2010

NEEDS ASSESSMENT OF DRUG AND ALCOHOL PROBLEMS IN EDINBURGH CITY

Report prepared for Edinburgh Alcohol & Drugs Partnership

EVIDENCE INTO PRACTICE

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Terminology

This report provides information from a range of sources throughout Edinburgh City and Lothian. When the term *Lothian* is used in this report it relates to the geographic area covered by NHS Lothian.

Abbreviations

The following abbreviations are used throughout this report.

AA	Alcoholics Anonymous
AOE	Aberlour Outreach (Edinburgh)
AP	Access Point
APS NHS	Alcohol Problem Service (NHS)
ALS	Alcohol Liaison Service
BCC	Bethany Christian Centre
CA	Cocaine Anonymous
CP	Castle Project
CHAI	Chai Support Service
Circle	Circle Family Services
CARS	Community Addiction Recovery Service
CDPS	Community Drug Problem Service
Crew	Crew 2000
DRT	Drug Referral Team
DTTO	Drug Testing & Treatment Order
ELCA	Edinburgh & Lothian Council on Alcohol
GC	Gowrie Care
HP	Harbour Project

HRT	Harm Reduction Team
HOP	Homeless Outreach Project
HYPE	HYPE
LPTPS	Leith Project, Turning Point Scotland
LEAP	Lothians & Edinburgh Abstinence Programme
MEARS	Midlothian and Edinburgh Alcohol Referral Service
MAS	Midpoint Accommodation Support
MTPS	Midpoint, Turning Point Scotland
NA	Narcotics Anonymous
NEDAC	North Edinburgh Drug Advice Centre
RI	Rankeillor Initiative
RRRT	Residential Rehabilitation Referral Team
SACRO	SACRO Arrest Referral Service
SHC	Simpson House Counselling
Street Work	Street Work
SURGE	Substance Use Reference Group Edinburgh
SW(ART)	Social Work Alcohol Referral Team
SW(BBV)	Social Work Blood Borne Virus Care Management Team
SEDAC	South Edinburgh Drug Assessment Clinic
WEAG	West Edinburgh Action Group
WESA	West Edinburgh Support Agency

EXECUTIVE SUMMARY

Background and Aims

This document presents the findings of the needs assessment conducted across Edinburgh City and reports on the future requirements for services for people with drug and alcohol problems in the area.

The purpose of this project is to assist Edinburgh Alcohol and Drugs Partnership (EADP) in meeting the recommendations of the Delivery Reform Group report (2009) by providing an assessment of current specialist drug and alcohol services, as well as a health needs assessment of local needs and gaps.

Figure 8 Consultancy Services Ltd. was commissioned by Edinburgh City Council in December 2009 to carry out the study, and field work took place between January 2010 and April 2010.

The specific objectives of this project were to assess current provision and examine current use of specialist drug and alcohol services across the three areas:

a. to conduct an assessment of local need for such services,
b. to identify gaps and areas of unmet need in current provision, and
c. to provide evidence-based recommendations for the development of local specialist services.

Methods

The study was conducted in six stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods including questionnaires, online surveys, one-to-one interviews and focus groups. Sample populations included service users, drug and alcohol service managers and staff and a range of wider stakeholders from health, social care, police and criminal justice settings.

Recommendations

The recommendations set out below are drawn from the evidence of current practice with regard to the range and capacity of alcohol services in Edinburgh compared to the research and guidance referred to throughout this report. These are presented for the consideration of the EADP and their partner organisations.

1) Edinburgh ADP should look at ways to reduce alcohol related hospital admissions, targeting those people who live in areas of where admissions are higher. This might include the better targeting of treatment services and/or public health campaigns.

2) Given that the rate of reported drug related maternities is twice the national average, Edinburgh ADP should ensure that the Prepare service and other treatment services are adequately resourced and targeted to work with this group of women and their families.

3) Edinburgh ADP should look further at the need for services to manage people who are drunk and incapable. This includes providing a place of safety as well as looking at ways to reduce the numbers of people who binge drink to this extent. Approaches to this issue would need to include the Licensing Board, the Police, Services for Communities, Children and Families, The Scottish Ambulance Service, NHS Lothian and key members of the voluntary sector. The ADP may also want to consider developing and/or reviewing initiatives such as the Street Pastors Projects which appear to have been successful in other cities.

4) There is a need to ensure that a full range of evidence based interventions is available to meet the identified needs of alcohol and drug dependent people across the city. Greater emphasis needs to be placed on the development of psychological and psychosocial interventions such as structured counselling, cognitive behavioural therapy and social skills training.

5) There appears to be a gap in the links between drug/alcohol treatment and recovery services and those supporting people to access employment. The ADP should ensure that drug/alcohol treatment and recovery services are identifying their clients' / patients' employment related aspirations and needs as well as looking at strengthening the links between education, training, volunteering and employment services and treatment / recovery services. Further thought should also be given to developing opportunities for people in recovery to access employment.

6) Given the prevalence of dual diagnosis the ADP should prioritise implementing the recommendations and good practice guidance contained in *Closing the Gaps* and support the development of multi-agency protocols and pathways for people with mental health and substance misuse problems. This would include an appraisal of the training needs of staff working across these areas.

7) Further work is needed to identify the numbers of children affected by a parent's problem drug/alcohol use. This may require joint working between Children and Families and Drug/Alcohol Treatment Services. Alongside this further work is needed to develop clear care pathways for pregnant women, parents with problematic drug/alcohol use and their children so that the needs of these people can be met at both a family and individual level.

8) There are almost 3000 people attending alcohol and drug services in Edinburgh yet there is a disproportionately low level of work with couples, families and carers. Further work is required to identify a range of measures to complement the existing provision in the city.

9) Further exploration as to the level of re-provision of drug and alcohol services for young people under the age of 18 is required. As the re-structuring of HYPE was taking place during the needs assessment no judgement of the extent to which the new provision will provide the range and capacity of services required can take place.

10) Further work is needed by the ADP to identify the need for residential detoxification and rehabilitation. Forthcoming guidance is expected from the National Treatment Agency in England on identifying the need for residential services which may be adapted to fit the Scottish context. Services will then need to be developed by the ADP to meet this need.

11) There needs to be a clear and well publicised pathway in place for people to access residential detoxification and rehabilitation. This should include criteria for access as well as support pathways post discharge.

12) Evidence from the gap analysis, as well as the existence of waiting lists suggests that there are challenges in terms of the capacity of services to meet the need. This may be due to an under-resource in terms of alcohol and drug treatment provision or due to the cost-effectiveness of the current treatment system. Evidence based on the national prevalence study points to a need for more services for men however no such gender distinction should be made on any additional resource put in place. The ADP should look at ways of making the current treatment system more cost effective so that capacity can be increased; further to this the ADP may need to increase investments in treatment services to meet any further short-fall in capacity.

13) A recovery oriented treatment system should be dynamic and offer pathways for service users to move through the service system as they progress in their recovery. This movement not only suggests progress for individuals but also suggests that there is throughput within the system. The ADP should ensure there is a clear pathway which identifies routes into, through and out of treatment and recovery services and should set up arrangements to monitor the throughput within the system.

14) The ADP should map the existing provision of self help services such as AA/NA/ SMART and identify ways to support the development of self help to ensure that it is an integrated part of the treatment and recovery system.

15) The planning and development of services should be built around the ambitions of service users and their families within a recovery-orientated system of care. Developing services in this way will provide benefits to people who use the service but will also help develop community based mutual aid and peer support networks, thereby enhancing the ability for people to move on from services. Consequently the ADP should develop a clear framework for how service users and their families should be involved in the delivery, development and commissioning of drug/alcohol services.

16) The ADP should have a role in facilitating the development of recovery communities within Edinburgh to support people in their recovery.

CHAPTER 1: INTRODUCTION

1.1 Background

The importance of alcohol and drug partnerships conducting a full needs assessment has been made in a number of national reports, for example, by the Delivery Reform Group. More recently in the Audit Scotland report, Drug and Alcohol Services in Scotland, one of the key recommendations for public sector bodies was to:

'Ensure that all drug and alcohol services are based on an assessment of local need and that they are evaluated to ensure value for money.'[1]

The recent Scottish Government delivery framework also reinforced the need for partnerships to conduct needs assessment.

The purpose of this project is to assist Edinburgh Alcohol and Drugs Partnership (EADP) in meeting the recommendations of the Delivery Reform Group report (2009) by providing an assessment of current specialist drug and alcohol services, as well as a health needs assessment of local needs and gaps.

Figure 8 Consultancy Services Ltd. was commissioned by Edinburgh City Council in December 2009 to carry out the study, and field work took place between January 2010 2009 and April 2010.

1.2 Scope of the Project

This document presents the findings of the needs assessment and reports on the future requirements for services for people with drug and alcohol problems across Edinburgh City. This includes:

- a comprehensive overview and mapping of both specialist and non specialist treatment and prevention services for drug and alcohol misuse, including carers of people with drug/alcohol problems, to identify gaps and overlaps;
- linked to the above, an assessment of the adequacy of current service provision and unmet need;
- assessment of current use of specialist services, both community and residential;
- consideration of geographical factors such as area deprivation and the consequent service requirements;
- analysis of the degree of user involvement;
- consideration of patterns of late-night, hazardous binge drinking and associated issues of public disorder resulting from city centre evening and late night entertainment/hospitality venues, to determine service requirements;
- drawing on national and local data to compare Edinburgh's prevalence and service provision with other local authority areas;

[1] Audit Scotland (2009) *Drug and Alcohol Services in Scotland.* Audit Scotland: Edinburgh

- evidence-based recommendations for development;
- identification of the impact, quality, effectiveness and efficiency, and current targeting of services.

1.3 Objectives

The specific objectives of this project, as indicated by the project brief, are as follows:

a. to assess current provision and examine current use of specialist drug and alcohol services in Edinburgh City,
b. to conduct an assessment of local need for such services,
c. to identify gaps and areas of unmet need in current provision, and
d. to provide evidence-based recommendations for the development of local specialist services.

1.4 Summary of Study Methods

The study was conducted in six stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods and sample populations. These are set out in Table 1.1 below. All questionnaires and interview schedules were approved by commissioners prior to use. Copies of these are available on request.

Table 1.1: Summary of Study Methods

Stage 1	Method	
Review of existing datasets	Desk-based review of national and local datasets	
Stage 2	**Method**	**Sample**
Quantitative Survey	Online survey	Managers of all specialist drug and alcohol services in Edinburgh
Stage 3	**Method**	**Sample**
Qualitative Interviews	Semi-structured interviews	• Service users • Potential users • Providers • Stakeholders
Stage 4	**Method**	**Sample**
Quantitative Survey	Online survey	All specialist service staff
	Paper-based survey	Service users
Stage 5	**Method**	
Gap Analysis	Desk-based comparison of range and capacity vs need	
Stage 6	**Method**	
Analysis & Reporting	Interim report in March 2010, final report and executive summary by end of April 2010	

1.5 Definitions and Concepts

The methodology of calculating need is derived from the Scottish Alcohol Needs Assessment[2]. This in turn uses the definitions and concepts set out in the Alcohol Needs Assessment Research Project (ANARP) conducted by Drummond and colleagues in England[3].

[2] Drummond C, Deluca P, Oyefeso A, Rome A, Scrafton S, Rice P. (2009) *Scottish Alcohol Needs Assessment*. Institute of Psychiatry, King's College London: London

[3] Drummond, C., Oyefeso, N., Phillips, T., Cheeta, S., Deluca, P. *et al* (2005) *Alcohol Needs Assessment Research Project (ANARP). The 2004 national alcohol needs assessment for England*. Department of Health: London

In order to ensure consistency and comparability these definitions and concepts have been adopted for use in this report. This chapter details the following terms as they apply to this report:

- Specialist Alcohol and Drug Treatment
- Needs Assessment
- Need
- Assumptions in Needs Assessment for Alcohol and Drug Use Disorders

1.5.1 Specialist Alcohol and Drug Treatment

This refers to a wide range and intensity of interventions from, for example, one or more sessions of Motivational Enhancement Therapy through to intensive residential rehabilitation lasting up to 12 months. What these interventions have in common is that they are provided for patients actively seeking help for substance misuse disorders, and the interventions are provided by specialist staff trained to provide them.

Specialist treatment is primarily targeted at people with alcohol or drug dependence, and the more intensive forms (e.g. inpatient or residential treatment) are generally reserved for people with more severe dependence and/or significant psychiatric comorbidities or social problems. Both alcohol- and drug-related harm and dependence exist on a continuum of severity and, although they are categorised within ICD-10, the precise point at which dependence or harm reach a threshold requiring a specialist intervention is, in practice, difficult to determine.

1.5.2 Needs Assessment

In broad terms, health care needs assessment (HCNA) is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way. It involves methods to describe the health problems of a population, identify inequalities in health and access to services, and determine the priorities for the most effective use of resources.

Health care needs assessment has become important as the costs of health care are rising and resources for health care are, at the same time, limited. In addition, there is a large variation in availability and use of health care by geographical area and point of provision (Andersen and Mooney, 1990)[4].

[4] Andersen, T.F. & Mooney, G. (eds) (1990) *The challenges of medical practice variations.* MacMillan Press: London

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

Doctors, sociologists, philosophers, and economists can all have different views of what 'needs' are, depending on definitions of 'need'. In recognition of the scarcity of resources available to meet these needs, health needs are often differentiated as needs, demands and supply (or capacity).

In Canada, Rush (1990) presented a model of alcohol needs assessment, which influenced the HCNA review and has been influential in alcohol needs assessment internationally[5]. Rush's model suggests a range of access to specialist treatment: an access level of 1 in 10 (10%) alcohol-dependent individuals entering treatment per annum is regarded as a 'low' level of access, 1 in 7.5 (15%) 'medium' and 1 in 5 (20%) 'high' (Rush, 1990). It is however important to note that Rush's model is based on a large number of assumptions about the size of the 'in-need' population, the process of referral to various agencies and treatment drop-out. Rush's study also used a large number of proxy measures rather than direct measurement of need and access. Therefore estimation of need for alcohol treatment and access would be improved by actual data from surveys as in the work presented in this report. In this study, we have followed the methodology recommended in the Health Care Needs Assessment Review of Alcohol Misuse (Cook, 2004)[6].

1.5.3 Need

In health care, need is commonly defined as 'the capacity to benefit'. If health needs are to be identified then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available (Wright, Williams & Wilkinson, 1998)[7]. The definition of need used in this study is 'the number of individuals in the general population with alcohol or drug dependence who could benefit from intervention'.

There are several challenges in estimating the prevalence of alcohol and drug dependence in the general population involving the definition of dependence and the methods used to obtain the estimate.

The estimates used for the drug component of this study are taken from the national prevalence study conducted by the Centre of Drug Misuse Research at

[5] Rush, B. (1990) A systems approach to estimating the required capacity of alcohol treatment services. *British Journal of Addiction*, 85: 49-59

[6] Cook, C. (2004) Alcohol Misuse, in A. Stevens, J. Raftery, J. Mant, S. Simpson (Eds), *Health Care Needs Assessment: the epidemiologically based needs assessment reviews. First Series Update.* Radcliffe Medical Press: Oxford

[7] Wright, J., Williams, R., & Wilkinson, J.R. (1998). Development and Importance of Health Needs Assessment. *British Medical Journal,* 316; 1310-1313.

University of Glasgow[8]. However these refer to a definition of problem drug use rather than dependence and are limited to opiate and benzodiazepine use, excluding primary stimulant misuse.

As stated in the SANA report, without carrying out a specific survey of alcohol dependence and need for specialist treatment, the next best method to do this is to use data from a general population survey, as is the case in the alcohol component of this study, and the recommended methodology for needs assessment.

1.5.4 Assumptions in Needs Assessment for Alcohol and Drug Use Disorders

Clearly the above definition of need is based on a number of assumptions. As in standard needs assessment methodology described above, it does not take account of natural remission: that is the proportion of people with alcohol or drug dependence who will recover without formal specialist or other interventions. This has been estimated in general population follow-up studies and using other methods, primarily in the US, and different studies have provided different estimates. We have not incorporated natural remission into the estimates since no specific estimates are available for Scotland. Furthermore, while there is evidence of natural remission of alcohol dependence over time, we have no way of knowing at present what proportion of people who eventually recover without specialist intervention would have had the course of the disorder shortened by a timely specialist intervention had it been available and accessible.

Another assumption is that the treatment provided is universally effective. This is clearly unlikely to be the case, but it is not possible to assess this within the scope or methodology of the research brief. Thirdly, not everyone who is offered treatment, assuming it is widely available, would want or accept treatment. Not everyone who a health professional would wish to refer to specialist treatment would necessarily be willing to accept referral as they may not be in an 'action' stage of motivational readiness to change (Prochaska & DiClemente, 1987)[9]. The subgroup of those in need who wish treatment is sometimes referred to as the 'potential demand' for treatment.

Fourthly, not everyone who indicates in a survey that they would potentially wish treatment, will actually access treatment. This may reflect partly a gap between what people say in surveys and what they actually do, and the barriers (real or perceived) to people actually accessing the services they need and want. Therefore, in line with previous alcohol needs assessments, in this study we

[8] Hay G., Gannon M., Casey, J. and McKeganey N. (2009) *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland*: Scottish Government

[9] Prochaska, J.O & DiClemente, C.C. (1983) Stages of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology,* 51, 390-395.

have studied the 'access' to treatment which is defined as 'the number of people with alcohol dependence who actually access treatment within a given year'. This is also referred to here as 'Service Utilisation'. Some US surveys have attempted to estimate potential demand as distinct from need based on survey questions as to whether people with alcohol dependence would want to access treatment if it was available. However, no comparable estimate is available in Scotland.

Clearly accessing treatment is not synonymous with receiving the full programme or course of treatment on offer, as some people will disengage prematurely. Also, within the limitations of the methodology we are unable to differentiate between people accessing treatment who are harmful drinkers as opposed to dependent drinkers.

1.6 Limitations and Assumptions

There are a number of factors which should be taken into account when reading this report. These are:

- The views of stakeholders interviewed are given in good faith and are representative of their organisation.
- The views of service users are drawn from those currently engaged with the services. This 'self-selecting' group are likely to be positively disposed towards the service, its staff and the interventions that they provide.
- Despite efforts to seek the views of carers, only one family member provided evidence. These comments are included to illustrate and provide commentary on issues of perceived importance but cannot be regarded as representative of a wider group.
- The prevalence rates and service activity used data to calculate the gap analysis relating to people with alcohol dependency or problem drug use. While it is recognised and acknowledged that a significant amount of work with people with drug and alcohol problems is conducted in primary care[10] and by mental health teams and criminal justice teams, the focus of this report and the international work cited is on the extent to which current specialist substance misuse services can meet need in their area.
- The standard age range commonly accepted for drug prevalence in Scotland has been 15 to 54 years. This range was used in both the 2000 and 2003 prevalence studies in Scotland (published in 2003 and 2006 respectively); however, this was changed to 15 to 64 years in the 2009 prevalence study[11]

[10] In Edinburgh 70% of GP practices have contracted to provide the National Enhanced Service for the treatment of drug misuse in primary care. This accounts for the care of approximately 2900 patients, two-thirds of all patients receiving treatment for drug dependence in Edinburgh. Source: Primary Care Facilitator Team, NHS Lothian (24/03/2010)

[11] As 8

to bring the Scottish data into line with other European countries. Also, the 2009 prevalence study did not provide breakdowns by gender in each area but provided an estimated national average of 70% males and 30% females. This is significantly different from the more accurate and locally useful 2006 report. These variations in age range and gender ratio result in significant differences in prevalence figures.

CHAPTER 2: PREVALENCE AND TRENDS OF DRUG AND ALCOHOL USE IN EDINBURGH

2.1 Introduction and Aims

The aim of this element of the project is to review existing datasets to provide a backdrop for the mapping exercise and to identify the prevalence and trends of alcohol and drug use in Edinburgh.

2.2 Method of Data Collection

Information was identified and drawn together from a range of local and national sources on prevalence and trends in the consumption of alcohol and drugs in Scotland over the past ten years.

