Turning Point Scotland and Simon Community Scotland

Overdose Response Teams Evaluation

Final report

December 2022

indigohouse

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SCOTTISH DRUG DEATHS TASKFORCE

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Executive Summary

Turning Point Scotland Overdose Response Teams

This evaluation has sought to provide insights on the Turning Point Scotland test of change Overdose Response Team Service - ORT. The key aims of the service is to provide a rapid response to near-fatal overdose to provide harm reduction interventions and advice; give a short, focused period of support maintaining contact through assertive outreach and to help individuals connect or reconnect to support services. It is an assertive outreach service including out-of-hours and weekends, reaching out to individuals and linking them to services in their communities. The aim of the service is also to test system change – to identify barriers to engagement with services.

Outcomes

The evaluation showed that the service was able to find people, engage with them, it saved lives and helped individuals engage with other services. There was considerable activity in reaching people in Glasgow, and growing number of cases in Greater Glasgow and Lanarkshire. TPS also worked with Glasgow HSCP in establishing its own statutory Crisis Outreach service.

Time, and the outreach elements of the service were critical for the individuals concerned, and the shortest engagement times had the more favourable outcomes. Referrals directly from hospital appeared to provide one of the quickest referral pathways. Interviews with 37 individuals using the service showed that the ORT service provided a critical immediate overdose response service to save lives, and support to engage with other services. Looking at the 18 individuals re-interviewed, this showed that for most there was an improved situation and 12 out of these 18 had not had repeat near fatal overdoses at the point of the follow-up interviews, around six months later.

> *"The big thing for me is that they came out to me, listened to me and they are helping me to fight the fear that I am not alone. They came to me. You know a lot of people are scared to go out so they came to me... There should be more of this for people. I think they need to get out on the streets and help people."*

External partner organisations rated the outcomes of the service very positively, although a small minority suggested limitations associated with external partners' own organisational resistance to change and embracing the third sector provision. Others identified the benefits of third sector provision including expertise, cost effectiveness and agility. The most positive attributes identified of the service were rapid responsiveness, the assertive outreach and out-of-hours offer, and the TPS staff commitment to individuals. There was a strong appetite for the service to continue, expand its capacity and the length of out of hours offered.

System change was tested, and the most significant system barrier identified was information sharing and there was collective frustration on this from the statutory and third sectors. This was despite good practice being evidenced through a formal information sharing protocol in Renfrewshire, Lanarkshire and a few other examples across Scotland. The inability of many HSCPs to overcome data governance barriers (while a few have been able to do so) suggests that national leadership and guidance is required. The evaluation has shown that collaboration across ADPs has worked for this service, but there were concerns from ADPs about the ability to continue this approach in the long term.

Recommendations

1. **Every ADP area in Scotland should have an assertive outreach response.** The evaluation shows that this model works, and with the key elements that underpin this model - out of hours, assertive outreach and organisational collaboration - it has been shown to be one of the essential elements that can contribute to reducing drug deaths in Scotland. Other elements include access to naloxone, risk assessment and clear pathways for information and support for those at highest risk to prevent crisis (overdose response teams can contribute to both of these), and effective treatment including access to residential rehabilitation.

2. **Collaboration works** and for the local Greater Glasgow and Lanarkshire services, the ADPs should collaborate to continue the Overdose Response service which has already established valuable partnerships in these areas. A steering group could be formed to help the specification, commissioning and monitoring of such an approach.

3. **The current system needs to change to enable these services. The key elements to address the limitations of the current system are:**

    - **Creating better referral pathways and information sharing protocols –** These referral pathways should be embedded through formal information sharing partnerships and protocols, such as the examples provided by Renfrewshire, and Lanarkshire. This may be best achieved when led by the local Health Board and bringing in all other relevant partners.
    - **Breaking down resistance to formal information sharing through national leadership from Public Health Scotland and Scottish Government** - This issue has been such a significant barrier that a national leadership role is required to drive change on this critical problem, quickly.
    - **Working with statutory services to break down the cultural barriers of professional wariness** – this was evidenced in mistrust from a significant minority of statutory services of third sector services. Breaking down these barriers will maximise the number of individuals suffering reached.
    - **Addressing structural barriers** including funding and commissioning, the complexity of which currently stifles the ability of coordinate across ADPs and get the benefits of economies of scale.

4. **The availability and capacity of support services needs to be improved** with key gaps being support services for those leaving institutions to help them access financial support for crises and to support setting up a tenancy, plus housing support and other wrap-around services, but a more general lack of support services for those moving on from crisis is evident.

5. **Developing greater capacity in a skilled workforce** is required for this specialist field and should be addressed through workforce planning undertaken collaboratively with Scottish Government, HSCPs and with the third sector.

1. Introduction and methodology

1.1 The Overdose Response Teams

Indigo House was appointed to undertake an independent evaluation of the Turning Point/Simon Community Scotland Overdose Response Teams (ORTs). The test of change is funded by the Scottish Government and at the outset there were three teams working in Glasgow, Lanarkshire (North and South), and Greater Glasgow (Renfrewshire, Inverclyde, East and West Dunbartonshire and East Renfrewshire). Funding for the services was provided to October 2022, although there has been an extension in some areas until March 2023. This report covers the service inputs and outcomes up until the end of August 2022.

1.2 Background

The Scottish Government Drugs Deaths Taskforce was established in July 2019 to tackle the rising number of drug deaths in Scotland. The primary role of the taskforce is to co-ordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death.

Much of the task force activity will be longer term in nature. There is a need, however, to take immediate steps to help avert the unprecedented trend of drug deaths in Scotland. This will involve tests of change intended to develop specific impact evidence and inform Task Force recommendations for national adoption. To support the work of the task force, a group of frontline workers from a range of organisations operating in Greater Glasgow and the surrounding areas were convened and put forward a proposal to complement current provision to directly address key gaps and vulnerabilities which were identified as:

- The absence of 'out of hours' provision;
- The absence of persistent and assertive 'wrap around' care at point of crisis;
- The inconsistency of intervention and follow-up care after near fatal overdose.

The Turning Point Scotland (TPS) service provides a rapid response to near-fatal overdose (NFO) providing a short, focused period of support to each person and assertively engaging them with mainstream alcohol and other drug services. Evidence tells us that prior non-fatal drug overdoses are predictive of subsequent fatal drug overdoses (64% of people who died as a result of drug overdose had experienced 5 or more previous non-fatal overdoses). Current figures suggest there are at least 55 such incidents per month within Glasgow City Centre. Early and effective intervention can therefore prevent drug related deaths.

The **Overdose Response Teams' aims and objectives** are to:

- Reduce and prevent drug related deaths caused by fatal overdose.
- Improve information and understanding of the extent of non-fatal drug overdose, identify barriers to engagement with services, and inform system change that works for people not services.

- Provide rapid response to near-fatal overdose which provides harm reduction interventions and advice.
- Give a short, focused period of support, maintaining contact through assertive outreach.
- Improve access and engagement to healthcare and support services through assertive outreach and linkage.
- Target people in localities and communities recognising that most drug related deaths occur when people are at home, alone.

1.3 How the Turning Point Scotland Overdose Response Team service works

The Glasgow Overdose Response Team service (GORT) started in November 2020 and has since been expanded to Lanarkshire (North and South - LORT) and Greater Glasgow (East Renfrewshire, East Dunbartonshire, Inverclyde, Renfrewshire, West Dunbartonshire - GGORT). The ORTs obtain referrals of individuals that have overdosed mainly through statutory services including Alcohol and Drug Partnerships/Services, other parts of Health and Social Care Partnerships, wider local authority services and a range of voluntary sector services. Through assertive outreach in the community the ORT Harm Reduction Practitioner (HRP) will then find and engage with the individual that has experienced an overdose with the aim of reaching them within a short period of time. The services is available out-of-hours until 10pm during the week, including over the weekend. Some individuals may be in immediate danger and require administration of naloxone, others may not as they will have already been in hospital or been seen by paramedics. After the immediate risk is addressed, the HRP will go through the ongoing risks with the individual, many of whom are not aware of the cumulative risks of overdoses. They will take a holistic approach talking through any recent social and medical life changes, whether they are known to services, and see if they can connect or reconnect them to services. There are two call backs to the client; while not providing ongoing support, the HRP aims there is a 'planned closure', aiming to ensure the individual is linked up to services e.g. social care or prescriber.

In addition to the engagement with individuals, the HRPs undertake training and awareness in the community e.g. supported housing, clubs, e.g. connecting with football clubs, other leisure and social clubs Tesco, foodbanks, shopping centres. A large part of the ORT co-ordinators and managers' work is to engage with the HSCP, Scottish Ambulance Service, Police Scotland and range of voluntary sector services to promote the service, work in partnership with these services, seek methods for information sharing, ultimately to achieve as many referrals as possible to ORT.

The TPS ORT model assumes:

- For Glasgow – originally this involved 8 specialist outreach staff with 2 coordinators. The service was in place between October 2020 and May 2022 and experienced 400 outreach cases, approximately 30-40 per week. The original target was for 1,000 cases in one year.

  TPS and Glasgow HSCP approached the Drug Deaths Task for funding for crisis overdose response services at a similar time through a parallel process as both wanted to meet a need and take up the resourcing opportunities through the Taskforce. TPS was able to set up its service quickly by October 2020, while there was ongoing joint working with the HSCP as it developed and rolled

the in-house statutory overdose response service (the Crisis Outreach Service) from February 2021. The statutory service drew on the lessons learned from the TPS GORT test of change with TPS involved in this strategic change in the City including training of the HSCP staff. In reading this evaluation it should be noted that the referrals dropped to the TPS service as the Glasgow HSCP service was developed and explains why the original target of 1,000 referrals was not met. Glasgow ORT ceased operating in May 2022 and so the data presented here for GORT covers only the Interim period – the first full year of operation of GORT.

- Lanarkshire – was set up July 2021 with 4 outreach staff and 1 coordinator
- Greater Glasgow – was set up September 2021 with 8 outreach staff and 2 coordinators.

1.4 Evaluation methodology

The **questions for the evaluation** were:

- Is the service making a difference to individual outcomes – can the service find people, can it engage with them, can it help them take up other services?
- Is there a group of people the service is not reaching – who are they and why?
- Is the service making an impact on system change – are there any differences by location (urban/city) and why?
- Is the service making a difference to information sharing across the various different services that work with people experiencing near fatal overdoses – what are the barriers to information sharing, from whom and what can be done to resolve these?

Indigo House started on the evaluation in September 2021. Interim findings were provided in April 2022, with this report updating those findings.

The **evaluation framework** below sets out the evaluation questions, and the method through which these have been answered.

Aspect of evaluation	Method of evaluation
Is the service making a difference to individual outcomes – can the service find people, can it engage with them, can it help them take up other services?	▪ Secondary data analysis ▪ Service user interviews ▪ Partner survey and interviews ▪ TPS ORT staff and manager interviews
Is there a group of people the service is not reaching – who are they and why?	▪ Secondary data analysis ▪ Partner survey and interviews ▪ TPS ORT staff and manager interviews
Is the service making an impact on system change – are there any differences by location (urban/city) and why?	▪ Partner survey and interviews ▪ TPS ORT staff and manager interviews
Is the service making a difference to information sharing across the various different services that work with people experiencing near fatal overdoses – what are the barriers to information sharing, from whom and what can be done to resolve these?	▪ Partner survey and interviews ▪ TPS ORT staff and manager interviews ▪ Comparative research with other services in Scotland

The **secondary data analysis** includes case management data from Glasgow, Greater Glasgow and Lanarkshire, feedback surveys and data from monitoring reports. This analysis was supplemented by analysis of case studies which provide more detailed insights of interventions and outcomes. The case management data analysis covered a year of operation for Glasgow (the Interim period) and the full period of operation of operation for Greater Glasgow and Lanarkshire until 30th August 2022. As more data is available for Glasgow, some trend analysis is available for the Interim period, with more detailed analysis of outcomes by age, sex and other circumstances possible for Greater Glasgow and Lanarkshire by the endline.

Qualitative research with individuals who had engaged with the Overdose Response Service, and their families involved a total of 23 men and seven women and five parents who were interviewed from November 2021 to September 2022. Ten individuals came from Glasgow, ten individuals and five parents from South Lanarkshire and ten interviewees from Greater Glasgow. Re-interviews with the same individuals took place between two and nine months after the initial interview (with the time varying due to the timing of the initial interview driven by the stage of the service in the different areas). The average length of time between interviews was six months, with some (five) less than five months. In South Lanarkshire, all the re-interviews with individuals and family members were achieved through support given by the ORT team. In Glasgow five re-interviews were achieved and information on two people established through contact with the former ORT service in this area. In Greater Glasgow, only three of the original ten were re-interviewed due to a range of circumstances. Information on another four originally interviewed from the area was established through contact with other services. In order to provide more information for the work happening in Greater Glasgow an additional seven interviews were achieved through the team, four females and three males. The ages of interviewees ranged from 21 years to mid 50s. All these interviews (30 original individuals plus five parents, 18 re-interviews and seven supplementary – 60 in total) were against a target of 30 interviews, 10 from each area, with subsequent follow up interviews at the end stage of the evaluation (60 in total). All interviews were in-person, apart from two undertaken by phone, were semi-structured and lasted typically 1.5 hours.

Qualitative research with TPS staff – Harm Reduction Practitioners, Co-ordinators, and Managers – were initially undertaken through three focus groups and one interview, involving twelve staff members from across the three Overdose Response Teams in Glasgow, Greater Glasgow and Lanarkshire in February 2022. The team in Glasgow were no longer operational by the final report, and so two follow-up focus groups and three individual interviews with the staff took place in South Lanarkshire and Greater Glasgow in August 2022.

External partners were consulted at Interim stage through a **partner online survey** which was issued to 53 contacts from which a total of 28 responses were received. That is a response rate of 53% overall, which is reasonable for an online survey. The small number of cases involved means the results from the survey need to be interpreted with caution. Follow up **in-depth interviews** were held with 8 key stakeholders from across Glasgow City, Lanarkshire and the Greater Glasgow areas at interim stage. Further interviews were sought through the summer 2022, so that by the end stage a total of 17 in-depth interviews had been undertaken by telephone/MS Teams (against a target of 15). These involved representatives from across the three areas from NHS (hospitals), Alcohol and Drug Partnerships, HSCP Alcohol and Drug services, and third sector service providers. At the end stage of

the evaluation in-depth interviews were also undertaken with individuals from two organisations with a national policy interest/focus on addictions, and with services providers in Aberdeen as a comparator, particularly around information sharing protocols.

All those participating in the evaluation were taken through UK GDPR requirements and assured of non-disclosure and that summarised key themes would be reported, with quotes included where relevant. All quotes are anonymised, with fictitious names for individuals that have used the ORT service, and non-disclosive illustrative case studies are also provided. For the partner survey quote and in-depth interview quotes, these are identified by GORT – Glasgow, LORT – Lanarkshire, and GGORT – Greater Glasgow areas.

1.5 Report structure

The report is structured in line with the objectives of the evaluation:

- Individual outcomes
- Who the service is reaching and not reaching
- System change and information sharing
- Summary and conclusions.

2. Individual outcomes

This section considers the question of whether the service is making a difference to individual outcomes - can the service find people, can it engage with them, and can it help them take up other services? The following sets out analysis of outcomes drawing on secondary data, qualitative research with individuals that have used the service, and opinion from stakeholders. Appendix 4 sets out detailed monitoring data by ADP area.

2.1 Referrals

The services rely on referrals to be able to access people in need of support. In **Glasgow (GORT)**, throughout the first twelve-months (November 2020-October 2021), the main source of referrals was the Alcohol and Drug Recovery Services, followed by the bulk A&E list. Comparison by quarter showed significant differences, with the Homeless Addictions Team (HAT) providing 39 referrals in the first quarter and 148 referrals in the second quarter but just seven referrals across the last two quarters. The Glasgow HSCP Crisis Outreach Service Team (COS) had referred 46 people in Quarter 3 and other statutory sectors 51, but they referred fewer than ten each by Quarter 4. As noted above the COS team were newly established as an overdose response team in February 2021, and overtime cases were dealt with by COS and therefore referrals to ORT naturally reduced.

Table 1: Source of referral by Quarter – GORT (1 November 2020-31st October 2021)

Referred By	Q1	Q2	Q3	Q4	Grand Total
A&E List			29	71	100
Ambulance			1	1	2
Glasgow Crisis Outreach Team			46	5	51
Glasgow Royal Infirmary	2				2
HAT	39	148	6	1	194
Housing		6	6	4	16
Hunter Street	15		17		32
Navigators			4	1	5
Ne Gadrs	11	25		13	49
Nw Gadrs	16	26	12	1	55
Phoenix Team				4	4
Police	1			1	2
Qeuh			1		1
S Gadrs	8	22		6	36
Self	1			2	3
Statutory Sector Other	5	16	51	8	80
Street Team	1	3	10	4	18
Vol Sector	8	16	17	18	59
Grand Total	**107**	**280**	**206**	**116**	**709**

Source: GORT case management data

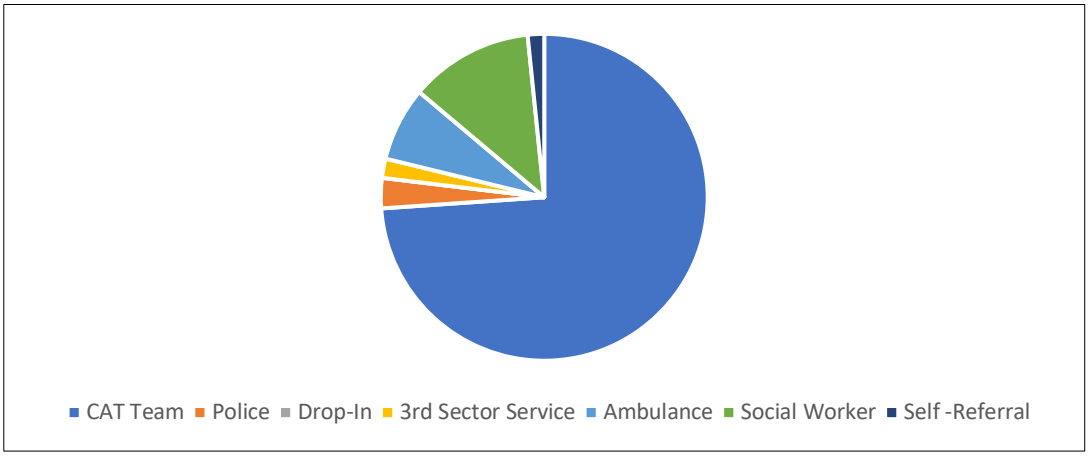
By the last quarter of this first year of operation, the A&E list was up to 71 referrals from 29 in quarter 3 and no referrals in the first two quarters. Referrals from the ADRS also peaked in quarter two, at 73 referrals, but in Q4 were down to less than a third of what they were in Quarter 2 and below Quarter 1 levels. It is also notable that there were only 2 referrals each from the Glasgow Royal Infirmary hospital and the Ambulance Service for GORT. By the end of 2021, the GORT team was relying heavily on the A&E list with some referrals from voluntary sector and other sources, with referrals falling. **Overall, there were 59 referrals per month over the first year of the GORT team.** If the target of 1,000 referrals had been met, this would have been 83 referrals each month. Due to the very low number of referrals after the first year of operation, it was decided to exclude analysis of GORT from November 2021 onwards as the number of referrals was so low due to the established COS team.

The **Greater Glasgow** ORT (GGORT) service started in late 2021. Over three-quarters of the referrals in the first four months of operation – 75 of 99 referrals – were from the **Community Addictions Team** (CAT team). The other referrals were from the Police, drop-in centres, 3rd Sector Services, Scottish Ambulance Service (SAS), Housing and Social Work.

By the end of August 2022, there had been a total of 368 referrals across the GGORT service (between 20th September 2021 and 31 August 2022). That represents an increased referral rate from around 25 referrals a month in the first 4 months to an average of **33 referrals a month over the whole period**.

