Staff Guidance

Glasgow Alcohol and Drug Recovery Services:

Addressing Missingness in Community ADRS

Lead:	ADRS Operational Managers, ADRS Service Managers, ADRS Senior Medical Officers
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Context and Purpose

Since the COVID-19 pandemic, our ability to maintain regular face-to-face contact with service users has been significantly disrupted. ADRS continues to face challenges in re-establishing consistent engagement and offering people the opportunity to build ongoing therapeutic relationships with a dedicated care manager.

These challenges are complex and require compassion and flexibility to overcome. It's important to acknowledge that people's expectations of care may have changed following the pandemic, and rebuilding engagement will take time.

When a patient is not using services in the way we expect them to, the first response should be curiosity – are there any engagement barriers and what can be done to overcome them?

This guidance has been developed to:

1. Outline best practice for supporting service user contact within usual care management.
2. Support staff in assessing risk and making informed decisions where engagement is difficult or contact is limited despite best efforts.
3. Reassure staff that these challenges are understood and shared by the service, helping to reduce individual stress and responsibility.

Part 1: Best Practice for Caseload Contact

All contact attempts and outcomes - no matter how small - should be documented. Even seemingly minor efforts are part of a wider pattern of engagement that can provide vital information.

Scenario 1: Telephone Contact without Face-to-Face Engagement

In these situations, continuity of care is key. Where there have been breaks in care or staff turnover, making every effort to offer consistency can help rebuild trust:

- Explore the person's priorities and goals for their care—short, medium, and long-term—to align support with what matters to them.
- Consider what needs to be dealt with now – i.e. health, social, safety issues and try to address/support.
- Help the person understand the value of face-to-face contact as a way to better understand and support them safely and effectively.
- Ask what might be getting in the way of attending in person, and explore solutions such as travel support or timing adjustments.
- Ask and record how they prefer to be contacted, this may change over time and should be checked regularly.
- Agree on a contact venue and frequency that works for the person (home, ADRS base, health centre or a more informal setting).
- Emphasise the range of support ADRS offers: holistic care plans including mental health support, physical health assessment, IEP, foil and naloxone provision, BBV screening

and treatment, welfare advice, bus tokens/passes, housing support, and referrals/signposting to recovery services and other community resources.

Scenario 2: No Contact Despite Attempts

This scenario often requires creativity, persistence, and a trauma-informed approach. Lack of contact, sometimes called "*missingness*[1]" may arise from fear, stigma, past experiences, or life instability - not a lack of willingness. It is important to consider any contributing service factors which could be adjusted.

Things to try to achieve contact:

- Phone calls or texts with positive, encouraging language.
- Visit the person's place of residence - leave a note encouraging contact if they are not in.
- Engage support staff at accommodation settings for insight re routines, risk etc.
- Check community pharmacy attendance – patterns, presentation and any concerns. Consider the possibility of going to the pharmacy if they usually attend at a regular time.
- Use positive written communication: "We would really like to see you in person. We're keen to support you. Please get in touch so we can make sure your care and treatment meets your needs."
- Adapt communication for literacy, language, or disability barriers (interpreters, alternative formats).
- Staff should be aware that many people report not opening letters due to previous negative experiences, fear and avoidance, also the person may not be staying at the registered address. Alternative ways to ensure a letter reaches someone should be considered i.e. through other services involved.
- Collaborate with other agencies (e.g., mental health, justice or housing) and consider joint visits.
- If the person is referred to Crisis Outreach Service (COS) from Scottish Ambulance Service or hospital admission, COS contact with care manager can add helpful information.
- Leverage existing appointments (Buvidal clinics, hospital admissions) to reconnect.
- Offer meetings in familiar or neutral spaces like recovery cafés or other local spaces such as parks or libraries.
- Provide practical support: bus passes, nearby appointments, or taxi arrangements (occasionally available with TL/NTL agreement).

[1] Understanding the causes of missingness in primary care | BMC Medicine | 2024

If these steps remain unsuccessful after a significant period, discuss with the usual prescriber and team lead (TL/NTL) to review next steps and escalate care planning. (See appendix tool for TL/NTL supervision – provides overview of contacts/attempts.)

Part 2: Future Care Planning and Risk Analysis

Step 1: Consideration of Risk Balance

Gather all available information from health and social care systems (EMIS, clinical portal, ECS, Carefirst), pharmacies and other services and partners. Information which should be considered (not an exhaustive list):

- known harms caused by drugs / alcohol use
- non-fatal overdoses
- hospital admissions (acute / psychiatry)
- physical / mental health issues
- harm to self / others
- justice / police custody
- housing instability
- care of children / vulnerable adults
- social circumstances
- domestic abuse[2]
- history of low engagement[3]
- use of crisis services
- involvement of support services

This will build a picture of current risks and highlight potential future risks.

Step 2: Review of Treatment Plan

(1) If contact remains unsuccessful, send a clear letter explaining that without in-person review, the care plan may need to be adjusted for safety. Provide a reasonable timeframe for response and clearly detail the timeframe in the letter. Consider how to ensure the letter is received and read. Consider that the person may make contact at a time the care manager is unavailable and what should happen in this situation.