2.3 Demographic Information

2.3.1 Population

- The most recent population data from the General Register Office for Scotland (GROS) estimate the population of Edinburgh to be approximately 471,650 people. When compared with other urban areas in Scotland such as Aberdeen (210,400 people) and Dundee (142,470 people), this is a high population estimate. However, it is below Glasgow which has a population estimate of approximately 584,240 people.[12]
- Lothian had the largest population increase amongst the NHS board areas in Scotland with a 1% increase. Edinburgh showed a population increase of 0.8% which is higher than was seen in similar urban areas such as Glasgow (0.4% increase), Aberdeen (0.5% increase) and Dundee (0.2% increase).[13]
- Lothian is the second largest NHS board in Scotland[14], with Edinburgh and West Lothian being classified as a large urban area (i.e. living in settlements of over 125,000 areas) and East and Midlothian being classified as other urban areas (i.e. living in settlements of 10,000 to 125,000 people).[15]
- Ethnic minorities make up 4% of the population in Edinburgh, significantly higher than the Scottish average of 2%.[16]

[12] General Register Office for Scotland, Mid-2008 Population

[13] As 12

[14] EstimatesNHS Lothian: Lothian Health and Life Survey 2002

[15] Scottish Government Urban Rural Classification (SGURC) 2007-2008. Scottish Government

[16] General Registry Office for Scotland, Census 2001

- The proportion of residents aged 16 or under in Edinburgh is 15% (compared to 17.7% of the Scottish population), with there being more males than females. Edinburgh has a slightly lower proportion of residents under the age of 16 in comparison to other urban areas within Scotland, such as Glasgow (16.5%), Aberdeen (15.5%) and Dundee (16.5%). The Edinburgh populations of males and females in this age group all show similar gender patterns to those for Scotland, with a slightly higher proportion of males than females in each of these urban areas.[17]
- The proportion of Edinburgh residents who are of a pensionable age is below the Scottish average. According to GROS, the proportion of residents of pensionable age within Edinburgh is 17%, compared to 19.5% for the Scottish population. This is higher than the proportion of residents of pensionable in Glasgow (16%), but lower than that in Aberdeen (18%) and Dundee (20.5%). All areas show a similar gender pattern to Scotland with there being more females than males of pensionable age within these areas.[18]
- The proportion of working age adults (16-65) in Edinburgh is higher than the Scottish average. GROS estimates the working age adults in Edinburgh to be 68.5%, compared to the 63% in Scotland. Other urban areas such as Glasgow, Aberdeen and Dundee show lower proportions of working age adults (67%, 66.5% and 62.5% respectively). All areas show the same gender pattern as Scotland with there being a higher percentage of male working adults than female working adults in each of these urban areas.[19]
- Life expectancy for both males and females in Edinburgh is higher than the Scottish average. According to the GROS data on life expectancy for 2006-2008, life expectancy at birth is 79 years in Edinburgh, compared to the Scottish average of 77.5 years. Edinburgh shows a higher life expectancy than other urban areas such as Glasgow (74 years), Aberdeen (77.9 years) and Dundee (76.8 years).[20]

2.3.2 Black and Minority Ethnic Populations within the Lothians

The table below shows the 2001 Census data on the minority ethnic populations of Scotland and Edinburgh compared with three other urban areas in Scotland: Glasgow, Aberdeen and Dundee. The ethnicity profiles of these urban areas show some similarities, with more than 94% of the population defining themselves as White (including 'White Scottish', 'Other White British', 'White Irish' and 'Other White'). According to the Census data, 4.2% of the population of Edinburgh identified themselves as belonging to a Minority Ethnic group (all

[17] As 12

[18] As 17

[19] As 17

[20] General Register Office for Scotland, Life Expectancy for Administrative Areas within Scotland 2005-2007

ethnicities excluding 'white'). This was lower than Glasgow (5.44%) but higher than Aberdeen (2.9%) and Dundee (3.66%). On average in Edinburgh, the largest minority ethnic group (1.5%) is the 'Other' group, composed of people describing themselves as 'Caribbean', 'African', 'Other Black', 'Any Mixed Background' or 'Other Ethnic Group'. The second largest minority ethnic group (1.3%) is comprised of people describing themselves as 'Pakistani, Bangladeshi or Other South Asian'. The 'Chinese' community accounted for 0.8% of the population and the 'Indian' community accounted for 0.5% of the population in Edinburgh.

Table 2.1: Population of Scotland, Edinburgh, Glasgow, Aberdeen and Dundee by Ethnic Group[21]

	Scotland		Edinburgh		Glasgow	Aberdeen	Dundee
	Number	**(%)**	**Number**	**(%)**	**(%)**	**(%)**	**(%)**
White	4,960,334	98	430,369	95.8	94.56	97.1	96.34
Indian	15,037	0.3	2,384	0.5	0.72	0.39	0.70
Pakistani, Bangladeshi or Other South Asian	39,970	0.8	5,765	1.3	3.04	0.57	1.63
Chinese	16,310	0.3	3,432	0.8	0.67	0.57	0.48
Other	30,360	0.6	6,574	1.5	1.01	1.37	0.85
ALL	5,062,011	-	448,624	-			

2.3.3 Employment

- According to the most recent Labour Market Profiles, Edinburgh has a higher working population (68%) than that of Scotland (62.6%). When compared with other urban areas, Edinburgh has a higher working population than Glasgow (67.1%), Aberdeen (66.3%) and Dundee (62.5%).[22]
- The Profiles also state that during the period July 2008 to June 2009, Edinburgh had a higher proportion of employed population than the Scottish average (77% and 75% respectively). Edinburgh also has a higher population in employment than Glasgow (65.5%) and Dundee (70%).[23]
- According to the latest labour market information, Edinburgh has its highest proportion of the population working in the 'financial services' sector (40.3%). Similarly, Scotland has its highest proportion of the population working in this sector (49.7%). Edinburgh shows a higher proportion of its

[21] As 16

[22] Nomis Labour Market Statistics, available at https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx. Figures cited are the most recent available at 15/03/10

[23] As 22

population working in the sectors of 'Public Administration, Education and Health' (25.5%), 'manufacturing' (2.5%) and 'transport and communications' (3%) when compared to the national averages of 20.2%, 2.1% and 2.2% respectively. However, when compared with national averages, Edinburgh has a relatively low population working in the sectors of 'construction' (1.6% and Scotland-2.2%) and 'distribution, hotels and restaurants' (14% and Scotland-18%).[24]

- Over the period of 2007 to 2008, Edinburgh experienced a drop in employment in the 'manufacturing' sector by 11% and the 'service' sector by 1% while Scotland showed a drop of 5% and 1% respectively.[25]
- Over the period of 2007 and 2008, the number of employee jobs in Edinburgh fell by 1%, while Scotland stayed fairly steady during the same period.[26]
- Over the period of June 2008 and July 2009, Edinburgh had 19.5% of its population as 'economically inactive'; this is slightly lower than the national average of 20.3%.[27]
- Over the period of July 2008 and June 2009, Edinburgh showed a lower unemployment rate (5.3%) in comparison to the average Scottish unemployment rate (5.9%) and other urban areas such as Glasgow (8.9%) and Dundee (8%).[28]
- Edinburgh also has a lower proportion of working age adults claiming Jobseeker's Allowance (3.5%) compared to the Scottish average of 4.5% and other urban areas such as Glasgow (6.3%) and Dundee (5.8%). However, it is higher than the population claiming Jobseeker's Allowance in Aberdeen (2.4%).[29]

2.3.4 Deprivation

- Edinburgh has 53,147 people living in Scotland's 15% most deprived areas, which is 11.7% of Edinburgh's population. This is a low percent in comparison to the national average – Scotland has a level of 15% of its population living in the 15% most 'access deprived' areas[30] [31] [32] – as well as

[24] The City of Edinburgh Council, Labour Market Information: January 2010

[25] Economic Briefing, Edinburgh. Educational Analytical Services Division, Scottish Government. (Most recent data available for 17/02/2010)

[26] As 25

[27] As 24

[28] As 22

[29] As 22

[30] Edinburgh: Health and Well-Being Profile 2008, Scottish Public Health Observatory 2008

[31] Aberdeen: Health and Well-Being Profile 2008, Scottish Public Health Observatory 2008

[32] Dundee: Health and Well-Being Profile 2008, Scottish Public Health Observatory 2008

other urban areas such as Dundee (28.9%), although it is higher than Aberdeen (8.9%).[33] [34] [35]

2.4 Alcohol Consumption

Alcohol misuse is a considerable and increasing problem in Scotland in terms of mortality, morbidity and social harm. From 2001 to 2005, alcohol-related deaths rose by 15% and general hospital admissions by 7%.[36] In addition, recent results from the Scottish Crime and Victimisation Survey indicate that people view alcohol misuse as a more serious social problem than antisocial behaviour or crime in general. High levels of alcohol consumption have been linked with many harmful consequences both for the individual and the wider community .[37,38]

The UK government has produced sensible drinking guidelines recommending weekly amounts based on units of alcohol. The current recommended weekly limit is 21 units for men and 14 units for women.[39]

Data on alcohol consumption for the NHS Lothian area suggest that the average weekly alcohol consumption level for males in this area is in line with the current recommended weekly amount and are similar to those seen in Scotland as a whole. Although the average weekly alcohol consumption levels for females in the Lothians is lower than the weekly recommended amount, this area has the highest consumption level across all Health Boards, as shown in Table 2.2.

[33] As 30

[34] As 31

[35] As 32

[36] How Much Are People in Scotland Really Drinking? Public Health Observatory Division, Health Scotland. 2008.

[37] 2006 Scottish Crime and Victimisation Survey: Main Findings. Scottish Government Social Research, 2007.

[38] Alcohol Statistics Scotland 2009. ISD Scotland.

[39] Global Status Report on Alcohol 2004. World Health Organisation, Department of Mental Health and Substance Abuse. Geneva.

Table 2.2: Estimated usual weekly alcohol consumption level, Health Board/Sex[40],[41]

	Male mean units per week	Female mean units per week
Ayrshire & Arran	19.3	9.2
Borders	18.2	9.3
Dumfries & Galloway	17.6	8.6
Fife	17.5	8.3
Forth Valley	20.1	7.2
Grampian	17.2	8.9
Greater Glasgow & Clyde	21.6	9.2
Highland	19.8	8.4
Lanarkshire	23.4	8.1
Lothian	21.5	11.9
Orkney, Shetland, Western Isles	15.3	7.8
Tayside	19.7	8.3
Scotland	20.3	9.1

As seen in Table 2.3 below, the percentage of male residents in the Lothian Health Board area consuming over the recommended level of alcohol units per week is higher than the national average. The percentage of males consuming over 21 units of alcohol is higher than any other Health Board area but the percentage of males consuming over 50 units is similar to the Scottish average. The percentage of women drinking over the recommended level of 14 alcohol units per week is significantly higher than the Scottish average. The percentage of women drinking over 35 units of alcohol is also higher than the Scottish average. Consumption levels can be seen in Table 2.2 and data from other health board areas are provided for comparison.

[40] Scottish Health Survey 2003
[41] Scottish Health Survey (2008) Revised Alcohol Consumption Estimates 2003 (Scottish Government)

Table 2.3: Estimated weekly alcohol consumption, percentage of individuals consuming over recommended amounts, by Health Board area and sex[42],[43]

	Males		Females	
	21+ units	50+ units	14+ units	35+ units
Ayrshire & Arran	29.6	8.1	22.1	6.1
Borders	30.1	6.2	25.0	1.8
Dumfries & Galloway	28.6	8.3	21.9	3.6
Fife	31.9	6.3	22.3	4.1
Forth Valley	33.8	9.7	16.3	2.7
Grampian	27.9	6.6	23.3	4.0
Greater Glasgow & Clyde	36.7	11.3	24.1	4.8
Highland	35.2	8.0	21.1	4.1
Lanarkshire	36.3	9.5	19.1	3.2
Lothian	39.9	9.1	31.5	6.0
Orkney, Shetland & Western Isles	18.6	7.7	17.1	5.2
Tayside	32.4	6.8	21.9	4.1
Scotland	34.1	8.8	23.4	4.5

2.5 Effect of Deprivation on Alcohol/Drug Consumption

Deprivation has been linked to problem drug use in that individuals who are socially and economically marginalised are seen as most at risk of developing drug problems.[44] However, the association between alcohol misuse and deprivation is not as clear and, in fact; there is evidence to suggest that the more deprived the neighbourhood, the lower the alcohol consumption level.[45]

[42] As 40
[43] As 41

[44] Drugs and poverty: A literature review. Published by Scottish Drugs Forum on behalf of the Scottish Association of Alcohol and Drug Action Teams. 2007

[45] Neighbourhood deprivation and alcohol consumption: does the availability of alcohol play a role? Pollack, Craig Evan; Cubbin, Catherine; Ahn, David; Winkleby, Marilyn. International Journal of Epidemiology, Volume 34, Number 4, August 2005 , pp. 772-780(9)

However, Scottish data currently suggests that although weekly alcohol consumption levels are higher for the least deprived communities, consumption over the daily recommended limits in one sitting is higher for individuals in the most deprived communities.[46] However, the relationship between area deprivation and binge drinking is different. Men's consumption of alcohol increased as deprivation increased. Those in the most deprived 20% areas were the most likely to drink over eight units per day. Women, on the other hand, did not show a consistent pattern between their alcohol consumption on the heaviest drinking day and area deprivation.[47] Data from Alcohol Statistics Scotland shows that individuals living in the most deprived communities are approximately six times more likely to be admitted to hospital as a result of alcohol misuse than individuals in the least deprived areas. The Alcohol Statistics Scotland also state that people living in the most deprived area were five times more likely to die of an alcohol-related death than those in the least deprived area. In 2007, Scotland's most deprived areas witnessed 66% of alcohol-related deaths ('underlying cause') while the least deprived areas only witnessed 19% of alcohol-related deaths with alcohol being the underlying cause. These percentages of alcohol-related deaths have been constant in the past five years between 2003 and 2007. [48]

Figure 2.2 displays alcohol-related general acute inpatient discharges by deprivation quintile[49] for 2004/05 for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee (1= least deprived; 5= most deprived). It can be seen that in Scotland, the proportion of discharges with an alcohol-related diagnosis showed a steady increase from the least to the most deprived quintile. Edinburgh as well as other urban areas such as Glasgow, Aberdeen and Dundee show similar patterns to Scotland. These results suggest that with an increase in deprivation, problem drinking increases as well. Scotland, Edinburgh and the other urban areas all show the highest rate of alcohol-related discharges in the most deprived quintile. This suggests that, those individuals in the most deprived areas experience the highest levels of problem drinking. It can further be seen that in the most deprived quintiles, Edinburgh, Glasgow and Aberdeen exceed the national rate of alcohol-related hospital discharges.

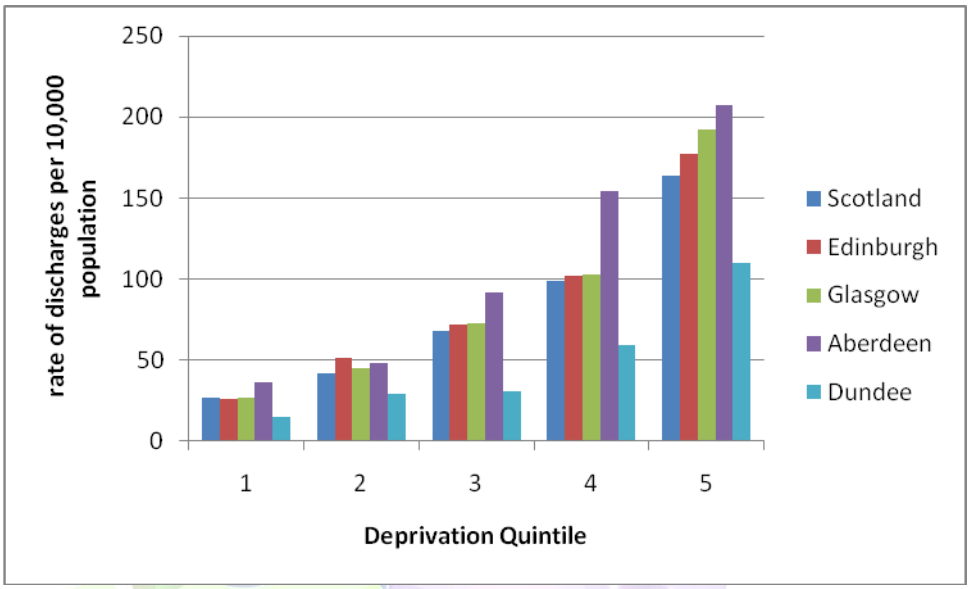
[46] Alcohol Statistics Scotland 2007, NHS National Services Scotland, ISD Publications

[47] The Scottish Health Survey 2003- Revised Alcohol Consumption Estimates

[48] Alcohol Statistics Scotland 2009, NHS National Services Scotland, ISD Publications

[49] Local Alcohol Profiles, ISD Scotland 2006, Table A19

Figure 2.2: Rate of general acute hospital discharges with an alcohol-related diagnosis by deprivation quintiles (rates per 10,000) in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee 2004/2005[50]



2.6 Alcohol Consumption- Health Harm

Evidence from clinical and epidemiological studies shows a relationship between heavy drinking and certain clinical presentations (for example injuries, physical and psychiatric illnesses, frequent sickness absence) and social problems.[51]

The tables below illustrate the extent of health-related harm due to alcohol misuse in Scotland and Edinburgh. These figures are compared to those in other urban areas in Scotland: Glasgow, Aberdeen and Dundee.

As can be seen in Table 2.4, hospital discharges with an alcohol-related diagnosis in Edinburgh have been lower than the national average up until 2007/08. Scotland has shown a steady increase in the rate of alcohol-related hospital discharges from 2003/04 to 2007/08. This same pattern can be seen in Edinburgh, Glasgow and Dundee. According to the latest Alcohol Profile of Edinburgh (2006), 28% of the discharges in 2004/05 were for harmful use, 17% for alcoholic liver disease, 13% for alcohol dependence and 12% for acute intoxication. These figures show a similar pattern to the national figures in 2004/05, harmful use was 30%, alcohol liver disease was 15%, alcohol dependence was 11% and 19% was acute intoxication. [52]

[50] As 49

[51] Scottish Intercollegiate Guidelines Network 74 (2003) The management of harmful drinking and alcohol dependence in primary care

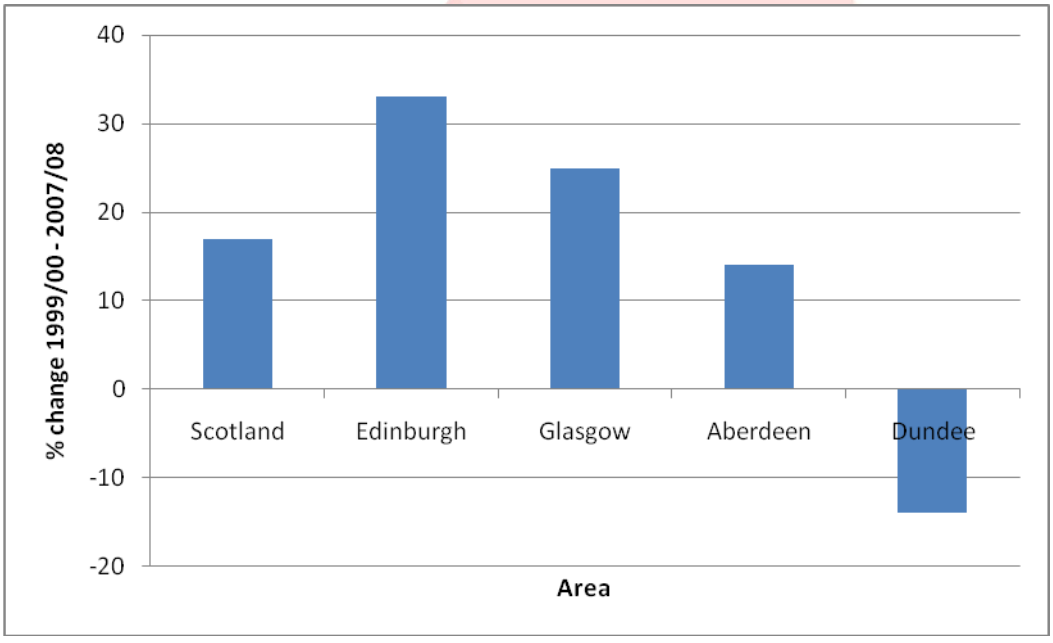
[52] As 49

Table 2.4: Rate of alcohol-related acute hospital discharges per 100,000 population for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee 2003/04-2007/08[53],[54]

	Scotland	Edinburgh	Glasgow	Aberdeen	Dundee
2003/04	666	***586***	1,100	869	696
2004/05	936	***597***	1,334	788	644
2005/06	698	***615***	1,307	862	687
2006/07	729	***670***	1,299	930	658
2007/08	777	***781***	1,379	991	602

Figure 2.3 represents the percentage change of alcohol-related acute hospital discharges for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee during the period of 1999/00 to 2007/08. Edinburgh as well as Glasgow and Aberdeen show similar patterns to Scotland, with Edinburgh showing the largest increase by 33% (Scotland-17% increase, Glasgow-25% increase, Aberdeen-14% increase). However, Dundee shows a decrease of 14% between 1999/00 to 2007/08.

Figure 2.3: Percent change of alcohol-related acute hospital discharges for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee between 1999/00 and 2007/08 [55]



[53] Local Alcohol Profiles, ISD Scotland, 2006. Table A15

[54] As 48

[55] As 48

Figure 2.4 represents the percentage change of Psychiatric inpatient discharges with an alcohol-related diagnosis for alcohol-related acute hospital discharges for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee during the period of 2004/05 to 2007/08. It can be seen that Edinburgh, Glasgow, Aberdeen and Dundee all follow the same pattern as Scotland, showing a decrease in psychiatric discharges during the four-year period. Edinburgh, Glasgow and Dundee show a greater decrease than the national average.