Across that 11-month period, the CAT team was responsible for around three-quarters of referrals, with Social Work and SAS the next most common referral source, followed by the Police. Third sector and self-referrals were less common.

Figure 1: GGORT referral sources (September 2021-August 2022)



Source: GGORT case management data

In **Lanarkshire** the ORT (LORT) service started in July 2021. Of the 81 cases in the database across the first four months of operation, the most common referral routes were Addiction Liaison in hospital (21 referrals) and Navigators in hospital (13) followed by Community Addiction Recovery Services (CAReS) (10) Crisis Overdose Response Team (CROT) (10) and supported accommodation providers (9). **Hospital referral was more significant in Lanarkshire** than elsewhere.

By the end of August 2022, LORT had received a total of 215 referrals. **This means that the referral rate has gone down in Lanarkshire, from around 20 referrals a month in the first 4 months to around**

17 referrals a month across the whole period. The table shows that the early months were skewed by very high referrals in October 2021. Referrals were at their lowest in June 2022, at eight referrals, increasing to 19 referrals in August 2022. Once the data sharing was put in place in Lanarkshire and with the Scottish Ambulance Service (September 2022) it is expected this will result in higher referrals. This drop in referrals was associated with a period of low staff capacity due to staff turnover. The very tight capacity in the workforce in the addictions field (and wider health and social care generally) across Scotland was noted by TPS staff, by external local partners and by national key players. It is clear from consultation that the short-term 'test of change' nature of this project has accentuated the workforce challenges and continuity as people seek out more permanent employment opportunities in a market where there are staff shortages.

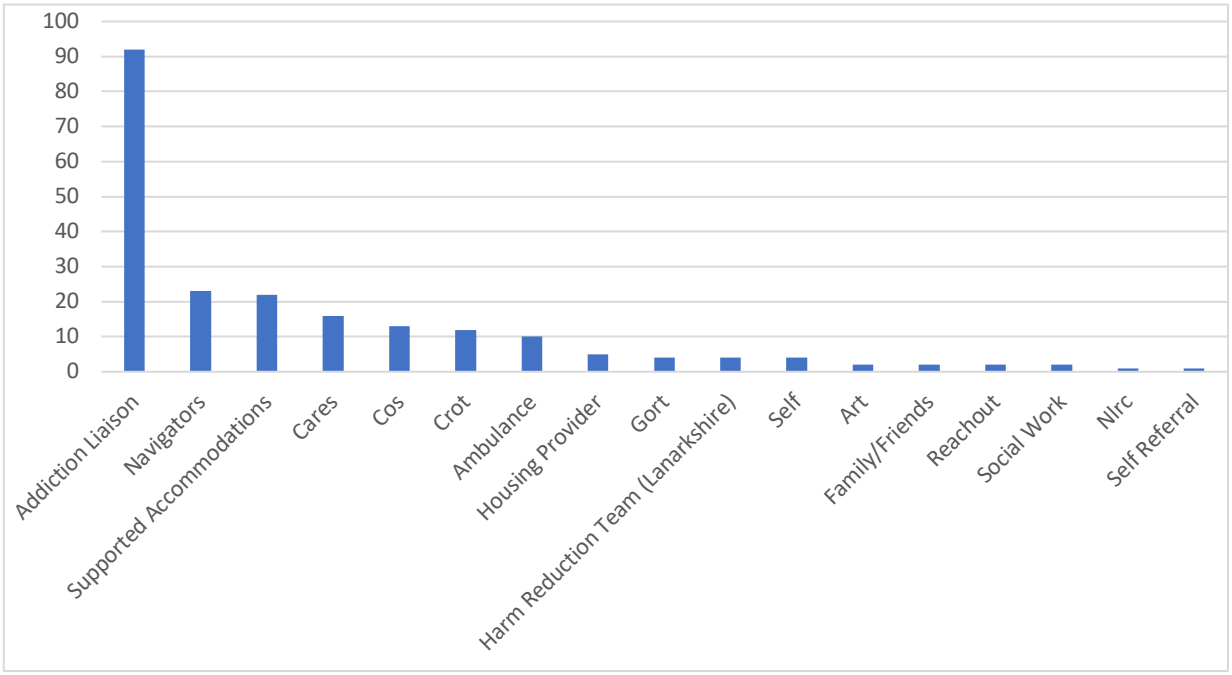
Table 2: LORT referrals over time (July 2021 to August 2022)

2021	**96**
Jul	2
Aug	10
Sep	14
Oct	34
Nov	21
Dec	15
2022	**119**
Jan	17
Feb	12
Mar	16
Apr	17
May	16
Jun	8
Jul	14
Aug	19

Source: LORT case management data

As the figure below shows, referrals from hospitals – from Addiction Liaison and Navigators – have remained very important in Lanarkshire.

Figure 2: LORT referral sources (July 2021-August 2022)



Source: LORT case management data

The fall in referrals in Glasgow in the last quarter of the first year of operation corresponded to a period where referrals were increasing in Lanarkshire and Greater Glasgow (as noted above which coincided with the COS service). The increasing referrals in the other areas reflected the fact that there were **few, or in some areas no other services that provide an assertive outreach service which is also out of hours**. The more recent reduction in referrals in Lanarkshire coincided with staffing issues, which had been resolved by August 2022.

2.2 Interventions

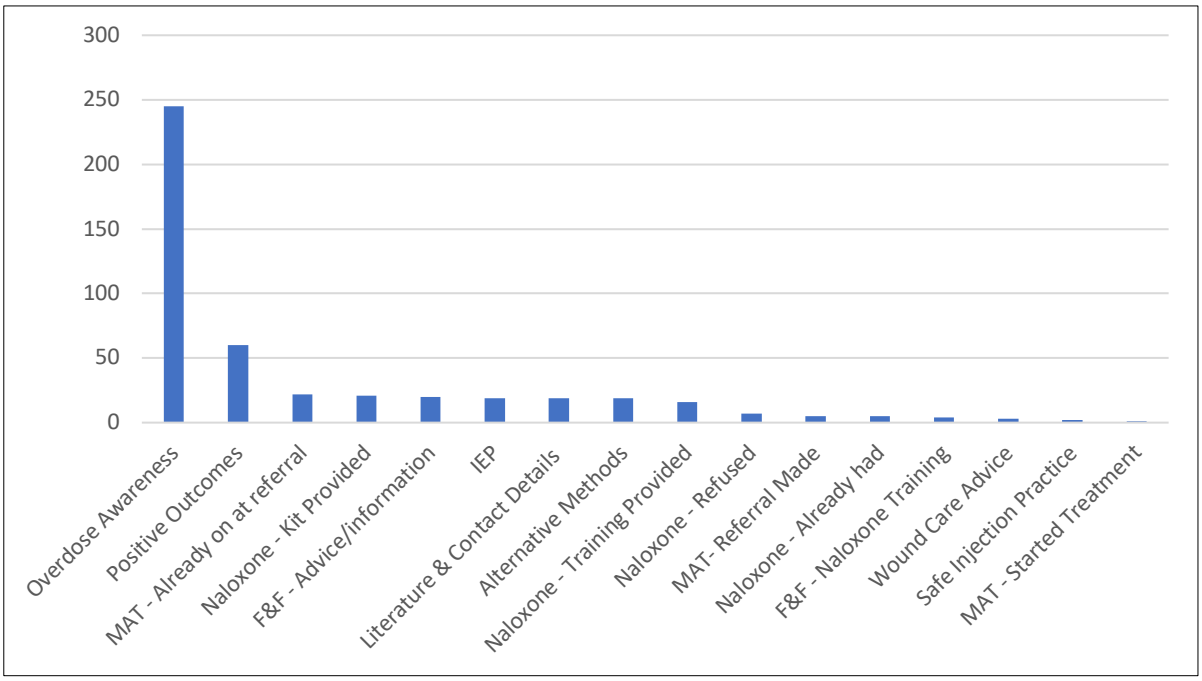
The management data provides an indication of the efforts made to contact people who have had a near fatal overdose.

The **Glasgow** 12-month monitoring report reported 3,397 interventions within the twelve-month period with 1,137 phone contacts, 417 emails, 286 face-to-face contacts and 256 outreach engagements. Key interventions include discussion of alternative routes for drug administration (423) overdose awareness (186) discussing safer injecting (80) providing Naloxone (72) and recovery literature (56). 71 Naloxone kits were dispensed, 15 instances of Naloxone training provided and 8 referrals for MAT recorded. As noted earlier, data was not collected for the period from November 2021 onwards due to the significant reduction in referrals as the COS replaced the service provided by GORT.

In **Greater Glasgow**, the most common interventions reported in the Interim data analysis report were - Overdose Awareness (245) Positive Outcomes (60) MAT - Already on at referral (22) Naloxone - Kit Provided (21) and Advice/information (20). 57 Naloxone kits were given out by 31st December 2021 with 16 cases of Naloxone training recorded and 5 referrals for MAT (with 22 already on a referral).

By the endline point of 31st August, a similar profile of interventions was apparent, with overdose awareness being the most common type of engagement, followed by positive outcomes.

Figure 3: GGORT type of service engagement (September 2021-August 2022)



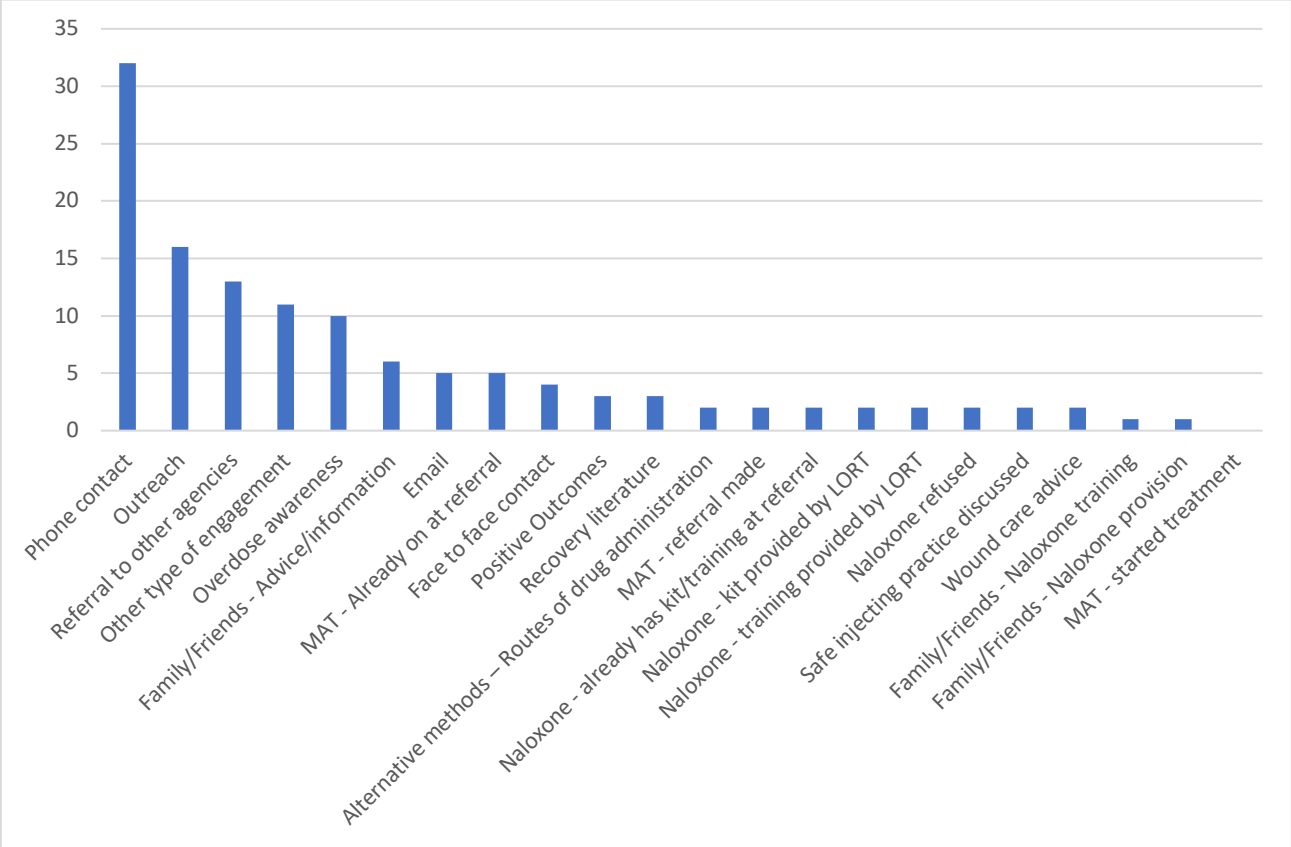
Source: GGORT case management data

In **Lanarkshire**, the most reported activities at the interim stage, from the latest monthly report were phone contact (22) outreach (16) referral to other agencies (13) other types of engagement (11) and overdose awareness (10). 8 training sessions for Naloxone were completed with service users and 8 with family and friends, with 6 referrals for MAT made. In LORT, the latest period (April-August 2022) showed a similar activity profile.

NHS data for Greater Glasgow and Clyde for the period from 1st November 2020 to 31st October 2021 found that **163 individuals** were supplied with Naloxone. This provided an annual benchmark to revisit at the end-line.

During the period between September 2021 and August 2022, Greater Glasgow reported providing 77 unique clients safer injecting kits (IEP), with 137 transactions across these service users, and provided 215 Naloxone kits, with 135 kits being the first supply. **In Greater Glasgow alone, this indicates a far greater use of Naloxone than in the previous year across the ORT for the whole of Greater Glasgow and Clyde.** This is likely to relate to the context withing Greater Glasgow, where the GGORT is the main provider of Naloxone, while in other areas other partners also issue Naloxone to service users.

Figure 4: LORT type of service engagement (April -August 2022)



Source: LORT case management data

LORT data found far more modest levels of Naloxone being issued in Lanarkshire, with 53 Naloxone kits given out between April and September 2022 and only one person provided with safer injecting materials. This indicates the different role of the LORT compared with GGORT, with GGORT the main provider of Naloxone but LORT one provider among many. Safer injecting is also less commonly required in LORT, due to the relatively low number of overdoses with heroin (13) compared with GGORT (69).

Time to engage

The interventions are aimed to be delivered within a **short space of time** after the NFO, to be able to have maximum impact.

In Glasgow, the average time to engage at the interim stage was 2.3 days but this reduced from 2.3 days in Quarter 1 to 1.2 days in Quarter 4 (increasing to 3.2 days in Quarter 2, when referrals were at their peak). Overall, 7 out of 10 cases saw engagement within 2 days, ranging from just over half in Quarter 2 to almost 9 out of 10 cases in Quarter 4. **Performance on time to engage may be better in Quarter 4 because more of the referrals are from the A&E waiting list rather than the ADRS, though it may also relate to smaller overall caseloads.** The data from November 2021 onwards has not been analysed, since the referrals dropped off so significantly when the COS came on-stream, this would not be a helpful comparison.

In Greater Glasgow, during the interim stage it had taken on average 2.3 days to engage, with more than three-quarters being engaged within 2 days. At the endline evaluation point of 31st August 2022, Greater Glasgow's average time to engage stood at 2.6 days, with 8 out of 10 people engaged within 2 days – a slight improvement to the interim position.

In Lanarkshire the average time to engage was just 0.6 days at the interim stage, with 9 out of 10 people engaged within 2 days. In Lanarkshire, across the whole period from July 2021 to August 2022, the average engagement time was just 0.5 days, with 9 out of 10 people engaged within 2 days – the same performance as at the interim stage.

The lower times to engagement in Lanarkshire may relate to the fact that Lanarkshire receive more referrals from hospitals – through Addiction Liaison or Navigators. It should also be noted that Lanarkshire only works with people experiencing NFOs, whereas GGORT also works with those at risk of NFOs which suggests that where a preventative approach is also this has a resource implication.

Outcomes

The majority of cases closed with the positive outcome of engaging with other services – at the interim stage this was the case in 7 out of 10 referrals in Glasgow, and Greater Glasgow and 8 out of 10 referrals in Lanarkshire. At the endline, Greater Glasgow's average time to engage stood at 2.6 days, with 8 out of 10 people engaged within 2 days – a slight improvement to the interim position. In Lanarkshire, the average engagement time was just 0.5 days, with 9 out of 10 people engaged within 2 days – retaining the same performance as at the interim stage. As noted earlier, Glasgow engagement times was not analysed at endline due to the drop-off of referrals towards the end of 2021 and the ending of the service.

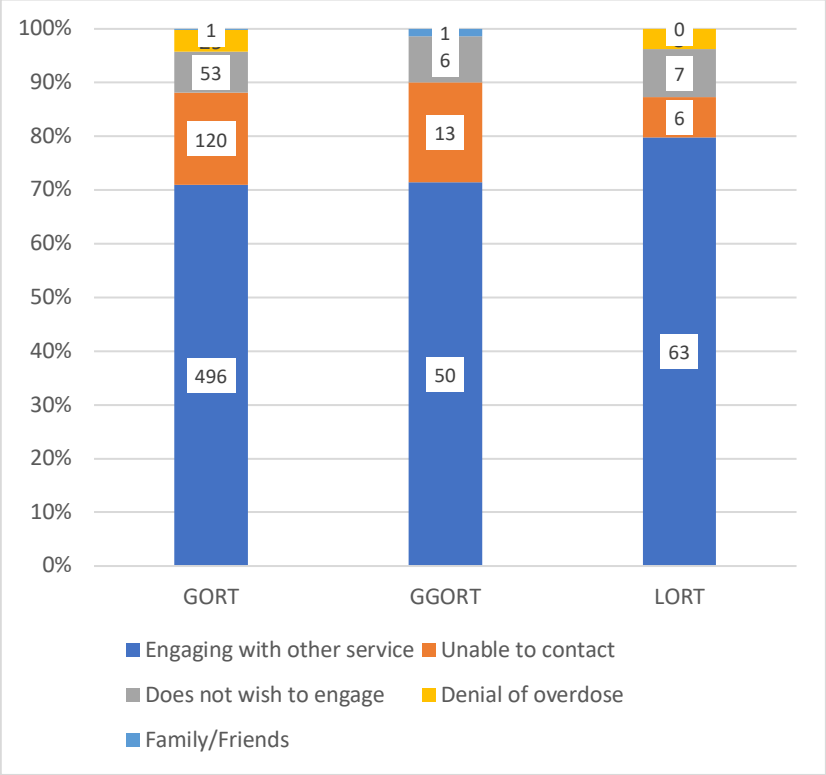
In terms of **engagement from individuals**, around 1 in 6 cases in Glasgow and Greater Glasgow and around 1 in 10 cases in Lanarkshire, workers were unable to make contact with the person that they had received a referral for. Fewer cases ended with people not wishing to engage – less than 1 in 10 cases in each area.

By the endline evaluation point of 31st August 2022, in GGORT the engagement rate was lower overall, with 52% of people engaging with services (compared with 7 out of 10 at the interim stage), 25% no contact and 23% not wishing to engage.

Lanarkshire appeared to have favourable outcomes at the interim stage, compared with Glasgow and Greater Glasgow – which may indicate the benefits of shorter engagement times and a different referral pathway, with more referrals directly from hospital. **In Lanarkshire, by endline, outcomes remained more favourable**, with almost three-quarters of service users in contact with other services at case closure (compared with 8 out of 10 at the interim stage).

