Drug Misuse Research Unit, University of Manchester. The project aims to describe the current status of waiting lists and times for drug treatment across England, to study the effects of waiting on treatment uptake and retention, and to investigate the effects of waiting on those seeking treatment. The investigation will have relevance for all those engaged in drug misuse and waiting for care.

The study has three components:

- a national survey of the dynamics and management of waiting lists
- a prospective study of the effects of waiting time on treatment uptake and retention
- an investigation of user perspectives

By identifying critical factors influencing waiting times and their effect, this study will inform policy makers and practitioners, and provide evidence for improved management of problem drug takers at the critical stage of engagement with services.

The project commenced in September 2000 and initial findings from the study will be published around November 2002.

Randomised Clinical Trial of the Effects of Time on a Waiting List on Clinical Outcomes in Opiate Addicts awaiting Out-Patient Treatment

This project is headed by Professor John Strang of the National Addiction Centre.

The project aims to assess:

- if time spent in waiting for treatment initiation is associated with an increased risk of treatment drop-out
- if time spent on the waiting list is associated with changes in substance use and other key treatment variables (such as frequency of injecting, physical health, psychological health and social functioning)
- the economic factors associated with time on a waiting list; and enquire whether it is of policy relevance to know what drug users actually do while they are waiting to begin treatment.

The project commenced in September 2000 and is due to complete in February 2003. Further information on the Drug Misuse Research Initiative is available at:

<http://www.mdx.ac.uk/www/drugsmisuse/>

6. Further resources

National Waiting List Toolkit Project: www.demandmanagement.nhs.uk/toolkit/

Capacity and Demand Management: www.npdt.org/cdm/intro.htm

National Treatment Agency: www.nta.nhs.uk

Audit Scotland : www.audit-scotland.gov.uk

NHS Beacons Learning Handbook: www.nhs.uk/beacons

WEST SUSSEX ADDICTIONS SERVICES – BEHAVIOURAL RISK ASSESSMENT

This form is to be used both at triage, and again after comprehensive assessment and multidisciplinary review of the history. Complete on all clients scoring 2 or more on risk to self/others. Tick whichever box is appropriate (Y for yes, N for no, or ? for unknown) for each question. Total score is the total number of Y's & ?'s.

SELF HARM: Deliberate & Suicide	Y ? N		Y ? N
Depressed mood (subjective)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Impulsivity	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Past history of non-suicidal self-harm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Suicidal ideas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Plans made	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Action taken on plan	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous suicide attempt (give details)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dangerous method (high risk to self & others i.e. irresponsibility)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Discovery avoided	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Final acts (notes etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1. Accidental Overdose	Y ? N	Regular intravenous use	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Poly-drug use	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Injects alone	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
History of past overdoses	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Has witnessed overdose(s) by others	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

HARM TO OTHERS: Aggression	Y ? N		Y ? N
Past history of violence to others (may include sexual violence)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Lack of provocation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Lack of regret	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thoughts/threats of violence	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Paranoid thoughts/delusions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Available weapon	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Identified target	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Impulsivity	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Prone to emotional arousal	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Relevant criminal record	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Conflict	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. Child Care	Y ? N	Currently pregnant	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Responsible for child under 5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Single parent	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Apparently intoxicated while solely responsible for child(ren)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

PERSONAL SAFETY: Self Neglect	Y ? N		
Reliant on others	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Past history	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cannot cope with or needs help or prompting in...		Long term institutional	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Cleaning the house	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Taking care of personal hygiene	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Budgeting/handling money/accommodation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Doing weekly shopping	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cooking for self	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Homeless/no fixed abode (give details)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Road/Machinery Safety	Y ? N		
Drink-drive conviction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Drives/works while intoxicated	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Chronic intoxication but still drives/works	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Drives/operates as part of occupation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Uncaring/indifferent to risk	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Risk/threat from others (give details)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Level of risk for self harm (High/Medium/Low):		Score:
Level of risk for harm to others (High/Medium/Low):		Score:
Level of risk for personal safety (High/Medium/Low):		Score:

WEST SUSSEX ADDICTIONS SERVICES – BEHAVIOURAL RISK ASSESSMENT**Guidelines for use of this assessment tool**

This is a multidisciplinary tool, and may be filled in by anyone who has completed an assessment and/or knows the service user well.

Assessing risk is a fundamental part of work with people with addictions, as their safety is our first goal, even before their recovery. Much of the time we do this informally, even instinctively; but to communicate with colleagues and formally demonstrate that we are caring properly for the service user, a formal process and record clearly shows we have covered the ground and thought of the service user's needs from all angles.

Remember that a single very high risk may be more important than a large number of minor risks.

The only reason to assess risk is to help know what to do about it – so high risks need to be managed. The management plans at the end of the E.T.O. triage document and the care plans at the end of the comprehensive assessment tool are the standard places to record care plans.

In complex cases specific guidance on areas of responsibility may help. The list below aims to help assess and manage the main likely risk areas, and is meant to be used in conjunction with both the Behavioural Risk Assessment tool and, if needed, the E.T.O. Complex Care Plan, which contains guidance on recording risk management, contingency and crisis plans.

The table is meant to be indicative rather than prescriptive. As a very rough guide, the level of responsibility should be similar to the level of risk (provided the patient is consenting to that level of care, and resources permit).

** These responsibilities imply care coordination may be needed. If other agencies are involved, the ETO complex care plan (or, for mental health shared care, the equivalent CPA documentation filled out by a mental health CPA care coordinator) is suggested as the best way of agreeing and recording the care plan.