Figure 2.4: Percentage change of psychiatric inpatient discharges with an alcohol-related diagnosis for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee between 2004/05 and 2007/08 [56]

Table 2.5 illustrates the details of the latest data for specific diagnoses of alcohol-related hospital discharges available for Scotland and Edinburgh between 1999/00 and 2008/09. These figures are compared with three other urban areas in Scotland: Glasgow, Aberdeen and Dundee. It can be seen that Scotland shows an increase in all alcohol-related conditions (25%), in all mental and behavioural conditions due to alcohol (27%), in alcohol liver disease (70%) and in toxic effects of alcohol (54%) between 1999/00 and 2008/09. Although Edinburgh also showed an increase in alcohol-related conditions (19%) during this period, it was less than the national increase. However, Edinburgh showed a higher increase than the national increase in mental and behavioural conditions due to alcohol (29%) for this same period. Edinburgh did not follow the same pattern as Scotland for alcohol liver disease and toxic effects of alcohol, but showed a decrease of 37% and 87% respectively. Glasgow and Aberdeen showed a higher increase in all alcohol-related conditions than Edinburgh (24% and 28% respectively). However, Dundee showed a smaller

[56] As 48

increase of 2% when compared to Edinburgh in all alcohol-related conditions.[57] [58]

Table 2.5: General acute inpatient discharges with an alcohol-related diagnosis, specific diagnosis for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee between 1999/00-2004/05[59],[60]

	Scotland		Edinburgh		Glasgow		Aberdeen		Dundee	
	1999/ 2000	2008/ 2009	1999/ 2000	2008/ 2009	1999/ 2000	2008/ 2009	1999/ 2000	2008/ 2009	1999/ 2000	2008/ 2009
All alcohol-related conditions	33,580	41,922	2,838	3371	6,673	8288	1,735	2220	1,085	1102
All mental and behavioural conditions due to alcohol	23,653	30,084	1,755	2272	4,793	6486	1,494	1672	768	634
Alcohol liver disease	3,970	6761	451	286	789	1336	144	247	165	158
Toxic effect of alcohol	2,913	4484	401	68	504	443	40	291	95	78

The average number of alcohol-related deaths in Edinburgh (52.4 per 100,000 population) was lower than the Scottish average of 54.1 per 100,000 population over the five year period 2003 to 2007.[61]

Table 2.6 shows the relative rates of alcohol-related mortality in Scotland and Edinburgh per year between 2003 and 2007. The figures for Glasgow, Aberdeen and Dundee are provided for comparison. The table shows that during this period, Scotland had its highest alcohol-related death rate per 100,000 population in the year 2003. However, Edinburgh had its highest death rate per 100,000 in the year 2005. Furthermore, it can be seen that over this five-year period, Scotland has shown a steady decrease in the alcohol-related death rate per 100,000 population with their lowest numbers being in the year 2007, whereas Edinburgh showed a fluctuating pattern with a slight increase of alcohol-related death rate between the year 2004 and 2005.

[57] As 48

[58] As 49

[59] As 49

[60] Alcohol Related Hospital Statistics, 2010. National Health Services, ISD Publications

[61] As 49

Table 2.6: Alcohol-related death (underlying cause) rate per 100,000 in Scotland, Edinburgh,Aberdeen and Glasgow, 2003-2007[62]

	Year				
	2003	2004	2005	2006	2007
Scotland	56.1	54	54.6	55.7	50
Edinburgh	51.7	52.9	62.6	49.2	45.4
Glasgow	122.9	113.9	105.9	127.1	100.5
Aberdeen	33.4	37.2	47.6	34.2	50.8
Dundee	87.1	91.6	77.8	68.9	64.3

Figure 2.5 below illustrates the percentage change in alcohol-related death rate per 100,000 population in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee during the five-year period 2003 to 2007. Scotland shows a decrease of 8% deaths due to alcohol during this period. Similarly, Edinburgh, Glasgow and Dundee show a decrease of 11%, 16%, and 30% respectively in deaths due to alcohol, with Dundee showing the largest change.

Figure 2.5: Percentage change in alcohol-related death (underlying cause) rate per 100,000 for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee between the period of 2003-2007[63]

[62] As 48

[63] As 48

2.7 Alcohol Consumption - Social Harm

Alcohol consumption is associated with a substantial burden of social harm and estimates from some countries suggest that it is roughly equal to the burden of health harm.[64] The results of the Scottish Crime and Victimisation Survey 2006 have shown that 95% of the respondents thought that alcohol abuse in Scotland was a problem, with nearly two thirds of them considering it to be a big problem.[65] Alcohol misuse is estimated to have cost Scotland around £2.25 billion in 2006/07.[66] It should be pointed out that this cost refers only to the financial burden of alcohol and not to the many other types of social harm associated with alcohol misuse. Interestingly, those people that lived in the most deprived areas responded more strongly about their dislike of alcohol abuse (9%) than those who lived in less deprived areas (2%).[67]

2.7.1 Drunkenness Offences

Figure 2.6 shows the drunkenness offences rates per 100,000 population for the five-year period 2000 to 2004. An average of 14.9 drunkenness offences per 100,000 population was recorded for the five-year period in Scotland, this was significantly higher than the average rates recorded in Edinburgh and Aberdeen, which were 4.6 and 3.2 respectively, but significantly lower than the Glasgow and Dundee rates which were 33.6 and 27.2 respectively. The figure below illustrates that all areas, including Scotland overall, show consistent drunkenness offences rates over the five years.[68]

[64] Room, R, 'International control of alcohol: alternative paths forward', Drug and Alcohol Review (November 2006), 25, 581-595.

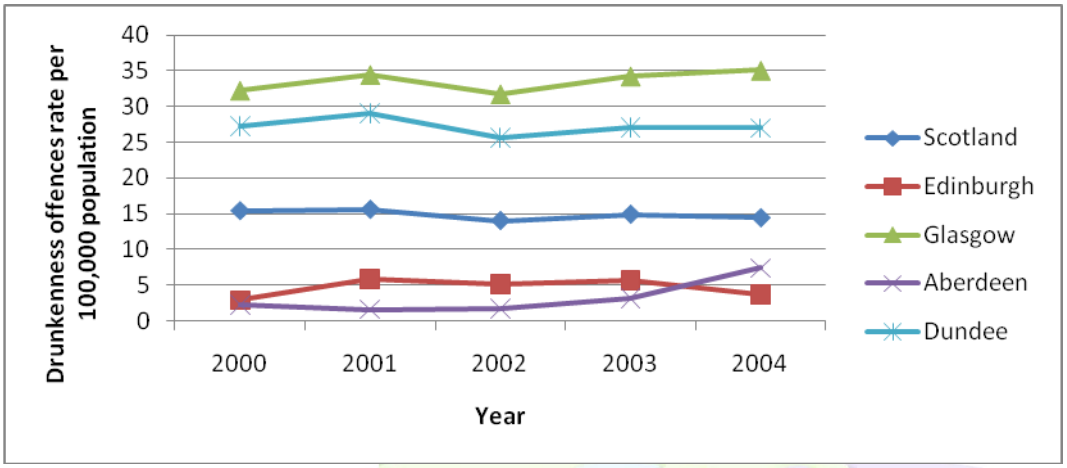
[65] As 49

[66] *Changing Scotland's relationship with alcohol: A discussion paper on our strategic approach*. Scottish Government, 2008.

[67] As 48

[68] As 48

Figure 2.6: Drunkenness offences rate per 100,000 population; 2000-2004[69]



In 2007/2008, 284 drunkenness offences were recorded by the Lothian and Borders Police (which includes drunkenness offences committed in the Lothians, the Borders and Edinburgh). The rate of drunkenness offences per 10,000 population recorded in the Lothian and Borders police force area during 2007/2008 was lower than in any other police area in Scotland and less than a quarter of the Scottish average.[70]

Table 2.7: Drunkenness offences by police force; 2007/2008[71]

Police Force	No. of drunkenness offences	Rate of drunkenness offences per 10,000 population
Strathclyde	4,156	19
Northern	866	30
Tayside	409	10
Fife	392	11
Lothian and Borders	284	3
Grampian	262	5
Central	198	7
Dumfries and Galloway	135	9
SCOTLAND	6,702	13

[69] As 49

[70] As 48

[71] As 48

2.7.2 Drunk Driving Offences

While the Lothian and Borders area recorded the second highest number of drunk driving offences in Scotland in 2007/2008, the rate of drunk driving offences recorded in this area per 10,000 population was the lowest in Scotland, at 18 per 10,000 population, as shown in Table 2.8 below. [72]

Table 2.8: Drunk driving offences by Police Force; 2007/2008[73]

Police Force	No. of drunk driving offences	Rate of drunk driving offences per 10,000 population
Strathclyde	4,538	21
Lothian and Borders	1,626	18
Grampian	1,129	21
Northern	863	30
Tayside	837	21
Fife	783	22
Central	620	21
Dumfries and Galloway	301	20
SCOTLAND	10,697	21

At local authority level, the highest proportion of drunk driving offences in the Lothian and Borders police area was recorded in the City of Edinburgh. Table 2.9 presents the number of drunk driving offences in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee over the five-year period of 2002/03 to 2006/07. It can be seen that Scotland has had a steady number of drunk driving offences and showed a small 1% decrease over this period. Similarly, Edinburgh showed a 5% decrease in drunk driving offences over this period. When other urban areas in Scotland are compared to Edinburgh over the five-year period, Glasgow also showed a 5% decrease in drunk driving offences while Aberdeen and Dundee showed larger reductions (12.5 % and 17% respectively).

[72] As 48

[73] As 48

Table 2.9: Drunk driving offences in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 2002/2003 to 2006/2007[74]

	Scotland	Edinburgh	Glasgow	Aberdeen	Dundee
2002/2003	11,838	881	1,689	576	445
2003/2004	11,571	767	1,713	614	465
2004/2005	11,061	811	1,588	609	383
2005/2006	11,257	887	1,640	535	368
2006/2007	11,707	836	1,605	504	368

2.7.3 Management of drunk and incapable people

There is a growing debate over the proper handling of drunk and incapable people who come into contact with the emergency services. While little data exists on the demand drunken and incapable people place on services, we do know that the impact on the police, Scottish Ambulance Service (SAS) and emergency departments can be significant. SAS, for example, report that in 2007 they attended an average of 73 incidents between 1 a.m. and 2 a.m. on Sunday mornings, compared with the normal hourly average of 38 incidents. On Hogmanay, incidents peaked at 150 between 2 a.m. and 3 a.m.[75] In addition, a recent audit of Scottish Accident and Emergency Departments found alcohol to be a contributory factor in at least 11% of all presentations,[76] while over 70% of adults presenting to emergency departments may be alcohol-related (with the majority of these being concentrated at weekends and involving young men).[77]

The demands of providing care and support to individuals who are drunk and incapacitated and who may be a danger to themselves or others can reduce the ability of emergency services to address other problems, with increased risks for those awaiting attention. In addition, police cells are inappropriate for the detention of drunk and incapable people who have no other reason to be there. There is, therefore, a need to identify more effective ways of dealing with such people.

Handling drunk and incapable incidents clearly puts a demand on emergency services in terms of time and money; however, at the moment there is little data available to accurately measure the extent of this impact.

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[74] Local Drugs and Alcohol Information, ISD Scotland, Alcohol and Social Harm: Drunk Driving

[75] Scottish Ambulance Service data.

[76] *Harmful Drinking One: The Size of the Problem,* NHS Quality Improvement Scotland. http://www.nhshealthquality.org/nhsqis/files/Alcohol_size%20of%20prob_web.pdf

[77] *Harmful Drinking Two: Alcohol and Assaults*, NHS Quality Improvement Scotland http://www.nhshealthquality.org/nhsqis/files/Alcohol_assaults_FINAL_web.pdf

The limited data that is available shows that:

- In 2006/07, 6,664 drunkenness offences were recorded by the eight Scottish police forces, constituting 0.7% of all recorded crime[78,79].
- In 2005/06, the Northern and Strathclyde police force areas recorded the highest rates of drunkenness (28 and 21 offences per 10,000 population). While Lothian and Borders, and Central police force areas recorded the lowest (2 and 4 per 10,000)[80].
- Figures uncovered under the Freedom of Information Act show that in 2006/07 more than 1,600 youngsters under 18 were arrested for being drunk and incapable in a public place. A third of those picked up by police were 15 or under[81].
- The busiest time for alcohol-related accident and emergency (A&E) presentations is between midnight and 4 a.m. on a Saturday morning. Four and a half times more patients presented during these four hours than at the same time during the rest of the week[82].
- One in four patients attending A&E for an alcohol-related problem had been seen for alcohol-related problems in past. [83]
- The most common presenting complaint was some form of alcohol-related injury (53%) followed by intoxication (23%).[84]

Findings from the 'Cost of Alcohol Use and Misuse in Scotland' report[85] (2008) offer some insight as to the monetary costs emergency services incur in response to alcohol misuse in general (including handling drunk and incapable people):

- It is estimated that in 2006/07 alcohol-misuse related A&E attendances cost the NHS £32 million (based on an estimated figure of 25% of all A&E attendances).

[78] Recorded Crime in Scotland 2006/7 figures

[79] In addition, it is assumed that alcohol is a key factor in a number of other offences.

[80] ISD Scotland (2007). Alcohol Statistics Scotland 2007. Available on: http://www.alcoholinformation.isdscotland.org/alcohol_misuse/files/Alcohol%20Bulletin.pdf

[81] www.mirror.co.uk/news/topstories/2008/03/04/rise-in-children-arrested-for-being-drunk-and-incapable-89520-20339683/

[82] NHS Quality Improvement Scotland (2008). Understanding Alcohol Misuse in Scotland: Harmful Drinking, Final Report. Available on: http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/30_04_08_alcoholreport.pdf

[83] Home Office (1998). Deaths in Police Custody: Learning the Lessons. Police Research Series, Paper 26.

[84] As 83

[85] The Scottish Government (2008). Costs of Alcohol Use and Misuse in Scotland. Available on: http://www.scotland.gov.uk/Publications/2008/05/06091510/0

- Similarly, it is estimated that in 2006/07 the Scottish Ambulance Service spent £31.5 million on attending alcohol-misuse related incidents (based on an estimated figure of 25% of all road ambulance incidents).
- The total cost of policing attributable in response to alcohol misuse in 2006/07 was estimated at £288 million (based on an estimated figure of 25% of recorded incidents in which alcohol was the critical factor).

A total of 152 persons were reported by Lothian and Borders police for being drunk and incapable of taking care of themselves in a public place between January and December 2008. Similarly, between May and October 2008, 175 drunken people were uplifted from the central area by the Ambulance service for treatment at Edinburgh Royal Infirmary. Within the same area, the ambulance service attended 29 incidents involving drunk people at licensed premises.[86]

2.8 Drug Use

In 2008/09, the Scottish Drugs Misuse Database (SDMD) showed 11,955 'new' individuals reported as drug misusers, this being a rate of 245 per 100,000 population.[87] Half a percent (0.5%) of these cases were individuals from ethnic minority backgrounds.[88]

According to the Health and Well Being Profiles (2008), Scotland has 77.6 people per 100,000 (age-sex standardised rate) using drugs. Illicit drug use causes significant problems for Scotland in terms of social harm in areas like antisocial behaviour, violence and crime, prostitution, homelessness and family breakdown. In addition, there is a substantial financial cost attached to drug misuse which is an estimated £2.6 billion per year.[89]

2.8.1 Prevalence and Characteristics of Drug Use in Edinburgh

- According to the NHS SDMD, a 'new' patient/client is defined as any person who, at the time of presenting, is not currently in contact with a service that provides specialist assessment of a client's drug misuse care needs.
- In 2008/09, 1,419 'new' individuals (256 per 100,000 population) were reported to the SDMD from Edinburgh. When this rate is compared to other urban areas in Scotland, it is higher than Glasgow (1587, 247 per 100,000 population) and Aberdeen (549, 240 per 100,000 population) but lower than

[86] As 74

[87] NHS Scotland National Services, National Statistics, Drug Misuse Statistics Scotland 2009

[88] As 74

[89] *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*. The Scottish Government, 2008

Dundee (877, 628 per 100,000 population).[90] Across Scotland the highest proportion of 'new' individuals were in the '25-29 year olds' group. This differed from all four major cities, Edinburgh, Glasgow, Aberdeen and Dundee, which all showed the highest number of 'new' individuals in the '30-34 years' age group.[91]

- As in Scotland, the main sources of referral in Edinburgh were self-referral, referral by a health-service (such as GP, mental health or primary care), referral by social work or referral by criminal justice. The proportion of 'new' individuals in Edinburgh who self-referred in 2008/09 was 18%, which was lower than the national average (34%). Other urban areas such as Glasgow and Dundee had higher proportions of individuals self-referring than Edinburgh (50% and 35% respectively). The proportion that was referred by health services in Edinburgh during 2008/09 (28%) was lower than the national average of 29%, and Aberdeen (42%) but higher than Glasgow (23%) and Dundee (23%).[92]
- Of the 'new' individuals in 2008/09 in Scotland, 33% also consumed alcohol (with 31% of them reporting alcohol consumption on a daily basis). Edinburgh appeared to have 20% of their reported 'new' individuals consuming alcohol (with 28% reporting alcohol consumption on a daily basis). This is significantly lower than Glasgow (54%), but higher than Aberdeen (18%) and Dundee (11%).[93]
- Of the 'new' individuals in 2008/09 in Scotland, the SDMD also showed 45% to have co-occurring mental health issues. Edinburgh had a larger proportion showing co-occurring mental issues (56%). Other urban areas such as Glasgow and Aberdeen had lower proportions of 'new' individuals with co-occurring mental health issues (36% and 42% respectively).[94]
- More than half of the 'new' individuals in Edinburgh were unemployed (74%), which is just above the Scottish average of 71%. Other urban areas such as Glasgow and Dundee all showed higher unemployed populations amongst their 'new' individuals (75% and 78% respectively).[95] Aberdeen had a lower unemployed population (66%).[96]
- According to the SDMD, of the 'new' individuals in Scotland, the highest proportion lived with other drug users (40%). Edinburgh, Glasgow and Aberdeen showed similar patterns to Scotland, with their highest proportions living with other drug users (48%, 53%, and 32% respectively). For Dundee the highest proportion lived alone (30%). Edinburgh and Glasgow had

[90] As 87, Table B1.1

[91] As 87, Table B1.2

[92] As 87, Table B1.5

[93] As 87, Tables B1.6 and B1.35

[94] As 87, Table B1.6

[95] As 87, Table A1.36

[96] As 87, Table B1.36

proportions notably higher than the national average living with other drug users (48% and 53% respectively).[97]

- The 'new' individuals in Edinburgh had a similar percentage of dependent children (46%) to the Scottish average of 42%.[98]
- In 2007/08 over half of the 'new' individuals in Edinburgh (59%) reported heroin as being their main choice of drug. This is slightly higher than the national average of 56%.[99]
- Of those who reported heroin use in Scotland in 2008/09, 52% reported using through injecting, while Edinburgh had 45% injecting. Glasgow also had 45% of their heroin users injecting, Dundee and Aberdeen had a larger proportion of injecting (59% in both areas).[100]
- According to the SDMD, among the 'new' individuals Scotland had 10% sharing needles in 2008/09. Edinburgh, had a smaller proportion than the national average at 9%, but Glasgow, Dundee and Aberdeen all showed a slightly higher proportion (14%, 11% and 12% respectively).[101]
- The data further suggests that 64% of the individuals reporting heroin use in Edinburgh were under the age of 25. This is higher than the Scottish average of 51%.[102]

2.9 Drugs - Health-Related Harm

In 2008/09, there were 5,867 drug misuse related hospital discharges in Scotland, with a rate of 118 discharges per 100,000 population. During the same period, Edinburgh had 617 drug misuse related discharges, with a rate of 116 per 100,000 population. Other urban areas such as Glasgow, Dundee and Aberdeen had higher rates of 180, 150 and 237 per 100,000 population (respectively).[103] The table below illustrates the change in the rate of drug misuse related hospital discharges over five years (2003/04 to 2008/09). The table shows that Scotland experienced an increase (32%) in drug misuse related discharges over this period. Although Edinburgh also showed an increase (30%), it was lower than the national increase. Other urban areas such as Aberdeen and Dundee showed larger increases than Edinburgh (54% and 32% respectively). However, Glasgow showed a decrease of 9% over the five-year period.