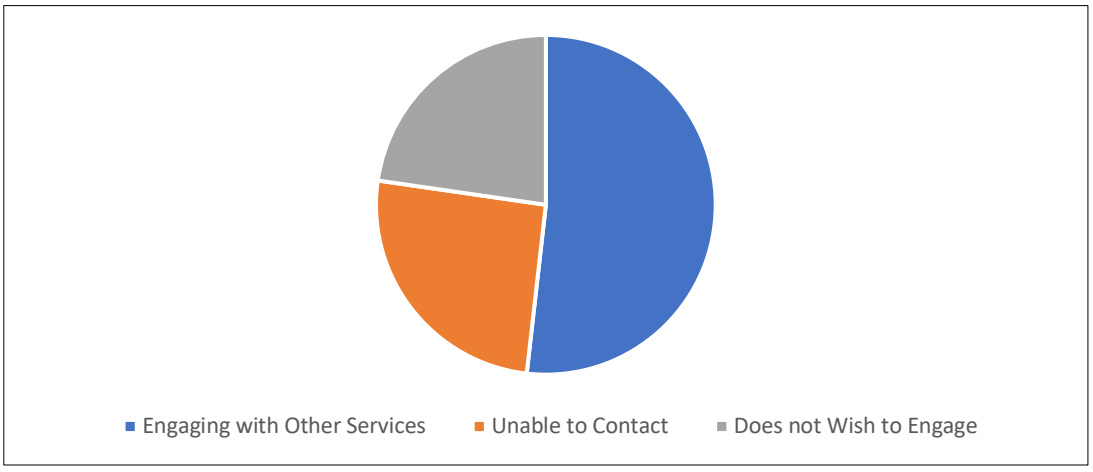
Glasgow also had fewer no contacts in Q4 than previously, which may indicate the benefits of reduced contact times and more referrals from the A&E list, or more refined referrals coming through the HSCP/COS. No data is presented for endline due to the ending of the service, after significantly reduced referrals.

Figure 5: Outcomes by location (Interim stage, all locations)



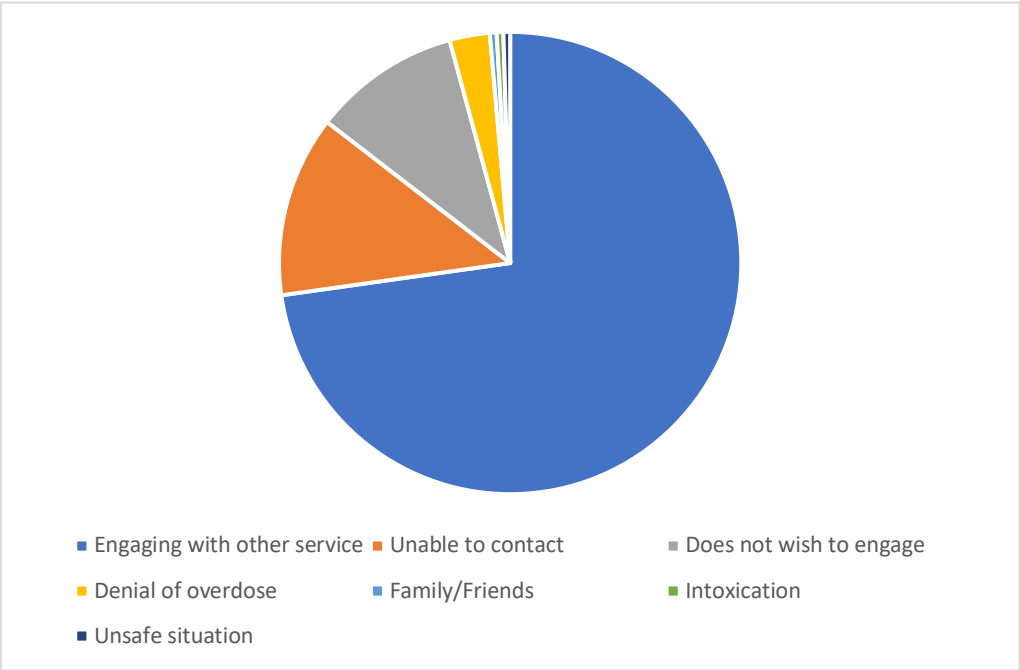
Source: Case management data

Figure 6: GGORT case status at closure (September 2021-August 2022)



Source: GGORT case management data

Figure 7: LORT case status at closure (July 2021-August 2022)



Source: LORT case management data

Referral on to other services is an important aspect of the work of the ORTs. In Glasgow, Hope Connections was one of the main referral sources the team referred on to. Hope Connections offer practical help such as mobile phones and peer support.

Partnership work also developed regarding referrals and overdose prevention pathways with Glasgow Drug Crisis Centre and Jericho House, which offer rehabilitation options. Other supported accommodation providers had been a source of referrals but also received overdose awareness training, Naloxone training and kits to support overdose prevention activities. GORT delivered presentations to encourage referral among a wide range of agencies across housing providers, support services and third sector agencies.

Case studies from **Glasgow** up until the interim stage showed a range of key outcomes for service users, including –

- Reconnecting with their care manager or the addictions team being facilitated by GORT, where they had lost touch or stopped engaging
- Raising or responding to wellbeing concerns with other service providers
- Accessing peer support services and family support services (e.g. Hope Connections)
- Help to link into health services for ongoing mental health issues or prompting to attend their GP, community pharmacy, etc.
- Linking to community pharmacy services (Phoenix) when not attending for methadone or where wound care/BBV is a concern

- Support accessing homelessness services or more suitable supported accommodation
- Help accessing residential rehab and support with preparing for detox (e.g. detox diary)
- Help accessing financial assistance or food assistance.

In **Greater Glasgow**, examples of outcomes across the interim and endline stages included –

- Overdose Awareness and Naloxone (with kit) training to service users, members of staff in supported housing, a young person's group and people in homeless accommodation
- An important strand of work is providing welfare checks at accommodation and ongoing liaison to help harm reduction/risk management, assertive outreach, and repeated visits to try and engage. This is often out of hours and can involve seeking out individuals in the community, using networks in other agencies.
- There were examples of complex cases with multiple previous NFOs, with the GGCORT team continuously delivering safer drug consumption interventions, alternative drug consumption routes, harm reduction intervention & advice, naloxone provision, medication assisted treatment advice and referral pathways.
- There are also examples of liaison across multiple agencies – care managers, HAT, pharmacy outreach and Social Work, as well as the Custody Team, including a case where there was a high risk to physical health but also instances where the lack of statutory provision such as same-day referrals or out-of-hours care has increased the risks of NFOs for some people, with the GGORT providing ongoing support until statutory services can respond.
- Assertive outreach and partnership working involves implementing the new MAT standards MAT3 and MAT4 – that all people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT, with harm reduction strategies offered on an ongoing basis.
- GGORT workers have provided help to service users in accessing advocacy services, mental health services and family support services as well as assisting them to access more suitable supported accommodation and tenancy support, linking with social work and housing services
- Referrals have been made to the pharmacy outreach team and HAT to access support where currently none was in place, including reconnecting to services and restarting MAT and providing assistance to support people attending assessments for rehab and ongoing support until admitted. These are very active, supported referrals with ongoing outreach to support in the interim, where there are delays or where out-of-hours support is needed.

In **Lanarkshire**, across the case studies collected at interim and end-line stage, referrals were reported to various agencies, most commonly Beacons, The Reachout Team, Addictions Recovery Team (ART) and North Lanarkshire Recovery Community (NLRC).

Examples of interventions and outcomes for service users include –

- Out of hours visiting in hospital as part of outreach activity, then assisting to access support services. Also, very intensive, and repeated assertive outreach at numerous locations to increase the chance of making contact and enabling the intervention.

- Facilitating the discussion of treatment options for very high-risk service users, including the example of a high-risk service user with multiple NFOs who is reluctant to engage with any services. This case has involved numerous welfare checks and liaison with multiple services to identify where and how engagement could be facilitated. This again shows a strong focus in meeting MAT3 and MAT4 standards.
- Linking family to multiple supports – social work, housing, and addiction support with active referral and support to access rehab services, with partnership working across agencies, including softer 'handover' in cases where service users are more comfortable with LORT than other support services and are reluctant to move on to others who they have not built up the same rapport with yet.
- Connecting to support services and mental health services and linking back to Throughcare services, with referral for peer support also.
- Linking into services, encouraged to attend online recovery meetings, and accessing detox care, including linking to addictions services and support services for the first time, with access to medical detox services, with some service users struggling to meet the requirement for these without support (e.g. help with drug diaries, etc.).

Alongside these multi-agency referrals, which take place quickly to connect and reconnect people to the support that they need, there is all the 'brief intervention' activities across the three areas – including overdose awareness advice, safer injecting advice and kits, Naloxone advice and kits. This includes outreach at home, in supported accommodation, working with the street team and outreach in hospital.

2.3 Experiences of individuals using the Overdose Response Team service

A total of 37 individuals were interviewed who had received ORT services (of these 18 were re-interviewed) and a further five parents were interviewed (a total of 60 interviews). The largest group of people said they were referred to the ORTs from hospital (20). Other referrals included Addiction services (8), Supported Accommodation (2), the Scottish Ambulance Service, homeless services, Job Centre, drop in centres, criminal justice social work or direct referral. All five parents found out about the service through their child. Most interviewees who were referred could not remember the exact circumstances at the point of referral and described their life at this point as having been 'a blur', due to the extent of their substance use and state of mental health at the time. All interviewees self-reported that they had hit crisis point.

"I got released from hospital for drug-induced psychosis. I had severe paranoia, I was on a different planet, totally gone and didn't want to even leave the house. Everything was gone. I was linked in with them after my near fatal overdose." (Donald)

Challenges Faced

Interviewees were asked about the challenges they faced in their lives. One of the most striking findings is that nearly all (34) of interviewees said they had felt isolated and were without any support in their lives at the point at which they met the Overdose Response Team, despite around a half (17), also reporting having had previous or current connections to services. Two women said they suffered

from agoraphobia. Some interviewees (11) reported struggling to deal with past sexual, physical and emotional abuse and the long-standing adverse impact this had on their feelings of self-worth, some also hinted that they had also been affected this way.

Some (12) described living in a 'bad area' in housing of poor condition and not knowing anyone and this had negatively impacted on their lives. People were living in very deprived areas and felt the quality of housing and internal amenities was exceptionally poor. Several examples were found where the interviewees had moved to an independent flat from various situations (supported accommodation, hospital, prison) where there were no white goods, curtains or a bed, heating or electricity and did not have the financial means or sometimes the life skills to obtain these. From these interviews, the support to help people start off afresh was lacking. One man who had a smashed window at the first interview with glass on the floor, with makeshift scraps of carpet making up the flooring and no heating. Although he was not at home when attempts for a further interview were made five months on, it was notable that the glass had still not been fixed five months later. He had a social worker but said they would not come out to the house. Another woman moved into a flat with no furniture and a male neighbour upstairs who was using drugs had given her furniture; she felt not having what she needed and having to rely on others for help, meant she was vulnerable and exposed.

One man who had just come out of hospital, described coming out to no support at all, with no heating in the flat, and no food. One young man who had spent twenty years in prison said he had 'no life skills' and had not been taught how to manage a household when he was in prison. He explained he had been receiving letters about his gas and electricity bill but didn't know how to pay them. When the worker looked into it, he was paying for an internet connection but did not even have a modern enough phone to use it. Although the man was entitled to statutory social work support, he had been 'missed' because he had been back on remand but found not guilty and re-contact with social work had not been established.

"Being in this place on my own in the middle of nowhere. I didn't know it and I was not in a good place…The biggest part of relapse is isolation and just that feeling of being disconnected…They should not be putting people into a flat with a blow up bed and no life skills. The lack of support needs to change…the (recovery) groups I would normally go to were miles away. I had no family there either… I know that I need people round and about me that make me feel that sense of belonging and I am not alone." (Peter)

"When I had got out of the hospital, the Council had come in whilst I was away and turned off my gas, so when I got back out nothing was working and they (The Overdose Response Team) were able to help with that. The Council can be brutal." (Donald)

""I am heavy struggling. I was in prison for 20 years and was remanded for another offence and then out and so I lost all of my support. I just feel like people say they will get things sorted for me and then nothing happens. I shouldn't have to keep on at people to get things done. I basically sit here all day and evening and do that day in day out, and then when I get my money, I get mad with it." (Jay)

These service users would be eligible for discretionary financial support from the Scottish Welfare Fund – a Community Care Grant and/or Crisis Grant – as those leaving institutional accommodation are a priority group, but they need support to ensure that they get the financial and other help that they require.

Some participants (13) said they had mental health issues, specifically depression and anxiety that had not been treated. Two people said they had psychosis and one woman had been diagnosed with bi-polar disorder and was in the process of getting the appropriate medication. Several others (9) had suffered recent unexpected bereavements of partners or close family members, and/or relationship breakdowns. One woman was in the process of undergoing tests for cancer. Some interviewees (9) also spoke about how they had completely lost hope and spoke openly about feeling stigmatised. In almost all cases, interviewees had a long-standing issue with substance use and this had escalated prior to their overdose.

"I had lost the wee ones…I was taking smack, crack and valium and I had hit rock bottom." (Joanne)

"Before coming in here (into supported accommodation) I was hectic. I was trying anything and everything." (Lisa)

"I was taking 60-100 street valium and my head was gone and I was drinking a lot. I had hit rock bottom." (Ian)

Around half of those interviewed (17) reported that services they were meant to be getting support from, such as their Care Manager or housing officer were hard to reach, or had not given them the support they felt they really needed.

"My Care Manager I haven't seen her in nine weeks. That is no good for me… I have a housing officer and she is like the Scarlett Pimpernell." (John)

"Before I would go to the CAT team, get my prescription and then just go home. I had no support." (Sarah)

A few participants (3) said they had been engaging with recovery groups, but these had stopped during the pandemic, creating a significant gap in their lives by way of connections to support, and for most these had not been re-established by the endpoint, or people had not re-engaged with them.

A common theme from all these interviews was the fact that isolation and vulnerability was exacerbated by various circumstances e.g. poor housing, poor environment, poor health, and in all cases individuals felt they needed more support to cope, and therefore help them manage their addiction.

Value of the outreach approach

Interviewees valued the Overdose Response Teams' approach. They highlighted that the service met with the person quickly after their near fatal overdose, going to where they lived, often out of hours taking time and really listening without judgement to what people said they needed and wanted from support, and responding. Interviewees said they had felt isolated, and the ORT teams really cared. Some commented that this was the first time in a long time they had been treated like a human being by another person. Several (8) specifically mentioned that they valued speaking to another person who had lived experience of what they were going through and truly understood how they felt.

"They (the hospital) normally just give you the number for Samaritans and so you get no support. When you feel as low as you do, you are not going to pick up the phone to someone

you don't know and talk to them about how you feel… I came out of hospital that day and they came to see me, so that level of support is a big change." (Sharon)

"The big thing for me is that they came out to me, listened to me and they are helping me to fight the fear that I am not alone. They came to me. You know a lot of people are scared to go out, so they came to me... There should be more of this for people. I think they need to get out on the streets and help people." (James)

Impact

Saved Lives

Most interviewees (23) and the five family members reported that the Overdose Response Teams had saved their (or their children's) lives. Two men had been saved in their own homes and one woman at a drop-in session held within supported accommodation, with naloxone administered directly by the team. One woman at the second interview, five months on, reported that she had used the naloxone given to her by the Team to bring a friend back to life after they had overdosed.

"They brought me back from the brink of death. My compass had gone. Looking back, I had wanted someone to talk to, someone to help me know what to do. You know when someone comes to you, like they did, you feel that bond." (Donald)

"The worker had come to my door. He had seen me that morning and I was out scoring. He had got the spare key from my pal and phoned the ambulance. There was two naloxone in me he had given me when I came around. I had taken street Valium. I know the worker. I refused to go to the hospital as I was confused and there were all these people in my house. I didn't mind him being there but not the rest of them (emergency response)." (Dan)

Immediate practical support

Some interviewees (13) spoke about the practical support given by the ORTs to get food, clothes, a phone, heating and to make key appointments they otherwise would not have been able to make. For those coming out of prison and hospital this was especially welcomed as they were without any other support. At one interview, it was noted how much time this took, with one man supported by the team to get emergency credit onto his smart meter, which required three different phone calls and an hour of waiting on the phone. It was explained that housing support in the area stopped working at 4.30pm and the man, who was without a phone or internet, didn't have any means of changing his situation on this own, and had no way of making a hot drink or food that evening, with a cold night ahead.

"When I came out I was told I was £50 in debt (in electricity) but then the Team called and got that wiped and then I got a £20 credit put on…It is good that they come to you…I didn't have a phone so they got me that. I was able then to call social work. They bought me food, toiletries, a kettle, essential food, bread, milk, cheese. I hadn't had any food that week." (Simon)

"They came and picked me up and took me to the hospital appointment. I would not have got there without that support. I have missed millions of appointments in the past, I need that kind of support." (Sarah)

By the second interview, almost all said they struggled to afford food and heating because of the rising cost of living. They were very concerned about the increasing price of heating and wondered how they would manage living on benefits. A few said they were reliant on family support and food banks to help them through. One woman reported living in her flat for eighteen years and paying £200 per month towards her private rental and was very concerned that this would be increased, she would be unable to afford it and be forced to leave.

Case Study
Michael is in his 40s, had overdosed on a drug he had never taken before, and was in hospital. The Overdose Response Team were out to see him afterwards and he was staying in a hotel in the city and felt very isolated. His friend had overdosed with him and he had been at the police station, had no clothes, no food and no phone. The Team got him all of these things and supported him to get a place in treatment. He is now abstinent, attending recovery meetings and has his own Temporary Furnished Flat. Without the service he feels he would have died.

Connections to treatment and support services

At the initial interviews, some (9) reported they were being supported into treatment by the ORT. Of this nine, six were re-interviewed; two having completed their alcohol detox, one near the end of her treatment, and three still not having accessed long-term rehabilitation, saying it was difficult to get a place. One man felt strongly that his Care Manager could have done more to make this happen and did not feel listened to.

> *"I want to get into treatment, the [centre] which is a 12 week programme, I have been asking about this for months but my Care Manager is not listening. He is telling people I can do this in the community without even having seen me. I spoke with one of my friends who works in this field and he said I should ask to see my care plan and what are the steps for me to get treatment. I was at a Centre years ago and after that I was clean for five years. I can't understand how there are people who seem to get it many times, and for me, it was just the once. It seems to be down to who your worker is. I have seen my worker three times in the past six months but no conversation, just giving you the prescription." (Dan, second interview, five months on)*

A few other interviewees (4) at the initial interviews said they had referred themselves onto an abstinence programme, an option they had not known about until they had been told by the ORT. Two were re-interviewed and said they had stayed less than a week at the programme and information from other services showed that one other person did not progress to take up their place. One of the men interviewed left the programme and took up a place at a local rehabilitation facility, which he completed in a few months and was now engaging there as a volunteer. He said he was completely abstinent from substances. For him and his family the support from the rehabilitation centre had been life changing. The other man moved into a new tenancy and continued to take drugs. He said he had reduced his use of street valium but was now using crack cocaine.

Through the Overdose Response Team, a few (4) were helped to have their cases expedited to access crisis support in one area, and two described how the worker had 'fought' for this on their behalf. Of this four, three were re-interviewed. Two were back using drugs and felt isolated, without support and back to 'square one' as summarised by one man who also felt he should be back in treatment. The other interviewee had relapsed when their time at the treatment centre was complete and it was

only when they had regained connections with the recovery community themselves, having hit a 'new rock bottom' that they felt they had got their lives back on track. In all cases they felt that the follow-on support after leaving crisis support was minimal and this needed to change. Information on the fourth person confirmed that they had not taken up their place in the treatment centre at all.

Case study
Jane who lives in Greater Glasgow was supported to regain support from a local recovery support service. She explained that she had missed many appointments before and would not have had the confidence to make contact again on her own, without support from the worker. She saw her addictions worker for an hour every week. She was now on buvidal (an injection to treat dependence on opioids) and felt this was the first time in years she had felt 'normal'.

Many other interviewees who had contact with community addictions teams from across the areas, felt that the contact was not enough, lasting only a few minutes every week, two weeks and in one case, once a month. These interviews highlight the pressure community addition services face in relation to capacity and lack of consistency in approach.