Substance misuse risks	Substance misuse responsibilities
Physical complications	Harm minimisation
Poly-substance misuse	Detox/substitution
Family problems/child care	Family support/child care**
Homeless/reduced social support	Links with PPP (police/probation/prison)**
Forensic issues	Mental health or general medical services**
Psychological disturbance	Complex care plan (other than as above)**
Violence (victim or perpetrator)	Supportive housing

When to complete this form

- At triage
- At comprehensive assessment (if assessment delayed, or risks significantly altered)
- At any joint assessment process or care planning meeting with another team
- At care plan review meetings in complex cases
- At 3, 6 or 12 month STORS review meetings, if there are significant remaining or new risks

If the risk assessment is being done as part of a shared care plan with the mental health services for a patient with mental health/addiction dual diagnosis and complex needs, here is a complementary set of risks and responsibilities. *The inclusion of psychiatric risks and responsibilities in this table is merely an aid to sharing of care with mental health teams, and should in no way be taken as an indication that Tier 3 drug and alcohol problem teams have the resources, contacts or experience to provide mental health care on their own.*

Mental health risks	Mental health responsibilities
Psychosis	Case management
Deliberate self harm	Relapse management/crisis planning
Poor compliance	Compliance therapy
Reduced social support	Supportive housing
Violence (victim or perpetrator)	Optimised/complex drug therapy

Thanks to Dr. Ken Checinski for permission to reproduce the original version of this table.

NEEDS ASSESSMENT, SERVICE PLANNING AND REVIEW

Needs assessment, service planning, service review and evaluation are key tasks in designing and delivering an integrated care approach. This is a particularly complex set of tasks in the drugs field because of the often wide ranging needs of individual users and the wide range of agencies and service providers that can respond to these needs effectively. We have set out below a four stage process: needs assessment, reviewing existing services, establishing whether services meet existing need and ensuring service provision is adequate. These are not one off exercises, but are part of a **cyclical** process of service review.

1. Needs Assessment

Needs assessment is a critical first step to better understanding the treatment, care and support needs of a population. Conducting a local needs assessment will help to establish the **extent and nature** of the drug problem in the area, to describe the socio-demographic profile of users and to examine the common routes through which clients are referred. This will help build a picture of area population need.

A single 'all purpose' approach to needs assessment simply does not exist. The approach to an assessment exercise will depend upon the characteristics of the area and the data available. Official data sources, prevalence studies, action plans, integrated care plans and the views and experiences of drug users, their families and the wider community can all provide potentially useful information for such an exercise.

In the first instance, DATs and partner agencies need to ascertain:

What data are available locally to inform a needs assessment. These can include: prevalence data, information on attendance and attendees at services, waiting times for services, information on socio-demographic characteristics and identified needs on action plans among others.

What additional data are needed to inform the needs assessment process (e.g. eliciting users' views and experiences, and those of their families).

Whether this can be conducted by the DAT, or whether this needs to be commissioned externally.

A guide on how to conduct needs assessment (specific to the Scottish context) will be produced by the EIU early in 2003. In the meantime, a guide to conducting needs assessment in the substance use field has been prepared by the World Health Organisation (WHO). It is available at: http://www.who.int/substance_abuse/PDFfiles/needsassessment.pdf

2. Reviewing existing services

In conjunction with the needs assessment it will be important to have current information about the appropriateness, accessibility and capacity of existing services. DATs should:

Map out which agencies and service providers are currently involved in developing and delivering services for drug users, including (among others) the number of general and specialist health care professionals, pharmacists, social workers, criminal justice social workers, debt counsellors, housing, employment and training professionals engaged in care.

Identify the relative roles of these agencies and service providers in caring for drug users, identify where partnership working between agencies exists (and where it does not) and ascertain whether there are referral procedures and joint working arrangements in place.

Map out the capacity and characteristics of these services (e.g. opening times, location, waiting times, assessment processes, target client groups, maximum case load and interventions delivered) to help assess how accessible and appropriate these services are to the population of drug users identified in the needs assessment exercise.

3. Establish whether the existing services meet existing need

The next stage will be to examine whether the capacity of both specialist and generic service provision is sufficient. Further, it will be important to assess whether the interventions delivered by these service providers do indeed meet the needs of the local drug using population, and that they are accessible. For example, if there are a substantial number (or a growing number) of stimulant users in your area, you need to establish whether services are attractive to these individuals and whether services are equipped to deal with problems they may present with. This type of exercise is sometimes called a 'gap' analysis. It involves:

Systematic comparison of the needs identified in the assessment exercise with the current level, nature and capacity of service provision in the area.

Identifying where gaps in provision exist, or indeed where services are under-utilised by the drug using population.

4. Ensure service provision is adequate.

If gaps in service provision are highlighted, DATs need to consider how these gaps can best be addressed. For example, if a DAT has identified a growing problem with stimulant use, how is this best managed? Filling gaps in service provision may be achieved by:

developing more effective multi-agency working to ensure a seamless service, ensure that individuals can be moved onto more appropriate services.

adjusting service characteristics: for example, by changing opening times, modes of working and location.

developing new approaches to meet the needs of the local drug using population: for example, by including more psychosocial approaches in treatment programmes.

developing new approaches specifically to target the harder to reach groups: for example, by providing outreach clinics in rural areas, or for women at home with children.