[97] As 87, Table B1.39

[98] As 87, Table B1.40

[99] NHS Scotland National Services, National Statistics, Drug Misuse Statistics Scotland 2008

[100] As 87, Table B1.25

[101] As 87, Table B1.28

[102] As 87, Table B1.10

[103] As 87, Table C1.1 and C1.2

Table 2.10: Number and rate (per 100,000) of general acute inpatient discharges with a diagnosis of drug misuse, 2003/04-2008/09[104]

	Scotland		Edinburgh		Glasgow		Aberdeen		Dundee	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2003/04	4,434	91	474	95	1,267	195	351	152	50	36
2004/05	4,449	91	472	92	1,143	178	403	180	49	35
2005/06	4,366	89	547	107	1,013	158	377	169	63	44
2006/07	4,764	97	587	111	1,115	171	458	204	75	55
2007/08	5,363	108	569	107	1,230	191	489	215	91	66
2008/09	5,867	118	617	116	1,156	180	542	237	210	150

Of the data recorded in 2008/09, the majority of hospital admissions in Lothian were 'emergency', reflecting the wider Scottish trend (93% and 92% of total admissions respectively).[105] The majority of these hospital stays (86%) in Edinburgh were less than a week in duration.[106]

During 2007/08, Edinburgh had a lower rate of psychiatric discharges with a diagnosis of drug misuse (26 per 100,000 population) relative to the Scottish average of 28 per 100,000 population.[107] Table 2.11 below demonstrates the changing pattern of the rate of psychiatric discharges with a diagnosis of drug misuse per 100,000 population for the six year period of 2002/03 to 2007/08 in Scotland and Edinburgh. The figures for Glasgow, Aberdeen and Dundee have been included for comparison.

Table 2.11: Rate of psychiatric discharges with a diagnosis of drug misuse per 100,000 population in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 2002/03 to 2007/08[108]

	Scotland	Edinburgh	Glasgow	Aberdeen	Dundee
2002/03	38	28	43	28	63
2003/04	36	25	39	21	54
2004/05	37	34	34	20	55
2005/06	34	27	42	24	76
2006/07	29	22	28	12	66
2007/08	28	26	30	13	52

[104] As 87, Table C1.2

[105] As 87

[106] As 87

[107] As 87, Table C2.2

[108] As 87, Table C2.2

Figure 2.7 shows the number of drug-related deaths in Scotland and Edinburgh over ten years (1998-2008), the drug-related deaths in the three other urban areas are included for comparison purposes. The figure demonstrates that, in 2008, Edinburgh had a lower number of drug-related deaths than Glasgow but a higher number than Aberdeen and Dundee. The number of drug-related deaths in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee in 2008 was higher than any previous years. [109]

Figure 2.7: Drug-related deaths in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 1998-2008[110]

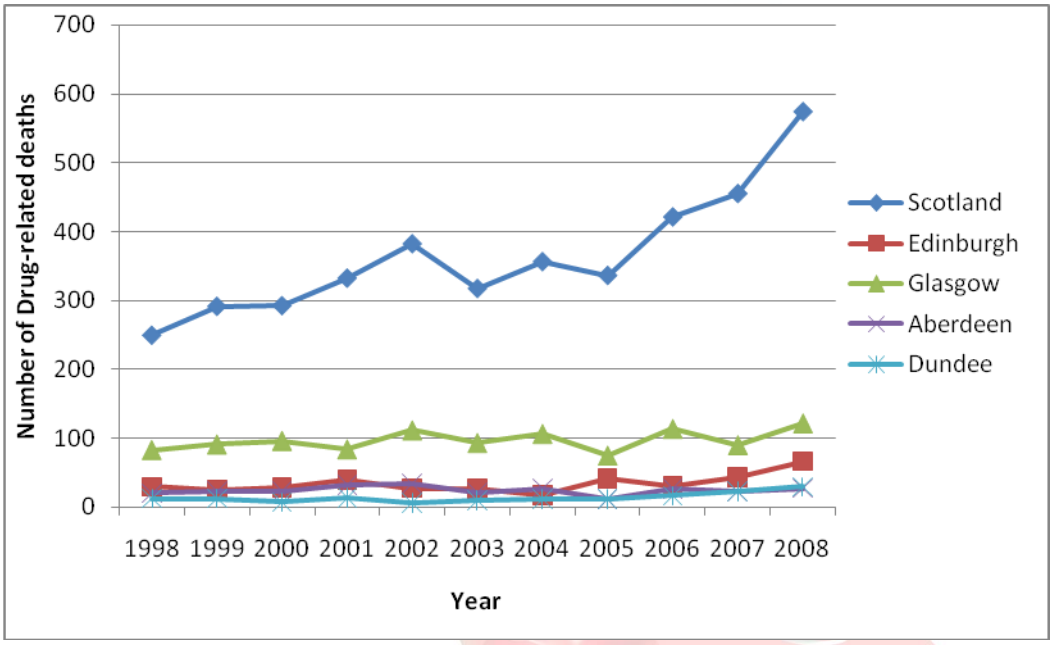


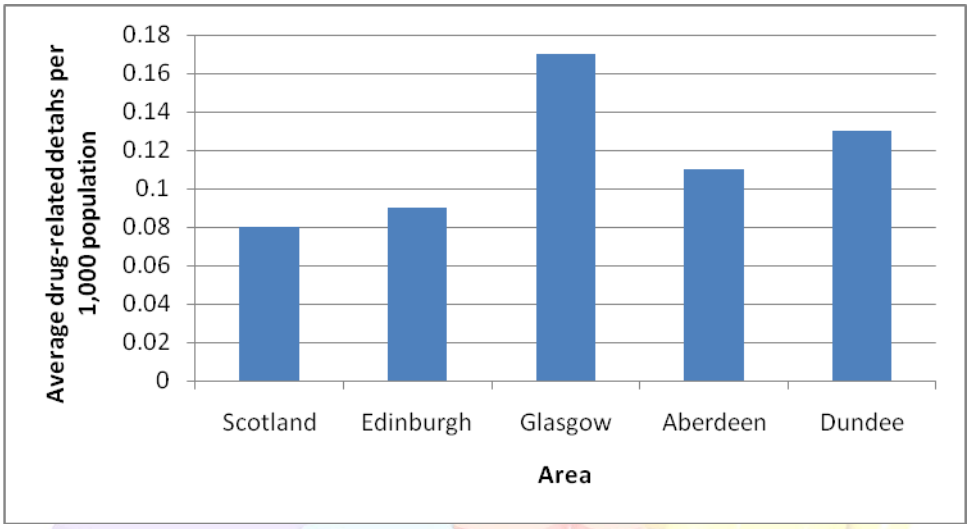
Figure 2.8 below shows average drug-related deaths per 1,000 population for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee between the period of 2004 and 2008. As illustrated in this figure, Edinburgh, Glasgow, Aberdeen and Dundee all show higher averages than the national average. Edinburgh had a lower average of 0.09 drug-related deaths per 1,000 population as compared to Glasgow (9 deaths per 100,000), Aberdeen and Dundee (0.17, 0.11 and 0.13 per 1,000 population respectively).[111]

[109] Drug-related deaths in Scotland (2008),General Register Office for Scotland (2009)

[110] As 87, Table C6.1

[111] As 87, Table C6.2

Figure 2.8: Average drug-related deaths in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 2004-2008[112]



2.10 Drugs – Injecting-related harm

Table 2.12 displays percentages of injecting frequency and related harm of all new clients attending services, as identified through SMR25 returns. The figures for Scotland, Edinburgh, Glasgow, Aberdeen and Dundee are set out below.

Table 2.12: Injecting related harm in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 2008/09[113]

Injecting related harm	Scotland	Edinburgh	Glasgow	Aberdeen	Dundee
Injected in the last month (%)	27	27	19	42	45
Never injected (%)	46	45	59	24	34
Sharing needles and syringes in the last month (%)	10	9	14	12	11
Hepatitis B tested (%)	70	83	64	80	73
Hepatitis C tested (%)	71	83	67	79	73
HIV tested (%)	67	82	61	74	71

These data illustrate that Edinburgh has similar rates of drug injecting and sharing of needles and syringes as the Scottish rates. These figures are lower than Aberdeen and Dundee. They are lower than Glasgow in terms of sharing

[112] As 87, Table C6.2

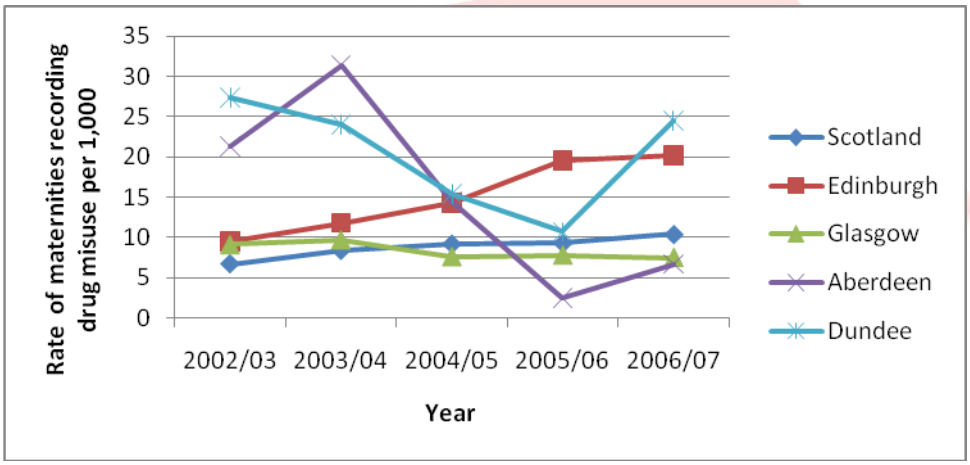
[113] As 87, Tables B1.20, B1.27 and B1.33

needles but Glasgow has a lower rate of drug injecting. Edinburgh has around the same percentage of drug users who have never injected as the national average. Edinburgh has a higher percentage of drug users who have 'never injected' than Aberdeen and Dundee, but lower than Glasgow. Edinburgh has a higher percentage of drug users who have been tested for Hepatitis B, Hepatitis C and HIV than the national averages.

2.11 Drugs – Maternity Harm

In 2008/09, Scotland had 499 maternities for which drug misuse was recorded, a rate of 8.9 per 1,000 maternities. Seventy-three percent (73%) of these maternities recording drug misuse were for mothers aged under 30 years compared to 53% of all maternities in Scotland during the same period. Almost half of births recording drug misuse (49%) were recorded as being in the most deprived (fifth) category.[114] Fourteen percent of the births recording drug misuse were preterm compared to 8% of all births in Scotland during the same period[115] and 6 per 1,000 of neonatal discharges recorded drug misuse.[116] The figure below compares the rate of maternities per 1,000 maternities that recorded drug misuse in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee over five years.

Figure 2.9: Rate of maternities recording drug misuse in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 2002/03- 2006/07[117]



It can be seen from the figure that Scotland and Edinburgh show a steady increase in the rate of maternities recording drug misuse over the five-year

[114] As 87, Table C4.4

[115] As 87, Table C4.3

[116] As 87, Table C4.5

[117] As 99

period. However, Glasgow shows a slight decrease and Aberdeen and Dundee show fluctuating patterns.

2.12 Drugs - Social Harm

In 2008/09, Edinburgh showed a lower rate of drug-related offences per 100,000 population when compared with the national rate (738 and 822 per 100,000 respectively). Edinburgh also showed a lower rate of drug-related offences per 100,000 when compared with other urban areas such as Glasgow (1,613 per 100,000 population), Aberdeen (1109 per 100,000 population) and Dundee (1055 per 100,000 population).[118] The table below illustrates the pattern of drug-related offences over six years in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee. It can be seen that Edinburgh has shown lower rates of offences (apart from the year 2006/07) than Scotland and Aberdeen over these six years. Edinburgh has continued to have lower rates of offences per 100,000 population than Glasgow and Dundee over the whole six years between 2003/04 to 2008/09.

Table 2.13: Number and rate (per 100,000 population) of Recorded Drug –Related Offences in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee; 2003/04 to 2008/09[119]

	Scotland		Edinburgh		Glasgow		Aberdeen		Dundee	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2003 /04	42,275	836	3,220	718	10,363	1,796	1,680	810	1,407	982
2004 /05	41,823	824	3,274	722	9,758	1,689	1,844	896	1,553	1,092
2005 /06	44,247	868	3,550	775	10,741	1,856	1,992	967	1,582	1,111
2006 /07	42,422	829	4,304	929	8,863	1,526	1,915	926	1,445	1,016
2007 /08	40,746	792	3,514	751	8,884	1,527	1,987	950	1,252	881
2008 /09	42509	822	3,483	738	9,426	1,613	2,333	1,109	1,503	1,055

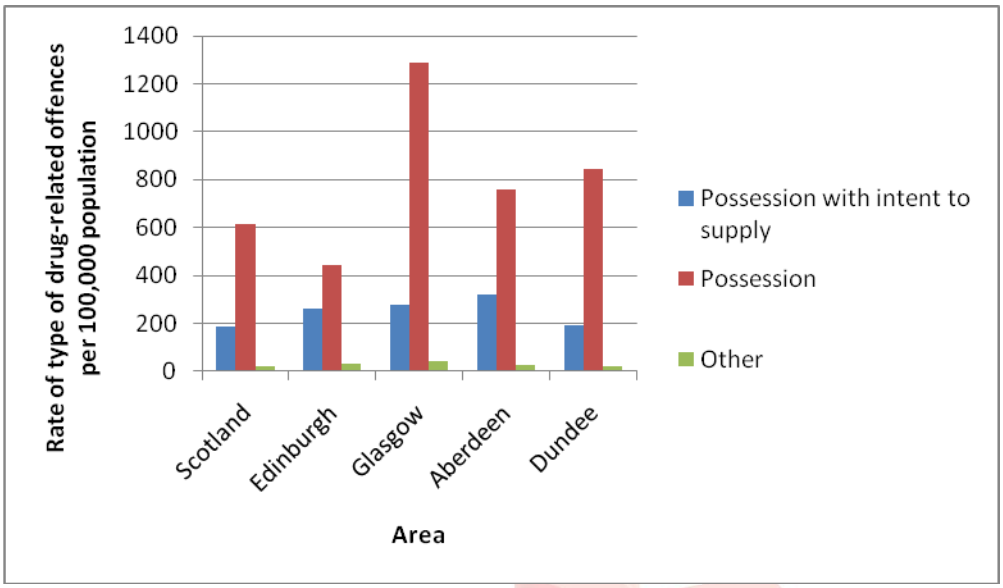
The figure below illustrates the types of drug-related offences in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee for 2008/09. The figure demonstrates that Edinburgh has shown a similar pattern to Scotland with the majority of drug-related offences lying in drug possession, rather than possession with intent to supply. Glasgow, Aberdeen and Dundee also reflect

[118] As 87, Table D1.1

[119] As 87, Table D1.1

the Scottish average over the same period. The figure illustrates that the other three urban areas (Glasgow, Aberdeen and Dundee) all show higher rates of drug possession than Edinburgh in the year 2007/08. However, Edinburgh shows higher rates of possession with intent to supply when compared to the national rate, as well as those of Glasgow, Aberdeen and Dundee.

Figure 2.10: Rate of type of drug-related offences per 100,000 population in Scotland, Edinburgh, Glasgow, Aberdeen and Dundee for the year 2007/08[120]



[120] As 87, Table D1.2

2.13 Key Findings

- Four point two percent (4.2%) of the population of Edinburgh identified themselves as belonging to a minority ethnic group – significantly higher than the Scottish average of 2%.
- Edinburgh has a lower unemployment rate (5.3%) in comparison to the average Scottish unemployment rate (5.9%) and other urban areas such as Glasgow (8.9%) and Dundee (8%). It also has a lower proportion of working age adults claiming Jobseeker's Allowance (3.5%) compared to the Scottish average of 4.5% and other urban areas such as Glasgow (6.3%) and Dundee (5.8%).
- Average weekly alcohol consumption level for males in this area is in line with the current recommended weekly amount and is similar to those seen in Scotland as a whole. Although the average weekly alcohol consumption levels for females within the Lothians is lower than the weekly recommended amount, this area has the highest consumption level across all Health Boards.
- The percentage of males consuming over 21 units of alcohol is higher than any other Health Board area but the percentage of males consuming over 50 units is similar to the Scottish average. The percentage of women drinking over the recommended level of 14 alcohol units per week is significantly higher than the Scottish average. The percentage of women drinking over 35 units of alcohol is also higher than the Scottish average.
- Scotland, Edinburgh and the other urban areas all show the highest rate of alcohol-related discharges in the most deprived quintile.
- Edinburgh has experienced a 33% increase in alcohol-related acute hospital admissions between 1999 and 2007. This rate is higher than Scotland, Glasgow, Aberdeen and Dundee. Conversely, the rate of psychiatric inpatient discharges with and alcohol-related diagnosis reduced by 32% between 2004 and 2007.
- An average of 14.9 drunkenness offences per 100,000 population was recorded for the five-year period in Scotland, this was significantly higher than the Edinburgh and Aberdeen rates which were 4.6 and 3.2 respectively but significantly lower than the Glasgow and Dundee rates which were 33.6 and 27.2 respectively.
- Of the 'new' individuals in 2008/09 in Scotland, the SDMD showed 45% to have co-occurring mental health issues. Edinburgh had a larger proportion showing co-occurring mental issues (56%). Other urban areas such as Glasgow and Aberdeen had lower proportions of 'new' individuals with co-occurring mental health issues (36% and 42% respectively).
- Of those who reported heroin use in Scotland in 2008/09, 52% reported using through injecting while Edinburgh had 45% injecting. Glasgow also had 45% of their heroin users injecting, Dundee and Aberdeen had a larger proportion of injecting (59% in both areas). Among the 'new' individuals

attending drug services in Scotland in 2008/09, 10% reported sharing needles. Edinburgh, had a smaller proportion than the national average at 9%, but Glasgow, Dundee and Aberdeen all showed a slightly higher proportion (14%, 11% and 12% respectively).

- Sixty-four percent (64%) of the individuals reporting heroin use in Edinburgh were under the age of 25. This is higher than the Scottish average of 51%.
- Edinburgh has similar rates of drug injecting and sharing of needles and syringes as the Scottish rates. These figures are lower than Aberdeen and Dundee. They are lower than Glasgow in terms of sharing needles but Glasgow has a lower rate of drug injecting. Edinburgh has around the same percentage of drug users who have never injected as the national average. Edinburgh has a higher percentage of drug users who have 'never injected' than Aberdeen and Dundee, but lower than Glasgow. Edinburgh has a higher percentage of drug users who have been tested for Hepatitis B, Hepatitis C and HIV than the national averages.
- Between 2005/06 and 2008/09 there were 18.4 maternity cases in Edinburgh where drug use was recorded out of every 1000 maternity cases. This is higher than the Lothian rate (13.9 cases) and almost double the Scottish average rate (9.5). Other comparative rates are Aberdeen (6.4), Dundee (16.6) and Glasgow (5.7).

CHAPTER 3: PROFILE OF CURRENT SERVICE PROVISION

3.1 Introduction

This chapter sets out the information provided by managers of drug and alcohol services in Edinburgh. An online questionnaire was sent to the service managers of 23 services in February 2010. Responses were received from 23 services: APS, CDPS, SW(DRT), SW(BBV), SW(ART), ALS, ELCA, MEARS, NEDAC, HOP, TPS, Crew, MAS, BCC, SHC, CARS, AOE, CP, Circle, RI, LEAP, HRT, and CHAI.

The questionnaire covered a range of topics including: demographic profile of client group; nature and extent of contacts; nature of interventions provided; and capacity of services. Respondents were asked to state if their responses were 'actual' or an 'estimate' for each of the questions. The responses were descriptively analysed and are summarised below. The tables relating to this Chapter are contained in Appendix 2 of this report.

3.2 Areas Served

The services included in this chapter are community based drug and alcohol services that deliver services to adults in Edinburgh.

3.3 Service Users Profile

3.3.1 Gender of Users

The male:female gender ratio in Edinburgh is 60:40 across all services. This is similar to national norms (67:33 alcohol and 70:30 drugs).

Fifty two percent of these responses were exact figures while the other forty eight percent were estimates.

3.3.2 Age of Users

Table 3.1 (contained in Appendix 2) demonstrates the different age groups that the services in Edinburgh provide their services to. It can be seen that none of the services cater for service users who are under 15 while all of the services cater for service users who are between 35 and 44 years of age. Additionally, sixteen (70%) of these services cater mostly for service users who are '25-34 years' while seven (30%) of the services cater mostly for service users who are '35-44 years'. Only one (0.4%) of the services caters mostly for service users who are '15-24 years'. It is notable that only eight (35%) of the agencies provide services to drug users who are over 65 years old. Similarly, eight of the agencies do not provide services to drug users who are '55-65 years'.

Of the responses provided, 48% were exact figures while the other 52% were estimates.

3.3.3 Ethnic Origin of Users

Table 3.2 (Appendix 2) provides details of the ethnic composition of service users in Edinburgh. Thirty nine percent of the responses were exact figures while the others were estimates.

The majority of service users in Edinburgh are either White Scottish or Other White British. Fifteen (65%) of the agencies see service users who are of an ethnic minority. None of the services have service users who are 'Bangladeshi' or 'Other South Asian'. However, four of the services have service users who are 'Pakistani', 'African', and 'Black' while five of the services have 'Other Ethnic Group' service users. Additionally, nine of the services have service users in the category 'Any Mixed Background'. Three of the services showed 'Indian' service users, one service showed 'Chinese' service users and one other service showed 'Caribbean' service users.