A few (4) of the additional interviewees from Greater Glasgow had been put in touch with the community addictions team, but all felt they did not have an issue with substances so this was not pursued, highlighting that people have to realise they have a problem if it is to be dealt with.

Case study
Matt left prison and returned to his home area with no phone and had not had his methadone prescription sorted in advance of his liberation. Despite support from the Overdose Response Team and repeated visits to the addictions team, his prescription was not put in place for three weeks. By this time, he felt he no longer needed it, as he had moved onto using heroin again over this time. It was his view that he had been set up to fail by services. By the second interview, five months on, he was still using heroin and explained he thought he could manage his habit but now dreaded each day. He had been prescribed diazepam and was waiting to get back on methadone.

A few (4) from Greater Glasgow said that without the advice and support given by the team to promote harm reduction and provide clean equipment to inject safely, they might have died.

Those who had completed the treatment programmes were engaging or wanted to engage in meetings in the recovery community. Some interviewees (11) from Glasgow and South Lanarkshire were linked in with recovery groups, that they did not have links with before. By the second interviews, all 11 interviewees had retained their connections. One man was even running his own recovery café one day a week in Glasgow. All recognised that it was when they were isolated that they were most vulnerable to drug use. Opportunities to meet others who understood and could share their experience, become involved in new activities around sobriety and away from substances, were really valued. It was notable that there were fewer opportunities for being involved in the recovery communities in Greater Glasgow than in the other two areas, highlighting that the Overdose Response Team can only connect people to what is available. Those in Greater Glasgow were the most isolated and vulnerable substance users with most complex needs, in comparison to the other two areas, and the team appeared to be doing much more harm reduction than in the other areas due to these vulnerabilities (this links to the earlier secondary data finding which showed the level of naloxone and safer injecting kits in Greater Glasgow was higher compared with the other areas). One woman who

had lived in South Lanarkshire had moved to Glasgow because she wanted a fresh start, but also because she said the support networks there for recovery were much more accessible.

Case study
Lisa is in her 20s and has been taking Valium and injecting heroin. She was abused when she was younger and suffers from anxiety. Over the past year she has come in contact with the Overdose Response Team and they have given her advice about injecting, training on how to use naloxone and also provided safer injecting equipment so she is not using dirty needles. She has found them easy to talk to and through their support she has become connected again with a local organisation that supports people in recovery.

Support for Families

Four of the five parents interviewed in South Lanarkshire had been linked to a community resource, set up to support individuals and families affected by substance use. They had not previously known about this option and valued the connections made, saying it was the first time they did not feel alone in dealing with these issues. By the second interviews, two of the parents were no longer attending as they did not feel they needed it, as their son was now abstinent, but the other two wanted to continue their engagement. In the other areas the level of family engagement was less in comparison, showing lack of consistency in the services available for families affected by substance misuse.

"I have a meeting with the addictions team and they are going to allocate me a Care Manager." (Simon)

"We went there with an open mind and we met other parents like us. We met two women who had both lost sons. It makes you realise that you are not alone but also that there are people out there that have it worse than you." (David, Justin's father)

Physical and Mental Health

Several interviewees (8), all of whom came from Greater Glasgow (of which five were additional interviewees) reported their substance use had not changed since meeting with the ORT. The remaining 29 interviewees from across the areas reported their substance use was more stable after they had been supported by the Overdose Response Team and some wanted to come off drugs completely. They also said they felt calmer and their mental and physical health had improved.

By the second interviews, over half (10) of the 18 people re-interviewed felt their physical and mental health had improved, they were supported and their substance use was more under control.

"That was three weeks ago and I have been off it all and I am even thinking about getting back to the gym. I feel well." (Justin)

"I am now eating three meals a day. I was not doing that before." (Sarah)

Of the rest, one felt they was no difference and was still using and isolated, and just under half (7) felt their health was worse, as apart from one person, they were back using drugs. All of these seven felt isolated.

Looking at the eighteen re-interviewed in more detail, this shows that six were now on some form of prescription to manage their drug use, five were still using drugs in a problematic way, four are

abstinent, two had reduced their use and one person wanted to move onto prescriptions. Those that had moved onto prescriptions thought buvidal, pregabalin and diazepam were viewed as life changing. In all cases getting prescriptions set up took months and it was during this time that people were often most vulnerable to a further near fatal overdose.

"I am sticking to it…I contacted my drugs worker and told her that if I didn't get the help I would end up dead…I was meant to get the prescription 8 months ago (for diazepam) but it is only sorted now." (Neil)

It was notable that in all of three areas long-term and community rehabilitation options were viewed as being either non-existent or extremely difficult to access. This meant that people, desperate to get some form of help signed up to or put themselves forward for an abstinence programme. This meant coming off all medication and drugs themselves before they could enter the programme and could be a dangerous option if not handled properly. For some though this option had been successful and shows the importance of people having a range of options. However, for others, abstinence was too difficult and not being able to take up their place because they were not able to come off substances themself or leaving the programme after a short time made them feel very frustrated at the lack of support available.

One man was not using substances any longer, but his health had drastically deteriorated since the first interview, he had lost a lot of weight and was awaiting tests to diagnose pain he had been having and suspected a serious disease.

Regaining Hope

Some said that the support given by the ORT initially and the connections to other services that the team facilitated, made them want to live again, highlighting that some walked a thin line between wanting to die and having a near fatal overdose beforehand.

I think since getting that support from the Response Team, they have changed my mentality so that I do want to live, and I really didn't want to before. I have not had any hospital admission over the past year. (Sharon)

By the second interview, those who retained these connections felt their life overall had improved. For those who were still isolated and felt there had been little progress, they were losing hope again. Three men said they had recently felt suicidal.

Case study

Peter was moved from supported accommodation into his own bedsit in an area he had never lived before and did not know anyone else who lived there and felt very isolated. He was living in a flat with a blow-up bed and little else and felt everything went downhill from there. His substance use escalated, his mental health got worse and he says he wanted to die. He had overdosed four times in five days and a third sector housing organisation who knew him referred him to the Overdose Response Team. The team visited him, and he wanted to get into crisis support. The team advocated for him on his behalf, and he was admitted within a week. He feels he would have died otherwise.

Regaining connections to family and friends

Several interviewees (6) described quite dramatic reconnections with families in the initial interviews after they had regained some control of their lives after almost dying, in some cases having lost those connections many years ago. Of the four re-interviewed, two had sustained these connections, despite their relapses.

"I have made contact again with my family and they are so relieved. My older brother lives in Canada and when I called and told him I was ok, it was the next call he said that he loved me, and he would never normally say that… I want to have contact with my son and stopping prescription drugs and life is good I can see where I want to go." (Peter)

In the other two cases, the family had decided they could no longer continue to provide support and had had enough, after their last relapse.

Some of the parents interviewed felt that through the support from the team had regained their children, and by them being 'well', also regained control of their own lives again too.

"I have seen a big change and she (daughter) is nearly there. I didn't know the person she had become before. She had hit rock bottom. You know you are trying to just get on with it. Trying before to keep her in, it was a big stress. Drugs affect everyone...I was up all the time and it is just that you are living with that fear. Where is she? Is she dead?" (Lorna, Joanne's mum)

"The reality is as well is that we had started to wash our hands off him. That sounds bad to say, but it is true. You know he was an embarrassment, in the shops and just the state of him. But now he is looking so well and even as I said my wee mum was so happy when she saw him as he is now." (Maureen, Justin's mum, nine months on)

Case study
Joanne lost her two kids and had been taking heroin, valium and smoking crack. Her addictions worker got in touch with the Team as they worried she would overdose. She had lost hope. The team have supported her and her mother to link in with community support, meeting other women who have been through similar experiences, and she has not taken drugs for the past six months. She now has her children with her a couple of days a week and wants to have full custody again. Her mother feels she is getting her daughter back again and no longer lives in fear of her dying.

Assessing Overall Impact

The interviews were semi-structured and interviewees were asked about the impact on their substance use from the first interview, whether they had had another near fatal overdose and whether they felt their lives had improved or were 'better overall' since the first interview.

Based on the initial interviews with service users, at interim evaluation stage, it was found that the service had made a significant difference to individual outcomes, had found people who have had a near fatal overdose, engaged with them very successfully and helped them take up support from other services.

By the follow-up interviews, of the 18 re-interviewed:

- Most of interviewees (11 out of 18) said they "were doing better" explaining their substance use had either been stabilised, reduced or stopped and they were no longer feeling isolated. Of this group three had had another near fatal overdose since the first interview. Significantly, all 11 had been supported by the Overdose Response Team to make connections with the recovery community and felt this had been instrumental in the changes they had made to their drug use in their lives.
- Of the other seven re-interviewed, a few (3) said their lives were still the same, meaning they continued to take drugs chaotically and were dealing with the same problems and still felt isolated. All three had had another near fatal overdose since the first interview and one of the men had had many repeated near fatal overdoses in supported accommodation. The remaining interviewees (4) felt their lives were "worse" now than in the first interview, specifically one woman was back using drugs and wanted help again from the Team; one man had left prison and his methadone script had not been put in place and was now back using heroin; finally, one man had left a rehabilitation centre and was back using to levels he himself said were "worrying"; finally one man was not using any substances but was very low because of his health problems and his current housing situation. In all these cases, where they said they were the same or worse, there was one clear commonality; this was the level of isolation and lack of connections and support they had. It was notable that in Greater Glasgow, where there are fewer services and a lack of recovery communities, this was where people were struggling most.
- In summary, 12 from the 18 individuals re-interviewed had not had repeat near fatal overdoses at the point of the follow-up interviews.

Six people were not re-interviewed but information was found through service providers (for which consent was provided at the first interview). In all cases, based on the service providers' information, that they were the same or worse than they had been before. Information on the two people from Glasgow not re-interviewed established that one man was still using drugs to the same level as before and in supported accommodation, and the other man had moved between different supported accommodation and was no longer taking street valium but drinking heavily. Of the four in Greater Glasgow, one man had completed a detox from alcohol but was drinking heavily again and not able to be found; one other man had been drinking heavily, begging on the streets and was hospitalised for an accident; one man was still using drugs to the same high levels; one other man had originally had a referral into an abstinence programme but did not take this up and was still using drugs to the same level.

Interviewees were asked about changes made to their lives to their substance use and how much they would attribute this change to the support given by the Overdose Response Team. Those re-interviewed could be split in two, with the eleven who felt they have progressed saying they had made significant changes, rating this between 7-10 improvement (where a score of 10 is the maximum). Five said that this was all down to the support they had from the Overdose Response Team, and the other half said that the support from the Team had contributed to their improvement, recognising their own effort, and the help of other services and connections. For the other group of seven, who felt their lives had made limited progress and their substance use was unchanged, the change was ranked by them to be between 2 and 5 (so closer to the minimum score of 1). They didn't feel they could blame

the lack of change on the Team, who in their view had done all they could within the time they had, but rather it was the whole context of their lives, including the experience of poor housing, lack of connections and isolation. Two of those with less positive outcomes wanted to get into more long-term rehabilitation but it was not accessible.

"I would say since I last saw you in terms of change, it has went right down to a 2. I would say none of this is down to the Team…I just want to get into the treatment centre. I think if I had got the detox I had asked for from my Dr a year or more ago I wouldn't have had to go down this road." (Dan, five months on)

"I would say my life is a 2 now and I wouldn't want to put that on the team at all. I think people do need more help. Yes, they are there when you really needed them, but then you are back to all the same issues and not getting the help you need." (Donald, nine months on)

Suggestions for Improvement

Two interviewees felt the service had done all they could and they were happy to end the relationship with the Overdose Response Team when they did, and they suggested no changes to the service. The main suggestion for improvement by all other interviewees was that they would have liked to have worked with the Team for longer and to be supported even more to make the links to organisations, to support them in meetings or engage with the recovery community. As one interviewee reflected, *"a lifetime of problems faced can't be dealt with quickly".*

Case studies – positive outcomes

Sean, Glasgow

Sean described how he had been in and out of institutions all his life, from being in care as a child, to residential care, prison and rehab. He was placed in a hotel in Glasgow that was infested with rats. He had taken what he thought was heroin with his friend there, who died and Sean was taken to the police station with all of his belongings seized. He was brought to court and given bail, returned to the hotel, alone and with nothing. He overdosed himself and when he came out of the hospital the Overdose Response Team met him; in his own words he was 'broken' and was thinking 'hurry up and die.' He described how the worker spoke to him like a human, something he had not experienced in a long while. They explained about an abstinence programme and Sean decided to go for it. They made the referral and helped him to prepare, making calls over the weeks he had to wait, encouraging him to keep motivated. Six months on he left the programme and has not touched drugs since. He presented as homeless after this and was supported by Shelter not to go back into the hotel, but to get his own temporary furnished flat instead. Sean feels if he had been made to go back to the hotel he would have been quickly back on drugs. He joined a fellowship and is now running his own recovery café one day a week, is back working in construction, in a relationship, and had just returned from his first holiday in years and was about to take up his own tenancy. He feels that having connections to others like him, who are on the same journey has been crucial and what is needed is services that can really help people, take them to their appointments and get their life on track. Without the support given by the Team he felt he would have died and it was through being able to speak to someone who really understood, who made him aware of the different options available and made the links, rather

than telling him what to do that made the difference. He also felt that people needed the support for longer and for it to be even more intense. He said:

"I would tell people that ORT are a really really good service and they are here for you when you need them, at the bitter end and they are able to help. I needed that human contact, because that had been lost, before I got it from the police, robbing shops, but that is not human contact. They really listened and that conversation, it makes you feel human again… They definitely saved my life. After that it was a case of me linking back in with things. They are just a short thing. I think they should look into helping people for longer but also linking in with what is there. I have heard of Housing First and things like that, maybe there should be more of things like that."

Sarah, Greater Glasgow

Sarah had been engaging with the community addictions team for years, but it was a case of picking up her methadone prescription and little else. She described being very isolated and addicted to street Valium, which she used to block out painful memories from the abuse she had suffered for years from her ex-partner and prior to this as a child. She had stopped eating and was being constantly physically ill and wanted to die. She overdosed and after coming out of the hospital the Overdose Response Team met her and in her own words *'were the first real support'* she had in years. The fact that they came out to see her was really important as she had stopped leaving the house because of her anxiety and lack of confidence. They helped her to go shopping and to buy food, to engage with online recovery meetings, get a detox and feel less isolated. Over a few weeks they saw her every week. They listened to her when she said she wanted to get help a support centre, which was in a different area to where she lived. The centre provided intensive support to women, to deal with their addiction and their underlying problems. Sarah had a criminal charge outstanding and was assigned a criminal justice social worker. Through support from the team and her social worker she was able to take up a place at the centre. The team also helped her to get her pet housed safely over this time, as otherwise she would not have gone. Five months on, Sarah was near completion of the programme and felt her life had been transformed. She was waiting on a temporary furnished flat and had written to an MSP to fight for her right not to be placed in a hotel, which she said she would not have had the confidence to do before. She was on buvidal and felt this was a lot better for her than being on methadone, and overall felt healthier and stronger. She was about to start college and was looking forward to a holiday booked with her family through a charity. She felt that without support from the Overdose Response Team she would have wanted to die, whereas now she was looking forward to the future. She said of the Team, *"If I hadn't had them I would be on my own."*

Justin, South Lanarkshire
Justin had overdosed and was experiencing a drug induced psychosis. The family called the Overdose Response Team who called the paramedics and persuaded them to take Justin to hospital. When Justin came out of hospital the Team came out to visit the family regularly over a couple of months, supporting Justin to understand his different options and offering emotional support to the parents. The Team linked his parents into a community initiative with families affected by substance use supporting one another. The parents welcomed the chance to meet others with similar experiences, and this helped them to feel less alone. Justin went to the abstinence programme but left after a day because he did not think it was for him. The Team supported him to get into community rehabilitation quickly and this was life changing for Justin. Seven months on Justin is living a life of abstinence, goes to the gym regularly, knowing that physical exercise is important for his mental health. He volunteers at the community rehabilitation, was about to move into his own flat and to begin a college course in Health and Social Care. Justin said he wants to use his lived experience to gain employment in the field, to help others. The family felt that the worker, by being honest about their own past addiction was able to 'get through' to Justin and helped the family understand there was hope and help available. All reflected that without the Overdose Response Team Justin would not be alive.

2.4 Stakeholder opinion on outcomes

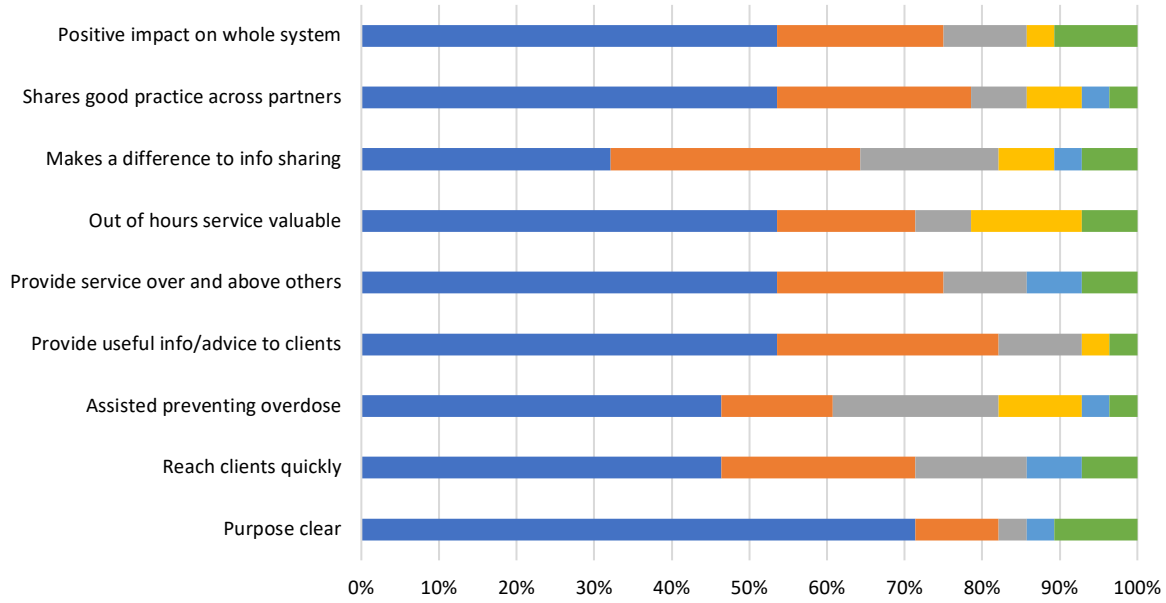
External stakeholders

An online survey was distributed to partners at the interim stage as a means of reaching all stakeholders with whom the ORT service has connected so far. A total of 28 responses (53% response rate) were received from partners across a wide geographical area, with the largest number of respondents working in Glasgow City (9) followed by South Lanarkshire (5) and West Dunbartonshire (5). Most responses came from HSCPs, and also came from voluntary sector organisations, the Scottish Ambulance Service, and local authorities (not HSCPs). Appendix 1 provides the survey questionnaire, and Appendix 2 provides more detail of the profile of survey responses.

The partner survey asked respondents about a range of areas of **outcomes and impacts of the service**. Across all outcome indicators, **most respondents agreed with each statement about impacts**, ranging from 17 of 28 (around 3 out of 5) agreeing that the ORTs had assisted in preventing overdose to 23 out of 28 agreeing that the purpose of the ORTs is clear and that the service provides useful information and advice for clients to link to other services (around 4 out of 5). The areas where there was strongest agreement were that the purpose of the ORTs is clear (20 agreed strongly and 3 agreed). Most respondents agreed that the service provides useful information and advice for clients to link to other services (15 strongly agreed and 8 agreed).

At the other end of the scale there were only 4 (out of 28) negative responses to any of these questions. Of the negative responses, these were evenly spread across the three areas.