(2) If there is no response in the time frame, changes to the treatment plan which may be considered at this stage, in the context of the individual and their circumstances, include:

[2] Hard Edges - Reality For Women 2024

[3] Morbidity, mortality and missed appointments in healthcare | BMC Medicine | 2019

- Adjusting frequency of medication dispensing and any supervision
- Changing prescription length
- Consider reducing or stopping non-opioid medication (e.g. begin diazepam step down)
- Alter paper prescription collection arrangements i.e. use the flexible working guidance to link prescription collection with an appointment. Note at this stage, the prescription would be delivered to pharmacy if the person did not attend. There should be no interruption of treatment.

Any change requires a documented risk/benefit analysis.

It should also be noted that any changes to treatment must be communicated to the person in advance of their attendance at community pharmacy. It is not the responsibility of the community pharmacy staff to deal with a person's reaction to an unanticipated treatment change. Relationships with community pharmacies can be key in these scenarios. Involving the pharmacy in any plans to make changes and being clear about attempts made to communicate these will help anticipate any difficulties.

Allow sufficient time for a response to any changes, this should be agreed between the care manager and prescriber.

(3) If still no engagement, convene a case discussion meeting including care manager, prescriber, TL/NTL, Operational Manager (OM), and SMO to agree a short term and longer term treatment plan.

This discussion will bring together all the available information about the person and consider the risks of their individual circumstances. It should include the clinical evidence detailed below regarding the increased mortality risks of interrupting or stopping OST.

The agreed care and treatment plan would include:

- Robust analysis of current risks and mitigations/safe guards
- Expectation of future care manager contact attempts
- Consideration for most appropriate option for future delivery of care e.g. core, STARS, shared care
- Plan for any prescribed treatments
- Role of any other involved services e.g. COS, community recovery hub
- Review and update CRAFT and RAG
- Plan for review of care plan
- Communication to GP and others involved

These decisions can be difficult and involve balancing many different risk factors and different priorities of the multidisciplinary team. A summary of the discussion, risk analysis and rationale for the agreed plan should be documented on Emis.

If agreement cannot be reached by OM, TL/NTL and SMO, the case should be escalated to the locality Service Manager.

Clinical Evidence Summary

The majority of people in GADRS who are prescribed medication and are missing from regular contact with care managers are prescribed Opioid Substitution Therapy (OST).

There is a strong body of international[4] and national[5] evidence demonstrating that OST is a protective factor, reducing mortality while in treatment. In Scotland, being in OST treatment reduces the risk of drug-related death by almost 3.5 times[6].

Continuity of OST is critical: mortality risk rises significantly when treatment is interrupted or stopped. Any changes to OST continuity should recognise the immediate 4 weeks after treatment interruption as a critical intervention point.

Chapter 4 of the UK guidelines[4] outlines the expectations around applying safe OST prescribing boundaries and concludes that any decision to temporarily or permanently exclude a patient from a drug treatment or to provide coerced detoxification will increase the risk of overdose death, contracting blood borne viruses and offending.

Making Risk Informed Decisions

Scottish Government's realistic medicine approach suggests use of the "BRAN" decision making tool[7] which may be helpful:

B – what are the **Benefits** of the proposed change?
R – what are the **Risks** of the proposed change?
A – are there any **Alternatives**?
N – what if we do **Nothing**?

Positive, Trauma-Informed Communication

Always use positive, respectful language[8]. Acknowledge barriers and express genuine concern:

"Thank you for being in touch today. We understand this may have been difficult. How can we support you further?"

Avoid language that induces guilt or shame. Try to avoid formal, professional jargon and focus on reassurance and collaboration, reserving any frustrations for discussions with managers, in supervision or reflective practice.

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[4] Drug misuse and dependence: UK guidelines on clinical management - 2017
[5] Drug-related deaths rapid evidence review: Keeping people safe. NHS Health Scotland; 2017
[6] Mortality among individuals prescribed OST in Scotland, 2011–20: The Lancet Public Health 2023
[7] Realistic Medicine | NHS inform
[8] Communicating effectively with inclusion health populations: 2022 ICCH symposium

Example scenarios to consider

If the risks overall are assessed as low and there may (or may not) be other services involved who can ascertain wellbeing (pharmacy / community support services / GP) the outcome of this risk analysis and care planning discussion may be an agreement that the lowest risk option is to continue OST treatment without regular direct contact from ADRS. It is possible that this person would be considered for transfer to shared care.

If the risks overall are high and there are concerns about the safety of continuing OST without contact, any change to treatment must only be made when it is assessed that the risks of continuing treatment without contact are greater than the increased risk of drug related death associated with an interruption in treatment.

Depending on the situation, it may still be decided that continuing OST in a high risk situation with no contact is less risky that interrupting it. The focus in these situations may be to try to provide support from other sources (i.e. COS, Simon Community street team) from who we can obtain information to support decision making and to keep the door open for more support if / when the person is able.

Appendix – Checklist tool

	Date and details
In Person contact	
Telephone contact	
Office / clinic space appointment	
Home visits / other venue	
Pharmacy contacted	
Letter sent	
Next of Kin contacted	
GP contacted	
Other agencies contacted	
Last BBV	
Last drug screen and result	
Last prescriber review	
Known barriers to engagement	
Risks assessed	
Discussed with prescriber	