3.3.4 Percentage of Dependent Children

Overall, amongst the 23 services who responded, the majority of services had between 30 and 60% of clients with dependent children. Table 3.3 (Appendix 2) provides the percentages of service users with dependent children in Edinburgh, by service.

It can be seen that amongst the responses, fourteen (61%) were estimates while the other 9 (39%) were exact figures. AOE and Circle have 100% of service users with dependent children while RI has no service users with dependent children. The remaining twenty services have a wide range (between 5% and 60%) of service users with dependent children, the majority (65%) of which have over 25% of service users with dependent children.

3.3.5 Economic Activity

The figure below demonstrates the economic activity of service users in Edinburgh. It can be seen that over half (52.3%) of the service users are unemployed while 25.7% are disabled or long-term sick. The figure shows that only 15.1% of the service users are employed and 5% are in full-time education/training. A small proportion (4.5%) of service users are in prison.

Sixty five percent of these responses were estimates while the other 35% were exact figures.

Figure 3.1: Profile of service users in Edinburgh drug and alcohol services – by economic activity status

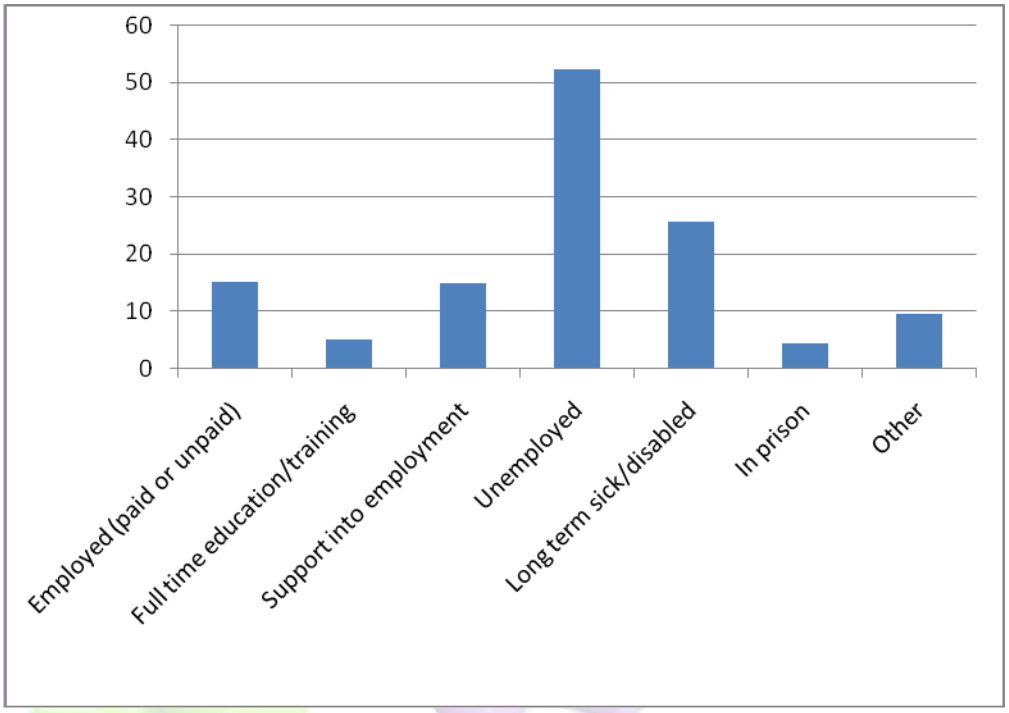


Table 3.4 (Appendix 2) shows the economic activity status of service users in Edinburgh by service. The majority (70%) of services showed their highest proportions of service users as 'unemployed'. Amongst the other seven services, three of them showed their highest proportions of service users as 'long-term sick/disabled'. Notably, Crew, ALS and ELCA showed their highest proportions of service users as 'employed'.

3.3.6 Legal Status of Users at First Contact

The figure below illustrates the legal situation of service users on average across all services in Edinburgh. Ninety one percent of these responses are estimates while the other nine percent are exact figures.

Figure 3.2: Profile of service users in Edinburgh drug and alcohol services – by legal status at first contact

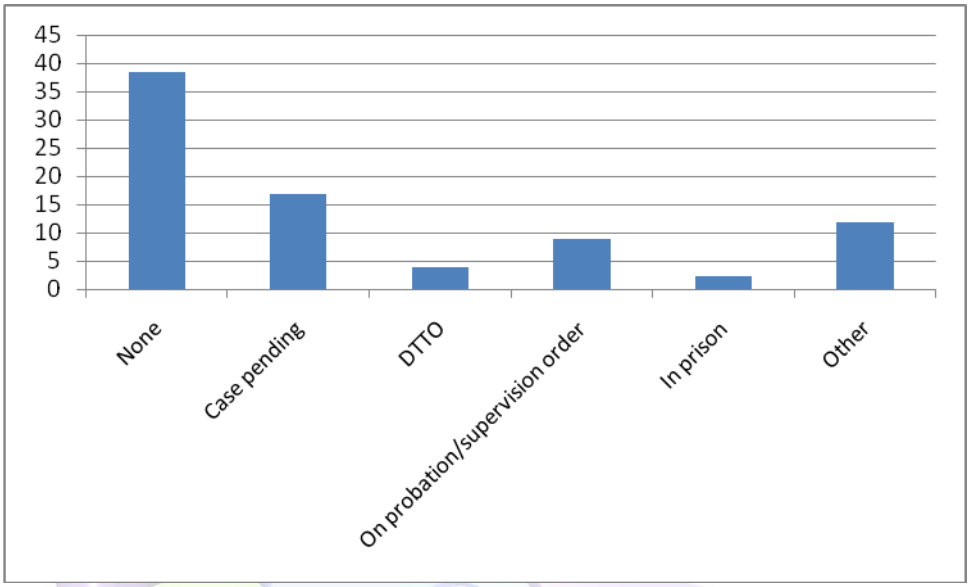


Table 3.5 (Appendix 2) provides the details of the legal situation of service users by service. The table demonstrates that the majority (57%) of services reported that most of their service users had no contact with Criminal Justice Services. A further 17% of services had most of their users with a case pending.

3.3.7 Accommodation Status of Users

Table 3.6 (Appendix 2) provides details of the accommodation status of service users by service. The table shows that the majority (83%) of services reported that most of their service users live in owned/rented accommodation. Two of the services (BCC and LEAP) reported that most of their service users were in residential rehabilitation. Five services reported having services users who are in prison. Seventy four percent of these responses are estimates while the other twenty six percent are exact figures.

3.3.8 Percentage of Users with Mental Health Problems

Table 3.7 (Appendix 2) demonstrates the percentage of service users that have been diagnosed with a mental health problem in each of the services in Edinburgh. The table also indicates which figures are estimates and which are exact figures.

As shown in the table, 72.7% of the responses were estimates. All the services apart from SW(DRT) recognised that a percentage of their users have mental health problems. The majority (70%) of services stated that over 30% of their service users have been diagnosed with a mental health problem. As CDPS and

APS are psychiatric services, they reported that all of their service users have been diagnosed with a mental health problem.

3.3.9 Duration of Service User Contact

Table 3.8 (Appendix 2) demonstrates the duration of service user contact by service. There is a trend towards longer-term contact: 45% of agencies who responded stated that service users were in contact for more than six months while 20% of the agencies reported that most of their service users were in contact for three to six months. It is notable that RI stated that all of its service users were in contact for more than six months. HOP, CARS and ELCA stated that most of their service users were in contact for a shorter period of one to three months, while SHC, ALS and MEARS reported only a single contact with most of their service users.

3.3.10 Reasons for Closed Contact

Table 3.9 (Appendix 2) describes the range of reasons for closed contact by service. The table shows that the majority of services (74%) have most of their closures as planned closures. However, MAS, SHC, CP, CARS and SW(ART) reported a lower number of planned closures and higher unplanned closures. MEARS reported 50% planned closures and 50% unplanned closures. Nine agencies stated that they closed cases for misconduct.

3.4 Services Provided

3.4.1 Referral Sources

Table 3.10 (Appendix 2) shows the range of referral sources used by each service in Edinburgh. Ten (45%) of the agencies that responded stated that they accept referrals from all the sources in the table (any agency, self referral, GP, health professionals, social work and court). All services use GPs as a referral source and all but one service (HRT) use health professionals and social work as referral sources. The table also shows that two services (SW BBV and ALS) do not use any agency as a referral source while four services (LEAP, CDPS, APS, SW DRT and SW ART) do not use self-referral as a source of referral. Additionally, 13 services accept referrals through Court. Some of the other referral sources that were mentioned included: family, friends, schools, employers and the Housing Department. MEARS did not provide a response to the question.

3.4.2 Profile of Service Users

Table 3.11 (Appendix 2) illustrates the range of service users catered for by service. The table shows that none of the services provide services to all of the client groups in the table. It can be seen that only two services work with service users who are under 16 years old (Circle and ALS). All of the services provide services to service users who are over 18 years old. Three of the services do not provide services to both sexes and BCC only cater for men. Sixteen of the services provide services to couples and 16 cater for couples with children.

3.4.3 Operating Hours

Table 3.12 (Appendix 2) provides the full details of opening days/times and out-of-hours services provided by the services in Edinburgh. Nine out of the twenty three services operate under normal business hours (9 a.m. – 5 p.m., Monday to Friday). Afterhours services are provided by eight services: NEDAC, HOP, Crew, AOE, Circle, RI, LEAP and ELCA, the details of which can be seen in the table.

3.4.4 Service Access Methods

Table 3.13 (Appendix 2) illustrates the means by which the services engage with service users. All but one of the services (SW BBV) uses an appointment system. Fourteen (61%) of the services provide home visits while only eleven (48%) have disabled access. Eight (35%) of the services provide a telephone helpline while none of the services require a contact address. Other forms of service access mentioned included: drop-in sessions, referrals and information/advice.

3.4.5 Substances Treated

Table 3.14 (Appendix 2) shows the results from the service managers' questionnaire profiling the substances that would be regarded as being within the remit of each service. Twelve (52%) of the services treat all of the substances shown in the table. ELCA only treats alcohol users while CARS and CDPS treat all of the substance users apart from alcohol users. Crew only treats those who use psychostimulants and hallucinogens, APS only treats those who use alcohol and benzodiazepines and HRT only treats those who use heroin/opiates/opioids and psychostimulants. Some of the additional substances mentioned by respondents included: polydrug use (NEDAC and SHC), gambling addictions (BCC) and legal highs (CDPS).

3.4.6 Service Provision

Table 3.15 (Appendix 2) illustrates the range of interventions that each service provides to its service users. Most common is advice and information (all but LEAP stated that they provide this service), closely followed by counselling (seventeen services offer this service). Twelve services provide outreach while eleven provide community rehabilitation. Ten services provide blood borne virus (BBV) services. Eight services provide needle exchange while six provide detox/abstinence services and family services. Only four services provide substitute prescription (TPS, HRT, CDPS and CHAI) and two services provides abstinence-orientated rehabilitation (LEAP and Bethany project).

Services were asked to state any additional services which they provide that are not stated in the table above. Some of their comments can be seen below:

> *'In terms of BBV services: partnership work with locality clinic prescribing service. In terms of substitute prescribing: harm reduction work / pre- and post-test counselling. Support to and through treatment.'*
>
> *'Holistic one-to-one support on addressing issues in relation to substance misuse.'*
>
> *'One-to-one support using counselling techniques.'*
>
> *'We would support a service user prior to residential rehab and support to detox in the community.'*
>
> *'Prescribing (NOT substitute prescribing though!).'*
>
> *'Signposting to other appropriate generic services. All services provide to assess and care manage the service user who is able to engage in meaningful work.'*
>
> *'Visiting support'*
>
> *'Patients who are admitted to hospital and are alcohol dependent, receive an inpatient detox.'*
>
> *'Education/Training'*
>
> *'Street work'*

3.4.7 Range of Detoxification/Abstinence Services and Prescribing Services

Eight out of the twenty three services stated that they provide detoxification/abstinence services. Table 3.16 (Appendix 2) provides details of these eight detoxification/abstinence services. The three most common types of detoxification/abstinence service provided were in-patient detoxification, out-patient detoxification and home-based detoxification, which are provided by five of these eight services. Least common were Subutex, Dihydrocodeine and Suboxone, which were only offered by two of these eight services. Outwith the

options given in the survey, CDPS stated that they also offer anti-depressants and APS also offer psychotropic medication.

3.4.8 Rehabilitation and Other Services

Table 3.17 (Appendix 2) illustrates the range of rehabilitation and other services offered by each agency. Seventeen of the services provided responses. Most commonly, services offer Aftercare Services (eleven services) and Education and Training (nine services). Notably, only four services provided structured day programme services. Eight services stated that they offer additional rehabilitation provision. These are SMART Recovery Group, Acupuncture and massage services.

3.4.9 Aftercare

The respondents were asked to state whether or not they felt there is sufficient aftercare available for their service, and to provide further comments on the kind of aftercare available and what they would like to see in terms of provision. Five of the service managers felt that there was enough aftercare available for service users. The nature of their comments can be seen below:

> *'The aftercare services available would be Job Training Education Employment Support.'*
>
> *'Comprehensive intensive aftercare from LEAP for two years, but also through partners Transition and via mutual aid groups.'*
>
> *'We offer CPN support for those who become stable on a prescription. It would help to have further support for training, education and housing issues.'*
>
> *'Service commenced on 01/02/2010. Sixteen week's service therefore no aftercare issues have [arisen]. However these may be issues for service users. How to manage an alcohol problem in an environment that is orientated [around] alcohol for relaxation and enjoyment. Supporting people into long-term counselling and negotiating with employers being in recovery if your family are drinkers.'*

The other seventeen service managers felt that there was not enough aftercare available for service users. The nature of their comments can be seen below:

> *'I think I would, err, on the positive and say that we have a new pathway that we have agreed within the partnership and we're looking to develop*

additional aftercare capacity because we reckon that's not there, and we have yet to bottom out what resources are required to do this.'

'General absence of appropriate support for homeless clients.'

'Maintaining accurate mapping of available aftercare services appears to be very difficult... There appears to be little co-ordination between drug and alcohol services and aftercare services and between different aftercare services except where individual staff have forged relationships... There is potential for the added value that existing services bring to joined up working and aftercare to be lost. This has already happened in the specialist field of homeless addiction services where expertise has been lost and gaps in service provision will be exposed. It is service users that will fall through these gaps.'

'Limited resources, funding issues, long waiting times, limited services to "move on" to. Trauma counselling supported accommodation, less intense outreach support after a period of settled living.'

'We have requested funding from the EADP for Addiction Support Aftercare but were unsuccessful last year. We do operate an aftercare service as an extension of the support provided in house, we would like to see this support developed and more robust, but are limited by resources.'

'Service users require sporadic support following their initial recovery. This is largely done by their original support agency but they have no funding for such events.'

'[We need] secure housing, supported accommodation for people with drug and alcohol, social activities that are not alcohol-related, counselling/psychotherapy, and services that can meet the needs of families with children of all ages.'

3.4.10 Accessibility Barriers

Table 3.18 (Appendix 2) shows that 22 (96%) service managers raised some concerns about the difficulties faced by service users in accessing their services. Crew expressed the most concerns about accessibility barriers. Seventeen of the services felt most strongly about capacity being an accessibility barrier. The

services felt least concerned about the availability of public transport (SHC and ARS M&E), confidentiality (Crew and ELCA), environment/accommodation of the service (TPS and Crew) and fear for safety (TPS and BCC). CP, BCC, SW BBV and SW ART each raised one concern (lack of childcare, referral/exclusion criteria, capacity respectively).

3.4.11 Staff Composition

Tables 3.19 and 3.20 (Appendix 2) set out the staff composition of the services. Nurses make up the largest professional group (57.4) in drug and alcohol services in Edinburgh. There are also high numbers of voluntary counsellors (31), key workers (29), social workers (18.2), support workers (16) and managers (16.2). Among the services that responded, it can be seen that ELCA, APS and CDPS have the highest number of staff working in drug and alcohol services in Edinburgh (42, 35 and 22 respectively). HOP and ALS appear to be the smallest teams, each with two members of staff.

3.4.12 Capacity and Duplication of Services

Respondents were asked for their opinions on service capacity and duplication of services. These are presented below.

Capacity

All of the services responded to the question, 'Do you feel that there is sufficient capacity in specialist substance misuse services in Edinburgh to meet demand?' Their responses showed that they all felt that there was insufficient capacity to meet demand. The nature of their comments can be seen below:

> *'No... although we have steady stats with referrals coming in and discharges going out, we have this rump of people that we just keep chipping away at, but we need a little bit of increased capacity and we're looking at this 10% figure to generate by various means.'*
>
> *'Not any commissioned services for homeless.'*
>
> *'No, long waiting times for substitute prescribing. Lack of capacity to provide one-to-one support to individuals who do not have/require a script. Lack of structured programmes to support people along their recovery paths. Lack of addiction support to the homeless community.'*
>
> *'No, resources are drained in locality clinics. Lengthy waiting times for substitute prescribing.'*
>
> *'No. For example waiting times [in this service] for service users to be prescribed substitute medication.'*

'Lack of specialist prescribing leads to waiting lists for treatment. Lack of detox/crisis inpatient options.'

'Not sufficient capacity. There is need to look at those on methadone and support for them to deal with their lifestyles.'

'Not enough capacity to offer recovery-oriented services. A shift in emphasis would be required.'

'No, we would need more funding to provide more capacity.'

'No, there continues to be an inequity of services as it often depends on the individual's postcode.'

'I think the demand is high for people to access recovery (abstinence) based services and stabilise their lifestyles. I therefore believe that more funding should be directed into this area.'

'No – one alcohol worker for the whole of South West Edinburgh – not feasible!'

Duplication

Nineteen (86%) services responded to the question, 'Do you feel that there is sufficient capacity in specialist substance misuse services in Edinburgh to meet demand?' Among these respondents, four services felt that there were areas of duplication in specialist services for substance misuse in their area. The nature of these comments can be seen below:

'Services are sectorised and consequently it appears that there is duplication - makes it hard to define.'

'There are numerous agencies in Edinburgh doing the same work. This could be an area to be looked at.'

'Yeah. Part of the rationale for the redesign and developing the new pathway was because there was an overlap between providers and what we're trying to do with the new pathway was for people to be clear about their role and to be delivering the appropriate interventions to the right person at the right point in the pathway, and to be reducing duplication. I think yes there is, but we're already taking steps to address it.'

However, eleven services felt that there was a lack of duplication in specialist services for substance misuse in Edinburgh. The nature of their comments can be seen below:

> *'A lack of duplication service provision exists in Edinburgh.'*
>
> *'I do not feel there is duplication of services as many services are area specific or substance specific. However I am also not sure if 'duplication' is just another word for 'choice', in which case duplication may not be a bad thing.'*
>
> *'More specialised substance misuse services are needed within the city including outreach. [Our service] is a specialised service with very experienced workers, funding issues in CEC may result in [this service] closing.'*
>
> *'There are no areas of duplication of the specialist work that [our service] carries out.'*
>
> *'Not so much duplication as a huge bias towards harm reduction and maintenance at the expense of recovery and abstinence services.'*
>
> *'No duplication in fact the opposite, different areas have different services even within the locality misuse directorates.'*
>
> *'There is paucity of alcohol service provision. This is the H&SC's response to the Scottish Government's paper, Changing Scotland's Relationship with Alcohol. The service went live on 01/02/2010 – three year's funding.'*

The other three services made no comment about the above question.

3.4.13 Responses to Recovery-Based Questions

Participants were asked to stipulate the extent to which they felt the Scottish Recovery Agenda had had an impact on their service in becoming more recovery-orientated. Seven responses were received, five of which stated that it had not had any impact, while one stated that it had changed alcohol services 'moderately' and drug services 'significantly'. The other response stated that:

> *'It has begun to affect the way we are delivering the service – moving away from creating a dependency culture to supporting independence and autonomy.'*

In response to the question, 'What do you think your service could do to become more recovery-orientated?', several respondents (n=7) expressed the view that their service was already recovery-focused.