Figure 8: Outcomes/areas of impact for the ORT



	Purpose clear	Reach clients quickly	Assisted preventing overdose	Provide useful info/advice to clients	Provide service over and above others	Out of hours service valuable	Makes a difference to info sharing	Shares good practice across partners	Positive impact on whole system
Strongly agree	20	13	13	15	15	15	9	15	15
Agree	3	7	4	8	6	5	9	7	6
Don't know / can't tell at this stage	1	4	6	3	3	2	5	2	3
Neither agree/nor disagree	0	0	3	1	0	4	2	2	1
Disagree	1	2	1	0	2	0	1	1	0
Strongly disagree	3	2	1	1	2	2	2	1	3

Source: Partner survey (n=28)

The partner survey also invited open responses about what they felt about the service and follow up interviews were undertaken with eight key stakeholders at interim stage, and a further nine stakeholders to discuss in more depth their experience of the service, and/or their opinion of the approach. The partners involved in the interviews came from a mix of statutory services (including ADPs, ADRS, NHS substance services, and local authority community protection) and voluntary organisations working in recovery services.

From the survey responses and the in-depth interviews, these suggested that the main positive impacts of the ORTs were the **high level of responsiveness and flexibility, assertive outreach and persistence with individuals, and particularly the out of hours aspect of the service**. This opinion was consistent from consultees at interim and endpoints of the evaluation. There were numerous comments about the value of the out of hours aspect of the service, which statutory services were not able to provide, other than emergency responses (Police and Ambulance services) who are not designed to provide the holistic overdose response and networking with other services required by many patients. One person illustrated this by saying:

Overwhelmingly positively received. The USP is that they operate outwith normal office hours. We are working with a chaotic group of people and their issues are not confined to office hours." (Greater Glasgow Stakeholder).

Several consultees also commented that this Overdoes Response Team was the **only** service in their area to provide an out of hours service (with the exception of Glasgow). Others referred to underfunding of addiction services and one NHS worker referred to removal of former intensive hospital and community based services targeting people that were frequently attending hospital due to addictions or near fatal overdoses. This consultee felt that the ORT service to some extent filled that gap with the nurses now being able to refer repeat patients to the Overdose Response Team and had confidence they were seen quickly. Some consultees also argued that TPS (and the third sector generally) tended to be more flexible and nimbler, better placed to provide services out of hours while networking with a range of statutory services including the Police, Scottish Ambulance Service and social care (discussed further in later sections on System Change).

Examples were provided of people being released from prison, or discharged from hospital on a Friday afternoon, or over the weekend and the ORT service being able to reach these people and mitigate harm. This gave referring agencies reassurance that individuals would be seen quickly, who otherwise would not be reached until a Monday or Tuesday if left to statutory services. Several interviewees compared this to the harm reduction teams within the HSCPs and stated that they were not able to provide assertive outreach required and were strongly of the view that overdose response services need to be 7-days a week and out of hours (some suggested 7 days, 24 hours a day). Many said they wanted to see the ORT project remain and grow, and that it was instrumental in saving lives.

"Out of hours and weekend response has been the most useful aspect of the service to expand our reach and support available." (Greater Glasgow stakeholder)

"The flexibility of the hours they work helps them to reach people who require the service." (Stakeholder working across all areas)

"They are saving lives, it's a wonderful service, they are linking in with the community safety partnership, working with us on the detection of drug users, and are good for intelligence and sharing information…. The out-of-hours is an absolute god send." (Greater Glasgow stakeholder).

Survey respondents and follow-up interviews also highlighted the **expertise of the ORT staff** and the commitment to their service users. Several, often in Greater Glasgow and Lanarkshire, commented that it was difficult to find the most appropriate agency with the right level of expertise and the ORT teams were helping to fill that gap. Several people commented on the importance of taking a holistic approach, and not just concentrating on the 'medical' model of provision.

"Staff are very motivational and clearly care for their service users." (Glasgow stakeholder)

"The knowledge and skill set of the teams, their availability, their leadership, always keeping the service user at the heart of everything, no hidden agenda or ego." (Stakeholder working across all areas)

"The expertise of the officers, and skills in relation to drugs. It's sometimes difficult to find the most appropriate agency. They are able to say what is dangerous or not, able to do a welfare check and give advice on what is safe or not. They are making sure the drug users are keeping themselves safe". (Greater Glasgow stakeholder)

"Knowing someone cares enough to be there at the times when they are needed, not 9-5, not a return appointment in a few days' time. They look at that person in their entirety, so looking at everything, not just seeing it as the medical issue." (Stakeholder working across all areas)

In terms of **actual impacts on individuals**, most partner consultees referred to qualitative feedback from their operational teams on the positive impacts achieved for individuals. Some others did not know the specifics of what individual impacts had been achieved directly through the ORT team, and felt it was early days or difficult to directly attribute positive outcomes to the ORT team. However, several ADP consultees noted that drug deaths had started to come down in their area and saw the overdose response service as one part of the pathway and service landscape, or 'family of services' required to make change happen. TPS provides regular monitoring data to the ADPs, and this evaluation report brings together that data and provides analysis from the range of quantitative data (including data on demographics, referral sources and interventions by each ADP as shown in Appendix 3) and qualitative data.

Areas for improvement

Areas for improvement were identified by a few survey respondents. While out-of-hours was seen as one of the most positive aspects of the service, some people wanted the **out-of-hours to be extended** further. Suggestions included the HSCPs covering more during the day, and the ORT service covering 12 midday to 12 midnight, with overlaps of cover between HSCP services and ORT to ensure warm handovers.

"Potentially widening the operational hours? Data would indicate if there's a need for that to capture the maximum amount of people. Maybe more relevant when SAS info sharing is in place?" (Lanarkshire stakeholder)

"In the ideal world it should be 7 days a week, 24 hours a day" (Stakeholder Lanarkshire)

Interviewees also wanted to see **more capacity in the service, struggling with workforce shortages.** As the value of the service had become better known and used more, there was also a desire for greater resilience (for example for staff cover for absences/holidays/vacancies). The issue of workforce capacity became more acute during the final stages of the evaluation as the short-term nature of the ORT pilot meant that inevitably staff members chose to move on to more permanent positions. As already discussed, all consultees (internal, external and national key players) identified the workforce shortages being experienced in health and social care generally, with most suggesting that this problem will take a long time to resolve through workforce planning and a national and UK level.

In relation to **information sharing**, the survey showed one of the least positive aspects was around 'making a difference to information sharing'. This is discussed further in the System Change chapter.

At the interim stage, two ADP interviewees commented on the **difficulty in navigating service delivery between the statutory and third sectors**. In one area there appeared to be lack of trust and '*professional competition'* from the ADRS service, questioning the expertise of the ORT staff – at the endpoint of the evaluation this ADP was still working this through, although with determination to resolve the historical cultural issues. Another area also pointed to the experience of initial wariness from ADRS staff, but this had been worked through by understanding of the complimentary service

offer and increased capacity, in particular the assertive outreach and out-of-hours approach which the statutory services "*don't offer".*

Some external third sector consultees lamented the challenges around professional landscapes, one pointing to **'*nurse led*' or medical approaches** of the statutory sector which they didn't believe would provide a fully holistic approach as was more commonly provided by the third sector. The ORT Harm Reduction Practitioners (HRPs) also expressed concerns about taking a medical based approach, and not taking a sufficiently person-centred approach to people's lives, for example dealing with housing or debt, would mean that the real issues underlying substance use would not be addressed. The counter to these arguments was the suggestion that a medical, nurse-led approach works effectively where there are clear pathways to community mental health services and in the case of statutory services these are all interlinked by common IT systems to access, record and monitor cases.

> *"Find the person, by going to them you know and see the reality of their lives, the context in which they are and what help they need… Put the individual at the Centre of provision rather than expecting the individual to fit into what a service provides." (TPS staff)*

Other areas in relation to culture and service approaches are discussed further in the 'System Change' chapter below.

TPS staff and managers

TSP staff reported at interim and endpoint of the evaluation that the service is **making a difference to individual outcomes**, is finding people, (although felt they could also be reaching more people) and helping individuals to take up other services, where these services were available.

Throughout the evaluation period, all staff reported incidents of saving peoples' lives by administering Naloxone directly. It was reported that the majority of people were happy to engage and welcomed the support from the ORT service. Staff observed that for some individuals, this was the first direct support they had had for years. The teams described how the model of assertive outreach and having a non-judgemental approach '*works*'. The holistic approach was described as having honest conversations, gaining an understanding of what has been *really* going on in people's lives and what people needed and wanted in terms of support. The HRPs came to the service with range of professional and personal experience, some with lived experience, which was considered relevant for engaging with, and understanding individuals' perspective. The teams described how they acted as a '*one stop shop'*, providing advice, information and making referrals for people, often overcoming difficult processes.

> *"We are not trying to 'fix' them, we are asking them what support they want. We allow the individual to drive the conversation and it is their decision to refer in or not. We also don't have a time limit on when we will see someone and I think that is a big thing."(TPS staff)*

However, the effectiveness of the ORT team's work and ultimate outcomes for individuals depended on the **wider landscape of services and treatment options**. In Greater Glasgow, the team felt that one of the main challenges was the lack of crisis support, treatment options, recovery communities and support for families to link people into, particularly in the more rural areas. Staff in Lanarkshire also echoed similar frustrations in relation to crisis support and treatment options. The team now operate

in North Lanarkshire and felt that in this area there were less services and support to link people into, and workers said they felt they were letting people down. Essentially, the Overdose Response Team are limited in terms of the connections they can help people make, to what is available in the local areas.

It was highlighted that the **practical support** provided by the service to individuals would otherwise not have happened, although as noted above, by the endpoint of the evaluation the staff teams noted their frustration at not being able to connect individuals to treatment options or community services quick enough. Very simple actions, such as giving someone a phone meant they could connect again, for example to their care managers. The service was also viewed as providing accountability, by following up on the connections made and sensitively working with care managers, supported accommodation providers and other services. By working alongside families, they were also able to connect them to support. The teams have delivered training and equipment to other agencies and supported accommodation providers, ensuring they are better able to deal with someone who has had an overdose and respond appropriately. All felt that they do not duplicate, but rather compliment what other services do, with the service looking at the social aspect of the person's life, taking account of the full context, not only the medical aspects.

The service has worked hard to **network and partner with other organisations** with successful referral pathways established with the Navigators in hospitals, supported accommodation providers, criminal justice social work and even chemists. In Lanarkshire they were especially proud of the connections established with the hospitals. Both Lanarkshire and Greater Glasgow teams do drop in sessions at the recovery cafes, supported accommodation providers, and HRPs had also taken people to appointments due to the poor public transport and the ORT staff knowing that they would not realistically be able to attend otherwise – demonstrating a truly proactive assertive approach. Other examples included in Greater Glasgow where HRPs had shadowed the Scottish Ambulance Service for mutual learning, and which has resulted in productive working relationships with referrals coming through this SAS team.

2.5 Summary

The case management data shows that most cases have a positive outcome, in some cases saving lives in the immediate crisis stage, and then supporting client to connect with services for longer treatment. There is significant evidence of activity in the monitoring data, but some variation in engagement times. Lanarkshire has the shortest engagement times on average and appears to have more favourable outcomes – which may indicate the benefits of shorter engagement times and a different referral pathway, with more referrals directly from hospital, also reflected through consultation with partners and TPS staff. The lack of referrals from hospital and the ambulance service in Glasgow was striking, even before the development of the statutory HSCP Crisis Outreach service. COS is now the main overdose response service in the City, and the original GORT test of change provided a crucial catalyst for strategic change working in partnership with the COS service. The Glasgow HSCP noted the positive experience that the GORT service played in development of the statutory service.

By the endpoint of the evaluation, there was evidence of increased engagement times and more difficulty engaging with service users in Greater Glasgow, and TPS staff pointed to difficulties in access and availability services generally in Greater Glasgow, and some ADP consultees noted some cultural

difficulty with fully adopting a third sector response – this more difficult service landscape may explain why engagement is more difficult in that area. Engagement levels and outcomes remained very favourable in Lanarkshire, though referrals had dipped due to challenges with staffing numbers in the LORT team.

Interviewees with 37 individuals showed that the ORT service provided a critical immediate overdose response service to save lives, and support to engage with other services. Looking at the eighteen individuals re-interviewed during the evaluation period, this showed that for most they themselves said they were in a better situation – some were on some form prescription to manage their drug use (although some had to wait long periods for this to be put in place) or had reduced or stopped their drug use. Some still using drugs in a way that they thought was problematic way. Those that had moved onto prescriptions thought buvidal, pregabalin and diazepam were life changing. While these outcomes cannot be directly attributed to the ORT service, it is clear from these testimonies that it is an essential part of the pathway to recovery, assuming there is access and availability of other recovery services including residential treatment services. However, many individuals interviewed criticised the lack of support or access to treatment that they felt they needed. It was also evident that wider circumstances (including housing, lack of living facilities, poor health or lack of life skills to resolve these) were barriers to recovery. The interviews confirmed that the ORT team made referrals assertively to statutory services and other support services including other third sector organisations, drop-in clinics and at supported accommodation. Families were also supported through the ORT team through information and advice. Based on these interviews, the impact of the service has been significant, saving lives, supporting people into treatment (where this is available), out of unsuitable accommodation, improving physical and mental health, and helping them to regain hope and re-building connections with family and friends.

Respondents to the partner survey and in-depth interviewees rated the outcomes of the service very positively, although a small minority suggested limitations - this was often associated with organisational resistance to change from some HSCP staff. The most positive attributes were rapid responsiveness, the assertive outreach and out-of-hours offer, and commitment to individuals using the service. Most of those interviewed considered the service as valuable in reaching those that the statutory services could not, especially in evening and over the weekends, and provided additional capacity, expertise, and reassurance. Consultees wanted the service to continue and expand in capacity and length of out of hours offered. The shortages of staff, exacerbated through the short term ‘test of change’ nature of the project was a key constraint for ORT, with workforce challenges experienced across health and social care sectors. There was widespread recognition of limitations of most statutory addiction services not providing sufficiently assertive outreach and out of hours approaches, and the cultural barriers and their lack of agility in developing the addiction services to make the required change.

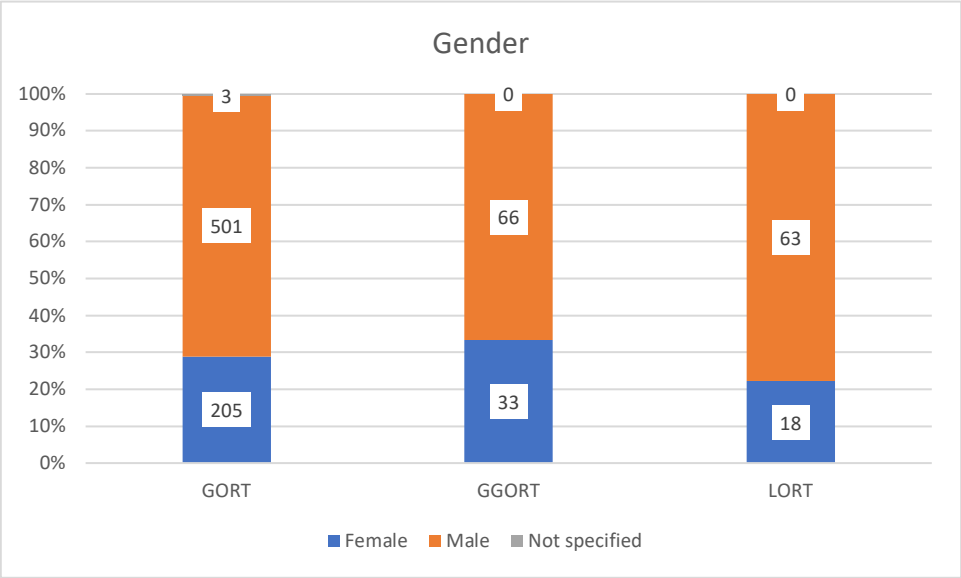
3. Who the service is reaching and not reaching

This section examines the evidence of whether there is a group of people that the ORT services is not reaching – who are they and why?

3.1 Who is the service reaching and not reaching?

Before considering who the service is **not** reaching, it is useful to consider who the interventions are reaching. At the interim stage, the majority of those referred to the ORT were male, across all locations, with just under 1 in 3 service users being female and around two-thirds male in Glasgow and Greater Glasgow and around 1 in 5 service users being female in Lanarkshire and around 4 out of 5 being male.

Figure 9: Gender of service users by location



Source: Case management data

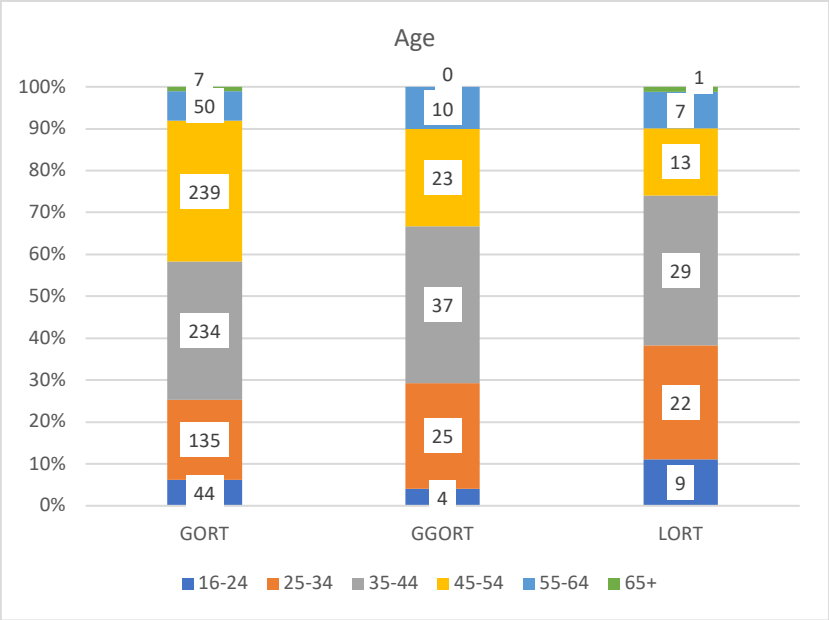
At endline a similar pattern was observed in Greater Glasgow and Lanarkshire, with 31% female and 69% male service users in Greater Glasgow and 19% female and 81% male in Lanarkshire. As noted previously, the small number of referrals from late 2021 onwards means analysis of Glasgow data weas not repeated at endline.

Service users tend to be spread among the middle of the age distribution, with the largest group in Greater Glasgow and Lanarkshire aged 35-44 years. In Glasgow there were similar numbers aged 45-54 years as aged 35-44 years and fewer younger people. In Lanarkshire, service users tend to have a slightly younger profile, with proportionately more aged under 35 years old than found elsewhere. Similarly, at the endline of the evaluation, 40% of Lanarkshire referrals were for people aged under 35 years of age compared with 32% of those in Greater Glasgow.

Over half of service users had their own tenancy across all areas (at interim and endline), with more people in B&B in Glasgow and Greater Glasgow compared with Lanarkshire and more living with family and friends or in a temporary furnished flat (TFF) in Lanarkshire. There were proportionately more

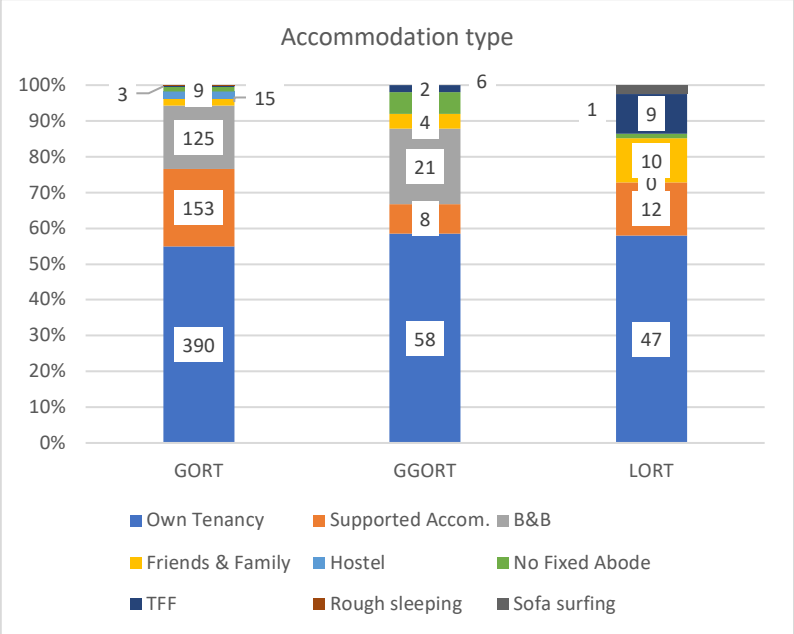
service users in supported accommodation in Glasgow, followed by Lanarkshire and then Greater Glasgow. At endline, Greater Glasgow had 21% of referrals from people in B&Bs compared with just 1% of those in Lanarkshire while 21% of referrals in Lanarkshire came from people in supported accommodation, compared with none of the Greater Glasgow referrals. This profile suggests that either GGORT are accessing people with more complex needs coming from B&B accommodation, or it indicates that the temporary accommodation situation is Greater Glasgow is more skewed to B&B provision compared to supported accommodation in Lanarkshire.

Figure 10: Age of service users by location (interim stage)



Source: Case management data

Figure 11: Accommodation of service users by location (interim stage)



Source: Case management data

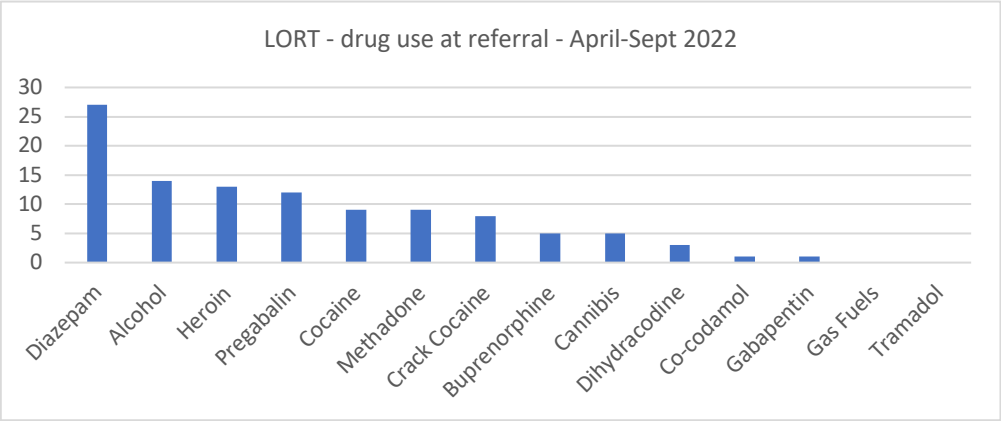
There is a lot of 'unknown' ethnicity data in all locations (unknown or missing in about half of referrals), so this is not currently robust enough to be useful for monitoring.

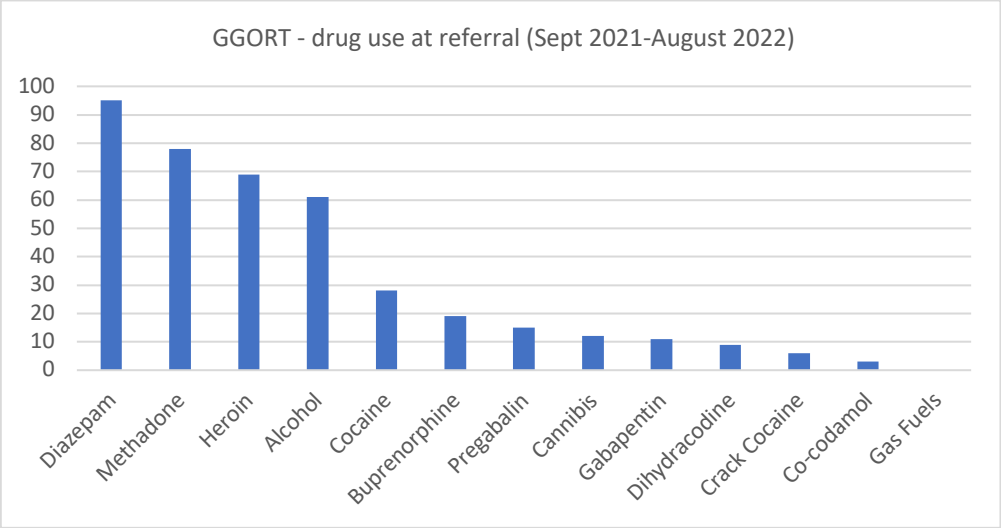
1 in 4 service users in Glasgow had accessed the service more than once at the interim stage, compared with 1 in 5 service users in Lanarkshire and 1 in 20 in Greater Glasgow.

By endline, almost a third of referrals in Lanarkshire were repeat referrals, compared with 1 in 5 at the interim stage. This included 15 people who had been referred 5 times during the lifetime of the project in Lanarkshire and 10 people referred 10 times. In Greater Glasgow, 1 in 5 referrals by endline were repeats, compared with 1 in 20 at the interim stage. In Greater Glasgow, 15 people were referred twice, 3 people referred 3 times and one person referred 30 times. This highlights the frequency of repeated NFOs, which remains considerable.

The most common drugs used in Glasgow were – Diazapam (298) methadone (228) alcohol (134) heroin (75) and cocaine (73). In Greater Glasgow, this was Diazapam (24) heroin (15) alcohol (13) and Pregabalin (12) while in Lanarkshire it was Diazapam (19) heroin (14) methadone (8) and alcohol (8). **Across all areas, the case studies provide evidence of common use of multiple substances.**

This was also evidenced at endline:





Source: Case management data

Diazepam remains the most used drug at the point of referral, while methadone was more common in Greater Glasgow, compared with Lanarkshire, where alcohol was more commonly mentioned.

Of the 37 TPS feedback surveys received from individuals using the service, most had realised they had overdosed but did not expect to, and did not see this is a normal part of drug use. Methadone, diazepam, alcohol and benzo diazepam were the most common drugs reported at that 4-week follow-up. Most people completing a TPS survey did not see prescribed medication as a factor, until told that it was. Few gave consent to contact family/friends. **This suggests that the focus on overdose awareness is important.**

The sample sizes in the monitoring data for Greater Glasgow and Lanarkshire were not sufficiently large at the interim stage to say anything about the characteristics of people who **do not engage** with the service, however, the Glasgow data did allow some analysis of this. There was some evidence of some harder to reach groups in Glasgow at the interim stage -

- Over three-quarters of female service users were accessing other services compared with around two-thirds of males. Around 1 in 5 males and around 1 in 10 females were not contactable.
- Over a quarter of those aged 16-24 were not contactable and fewer were engaged with other services.
- Over two-thirds of those of no fixed abode and those in TFFs were not contactable compared with just under 1 in 5 overall.

Although numbers are small, there are some indications that harder to reach individuals are:

- younger people
- males (although women were harder to engage with the Greater Glasgow and Lanarkshire)
- homeless people not in supported accommodation or B&B.

At endline, there were enough referrals in Greater Glasgow and Lanarkshire to allow analysis of who is harder to reach. In Greater Glasgow, it was more difficult to contact younger people (aged under 35 years) but those aged 35-44 years more commonly did not want to engage, compared with younger or older people. Female engagement lagged males (57% of females were engaged, compared with 65% of males – this is in line with engagement levels nationally). Those in B&Bs and hostels were less likely to want to engage, while those with No Fixed Abode were less likely to be able to be contacted.

In Lanarkshire, no contacts were also more common among those less than 35 years of age, while the 'middle-aged' - those aged 35-54 years were less likely to engage. Females were less commonly unable to be contacted but more commonly did not want to engage, compared with males. Overall, 19% of referrals were for females, while 15% of those who were unable to be contacted and 27% of those not wishing to engage were. Although those in their own tenancy were 59% of all referrals, they were 85% of no contacts and 73% of those not wishing to engage.

Different strategies may be needed for younger people and males/females, and for those living in the community (as opposed to in homeless accommodation, where people may be easier to find

and engage with the support of other agencies) to increase the likelihood of contact and positive engagement.

3.2 Stakeholder opinion on who the service is not reaching

The partner survey and in-depth interviews asked whether there is a group of people that the ORT cannot, or haven't been able to reach so far. Overall, 18 of 28 respondents said there was not any, and 10 of 28 (around a third) said there was. The in-depth interviews explored this question at interim and endline stage of the evaluation, and there was consistency in opinion at both stages about people that are hard to reach.

Homeless people and those with more complex needs were identified as key groups, including people who *'just do not want to engage with services'*. Others identified were those with added vulnerabilities, LGBT+ and ethnic minorities. **Women** were identified by several consultees as difficult to reach due to complex vulnerabilities including domestic abuse, societal stigma, and the risk of losing children if problematic drug use was highlighted to statutory services. The HRP staff cited examples of women leaving hospital admission quickly to get back to children leaving insufficient referral data for them to be reached.

Cultural barriers and stigma around drug addiction were also identified, meaning people wouldn't engage or 'go to' services. One Greater Glasgow respondent who was supportive of the ORT service highlighted the need to keep raising the profile of the ORTs with hospital staff otherwise people may be missed. This compares to the very successful pathway that has been developed with hospitals in Lanarkshire which could be replicated elsewhere. This example also emphasised the importance of out-of-hours services, and the fatal consequences of lost time:

"We experienced a person who was in hospital and he self discharged then went on to have a fatal OD. The hospital staff were unaware of the overdose response team and did not make a referral. By the time the ADRS made a referral it was too late. He died. Hospital staff need to be made aware of the NFOD service." (Greater Glasgow Stakeholder)

Many stakeholders kept going back to the **importance of assertive outreach and ongoing persistence** with individuals which the ORT service brought; *"they are very patient, and person centred which is what is needed"*. This was compared to statutory services which many consultees said had to change culture within existing addiction services so that they should no longer expect individuals to come to them, but went to and found the individual.

"We know 52% of people who die are not in treatment, we know there is need for assertive outreach, but ADRS are having none of it. They expect people to come to them. The only people they chase are the people that are known to them, to get those people back into the service…. They provide a liaison service with A&Es, but they are not out chapping doors." (GG Stakeholder)

"Addiction services need to be 7-days a week and more assertive. They should not be asking people to come to them at a set time in a certain place, services need to be more flexible and suit the patients more". (All areas)

"When people are 'harder to reach', we need to find a way of getting to them by working together." (All areas)

This mirrors the findings of the research with service users, which found that those who had less positive outcomes were not connected to services and did not have support. Actively reaching out to those who are not currently engaging is key to improving outcomes.

Consultees talked about the need for **better joint working across statutory and third sector services to ensure people were reached**. The sense during this evaluation was that this was gradually changing in many areas (although still with some frustrations in other areas). Several statutory consultees noted that the third sector are good at networking and partnership building, navigating what one called the "*power barriers in the statutory sector*". Some of the frontline TPS staff felt these power imbalances (or professional egos) were frustrating and wished for easier and more systematic information sharing to be able to reach more people.

> *"We should be working in collaboration with services, you know some services need to take off their superman capes. It is the people who need help who are losing out by services not working together. People are dying." (TPS staff)*

3.3 Summary

Individuals that have been assisted by the ORT service tend to be predominantly male and aged between 35-45 years, though Glasgow has an older profile and Lanarkshire has a younger profile. More than half had their own tenancy, but there are more people in B&B in Glasgow and Greater Glasgow, and more living with family and friends or in a temporary furnished flat in Lanarkshire. At endline, Greater Glasgow had far more referrals from those in B&Bs while Lanarkshire had more in in supported accommodation. This profile suggests that either GGORT are accessing people with more complex needs coming from B&B accommodation, or it indicates that the temporary accommodation situation is Greater Glasgow is more skewed to B&B provision compared to supported accommodation in Lanarkshire.

Although numbers were small, there were some indications from the monitoring data that younger people, males, and homeless people not in supported accommodation or B&B are harder to reach, though middle-aged people and females may be harder to engage. There would appear to be the need for different strategies to engage younger people and females, and for those living in the community (as opposed to in homeless accommodation, where people may be easier to find and engage with the support of other agencies) to increase the likelihood of contact and positive engagement.

Partners also highlighted homeless people and those with more complex needs as a key group that may not be within reach of the ORT. Other hard to reach groups identified included those with added vulnerabilities, LGBT+, ethnic minorities and women. There were particular vulnerabilities highlighted for women, including around domestic abuse, stigma and fear of losing children due to addiction and therefore not presenting to health and social care authorities.

There was a strong theme from partners and TPS staff that people who are hard to reach, by their nature, require strong collaborative working, continual awareness raising of the ORT services, and assertive outreach so that people not engaging with statutory services can be found within communities. Through the course of the evaluation communication and collaboration appeared to be improving, but this did not necessarily improve formal information sharing as discussed in the next chapter.

4. System change and information sharing

This section considers whether the service is making an impact on system change including information sharing. It also considers whether there are any key differences in services requirements by different types of location (urban/rural).

4.1 System change

From the partner survey findings, the rating of sharing good practice and the **positive impact on the whole system** were generally favourable overall, with 21 of 28 of survey respondents saying the ORT had a positive impact on the whole system. There were 7 respondents that **did not agree** that there was system change. Those not agreeing that ORT had impacted on system change were spread evenly across the three areas.

Positive aspects of system change highlighted in the survey open responses, and the in the follow-up interviews related to the speed of **referral and responsiveness, assertive out of hours service,** and **effective and complimentary partnership working.** Given the observed value of the assertive approach from the ORTs, one person argued that a national definition of assertive outreach would be useful so this can be delivered properly and consistently, whether by statutory or third sector services. The quick referral process was also mentioned by several consultees, described as a one page process and much shorter that most other providers, with swift responses from the ORT teams. There was one suggestion for improvement in the referral process that there should be one referral email box that partners can use, rather than emailing individual TPS staff members, which could result in the communication being missed when shifts changed.

"They have responded quickly when I have made referrals often at short notice. I have been able to refer high risk people (those who have had multiple overdoses) at high-risk times" (Glasgow stakeholder)

"It has complemented our work and enabled us to have someone to provide support quickly. It has allowed the link into the community for those disengaged from services to engage with recovery support." (Lanarkshire stakeholder)

It was notable from several interviews from across statutory and third sectors that the ORT staff **added value in expertise** and support to their organisations (over and above the support provided to individuals requiring an overdose response).

"Their commitment is second to none. They have formed some great partnerships and influenced service delivery within the drug services." (All areas)

"Out of hours, guidance for us as workers (in the recovery community), so if we are concerned about someone we can seek guidance and get support for it (from the ORT team). Support as well for the team, it can be disheartening when you hear that people overdosing, but having someone there that you can tell and they can follow up, having that safety net is really powerful for us" (Greater Glasgow stakeholder)

Some interviews commented that the **overdose response services is a critical element within a wider picture of provision** to tackle addictions and drug deaths, with one respondent with a national

perspective citing research[12] which clearly shows that a near fatal overdose is a clear marker of potential death and that any area must have a rapid response service as a strand of its service provision for addictions. One consultee from the statutory sector noted that while this type of service can be achieved in the statutory sector (as for Glasgow), the third sector is more agile in developing services quickly, and claimed it is more cost effective at delivering an out of hours service. Others noted the 'cultural baggage' related to statutory services providing outreach services where there is long standing resistance to truly assertive, community-based approaches. Other key elements of an effective addiction service provision identified by consultees were increasing access to naloxone, having clear pathways for anyone that has problematic drug use to know where to go to get help, and stabilisation units/inpatient facilities to treat those experiencing periods of very high drug use with multiple substances. Several consultees criticised the lack of residential bedspaces for this purpose (discussed further below). Consultees claimed that getting to people '*the sooner the better*' will improve chances of survival, reaching people in their own homes who may not be engaging, at the same time reducing stigma, and also reaching families to provide them with information and advice who may not otherwise have been seen.

External stakeholders from Lanarkshire and Greater Glasgow pointed to the service being able to provide assertive outreach to individuals in **rural areas**, which was a change to the normal statutory response of expecting people to come to addiction services in the urban areas which was challenging due to public transport limitations. The need for **greater capacity and resilience** was also noted in these areas, despite the ORT teams' contribution. The TPS staff reflected that in the more rural areas there were little or no crisis or tier three services, less services generally, limited recovery cafés or hubs or community outreach services, so linking people into support services was challenging. It was suggested that these areas should have more satellite and/or outreach service provision.

Despite the value that ORT was seen to bring to the system, a whole range of consultees (internal TPS and external stakeholders) were concerned about the **ongoing service shortages and lack of capacity in the system** to address the core needs of people vulnerable to overdose. The problems were put down to long-term cuts in resources and continued current lack of funding for addiction services, bureaucracy, inadequate pathways, the need for more short- and longer-term residential rehabilitation options, and the inability of public services to be flexible and agile to cater for the identified needs. A number of consultees noted that the relative recent change in Scottish Government attention to the addiction problem in Scotland was welcomed but that *"it wouldn't be fixed overnight – we need 3-5 years to make the current plan work*". There was a desire to continue ORT services in all areas consulted (Glasgow having its own HSCP service), but there were fears about the funding to continue the service. For this reason, some of the ADPs were collaborating to assess whether a joint approach would make the service feasible after pilot status had completed.

[1] Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs, Drug Alcohol Depend. 2016 May 1; 162: 51–55.
[2] Risks of fatal opioid overdose during the first year following nonfatal overdose, Drug Alcohol Depend . 2018 Sep 1;190:112-119. doi: 10.1016/j.drugalcdep.2018.06.004. Epub 2018 Jul 4.

Linked to issues of lack of capacity and ORT's holistic approach, some consultees mentioned that the ORT teams were **working with individuals longer than is intended** due to the lack of capacity in the HSCPs to meet needs. The ORT was designed as an initial response service and then to help the individual to link/reconnect to other services, but as evidenced in the outcomes chapter above, it is clear that the HRPs are sticking with people longer until there is a positive outcome achieved i.e. picked up by the care manager or other HSCP or voluntary sector longer term support provider. This was confirmed through discussions with the TPS HRP staff who identified a need for much more capacity in social care system so that clients were contacted more regularly to help avoid crisis. Despite their understanding that this is a response service, there was a strong feeling from TPS staff that they would prefer to offer more than a response intervention. All felt that there was a need to have more time to engage, to support people to make the connections to referrals made, and step back more slowly from the case, rather than seeing individuals once or twice. This is a reflection of the HRPs dedication to individuals, who often '*keep people on their books*' noting that otherwise they know the person is without support. However, the HRPs' experience demonstrated **continued limitation of the existing system** where they had little reassurance that they are able to effectively refer people on.

> *"I think it would be good to have longer-term involvement so we are able to even say do a once a week check in and help them to make the connections, and also for those who say they do not want to engage with services, we can pop back to them and check that is still the case. We had one person for example over Xmas that we kept open and the [X service] had been closed because of lockdown. We just contacted him by phone every day until that became available, and it helped him to keep motivated and know someone was there. He even self-referred himself back into the service." (TPS staff)*

A strong theme from all consultees was the **lack of capacity in the workforce**, with the opinion appearing to increase on the extent of the problem through the course of this short evaluation. This was born out through the experience of shortages in the ORT teams during the evaluation, although it was exacerbated by the short-term nature of the pilot project and people moving on to more permanent roles. Some statutory service consultees called for an end to pilot projects so that organisations could resource, plan and recruit to deliver a three-to-five year plan across all services and then evaluate on outcomes at that point.

Several consultees referred to the fact that the project had exposed the **need for cultural change** in the addictions sector, to overcome professional rivalries and scepticism from parts of the statutory sector of the third sector's role. Several pointed to the national and local leadership required to make that change happen, although it was felt that had started, including the shift to assertive outreach. Some referred to historical "*very poor attitudes*" in the profession but with a sense that through the national and local change programmes that this had started to change. Two different local consultees referred to their change programmes in their addiction services that "*hadn't been touched in 20 years*."