> *'I believe our service is (and always has been) recovery-oriented; however, there is room for further development.'*
>
> *'[This service] is very recovery-orientated. It is high on our agenda and discussed at team meetings.'*
>
> *'The Road to Recovery was welcomed and reinforced the approach and ethos offered at [this service] for many years.'*
>
> *'We are highly recovery-orientated and have been for decades. We have long witnessed the tremendous value in seeing many men have their lives turned around and move out of chaos into stability, out of addiction into freedom, and out of brokenness into wholeness. I am pleased that the Road to Recovery has highlighted recovery as a clear aim for individuals, based on their needs and aspirations.'*
>
> *'We predated the policy – but it has resulted in more acceptance of what we do from other services.'*
>
> *'Although this does not directly affect our service - we work in this way with our service users and will continue to do so.'*
>
> *'We already work in a person-centred way to promote recovery and in doing so we take account of the social and personal contexts of people's substance misuse.'*

Some specific examples provided of recovery-orientated activities currently being undertaken in services included:

> *'[This service] has a Recovery Champion within the project who liaises with the Recovery Manager within the head office and feeds back. We have service user involvement peer groups relating to Recovery.'*
>
> *'Drug users with HIV have been offered a harm-reduction approach given the high level transmission of HIV and Hep C. With improved antiretroviral therapies we can now begin to address the "recovery" agenda with people with HIV.'*

'Clients get to choose their own goals, whether it be harm reduction, controlled drinking or abstinence and are invited to explore other areas of their life which they feel are affecting them.'

'We will give support and make referrals to assist with any issue which service users need help with.'

Another respondent mentioned ways in which service user involvement was currently being encouraged:

'We have service users on the Redesign Steering Group, so they're inputting that way, and I think we need to be much smarter at engaging the service users in management groups. LEAP has one on their Management Group, and on the Quality Improvement Team in the Directorate, so it's about engaging them in a way that works for them, and for them kind of stepping up to the plate as well, being prepared to share the pain, because service users coming in saying "can we have a blank cheque please because we need this", isn't going to work, they need to understand the financial constraints as well.'

However, one respondent felt that their service would have been more recovery-orientated if it had been able to retain its rehabilitation unit for women with children.

'If we had retained our rehabilitation unit for women with children, we feel that we then would be able to implement the Road to Recovery Agenda more effectively as most of our service users would like to become abstinent but are unable to access rehabilitation with their children.'

Other suggestions were made as to how services could become more recovery-orientated. As illustrated in the comments provided below, some of the common themes included the need for: (i) increased diversity of approach and treatment options building on existing capacity and resources; (ii) improved joint/partnership working between services; (iii) increased service user consultation and involvement in services; and (iv) more peer support.

'Encourage individuals to see beyond substitute prescribing, encourage diversity in approach and options. Build on partnership work with other agencies both harm reduction and abstinence-based, also therapeutic communities to ensure clear and individual recovery pathway. Remain impartial and person-centred.'

'It needs to build capacity within the existing resources in terms of treatment. There needs to be more contracts with patients and more opportunities for them to achieve their goals. This also includes clearer objectives across all the sectors and more joint working.'

'Accepting relapse as a recognised consequence of working on difficult areas of a client's life issues.'

'We want to introduce more peer support and begin recovery coaching. Working with families and folk waiting for a bed are also priorities. We would like to see recovered people working in other parts of the services (e.g. harm reduction to signpost recovery and serve as peer supporters for folk at different stages).'

'There is a need to develop more service user consultation to capture people who drop out and to get their feedback about how a service might improve.'

'Need more service user involvement.'

'Continue the development of our peer support group.'

Service Users' Role in Recovery

Respondents were also asked to identify what sort of things they feel service users themselves need to do to promote their own recovery, as well as ways in which services and service planners could promote and encourage clients to identify these responsibilities and address these issues. The things that respondents feel service users need to do included the following:

- Maintain contact with services
- Develop a recovery plan based on an honest evaluation of their strengths and their own realistic goals and objectives
- Take responsibility and become motivated
- Get involved in mutual aid groups
- Become actively involved in service delivery and recovery-based activities

Maintain contact with services

'Maintain contact with services as they work through difficult and challenging aspects of their lives and substance use.'

Develop a recovery plan based on an honest evaluation of their strengths and their own realistic goals and objectives

'Ask themselves the question "what does recovery mean to me?" and identify a recovery journey/plan reflecting the small, realistic goals required to achieve these. Encourage honesty and engagement.'

'Look at identifying their strengths and build on these in a peer supported environment.'

'Service users will be most ready to promote their own recovery when they want to engage with services in an open and honest way. There is a greater chance of this happening when they feel their own worth and feel safe.'

Take responsibility and become motivated

'Service user involvement in their own recovery, challenging the passive victim role where the assumption is that someone else must do something for me. They must have felt a sense of ownership of their own recovery journey.'

'Take responsibility for own drug use – become educated about drugs and their long-term effects.'

'Service users themselves need to be motivated to make changes to their lifestyles.'

'Be ready and willing to engage in their recovery process. Attend regular appointments.'

Get involved in mutual aid groups

'Get to mutual aid! Take other service users to mutual aid and the Recovery Café.'

Become actively involved in service delivery and recovery-based activities

> *'Form service-user groups and lobby for change in services where required. Get involved with the Recovery Consortium and get their voices heard. Volunteer in services and deliver training to staff and be involved in overdose prevention and harm-reduction advice.'*

Service Providers' Role in Recovery

It is clear that services and service providers have a key role to play in creating the conditions necessary for service users to identify their responsibilities and become actively involved in their own recovery. Some of the suggestions made by respondents included:

- Ensure services are flexible with a person-centred approach
- Increase service capacity
- Change the ethos and culture of services
- Increase the provision of aftercare services and continued support
- Increased awareness and promotion of services and positive alternatives to substance misuse
- Ensure workers are adequately training and equipped to support recovery
- Increase service user involvement
- Encourage active support planning and case management

Ensure services are flexible with a person-centred approach

> *'Services to provide flexible/client centred service that can work with clients with complex needs while recognising that the road to recovery may not be a linear journey.'*
>
> *'Ensure a person-centred work ethic is adhered to at all times and that each service user is treated as an individual.'*
>
> *'In most cases they need reassurance that an improvement in their situation is possible and in all cases they need to understand that this will require some effort of them. Techniques such as motivational interviewing and, in general, an approach that places the service user at*

the centre of the process in which they are engaging are useful ways of helping them to accept that changes is required, help is available and they will be treated with care and respect while engaging with support and treatment.'

Increase service capacity

'Create capacity within the services to assist service users to move out of chaos. Provide capacity within services to support individuals along their identified pathway and build capacity to provide aftercare.'

'Extended opening hours and appropriate resources to respond to the individual's recovery plan.'

Change the ethos and culture of services

'An "ethos" change to really believe that recovery is possible.'

'Stop being reliant on substitute prescribing.'

'See beyond medical interventions - substitute prescribing.'

Increase the provision of aftercare services and continued support

'Ensure sufficient aftercare and continued support by planning service provision to ensure service users needs are met throughout the recovery journey.'

Increased awareness and promotion of services and positive alternatives to substance misuse

'Knowing what services are available.'

'Updated literature on services available to clients throughout Edinburgh would be useful to help them know what range of services is available and how to access these.'

'Life needs to be more attractive without substance abuse or dependency; the services that we offer need to reflect strong positive alternatives through access to education, employment opportunities, life skills, being

given responsibility, fun and laughter, recreation and leisure options, companionship and belonging, spiritual meaning, and people being highly valued and shown genuine love.'

Ensure workers are adequately training and equipped to support recovery

'Designing services that provide time for therapeutic engagement with trained and experienced staff who feel valued themselves.'

'Having services with specialised workers with knowledge and understanding might encourage more clients to engage. For example, having a specialist Criminal Justice Service which would work with clients in the prison setting and on their release would offer more consistency and continuity for clients as their relationship would already have been built up.'

'Staff members employing motivational interviewing skills, brief interventions, and generally being skilled in helping move a person forward in motivational change.'

Increase service user involvement

'Stability and continuity for services and a voice for service users.'

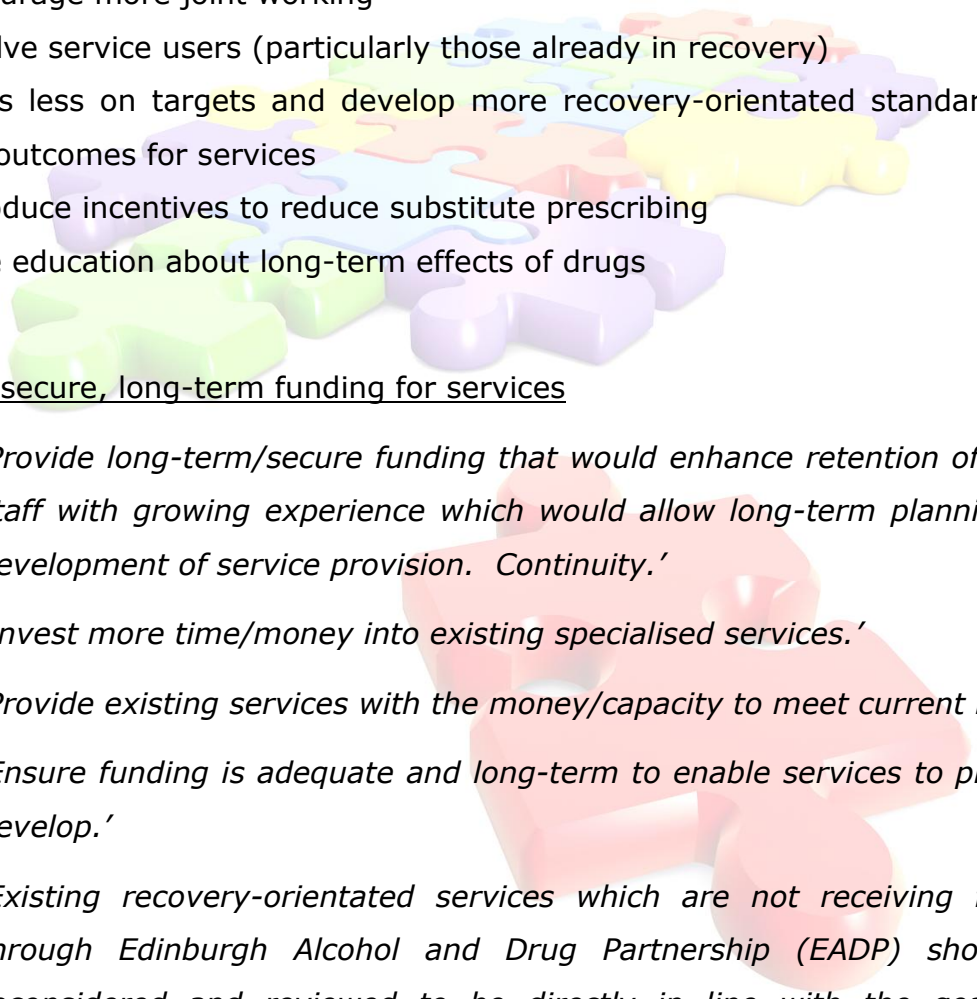
'For those we have entered into recovery, we have seen a lot of really positive actions develop. People have shared their own individual story where appropriate which gives people hope and demonstrates to society that recovery is possible.'

Encourage active support planning and case management

'In terms of promoting an individual's recovery for themselves, our experience has been that there are multiple needs which require active support planning and case management to ensure that the various presenting needs are being fully addressed.'

Finally, respondents were asked to provide suggestions as to what service planners and/or commissioners should be doing to promote recovery. The comments received have been categorised under the following headings.

- Provide secure, long-term funding for services
- Develop broad range of treatment options based on assessed need
- Adopt a more holistic and community-based approach to service provision
- Encourage more joint working
- Involve service users (particularly those already in recovery)
- Focus less on targets and develop more recovery-orientated standards and outcomes for services
- Introduce incentives to reduce substitute prescribing
- More education about long-term effects of drugs



Provide secure, long-term funding for services

'Provide long-term/secure funding that would enhance retention of skilled staff with growing experience which would allow long-term planning and development of service provision. Continuity.'

'Invest more time/money into existing specialised services.'

'Provide existing services with the money/capacity to meet current needs.'

'Ensure funding is adequate and long-term to enable services to plan and develop.'

'Existing recovery-orientated services which are not receiving funding through Edinburgh Alcohol and Drug Partnership (EADP) should be reconsidered and reviewed to be directly in line with the goals and aspirations of the Road to Recovery document and funding arrangements considered.'

'Adequately resource the current treatment services.'

Develop broad range of treatment options based on assessed need

'Developing a broad range of options will ensure that service users have choice. Supporting the development of new initiatives while continuing to fund successful existing initiatives. Ensuring that experience and added value are not lost in the commissioning and tendering process. Instilling hope.'

'Planners/commissioners need to make services available for when service users are ready to make the necessary changes to their lifestyles. Perhaps the availability of information i.e. more agency awareness of the different services available.'

'More realistic objectives as there are a lack of detoxification and rehabilitation services – so how do you get people on the path to recovery?'

'Greater supervision of people on methadone scripts.'

'Ensure funding to a wide variety of approaches.'

'More intensive detox and rehab services which also cater for children's needs.'

'Look at full costs recovery. Look to see if there is any scope for expansion or adaption or flexibility of existing service providers, and direct money accordingly. Identify gaps in service provision and commission accordingly. Take into account the grassroots experiences of people working directly with clients. Open and transparent procurement processes.'

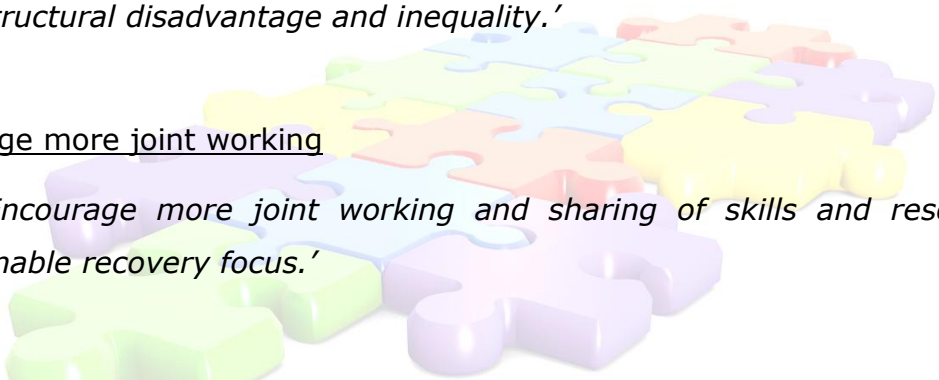
'Needs Assessment Strategy: work the strategy; review; refine.'

<u>Adopt a more holistic and community-based approach to service provision</u>

'Work with Recovery Academy and the Consortium to engage services. Train on assertive referral to mutual aid and support mutual aid group growth and development. Support the Recovery Cafe locally.'

'Getting away from drug services for drug users and challenging generic services to work with drug users. Drug users with disabilities are an emerging service user group. They need an integrated holistic approach to their needs.'

'Service planners need to be aware of the high levels of disadvantage in the lives of many people with substance misuse issues and the effects these can have: poverty, unemployment, poor housing, high levels of illiteracy and other aspects of low educational attainment, low levels of self esteem, criminality, territorialism, sectarianism, racism, etc., any of which can adversely affect people's likelihood of engaging fully with support and treatment agencies. To view recovery from substance misuse in isolation would be a mistake. Action is needed at every level to tackle structural disadvantage and inequality.'



Encourage more joint working

'Encourage more joint working and sharing of skills and resources to enable recovery focus.'

Involve service users (particularly those already in recovery)

'Listen to the wants/needs of the service user.'

'Ex-service users in recovery could really inform planners/commissioners, and would I believe be willing to do so, perhaps through this type of survey that is currently ongoing.'

'I liked the idea of the Stories of Recovery - I am not sure how developed that is but it would be a great resource for individuals and services to access and would be easily populated.'

'Get recovered people involved.'

'Service user involvement in planning process.'

'Listen to what service users say works for them – let service users know that the service are available for them and reduce barriers to services.'

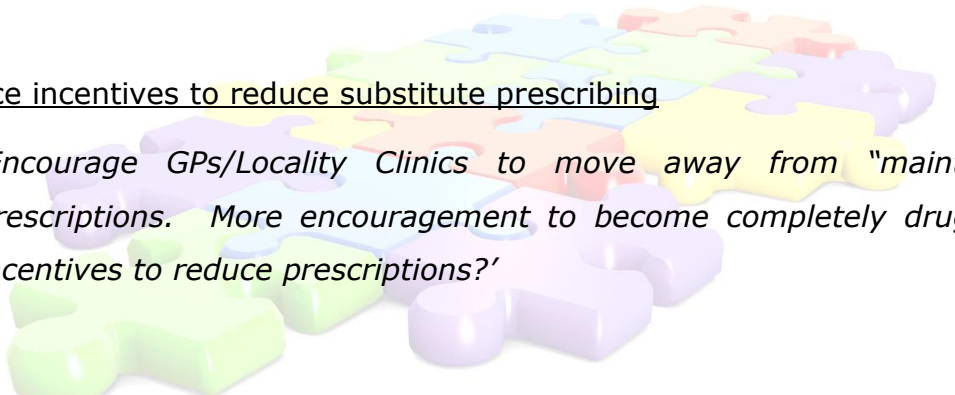
'More service user involvement (particularly with regards to alcohol).'

Focus less on targets and develop more recovery-orientated standards and outcomes for services

'Think more about soft outcomes rather than unrealistic targets.'

'Existing services could be encouraged/expected to meet more recovery-orientated standards and outcomes. The National Quality Standards for Substance Misuse Services should be promoted and monitored.'

'Create checklists for recovery-oriented services and commission them against these criteria. Form recovery outcomes tools to monitor performance. Showcase success and train those who need to aim higher. Decommission services which can't demonstrate that they are making a difference to people's lives.'

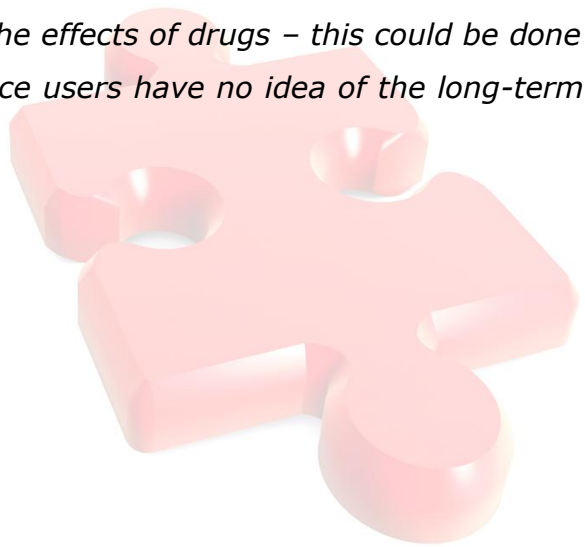


Introduce incentives to reduce substitute prescribing

'Encourage GPs/Locality Clinics to move away from "maintenance" prescriptions. More encouragement to become completely drug free – incentives to reduce prescriptions?'

More education about long-term effects of drugs

'Educate drug users about the effects of drugs – this could be done by GPs at first contact. Many service users have no idea of the long-term effects of Diazepam for example.'



3.5 Key Findings

- The male:female gender ratio in Edinburgh is 60:40 across all services. This is similar to national norms (67:33 alcohol and 70:30 drugs).
- Service managers estimated that 34% of clients have dependent children.
- Over half (52.3%) of all service users are unemployed while 25.7% are disabled or long-term sick, 15.1% are employed and 5% are in full-time education/training.
- Most services estimated that over 30% of their service users had a mental health problem, as well as a drug or alcohol problem.
- Forty five percent of agencies who responded stated that service users were in contact for more than six months while 20% of the agencies reported that their service users were in contact for three to six months.
- Most services provide advice and information, 16 agencies stated that they provide counselling.
- Nurses make up the largest professional group (57.4) in drug and alcohol services in Edinburgh. There are also high numbers of voluntary counsellors (31), key workers (29), social workers (18.2), support workers (16) and managers (16.2).
- Confidentiality concerns were not considered to be barriers to access by staff and service managers. Waiting lists and capacity problems were most often cited as barriers.
- Most service providers considered aftercare to be lacking. The provision of aftercare was seen as a priority.
- Service managers were able to identify key recovery plans for service users, service providers and service planners.

CHAPTER 4: THE GAP BETWEEN NEED AND ACCESS

4.1 Introduction

This phase of the study uses data derived from Chapter 2 on the prevalence of alcohol and drug dependence in Edinburgh, combined with the estimated access to treatment set out in Chapter 3. The ratio of need to access is defined by Oyefeso *et al* as the Prevalence-Service Utilisation Ratio (PSUR)[121]. The PSUR provides a numeric estimate of the local or national gap between need for and access to treatment. This can also be expressed in terms of specifics, such as age, gender or ethnic groups.

The key data from the agency survey for this gap analysis is the number of people that can access the service any one time; this is termed as the capacity of services. In some cases capacity might be higher than current activity (e.g. due to staff sickness or absence) or lower than current activity (e.g. when services are involved in contingency measures such as overtime to address waiting times). The capacity of services in each area is set out in the following sections.

The Scottish Needs Assessment for Alcohol (SANA) established from the agency survey that, across Scotland, 8.2% of people accessing treatment were referred by other alcohol treatment agencies. This 'double counting' provided an over-estimate of the total number of people accessing treatment. We have replicated the SANA methodology and therefore adjusted the estimated access to services in Edinburgh by -8.2%. We were also able to establish from the survey of service managers in Edinburgh that 60% of people accessing treatment were male and 40% were female. This was similar to the national needs assessment ratio (67:33) and the national prevalence study of drug use (70:30).