> *"The system is changing, and it takes leadership to make that happen – the whole culture needs to change, but it is encouraging to see a start on that …there needs to be a shift to assertive outreach and a willingness to get lived experience involved. (All areas)*

As discussed above, change is gradually happening with more **collaboration** between sectors. In many areas examples were provided of improving communication methods between the statutory and third

sector where the ORTs participated including regular complex case meetings, daily tasking meetings with representatives across sectors and with different departments in local authorities, and co-location also helped. One example of effective partnership working was discussed where the ORT was linked formerly to all the statutory services through a signed information protocol. This is discussed further below.

> *"All the services are linked through the Partnership, and through daily and monthly tasking meetings with 14 partners - I can't see who is missing, and they all link well, and each individual should have a single point of contact". (Greater Glasgow stakeholder).*

When external stakeholders were asked **what the system should ideally include**, the most common responses included:

- A rapid overdose response in every area
- Out-of-hours service 7 days a week – ideally 24 hours
- Assertive outreach with the service reaching out into communities, including lived experience of workers so that individuals using the service can relate to them
- Better access to mental health services including change in protocols in relation to when someone is in mental health crisis and also under the influence of alcohol or drugs (where currently they will often not accept referrals due to high levels of alcohol or drug use)
- Alterative to A&E – emergency of crisis beds for stabilisation with clinical support but as an alternative for those who don't want to go to hospital
- More residential spaces for stabilisation and rehabilitation
- Proactive risk identification upstream across different statutory and non-statutory services, with earlier intervention to prevent crisis
- An effective data sharing system.

In line with the external stakeholder opinion, the TPS staff felt that the learning from this initiative has been that more services should move towards out of hours support and assertive outreach. It was pointed out that community addiction teams are still working on an appointment basis and it was argued that as a result people are being lost to the system.

4.2 Information sharing

The evaluation considered whether the ORT service was making a difference to information sharing across the various services that work with people experiencing near fatal overdoses. The barriers to information sharing were explored, where these stem from and what can be done to resolve these barriers.

Current approaches

Discussions with the TPS managers and external stakeholders outlined what the current information sharing arrangements are. It was confirmed that there is only **one formal data/information sharing agreement** with **Renfrewshire Community Safety Partnership** where a public protection information

sharing protocol has been entered. At the point of drafting of the final evaluation report, an Information Sharing Agreement was also agreed for Lanarkshire (September 2022).

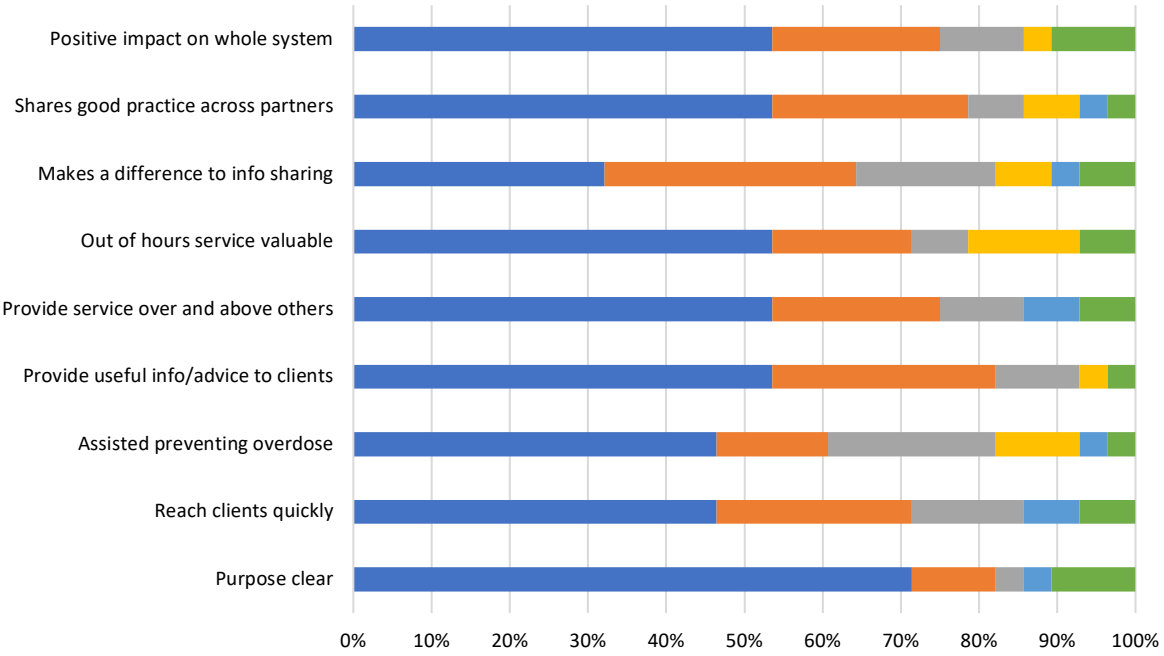
The **Renfrewshire Community Safety Partnership** involves agencies across Police Scotland, the HSCP (social work, community mental health, addictions service), community wardens and other services across the local authority and third sector including Turning Point Scotland Overdose Response Team. It involves daily tasking meetings with 14 partners to consider areas of community concern over the last 24 hours e.g. suicide, sudden deaths, anti-social behaviour, fires. These act as early intervention meetings to make sure action is taken immediately by the right person which work over and above services normal triage systems. There is also a monthly tasking group which provides a strategic view where a range of issues are considered holistically for individuals at risk – housing need, child protection, overdose risks, etc where information sharing is considered in the entirety across partners. The Partnership is governed through a Public Protection Information Sharing Agreement to which TPS is signed up. There is also a physical Community Safety Hub which adjoins the Police Scotland offices. TPS has direct access to the hub and works alongside other services which help services respond quickly and safely to drug overdoses. TPS is seen as a valuable addition to the Partnership through their assertive outreach and out-of-hours response, providing assurance on being able to keep people safe, and also supporting other partner services through expert information and advice.

There were no other formal information sharing agreements in any of the other ADP areas (although Lanarkshire agreed one in September 2022), where individual consent is required for information to be shared with TPS staff. In some cases, this is overcome where there may be life threatening circumstances, and there may also be general discussions through in-person and other verbal communication to be able to share critical information. There are also various informal agreements to share electronic information through password protected files where individual consent had been provided. Co-location with NHS/ADRS staff in some areas has helped where the ORT practitioners hot-desk which helped with information sharing, but also helped to build partnership working across different services. As noted above, in many of the ADP areas ORT staff are regular participants in weekly tasking meetings. In relation to Police Scotland and the Scottish Ambulance Service (SAS), information is only shared where consent is provided by the individual and there are no formal information sharing agreements, unless through a separate Partnership agreement e.g. Renfrewshire Community Safety Partnership. On a local basis SAS shares personal data with an individual Health Boards governed through sharing agreements – there is no national Scottish SAS/NHS approach. In practical terms this problem means that internal HSCP/NHS services can share data, and SAS can share data with the HSCP/NHS if there is a local data sharing agreement. But it is down to the NHS to decide what data is shared with commissioned services.

4.3 Stakeholder opinion on information sharing

From the partner survey and follow-up interview, making a difference to **information sharing was a less positive aspect**. The survey showed that although most agreed that the ORT had made a difference to information sharing, a lower proportion agreed - just 18 of 28 respondents - compared with 23 of 28 agreeing that the ORTs had a clear purpose.

Figure 12: Agreement with positive outcomes



	Purpose clear	Reach clients quickly	Assisted preventing overdose	Provide useful info/advice to clients	Provide service over and above others	Out of hours service valuable	Makes a difference to info sharing	Shares good practice across partners	Positive impact on whole system
Strongly agree	20	13	13	15	15	15	9	15	15
Agree	3	7	4	8	6	5	9	7	6
Don't know / can't tell at this stage	1	4	6	3	3	2	5	2	3
Neither agree/nor disagree	0	0	3	1	0	4	2	2	1
Disagree	1	2	1	0	2	0	1	1	0
Strongly disagree	3	2	1	1	2	2	2	1	3

The rating of **sharing good practice** was generally more favourable, with 22 of 28 agreeing that the ORT had led to sharing good practice. There were 10 that did not agree that the ORT had made a difference to information sharing and 6 respondents that did not agree that good practice was shared. Those **not** agreeing that the ORT had made a difference to information sharing were spread across the 3 areas.

Responses from the partner survey and the follow-up interviews showed a very high level of **collective frustration across all statutory and third sector services around information sharing**, with the strong theme from most that this caused delay, stifled effective partnership working and could mean people were missed in life threatening situations. Many felt that TPS (and other third sector services) should have access to the same data as public services, but the barrier was put down to GDPR constraints, although few seemed to understand why due to life saving considerations (with Renfrewshire being the clear good practice exception). Several examples were provided that despite the ORT service being available over the weekend out of hours, if SAS had a case out of hours and this case had not gone to the NHS then the person would remain unknown to wider health and social care service, and the third sector able to provide a holistic overdose response. Another consultee provided the common example of HSCP staff providing information to ORT from the NHS Hub until 3pm on Saturday (which may have

included referrals from SAS) but after that point there was no way of providing referrals to the ORT until Monday morning. Until then it would only be emergency services that could deal with overdose response.

While most people were frustrated with this situation and talked about informal information sharing approaches, there was also feedback about cultural barriers which drove lack of information sharing from some services. Solutions put forward included becoming more embedded in the statutory services including in the hospitals, and finding more regular communication methods as described above. Senior strategic and operational consultees in the statutory sector commonly referred to the need for national leadership on the issue to provide common guidance for all local services to follow given the apparent deadlock and caution for local data governance team. Some suggested that someone in Scottish Government should be assigned responsibility to resolve the issue. A few argued that where immediate lifesaving action was needed, then it was already clear in legislation that it was better to respond to the identified need, even without individual consent.

"Scottish Minsters say they can't help. There are lots of meetings with governance people and it comes to nothing. It's one of these things that get pinged back and forwards. Some of the local organisations have sorted it, others have not and the ones that haven't say it needs a national person to say what to do." (All areas)

"Yes, it is fundamental SAS share overdose data with TPS as well as NHS as most community services are closed out of hours and this provides a delay in the sharing of information." (All areas)

"It's a nonsense that people are dying and at risk – people are not doing anything about it because they are scared of sharing personal data with services that can help". (National agency)

There was also a suggestion for a steering group to be convened across the various ADPs to share learning in relation to the Overdose Response Teams and how different approaches had worked well, or not.

From the ORT HRPs' perspective, across the three areas the staff reflected that their biggest challenge and frustration was the lack of information sharing from statutory services, and this continued through the whole period of the evaluation. The exception to this (as illustrated above) was the Partnership in Renfrewshire where the formal information sharing protocol, regular meetings and hot desking were all seen to aid relationships building over the past six months. By the endpoint of the evaluation , other partners had developed workarounds, including daily tasking meeting and informal exchange of data, and information sharing had improved across the areas. However, this was because relationships between ORT staff and the NHS had developed, and the downside was, as experienced, when staff moved on to a different role the information sharing stopped. The staff team felt the result of ineffective information sharing was people being missed, time lost, and the referrals being generated by the ORT staff though separate pathways which was not the original intention.

"We know there are people out there who are having overdoses and we are not finding out about them because the sharing of information is not happening." (TPS staff)

The TPS staff reported that information sharing by third sector partners has been good, although it was noted Glasgow had a 'crowded' organisation landscape which resulted in competition and did not lead to a good environment for partnership working. For the Greater Glasgow team another challenge raised was that the team are effectively working with five different ADPs and therefore five different systems, services, risk assessments and ways of doing things. All those consulted concluded that there was a need to get a solution from those at a 'high level' to change the information sharing challenge. This information sharing barrier was seen by TPS staff as a "*matter of life and death*".

As part of the evaluation a comparator approach was examined in Aberdeen where another formal information sharing protocol has been agreed between the NHS/HSCP, wider local authority services SAS, Police, and relevant third sector organisations. This information sharing protocol used there was found to be effective and reported to be working well - the fact that the partners are dealing with high risk of death motivates people to share information appropriately and drives the public tasking around that individual. The approach is said to cut down on time and bureaucracy; typically, an individual identified at risk in the morning may be seen by the afternoon with offers of support.

It was noted through the consultation for this study that Public Health Scotland (PHS) and Scottish Government is aware of the challenges around information sharing, and is understood to be a priority workstream through Medicated Assisted Treatment three (MAT 3) – 'All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT'.

4.4 Summary

The partner survey and interviews were generally positive about system change, with positive aspects highlighting the ORT speed of response, truly assertive approach, out-of-hours, and effective partnership working. The vast majority of consultees welcomed the ORT service and its added value to fill an essential gap in the service landscape, particularly since there are no statutory services which provide out of hours overdose response services in these areas, apart from the Glasgow COS service now established. It was noted that while an outreach service *could* be provided through the statutory sector (as for Glasgow), the third sector is more agile in developing services quickly, is well practiced at negotiating partnerships, does not have the 'cultural baggage' including resistance to truly assertive outreach approaches, and is argued as more cost effective at delivering an out of hours service.

Information sharing was a key area barrier identified in the partner survey where progress had not been as good as for some other outcomes. There was collective frustration across the statutory and third sectors. While communication improved across sectors through the course of the evaluation and various 'workarounds' were used, it was recognised that this was no replacement for a formal information sharing agreement. However, while these informal arrangements were sought to make things work, it was recognised that the lack of formal partnership working and information sharing agreements (with one exception from Renfrewshire) between the statutory and third sector, was a barrier and a risk to ensuring systematic organisational approaches which maximised access to individuals that needed the service.

The challenges associated with information is known by PHS and Scottish Government and said to be a key priority under MAT 3.

5. Summary, conclusions and recommendations

5.1 Purpose of the evaluation

This evaluation has sought to provide insights on the Turning Point Scotland test of change Overdose Response Team Service - ORTs. The key aims of the service is to provide a rapid response to near-fatal overdose to provide harm reduction interventions and advice; give a short, focused period of support maintaining contact through assertive outreach and to help individuals connect or reconnect to support services. It is an assertive outreach service (including out-of-hours and weekends), reaching out to individuals and linking them to services in their communities. The aim of the service is also to test system change – to identify barriers to engagement with services.

A total of 37 individuals that has used the service were interviewed, 18 of which were re-interviewed during the course of the evaluation to see things had change over time for them. In addition, five family members were interviewed. An online survey was completed by 28 partners for the interim stage, and in-depth interviews provided more context from 17 interviewees across the statutory and non-statutory sector. Two respondents with a national perspective were interviewed.

Each of the evaluation questions are summarised and concluded upon below, and linked back to the service original objectives which were to:

- Reduce and prevent drug related deaths caused by fatal overdose.
- Improve information and understanding of the extent of non-fatal drug overdose, identify barriers to engagement with services, and inform system change that works for people not services.
- Provide rapid response to near-fatal overdose which provides harm reduction interventions and advice.
- Give a short, focused period of support maintaining contact through assertive outreach.
- Improve access and engagement to healthcare and support services through assertive outreach and linkage.
- Target people in localities and communities recognising that most drug related deaths occur when people are at home, alone.

5.2 Summary and conclusions

Individual outcomes

The evidence gathered shows that the service has been able to find people, engage with them, it has saved lives and helped individuals engage with other services. The evidence shows that there was considerable activity in reaching people in Glasgow, and growing number of cases in Greater Glasgow and Lanarkshire, albeit limited in the latter case by staffing issues towards the endpoint of the evaluation. TPS worked with Glasgow HSCP in establishing its own statutory Crisis Outreach service which meant the GORT service was no longer required in the City.

Time was critical for the individuals concerned, and the shortest engagement times had the more favourable outcomes – referrals directly from hospital appeared to provide one of the quickest referral pathways, and there were clearly lessons to be learned from how the Lanarkshire hospitals had developed a strong direct relationship with the ORT staff to provide fast referrals. There were opportunities to develop this approach elsewhere. Most other referrals came from Community Addiction Services, with the exception of Renfrewshire where all Community Safety partners were involved.

Interviews with 37 individuals showed that the ORT service provided a critical immediate overdose response service to save lives, and support to engage with other services. Looking at the eighteen individuals re-interviewed during the evaluation period, this showed that for most there was an improved situation – most were either abstinent, were on some form prescription to manage their drug use or had reduced their drug use; 12 from the 18 individuals re-interviewed said they had not had repeat near fatal overdoses at the point of the follow-up interviews. Five were still using drugs in a problematic way, and one person wanted to move onto prescriptions. Those that had moved onto prescriptions thought buvidal, pregabalin and diazepam were life changing.

While these outcomes cannot be directly attributed to the ORT service, it was clear from these testimonies that it was an essential part of the pathway to recovery, assuming there was access and availability of other recovery services including residential treatment services. However, many individuals interviewed criticised the lack of support or access to treatment that they felt they needed. It was also evident that wider circumstances (including housing, lack of independent living skills, poor health or lack of life skills to resolve these) were barriers to recovery. The interviews confirmed that the ORT team made referrals assertively to statutory services and other support services including other third sector organisations, drop-in clinics and at supported accommodation. Families were also supported through the ORT team through information and advice. Based on these interviews, the impact of the service has been significant, saving lives, supporting people into treatment (where this is available), out of unsuitable accommodation, improving physical and mental health, and helping them to regain hope and re-building connections with family and friends.

> *"The big thing for me is that they came out to me, listened to me and they are helping me to fight the fear that I am not alone. They came to me. You know a lot of people are scared to go out so they came to me... There should be more of this for people. I think they need to get out on the streets and help people."*

Partners rated the outcomes of the service very positively, although a small minority suggested limitations - this was often associated with external partners own organisational resistance to change and embracing the third sector provision. The most positive attributes were rapid responsiveness, the assertive outreach and out-of-hours offer, and commitment to individuals using the service. There was strong appetite for the service to continue, expand in capacity and length of out of hours offered. Shortages of staff, exacerbated through the short term 'test of change' nature of the project was a key constraint for ORT as individuals moved on to longer term permanent positions. At the same time workforce challenges experienced across health and social care sectors, and the addictions sector in particular were noted by many stakeholders. There was widespread recognition of limitations with most statutory addiction services not providing sufficiently assertive outreach and out of hours

approaches, and the cultural barriers and their lack of agility in developing the addiction services to make the required change.

Who the service is reaching and not reaching

Individuals assisted by the ORT service tended to be predominantly male and aged between 35-45 years, though Glasgow had an older profile and Lanarkshire had a younger profile. More than half had their own tenancy, but there were more people in B&B in Glasgow and Greater Glasgow, and more living with family and friends or in a temporary furnished flat in Lanarkshire. There were proportionately more service users in supported accommodation in Glasgow. At endline, Greater Glasgow had far more referrals from those in B&Bs while Lanarkshire had more in in supported accommodation. This profile suggests that either GGORT are accessing people with more complex needs coming from B&B accommodation, or it indicates that the temporary accommodation situation is Greater Glasgow. There were indications of more cases with complex needs in Glasgow and in Greater Glasgow, with the numbers of multiple referrals increased in Greater Glasgow and high use of naloxone and safer injecting kits by endline.

The evidence suggests that those less likely to be reached were younger people, males, and homeless people not in supported accommodation in Glasgow, particularly those with more complex needs, and women experiencing domestic violence, and not engaging with services for fear of losing their children. In Lanarkshire and Greater Glasgow, there appeared to be a need to focus activities on being able to contact younger people and engaging females, and on outreach for those in their own tenancies, and those with No Fixed Abode. Those in B&Bs and Supported Accommodation appeared easier to contact but harder to engage with.

There was a strong theme from partners and TPS staff that people who were hard to reach, by their nature, required strong collaborative working, continual awareness raising of the ORT services, and assertive outreach so that people not engaging with statutory services could be found within communities. Through the course of the evaluation communication and collaboration appeared to be have improved, but this had not necessarily improved formal information sharing.

System change and barriers to information sharing

The partner survey and interviews were generally positive about influences of ORT on system change, with positive aspects highlighting the ORT speed of response, truly assertive approach, out-of-hours, and effective partnership working evidenced. The vast majority of consultees welcomed the ORT service and its added value to fill an essential gap in the service landscape, particularly since there are no statutory services which provide out of hours overdose response services in these areas, apart from the Glasgow COS service now established. It was noted that while an outreach service could be provided through the statutory sector (as for Glasgow), the third sector was more agile in developing services quickly, well practiced at negotiating partnerships, did not have the 'cultural baggage' including resistance to truly assertive outreach approaches, and was argued to be more cost effective at delivering an out of hours service.

While an assertive overdose response service is a critical element within a wider picture of provision to tackle addictions and drug deaths, it alone cannot reduce drug deaths in Scotland. Other key

elements of an effective addiction response identified was increasing access to naloxone (to which the ORT project has contributed), having clear pathways for anyone that has problematic drug use to know where to go to get help (again ORT has contributed), and stabilisation units/inpatient facilities to treat those experiencing periods of very high drug use with multiple substances. Individuals using the ORT service complained about lack of treatment facilities, and wider stakeholders criticised the lack of residential bedspaces for this purpose. Workforce capacity building, combined with long term planning and resources for addiction services were also seen as essential to cementing change.

Information sharing was a key area barrier identified throughout the evaluation, and there was collective frustration across the statutory and third sectors. This was despite good practice being evidenced through a formal information sharing protocol in Renfrewshire, and wider examples existing across Scotland, with Aberdeen provided as a case study example. The inability of some HSCPs to overcome data governance barriers (while others have been able to do so) suggests that national leadership and guidance at the Scottish level is required to contribute to the overall aim of saving lives.

5.3 Recommendations

Taking all the findings into account the following recommendations are put forward:

- **Every ADP area in Scotland should have an assertive outreach response.** The evaluation shows that this model works, and with the key elements that underpin this model - out of hours and assertive outreach - it has been shown to be one of the essential elements to contribute to reducing drug deaths in Scotland. Other elements include access to naloxone, risk assessment and clear pathways for information and support for those at highest risk to prevent crisis (overdose response teams can contribute to both of these), and effective treatment including access to residential rehabilitation.

- **Collaboration works** and for the local **Greater Glasgow and Lanarkshire** services, the ADPs should collaborate to fund the piloted Overdose Response service which has already established partnerships in these areas. A steering group could be formed to help the specification, commissioning and monitoring of such an approach.

- **The current system does not encourage collaboration that is required. The key elements are:**

    - **Creating better referral pathways –** these should be developed across local statutory and non-statutory services. These referral pathways should be embedded through **formal information sharing partnerships and protocols**, such as the examples provided by Renfrewshire, and Lanarkshire. This is often best achieved when led by the local Health Board and bringing in all other relevant partners.

    - **Breaking down resistance to formal information sharing through national leadership from Public Health Scotland and Scottish Government**. This issue has been such a significant barrier that a national leadership role is required to drive change on this critical problem, quickly.

    - **Working with statutory services to break down the cultural barriers of professional wariness** evidenced in mistrust from statutory services of third sector services. Breaking down these barriers will maximise the number of individuals suffering reached, as evidenced through this evaluation.

  - **Addressing structural barriers** including funding and commissioning which stifles the ability of coordinate across ADPs and get the benefits of economies of scale.

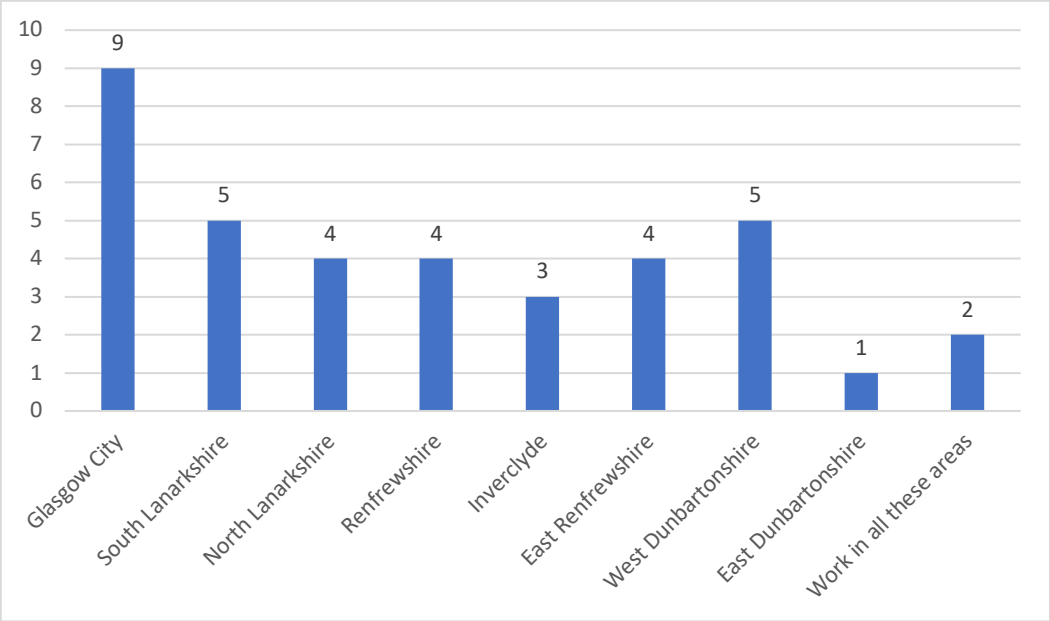
- **The availability and capacity of support services needs to be improved** with key gaps being support services for those leaving institutions to help them access financial support for crises and to support setting up a tenancy, plus housing support and other wrap-around services, but a more general lack of support services for those moving on from crisis is evident.

- **Developing greater capacity in a skilled workforce** required for this specialist field should be addressed through workforce planning undertaken collaboratively with Scottish Government, HSCPs and with the third sector.

Appendix 1- Partners survey questionnaire

Appendix 2 – Partners survey response profile

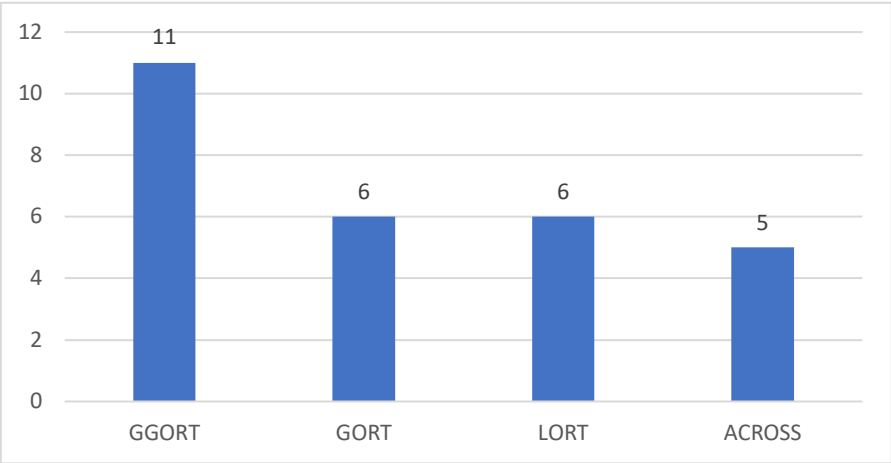
Figure A1: Geography of partner survey respondents



Source: Partner survey (n=28)

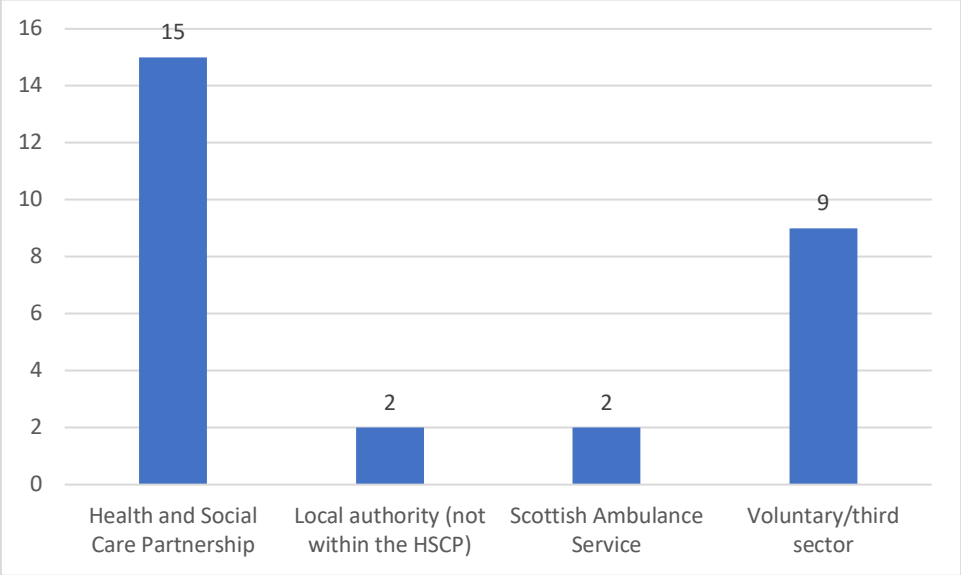
Some partners worked across a range of areas, so would be responding in relation to more than one ORT location. Five respondents indicated working across more than one ORT location while 11 were in Greater Glasgow, 6 in Glasgow City and 6 in Lanarkshire.

Figure A13: ORT area of respondents



Source: Partner survey (n=28)

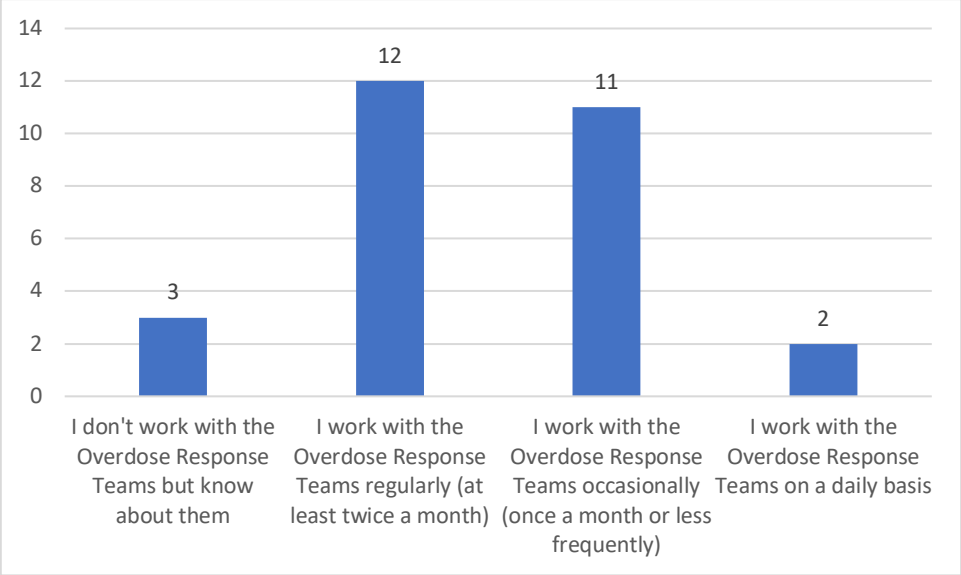
Figure A3: Organisation of respondents



Source: Partner survey (n=28)

The largest group of respondents were in the Health and Social Care Partnership (15) followed by the voluntary/third sector (9) with 2 local authority respondents and 2 from the Scottish Ambulance Service.

Figure A4: Working relationship with the ORT

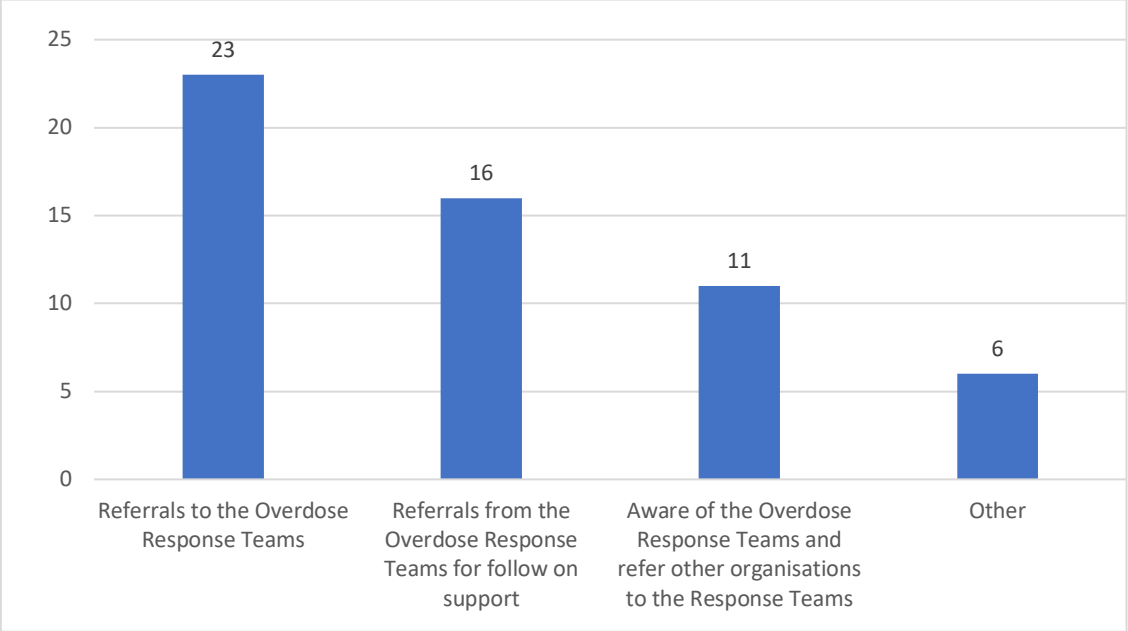


Source: Partner survey (n=28)

The largest group of respondents (12) said they worked with the ORTs regularly (at least twice a month) or occasionally (11 said once a month or less frequently). Three respondents knew of the ORT but had not worked with them and two respondents worked with the ORT on a daily basis.

Most respondents (23 of 28) referred to the ORTs, while 16 got referrals from the ORT and 11 referred other organisations to the ORT.

Figure A5: Referrals to and from the ORT



Source: Partner survey (n=28)

Appendix 3 – Monitoring data by ADP

Referrals by gender

Gender	Lanarkshire (N/S)	South Lanarkshire	North Lanarkshire	Total LORT	GORT
Female	1	25	15	41	205
Male	3	96	75	174	501
Not specified	-	-	-	-	3
All	4	121	90	215	**709**

Source: LORT case management data (N/S – location not specified); GORT case management data

Gender	West Dunbartonshire	East Dunbartonshire	East Renfrewshire	Inverclyde	Renfrewshire	Total GGORT
Female	57	14	5	9	30	115
Male	93	27	18	17	98	253
All	150	41	23	26	128	368

Source: GGORT case management data

N.B. LORT data covers the period from July 2021 to August 2022, GORT data is for the period from 1st November 2020 to 31st October 2021, GGORT data covers the period from September 2021-August 2022

Referrals by age

Age	Lanarkshire (N/S)	South Lanarkshire	North Lanarkshire	Total LORT	GORT
No age data		1		1	
16-24		19	5	24	44
25-34	4	26	33	63	135
35-44		32	31	63	234
45-54		33	19	52	239
55-64		9	2	11	50
65+		1		1	7
Grand Total	4	121	90	215	709

Source: LORT case management data (N/S – location not specified); GORT case management data

Age	West Dunbartonshire	East Dunbartonshire	East Renfrewshire	Inverclyde	Renfrewshire	Total GGORT
16-24	10	8	2	2	10	32
25-34	40	12	3	7	22	84
35-44	53	12	10	10	44	129
45-54	36	7	7	5	48	103
55-64	11	2	0	0	4	19
65+	0	0	1	2	0	1
All	150	41	23	26	128	368

Source: GGORT case management data

Referral sources

Referral source	Lanarkshire (N/S)	South Lanarkshire	North Lanarkshire	Total LORT
Addiction Liaison	1	52	39	92
Navigators		9	14	23
Supported Accommodations	1	3	18	22
Cares	1	14	1	16
Cos		10	3	13
Crot		11	1	12
Ambulance		7	3	10
Housing Provider		2	3	5
Gort	1	1	2	4
Harm Reduction Team (Lanarkshire)		3	1	4
Self		3	1	4
Art		1	1	2
Family/Friends			2	2
Reachout		2		2
Social Work		2		2
Nlrc			1	1
Self Referral		1		1
All	4	121	90	215

Source: LORT case management data (N/S – location not specified)

Referral source	Total GORT
A&E List	100
Ambulance	2
Glasgow Crisis Outreach Team	51
Glasgow Royal Infirmary	2
Hat	194
Housing	16
Hunter Street	32
Navigators	5
Ne Gadrs	49
Nw Gadrs	55
Phoenix Team	4
Police	2
Qeuh	1
S Gadrs	36
Self	3
Statutory Sector Other	80
Street Team	18
Vol Sector	59
All	**709**

Source: GORT case management data (N/S – location not specified)

Referral source	West Dunbartonshire	East Dunbartonshire	East Renfrewshire	Inverclyde	Renfrewshire	Total GGORT
CAT Team	124	38	11	18	81	272
Police	0	1	4	0	6	11
Drop-In	0	0	0	0	0	0
3rd Sector Service	4	0	0	2	1	7
Ambulance	10	1	3	6	7	27
Social Worker	7	1	4	0	33	45
Self -Referral	5	0	1	0	0	6
All	150	41	23	26	128	368

Source: GGORT case management data

Interventions

First intervention	Lanarkshire (N/S)	South Lanarkshire	North Lanarkshire	Total LORT
Email		35	32	67
Phone contact		34	23	57
Other type of engagement	4	28	17	49
Outreach		16	7	23
Face to Face contact		2	3	5
Alternative methods		1	2	3
Scottish Ambulance Service		1	2	3
Alternative methods - routes of drug administration		1		1
MAT - already on at referral			1	1
MAT - referral made		1		1
Naloxone - kit provided by ORT team			1	1
Overdose awareness			1	1
Grand Total	4	119	89	212

Source: LORT case management data (N/S – location not specified)

Service Provided	Total GORT
Alternative methods - routes of drug administration	423
Email	417
Face to face contact	286
Family/Friends - Advice/information	33
IEP	37
Recovery Literature	56
GORT NFO Questionnaire	49
Naloxone Refused	**38**
Naloxone - already has kit/training at referral	70
Naloxone - kit provided by GORT	72
Other type of engagement	257
Outreach	256
Overdose awareness	186
Phone contact	1137
Safer injecting practice discussed / BBV Awareness	80

Source: GORT Annual Report (1st November 2020 – 31st October 2021)

Service Engagement (all)	West Dunbartonshire	East Dunbartonshire	East Renfrewshire	Inverclyde	Renfrewshire	Total GGORT
Alternative Methods	41	25	23	9	86	184
F&F - Advice/information	32	12	34	16	155	249
F&F - Naloxone Training	3	2	2	3	1	11
IEP	23	0	4	3	74	104
Literature & Contact Details	18	36	4	0	13	71
MAT - Already on at referral	177	46	8	1	50	282
MAT - Started Treatment	27	0	1	1	27	56
MAT- Referral Made	19	10	1	0	30	60
Naloxone - Already had	7	2	4	2	8	23
Naloxone - Kit Provided	45	15	2	3	30	95
Naloxone - Refused	14	6	1	1	9	31
Naloxone - Training Provided	21	2	2	1	13	39
Overdose Awareness	520	196	37	12	168	933
Positive Outcomes	134	53	18	11	125	341
Safe Injection Practice	4	2	2	0	13	21
Wound Care Advice	4	0	2	0	11	17

Source: GGORT case management data