4.2 Benchmarking

Previous studies have shown that at any given time, the number of people who need treatment greatly exceeds the number who actually access treatment. In North America a 'low' level of access is considered to be 10% or one in ten people in need accessing treatment per annum. Fifteen percent is considered to be a 'medium' level of access, and 20% a 'high' level of access (Rush, 1990)[122].

However, it should be noted that in the drug misuse field which has seen a large increase in availability of treatment in recent years, through considerable investment in expanding services in England, the level of treatment access for

[121] Oyefeso, A., Ghodse, H., Goldfinch, R., Keating, A., Marshall, F. and Miller, J. (1997) *Consultative Report of Drug and Alcohol Services in Merton Sutton and Wandsworth*. Report submitted to Merton Sutton & Wandsworth Health Authority

[122] As 5

'problem drug misusers' per annum is currently approximately 50% equating to a PSUR ratio 1:2 (National Audit Office, 2008). The *Reducing Harm; Promoting Recovery* Report produced by SACDM in 2007 states that:

> *"The Scottish Executive estimates that 18,017 (34.9%) [of the 51,182 PDUs] were receiving methadone in 2003, though, no definitive audit of drug users in treatment has ever been carried out in Scotland. The prevalence study [Hay et al, 2005] also reviewed drug treatment databases in every council area in Scotland and identified a total of 18,037 individuals in treatment."*

This report postulated that if the PSUR for drug services in Scotland was the same as that found in England (50%), the percentage of those in contact with services who were prescribed methadone would be in excess of 70% (18,000/25,600).

The level of access and PSUR should be used to compare relative levels of access in different areas or countries, and between different demographic groups, rather than there being particular value in studying or applying the absolute levels to service planning or development. In this respect the alcohol PSUR for each area is presented in comparison to the *Lothian, Fife, Borders* composite rate and also against the Scottish overall rate.

The estimated number of people in the population with alcohol or drug dependence is compared to the number accessing treatment. This can be expressed in two ways. First, in terms of the prevalence-service utilisation ratio (PSUR), a ratio of the number of people needing treatment compared to the number actually accessing treatment, which for Scotland as a whole is 12.1:1 (Alcohol). Second, this can be expressed as a percentage of the alcohol or drug dependent population that is accessing treatment.

4.3 Percentage Accessing Treatment

This section sets out the PSUR for alcohol and drug treatment in Edinburgh. Table 4.1 displays the capacity of each specialist drug and alcohol service in the area as reported by service managers. It also provides the gender ratio for each service. Where services have a remit for drug and alcohol, this gender ratio is a composite figure across all clients using the service. Table 4.1 provides the raw number accessing treatment and the mean gender ratio required to calculate the PSUR values.

Table 4.1: Capacity of drug and alcohol services in Edinburgh

Service	Gender		Capacity		
	M	F	Total	Drugs clients	Alcohol clients
North Edinburgh Drug Advice Service	57	43	184	127	57
Homeless Outreach Project	60	40	62	41	21
Turning Point Scotland, Leith 3 Smiths Place	56	44	130	117	13
Crew	60	40	28	28	N/A
Midpoint Accommodation Support	83	17	18	18	N/A
Simpson House Counselling	66	34	78	78	N/A
Community Addiction Recovery Service (Turning Point Scotland-CARS)	62	38	24	24	N/A
Aberlour Outreach Edinburgh	10	90	20 families	16	4
The Castle Project	60	40	135	128	7
Circle	50	50	70 families	49	21
Bethany Christian Centre	100	0	17	7	10
Rankeillor Initiative	90	10	22	16	6
Lothians & Edinburgh Abstinence Programme (LEAP)	67	33	66	33	33
Harm Reduction Team	70	30	60	60	N/A
Community Drug Problem Service (CDPS)	60	40	820	820	N/A
Alcohol Problem Service (APS)	60	40	920	N/A	920
Social Work (Drug Referral Team)	60	40	84	84	N/A
Social Work (BBV Care Management Team)	47	53	36	36	N/A
Social Work (Alcohol Referral Team)	50	50	72	N/A	72
Alcohol Liaison Service, RIE	66	34	N/A	N/A	N/A

Edinburgh & Lothian Council On Alcohol	63	37	179	N/A	179
Edinburgh and Midlothian Arrest Referral Service	82	18	50	25	25
CHAI	60	40	105	84	21
TOTAL	60	40	3180	1791	1389

PSUR - Alcohol

Table 4.2 sets out the PSUR for alcohol services in Edinburgh. The total population has been adjusted to reflect the age ranges appropriate to specialist alcohol services (15-64, 65+). The raw number accessing treatment was provided by the services as set out in Table 4.1 above. From this a calculation has been done to compensate for double-counting, i.e. clients attending more than one service at a time. The PSUR is calculated between the adjusted prevalence figure and the adjusted access figure.

Table 4.2: Prevalence Service Utilisation Ratio – Alcohol

	Total Population	Adjusted prevalence alcohol dependence		Adjusted by age		Raw number accessing treatment	Adjusted number accessing treatment (-8.2%)	PSUR	Percent accessing treatment
				71.5%	14.5%				
	Number	%	Number	15-64	65+	Number	Number	Ratio (95% CI)	%
All	471,650	5.0	23,582	16,861	3,419	1389	1267	1:16	6.2%
Male %		67	15,800	11,297	2,291	(60.3%)	764	1:18	5.6%
Female %		33	7,782	5,564	1,128	(39.7%)	503	1:13	7.5%

These calculations show a PSUR ratio of 1:16, meaning that 6.2% of alcohol-dependent people in Edinburgh are accessing specialist alcohol services as defined earlier in this report. This is a lower rate of access than both the regional rate (8.1%) and the Scottish rate (8.2%). This is based on the assumption that the 1267 people accessing specialist alcohol services are alcohol dependent.

Variables

The national needs assessment research found that 81.1% of people attending community alcohol services were defined as moderately or severely dependent. However, this was based on a small number of responses. Adjusting the figures using this factor would yield an Edinburgh PSUR ratio of 1:20, equivalent to 5.0% access rate.

Assuming that there was no overlap between services, i.e. that none of the 920 clients of the APS were attending ELCA, and *vice versa*, the PSUR would be calculated on a total of 1389 clients (assuming all are alcohol dependent). The PSUR would reduce slightly to 1:15.

PSUR - Drugs

The calculation for PSUR for drug services is similar to that of alcohol services except in calculating the age adjusted prevalence figure. The standard age range commonly accepted for drug prevalence is 15-54 years. This range was used in both the 2000 and 2003 prevalence studies in Scotland (published in 2003 and 2006 respectively); however, this was changed to 15-64 years in the 2009 prevalence study to bring the Scottish data into line with other European countries.

Table 4.3 sets out the PSUR calculations based on the newer prevalence rate and wider age range used in the 2009 report. Unlike previous studies, the 2009 prevalence study did not provide breakdowns by gender in each area but provided an estimated national average of 70% males and 30% females. This is significantly different from the more accurate and locally useful 2006 report. These three variations: prevalence rate, age range and gender ratio, result in significant differences in PSUR values from those calculated using the previous prevalence figures.

Table 4.3: Prevalence Service Utilisation Ratio – Drugs

	Total Population	Prevalence of problem drug use		Adjusted by age	Raw number accessing treatment	Adjusted number accessing treatment (-8.2%)	PSUR	Percent accessing treatment
	Number	%	Number	15-64 (68.5%)	Number	Number	Ratio (95% CI)	%
All	471,650	1.61	7,594	5,202	1,791	1644	1:3.2	34.4%
Male %		70	5,316	3,641	1063 (59%)	970	1:3.8	26.6%
Female %		30	2,278	1,561	728 (41%)	674	1:2.3	43.2%

It can be seen from these calculations that the percentage accessing drug treatment (34.4%) is relatively higher than those accessing alcohol services (6.2%) in Edinburgh. However, the expectation based on the NTA guidance in England and the SACDM report in Scotland is that access to drug services should be 50%. In this regard, there is a gap between the prevalence of problem drug use in Edinburgh and the capacity of available services. On further examination it can be seen that the gap is more in relation to males accessing services (26.6%) than females (43.2%).

4.4 PSUR including Primary Stimulant Users

The prevalence of problem drug use, as defined by Hay *et al*[123], relates to the use of opiates and benzodiazepines. The assumption that the above calculations are based on is that all people attending drug services in the Lothians fit into this criteria. The Drug Misuse Statistics (ISD, 2008) state that, of the 10,248 new notifications in Scotland reporting illicit drug use, 7035 (69%) reported using opiates (e.g. heroin, methadone or dihydrocodeine) and 555 (5%) reported using benzodiazepines (e.g. diazepam)[124] as their main drug of use.

This has possible implications for the calculation of identifying gaps. If the 5202 (opiate and benzodiazepine) PDUs identified by using the national prevalence rates across the three areas represent 74% of those accessing services, then the actual prevalence of problem drug use with a wider definition than that applied by Hay *et al* (i.e. including primary stimulant or hallucinogenic drug use) is approximately 7030. This would result in the PSUR being 1:4.3, or 23.4% accessing treatment, rather than the 34.4% calculated using Hay's definition of PDUs.

[123] As 8

[124] As 87

4.5 Waiting Times

A proxy measure of the synergy between service provision and demand is the extent to which waiting times exceed a reasonable administrative period. It is not unreasonable to expect a length of time to elapse between a referral being made and the provision of treatment or care.

The National Waiting Times Framework sets out the key stages between which waiting times should be calculated.

A HEAT target for drug service waiting times is currently being devised by Scottish Government and is due for implementation in 2010/11. At this time this process refers to drug services only.

4.5.1 Waiting times in Edinburgh

The drug and alcohol services in Edinburgh have a range of waiting times; however, the majority of services are able to see new drug and alcohol referrals reasonably quickly. Castle Project in particular has no waiting times for both drug and alcohol referrals. Other services such has HOP and RI have short waiting times of one week and two weeks respectively for both drug and alcohol referrals.

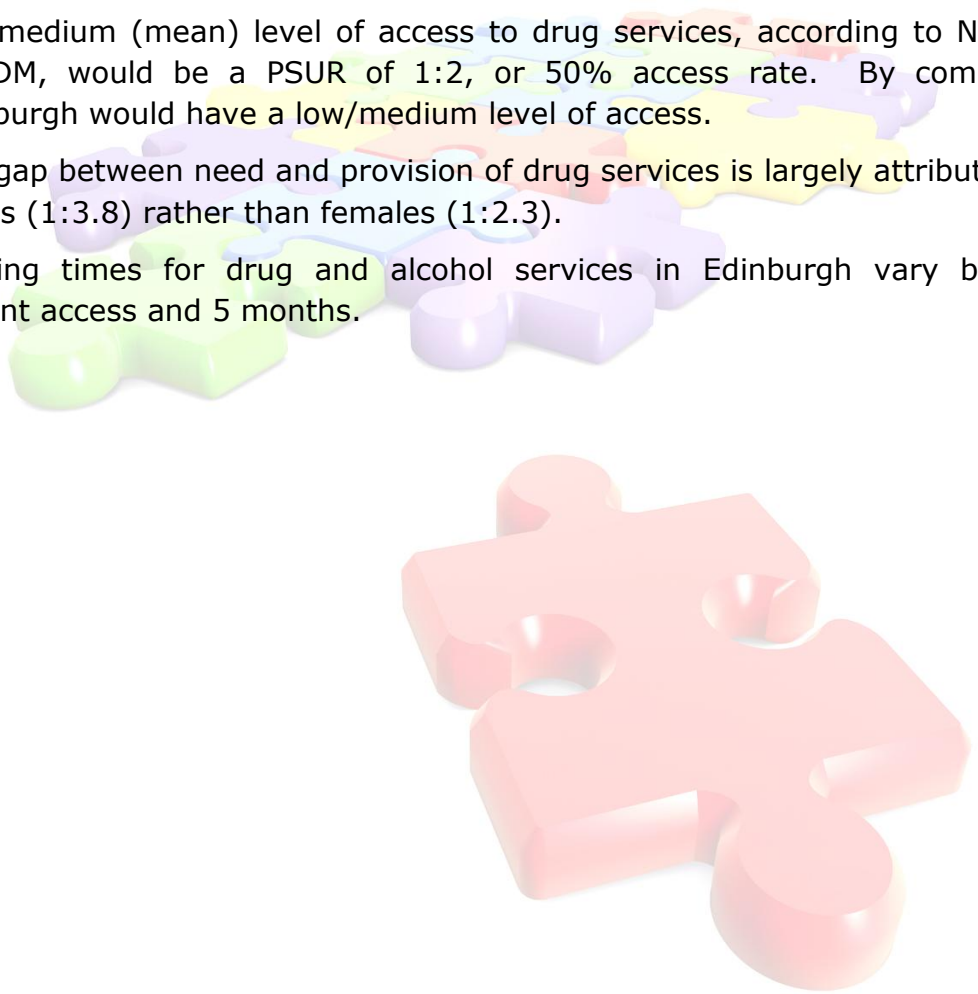
Drug and alcohol services such as Crewe, SHC, CARS, LEAP and ELCA can see new clients within two to three weeks of receiving the referral. Waiting times for BCC can be anywhere between immediate and up to six weeks. Similarly, NEDAC currently has a waiting time of six weeks; however this may be due to a shortage of staff at present time.

CDPS has an approximate waiting time of 12 weeks but this can vary. Similarly, HRT can normally see referrals within 12 weeks. SW BBV currently has a waiting time of eight weeks but SW DRT has a longer waiting time of 20 weeks.

Alcohol services, such as APS, normally take about 18 weeks to see alcohol referrals.

4.6 Key Findings – Gap Analysis

- In Edinburgh there are approximately 1791 people accessing alcohol services and 1389 accessing drug services.
- The ratio of need for alcohol services in relation to the provision of services is 1:16. This is equivalent to 6.2% of people in need accessing service. This is lower than both the regional and the national rate.
- By North American standards, this would equate to a low level of access.
- The ratio of need for drug services in relation to the provision of services is 1:3.2. This is equivalent to 34.4% of people in need accessing services.
- The medium (mean) level of access to drug services, according to NTA and SACDM, would be a PSUR of 1:2, or 50% access rate. By comparison Edinburgh would have a low/medium level of access.
- The gap between need and provision of drug services is largely attributable to males (1:3.8) rather than females (1:2.3).
- Waiting times for drug and alcohol services in Edinburgh vary between instant access and 5 months.



CHAPTER 5: WIDER STAKEHOLDER CONSULTATION

5.1 Introduction and Aim

The purpose of this element of the research was to seek the views of the wider stakeholders on the current provision of alcohol and drug services within the City of Edinburgh in order to assist in the identification of any current gaps or future service requirements.

A number of themes emerged from these interviews and are discussed below under the following sub-headings:

- Perceptions of Current Drug and Alcohol Service Provision
- Current Provision of Services
- Groups Not Well-Catered For
- Rehabilitation and Detoxification Service Provision
- Service Access
- Joint Working
- Effective Current Provision
- Views on the Scottish Recovery Agenda in relation to service provision within Edinburgh
- Views on Future Investment

5.2 Method

A total of thirty-nine stakeholder interviews were conducted with persons either directly or indirectly involved in alcohol and or drug service provision within the City of Edinburgh. The list of interviewees was agreed with the contract managers and is set out in Appendix 1. Contact was also made with Edinburgh Capital City Partnership with a view to inviting parties involved in the Edinburgh Community Representatives Network to input to the needs assessment. Following discussions an invitation letter and information document were forwarded to ECRN on 14th April 2010 for wider distribution.

A semi-structured interview schedule was devised in order to explore the pertinent issues during the stakeholder consultations. This schedule was based on findings from the earlier stages of research, including the analysis of activity, as well as previous needs assessments. The average interview time length was around one hour. All stakeholder comments have been anonymised.

5.3 Perceptions of Current Services

5.3.1 The Range of Services and Types of Interventions

The stakeholders were asked to describe and comment on the range of services and the types of interventions currently available within the City of Edinburgh, for those with alcohol and drug misuse problems, including any services being utilised within other regions.

The key feature of almost all of the interviews was that most stakeholders were well-informed, with the majority of people being able to identify some or all of the main statutory and non-statutory drug and alcohol services within their area.

However, it is evident that service provision within the City of Edinburgh is complex as well as continually evolving, and so keeping abreast of developments is challenging for those stakeholders not involved on a daily basis.

With regards to the range of pharmacological and non-pharmacological interventions currently available, most interviewees stated that this was good, certainly for adults; though most stressed they could only comment from the perspective of their own knowledge, which was not necessarily comprehensive.

5.3.2 Current Provision of Services

Stakeholders were asked to comment on whether current service provision meets the need, and whether they could identify any interventions that are needed, but not currently provided. Any issues regarding the sourcing of services external to the City of Edinburgh were also explored at this point.

The majority of stakeholders did indicate that demand for nearly all services is very high and so in most cases, provision does not meet this demand, often causing 'long' waiting times.

The comments made by stakeholders are noted under two main headings: 'Adult Services' and 'Children and Family Services'. Issues raised relating to Young People's Services are set out in section 5.3.3.

Adult Services

Rehabilitation and Detoxification Service Provision

There are two rehabilitation facilities within the City of Edinburgh; Lothians and Edinburgh Abstinence Programme (LEAP), which is a quasi-residential service located in the Stockbridge area of the city and Bethany Christian Centre, a residential facility in Casselbank Street.

LEAP caters for adults aged 16 years and upwards and is a three-month day programme for substance-dependent people (including opiates, stimulants, cannabis, tranquillisers and alcohol). The programme takes the form of an intensive intervention based on a modified Minnesota Model.

The vast majority of stakeholders commented that LEAP was an excellent programme, which should continue to be funded within the City. However, concerns were raised with regards to the fact that it does follow a very specific model, which is not suitable for everyone and so there is a gap in relation to alternative forms of rehabilitation available locally to clients. Stakeholders commented that the cost of sending people to services in other locations must be substantial and so setting up a different facility within Edinburgh would potentially be beneficial.

Bethany Christian Centre is a residential service offering full housing support alongside an in-house programme of recovery phases, incorporating Twelve Step Facilitation, Relapse Prevention, Cognitive Skills and Life Skills Training, Addiction Counselling (clinically supervised), Employment Skills Preparation, Recreation programmes, Access to education & training, Aftercare, Case Management etc, delivered in group and individual settings within an abstinence context for newly recovering male individuals (aged 17-70), admitted at the point of commencement of abstinence.

Stakeholders were less aware of the existence of Bethany Christian Centre and those who were aware were less knowledgable of the range of services offered in comparison to LEAP. Bethany provides a faith-based programme which, although open to anyone, may not suit people with different beliefs.

In addition, stakeholders emphasised that currently there are no rehabilitation facilities for women who are substance-misusing parents and therefore this is a gap that requires review. Interviewees stated that it is not an acceptable situation for mothers to have to be separated from their children in order to be able to attend LEAP for instance. At present, the only option for mothers is to obtain funding to attend Phoenix Futures in Sheffield. However, this means the woman has to commit to moving away from the Edinburgh area, potentially on a long-term basis, which many stakeholders stated is an unacceptable situation.

A number of interviewees commented that the 'hurdles' that clients have to overcome in order to gain a place in rehabilitation were too demanding and thereby discriminate against the vast majority of people who misuse substances. Although stakeholders fully understand the reasons for implementing such criteria, many felt these to be unhelpful because there appears to be no evidence to suggest that the present conditions necessarily facilitate selection of those candidates most likely to complete the programme. Several stakeholders commented that they have personally known clients who under current criteria would fail to obtain a place at LEAP, but have still done very well when in attendance at other similar rehabilitation facilities.

The rehabilitation centres outwith Edinburgh presently being utilised by clients are Castle Craig in West Linton, Phoenix House in Glasgow, and Red Tower in Helensburgh. Other facilities may be accessible, but these were the ones mentioned by interviewees.

With regards to the provision of detoxification services, stakeholders generally felt this to be inadequate and emphasised that current resource is not meeting the demand. Comments were made regarding the long waiting times, especially since the closure of the inpatient facilities available through the Links Project. Hence this was cited as another major gap to be addressed in the region.

In relation to the Alcohol Problem Service (APS), specifically the inpatient facilities available at the Ritson Clinic, stakeholders explained that there is a growing need to expand the existing 12-bed unit. Apparently there are plans in the early stages to shift the facility to another site within the Royal Edinburgh Hospital, where additional beds could be accommodated, given the present capacity issues. This need has arisen due to an increase in demand for inpatient detoxification facilities in the City, especially in the light of other services closing. In addition, the Ritson Clinic now offers a combination of drug and alcohol detoxification, as well as drug stabilisation (having been solely an alcohol detoxification unit in the past) and so this has increased the demand for treatment at the facility. Interviewees commented that this shift in provision has also created a variety of staff training needs that need to be addressed. Furthermore, the pressures on the staff working in the facility means there is a shortage of input from disciplines such as Community Psychiatric Nurses, Psychology, Occupational Therapy, Pharmacy and Community Services.

The Provision of Psychological Therapies

There are psychologists based within the sector addictions teams, one person at the Genito-urinary Medicine (GUM) Clinic and another at the Regional Infectious Diseases Unit at the Western General Hospital. These psychologists work directly with clients who have complex psychological problems and concurrent substance misuse difficulties or HIV infection. In addition, it is part of their role to offer advice to colleagues when it comes to addressing the needs of those clients who have less severe psychological difficulties and therefore do not require direct input from a fully trained clinical psychologist.

Discussions regarding how to further develop the Psychology Service are ongoing. One area of review relates to the subject of how to assist staff working in partnership agencies, especially in terms of the development of recovery-based programmes. However, stakeholders did comment that psychological service provision is under immense pressure and that there are not enough intensive services available to attend to the complex needs of existing client groups.

Furthermore there is a lack of quality assurance when it comes to current provision, and even when there are governance procedures in place (for example supervision), these are often inadequate. This is an area that needs to be addressed at an inter-agency level according to interviewees. On another note, stakeholders identified the need for psychologists to be more active in relation to conducting research to review the efficacy of different forms of treatments and interventions. In addition, it might be useful to explore the delivery of group-based psychological therapies within the region, as at present most consultations are delivered on a one-to-one basis.

Lastly, concerns were raised about the lack of administrative support within the service and the fact that psychologists and nursing staff have to spend a considerable amount of time on tasks such as photocopying, instead of actually treating patients. This is an area that needs to be addressed because staff time at this level is expensive and should be focussed appropriately. If the service could be run more efficiently this would reduce waiting lists and enhance patient care.

Homelessness and Housing

Stakeholders raised concerns regarding the lack of resources in terms of funding pools for homelessness services. Interviewees raised concerns regarding the tendering process for non-accommodation services within Edinburgh. They stated that this has had a dramatic effect on service provision for the homeless and, given the vulnerability of this client group, is a key issue to address.

Another area that requires review is the way services are structured to meet the needs of homeless clients. There are issues in relation to Housing Services organising accommodation for people, but following this there being no timely support for individuals in terms of their addictions. This seems to be a frequent problem, which often means chaotic people will fail to keep their tenancy for a variety of reasons related to their drug or alcohol use. Stakeholders would like to see these vulnerable individuals prioritised within the system because otherwise resources are not being utilised effectively.

Furthermore there are a significant numbers of people who are provided with accommodation in 'Bed and Breakfasts' and hostels within the City and who are not being referred to substance misuse services. Interviewees would welcome a system to ensure all vulnerable people are given opportunities to engage with services.

Another area that needs to be addressed is the lack of patient tracking and follow-up since 'homeless' clients are often shifted from one form of accommodation to another without changes in address being documented with substance misuse services. This can result in people literally being 'lost' in the system, especially when the current lack of capacity within addiction services means there are long waiting lists which often increase the likelihood of such occurrences.

Stakeholders commented that the Edinburgh Access Practice does great work with the homeless and has excellent links with other services such as NEDAC and Social Work for example. However, stakeholders raised concerns regarding the lack of effective joint working with the Community Drug Problem Service. Finally, interviewees would like to see the implementation of in-patient liaison service for drug misusers.

In relation to housing provision through Edinburgh City Council, historically (around five years ago) it was felt that there were a plethora of providers in the City and the procedures for the funding of proposals were not perceived to be very rigorous. EADP carried out a branch review of this area and attempted to link provision to the measurement of outcomes in order to identify effective interventions. However, stakeholders commented that more needs to be done to ensure that this is still occurring and perhaps an overarching review is now required to determine which areas should be targeted as a matter of priority.

Stakeholders were concerned that there may be a potential gap within Edinburgh in terms of there being no night shelters available through the Council. However, the Bethany Christian Trust operates a night shelter scheme within church halls between the months October and April. Therefore Edinburgh City Council Housing Department are presently reviewing this area in conjunction with the Bethany Christian Trust.

Harm Reduction Issues

Methadone Dispensing/Prescribing

A number of stakeholders made comments about how some GP practices in the region have still not taken up the National Enhanced Service, thereby putting a pressure on other more specialised services.

In addition, interviewees felt more needed to be done to ensure General Practitioners follow-up with clients who are on methadone prescriptions in order to review their progress.

On another note, some stakeholders raised concern regarding the fact that there are people on methadone prescriptions who are also attending Needle Exchange Services and so more needs to be done to address this issue.

Needle Exchange

In terms of Needle Exchange Services, the majority of stakeholders did not have any specific comments to make, other than to state that the current level of funding was adequate as a result of monies becoming available in relation to Scotland's 'Hepatitis C Action Plan'.

In addition, interviewees mentioned that the new Injecting Equipment Provision (IEP) Guidance has helped to improve service provision.

Furthermore, in relation to needle exchange, the development of the Managed Care Network for Hepatitis C has apparently been very helpful. This prevention group meets regularly to discuss relevant issues and is facilitated by Health Protection Scotland. It part of a range of initiatives to develop a consistent approach to IEP across Scotland.

On another note, interviewees mentioned that the Harm Reduction Team (HRT) would be keen to increase the capacity in their clinics and this probably would not incur additional staffing costs.

Accident and Emergency

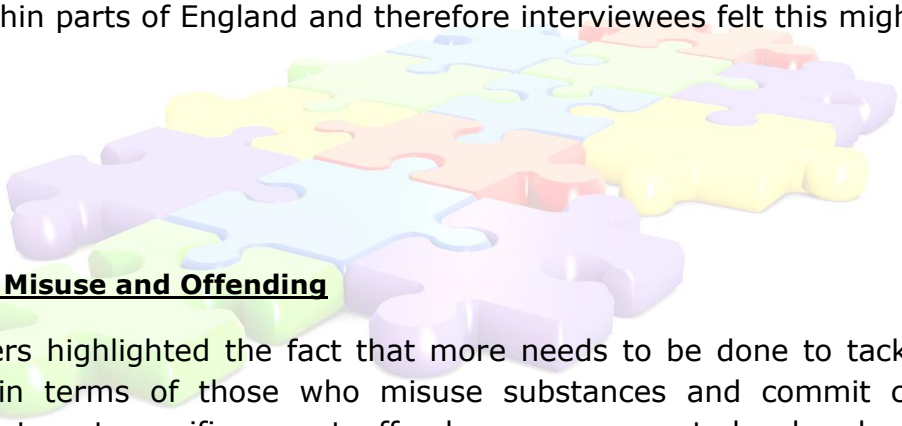
Concerning admissions to the Accident and Emergency Department at the Royal Infirmary, Little France, stakeholders commented that they would like to see a scheme implemented whereby vulnerable individuals (both in terms of alcohol and drug misuse, as well as for those admitted due to their co-morbid mental health problems) who are reviewed by A&E staff, can then be (where appropriate) referred on to Addiction Services. At present this does not occur, mainly because a number of these patients may not be registered with a General Practitioner and so A&E staff simply discharge these clients after treatment. Interviewees felt this was a gap that needed to be addressed, because the fact that clients are not registered with a General Practitioner, should not mean that they cannot be routinely referred to other services that would provide the support these people often need. The time it would take to make a referral to a GP would be the same as it would take to complete a referral to Addiction Services; therefore this process would not add to the workload of A&E staff. Stakeholders commented that it would be fairly straightforward to implement such a scheme, though it would be necessary to provide NHS staff with information regarding where and how to refer individuals to services within Edinburgh. However, the potential benefits of providing this service, especially in relation to those individuals who are seen repeatedly in A&E due to substance misuse problems, could be significant.

Designated Places of Safety and Related Initiatives

With regards to the subject of 'Designated Places of Safety' for individuals deemed 'Drunk and Incapable' (D&Is), stakeholders agreed this was a potential gap in provision within the City of Edinburgh. Interviewees felt that a cost effective method could be provided, but in order to implement a suitable scheme, there would have to be someone put in charge of reviewing and managing the project. At present there are a number of people who have given up their time to evaluate suitable options, but since these people have full-time

jobs with remits that do not specifically include this area, it is difficult for progress to be made. All parties directly involved therefore indicated that the best way forward would be to nominate a specific person, preferably someone who has experience in financial planning, to evaluate the possibilities and come up with a cost-effective solution.

Another initiative that interviewees would like to see fully explored is a joint mobile triage service between the Police and the Ambulance Service. This would take the form of a paramedic and police officer sharing a car together in order to attend incidents to make appropriate assessments, especially in terms of those considered to be Drunk and Incapable. This joint response taskforce approach is utilised within parts of England and therefore interviewees felt this might work in Edinburgh.



Substance Misuse and Offending

Stakeholders highlighted the fact that more needs to be done to tackle repeat offending in terms of those who misuse substances and commit crime. A scheme to target specific repeat offenders was suggested, whereby addiction workers would engage with individuals whilst they are in custody. At present some work is being conducted through the Criminal Justice Authority, but there is room to expand this initiative perhaps with support from the EADP.

In addition, since the funding for the organisation SCOTPEP was withdrawn, stakeholders highlighted that there is a gap in relation to support for street workers and so this is a further area that requires review.

Stakeholders commented that the Drug and Treatment Testing Orders (DTTOs) appear to be broadly effective in terms of helping people re-integrate back into society. However, interviewees indicated that a lot more needs to be done for those individuals coming off orders as there is still a lack of aftercare support. The average length of an order is between 15 and 18 months and so it is vital to have well-planned support packages for people after this intensive phase.

Furthermore, for those people who have substance misuse problems and custodial sentences imposed on them, there is a need to provide much better support as they are released from prison back into the community. Stakeholders commented that the positive work that is completed in prison often fails to bridge the gap and this sub-group is especially vulnerable to relapse in terms of substance abuse and returning to criminality.

In terms of alcohol misuse, the Procurator Fiscal only has one non-court disposal available to deal with people who have committed offences. This usually takes the form of a fiscal fine such as a SACRO diversion. The latter can be imposed where there is an identifiable victim and there is potential for reconciliation

between parties. However if both parties, the accused and the victim, do not agree to the terms of this arrangement, the matter has to be dealt with through the court. This only serves to criminalise behaviour that could potentially be dealt with in another way, for example through structured treatment, which might avoid or militate against future criminality. At present, the only way to obtain treatment for those people with alcohol problems who have committed offences is through a court order and this is therefore an area that urgently needs to be addressed.

Parasuicide amongst drug and alcohol users was also considered by stakeholders to be an area which lacked attention. The police have limited options to deal with such situations, especially as psychiatric services tend to deem these individuals non-sectionable under the Mental Health Act[125]. This in turn leaves the police with no alternative apart from to charge these people with 'breach of the peace' in order to take them into custody for their own safety. Consequently this will often involve the person spending a night or weekend in the cells, until it is possible for the Procurator Fiscal to take the decision to release them without charge. The police cannot afford to take the responsibility for releasing the person, since they would potentially be found negligent if that person was to go on to commit suicide after being in their care. Hence the entire process is a formality to protect all parties from being found to be lacking in their duties. Stakeholders stated that the situation is entirely unsatisfactory since the client fails to receive any form of support and furthermore the police and the Procurator Fiscal have to commit time and resources, which could be channelled in other ways. According to the stakeholders, the number of admissions to police custody suites in relation to parasuicide is significant and this matter should be investigated as a matter of priority.

Interviewees highlighted the fact that perhaps funding should be distributed differently in terms of community safety and the gaps in provision that have been identified. Stakeholders would like to see more initiatives with bridge funding so as to involve not just health or social work exclusively, but proper partnership working between services, with the view to addressing some of these issues.

On another note, 'The Willow Project' was mentioned as an excellent initiative for integrating female offenders back into society. It is based in Edinburgh and the project helps women with social skills, housing, employment and other areas that which aids in their rehabilitation.

Children and Family Services

With regards to services for children and families affected by substance misuse, stakeholders highlighted the need to develop strategies that bridge with adult

[125] Mental Health (Care and Treatment)(Scotland) Act, 2003

services that are supporting substance-misusing parents. At present, there is felt to be a clear divide between these two areas of provision and very little joint working to achieve objectives. In addition, interviewees stated there needs to be a wider debate about what the key objectives are within the constraints of current service provision and how the HEAT targets and various government strategies link into this picture. There seems to be concern regarding people falling through the gaps because there is such an emphasis placed on services meeting targets. Stakeholders stated that this is starting to affect the quality of care clients receive.

On another note, interviewees raised concern regarding the increasing numbers of children accommodated away from home within Edinburgh, given that the majority of these cases result from substance misuse problems within families. Apparently the growth is in relation to younger children, generally from babies up to those aged around ten years old. Furthermore, there is a need to address the lack of support for Kinship Carers within the region.

Other concerns that were raised relate to the need for a specific review in terms of how to address issues arising from cases of neo-natal abstinence syndrome, foetal alcohol syndrome, and other conditions that have a long term impact on child development.

Finally, stakeholders mentioned they would like to see a more targeted approach to the provision of family planning services for substance-misusing women in order to minimise situations where women have multiple pregnancies, which result in children being taken into local authority care. Such an approach would need to consider the needs of the mother as well as the children.

5.3.3 Groups Not Well-Catered For

Stakeholders were asked if there are any groups of people that they are aware of which services do not cater for adequately. Specific groups discussed include:

- Young people
- Non-opiate users
- Women
- Ethnic minorities
- Clients suffering from forms of brain damage as a result of long-term alcohol abuse
- Dual diagnosis clients
- Older drug users

The comments are discussed below under these different sub-headings.

Young People

There are a number of services in Edinburgh that assist young people with substance misuse problems. These include services such as Hype, Crew 2000 and Includem.

Stakeholders mentioned the fact that it can be difficult to source support for young people in Edinburgh and that there is too great a focus on adult treatment services. This was a concern because interviewees felt that there is no long-term plan for tackling substance misuse in a preventative manner, or at least in a way that addresses problems in their early stages. Some people said that we fail people in our present society by simply attempting to address issues once they have arrived in their severest forms and that the young people currently misusing substances are simply going to grow up to be the next generation of adults with complex problems.

There were a lot of concerns raised about the reconfiguration of 'Hype' because the majority of interviewees stated that this was an excellent service. Stakeholders hoped any changes would not decrease the quality of this service and so reduce the standard of care for young people within Edinburgh.

On another note, interviewees stated that there could be more assistance provided for young people in terms of 'mentors' and 'befrienders'. In addition, the transition for young people to adult services is an area that needs to be reviewed.

Non-opiate Users

In terms of issues relating to non-opiate users, a number of stakeholders felt more needed to be done to help these people. Stakeholders commented that services were too opiate-focused and that there does not seem to be a strategic approach in Edinburgh for dealing with non-opiate users, whether this is cocaine misuse or cannabis.

Women

The majority of stakeholders did not really know if there were any issues specific to this group. A few people said that women only get priority if they are pregnant or have dependent children. Furthermore, interviewees highlighted the lack of provision for women who have suffered from some form of trauma, such as sexual abuse. It was felt that more needed to be done to address these very important issues as they are so inextricably linked with substance misuse in this group of clients.

Ethnic Minorities

In general, stakeholders within Edinburgh said they were unaware of ethnic minorities with substance misuse problems existing in any significant numbers and so interviewees seemed to feel there were probably not any needs associated with this group. However, a few people did question whether we were simply not accessing existing populations and so perhaps more work had to be done to review this area.

Alcohol Users with 'Brain Damage' from Long-term Misuse

There was concern raised about the lack of service provision for people who have suffered brain damage as a result of their long-term alcohol misuse and stakeholders highlighted the need to have a strategy for dealing with such clients.

Dual Diagnosis Clients

Another area of concern centred on dual diagnosis and the lack of mental health services for people. This subject was continually highlighted as requiring attention within Edinburgh, as a matter of priority. Stakeholders seemed to feel substance misusers were discriminated against in terms of access mental health care. However, interviewees did mention that staff working in the Community Drug Problem Service (CDPS) and Alcohol Problem Service (APS) do try their very best to provide assistance, but the waiting lists for psychiatric assessment are often several months long.

Stakeholders also commented that mental health services and substance misuse services are not integrated and that this is part of the problem as mainstream psychiatric services refuse to see these clients. One interviewee stated:

> *'That there are very powerful voices that are resistant to working together, because…I don't know if it's fantasy or reality but in terms of…there's vested interests keeping it separate, because people are happy at different levels. That needs to be really addressed because it's really letting people down!'*

In addition, interviewees highlighted a potential gap in relation to the provision of care for people diagnosed as 'learning disabled'. Apparently increasing numbers of people from this sub-population are falling through the gaps within current provision and are often ending up homeless. This trend was echoed by those working within homeless services as an issue of concern.

Older Drug Users

Stakeholders raised the issue that drug users are living longer as a result of harm reduction strategies and suggested that this is a sub-population that will

require specific services in the not so distant future. Interviewees seemed to feel service commissioners need to review what impact an aging population of substance misusers may have on current provision and should take a forward planning approach to the matter.

5.3.4 Joint Working

Stakeholders were asked how well they thought services work together in the area in terms of joint assessment, care-planning and review. The majority of comments were very positive and interviewees seemed to feel this was a real strength in terms of substance misuse services within Edinburgh. The only area that seemed to be lacking was in relation to a need for greater joined-up working between 'Adult Services' and 'Children and Family Services' as well as in terms of 'Substance Misuse Services' and 'Psychiatric Services'. In addition, interviewees frequently mentioned issues relating to the 'Edinburgh Alcohol and Drug Partnership' (EADP) and these comments are summarised below.

The Edinburgh Alcohol and Drug Partnership

The majority of stakeholders commented that they felt that the Edinburgh Drug and Alcohol Partnership needed to be more transparent, especially in relation to funding decisions. Interviewees said they would like to see the EADP clearly outline who is in charge of making certain decisions and the reasons for these choices. Stakeholders stated that the three-year tendering process is making service provision very complicated, particularly because non-statutory services receive funding from a number of different sources, and so a longer period such as five years would be more suitable.

Furthermore, stakeholders expressed dissatisfaction at the lack of joint working and effective communication between the various sub-groups that meet and feed information up to the EADP.

There were numerous comments from individuals stating that they felt the members of the EADP were not taking appropriate action as and when required, and many said the EADP just represented a further level of bureaucracy. In addition, some interviewees did not know what the EADP does or who is on the Committee. A number of people said the Partnership lacked good leadership and that service provision within Edinburgh would not improve unless there were changes made to the way the EADP currently functions.

On a more positive note, stakeholders commented that they were pleased that there would be a new person joining the Partnership shortly. In addition, several interviewees praised the work Mr Peter Gabbitas has been doing to ensure that organisations are utilising funding appropriately in order to provide effective service provision.

5.3.5 Effective Current Provision

Stakeholders were asked if there was anything that they felt works well in terms of the local provision of drug and alcohol services.

The Blood Borne Virus Service and the Manage Care Network for Hepatitis C were highlighted by a few interviewees. In addition, the Substance Use Reference Group Edinburgh (SURGE) was mentioned several times as being excellent.

5.3.6 Views on the Scottish Recovery Agenda in relation to Service Provision within Edinburgh

Stakeholders were asked to what extent they felt that the Scottish Recovery Agenda has had an impact on drug and alcohol services within Edinburgh. The choices of answers given to them were:

- It has not had any impact.
- It has had very little impact, but there have been some minor changes.
- It has significantly changed the way services work.
- It has changed services moderately - as there have been some larger changes.

Furthermore, interviewees were asked to comment in relation to the following areas.

- What do you think needs to be done in order to make services (or if appropriate, their specific service) more recovery-orientated?
- What do you think service users themselves need to do in order to promote their own recovery? How do you feel services and service planners can help to promote clients to identify these responsibilities and encourage them to address these issues?
- What do you think service planners/commissioners should be doing to promote recovery?

The majority of stakeholders stated that the Scottish Recovery Agenda has 'not had an impact' or only 'very little impact' on service provision within Edinburgh. A few people did feel that the agenda has changed services moderately, but overall interviewees stated that much more needs to be done to promote a change in thinking and especially people's attitudes.

In addition, stakeholders highlighted the fact that perhaps the most important issue is the lack of translation in terms of what this agenda actually means for services within Edinburgh, especially given the current economic climate.

Furthermore, many stakeholders emphasised the fact that this agenda may be known about by senior staff involved in commissioning, planning and those at

upper management levels, but for the ordinary worker actively providing support to substance misusers, such information rarely filters down to this point. Stakeholders commented that it is these people who will ultimately have to change how they practice and so educating staff about recovery at this level is vital. Also, interviewees felt that there is a lot of confusion about the definition of recovery and this needs to be clarified to all staff working in services. Stakeholders commented that there is a need for some form of baseline 'blanket' education for all staff working in services regarding recovery, i.e. not just an induction programme for new staff (though stakeholders said 'any form of education is better than none'), because it is vital to change the attitudes of those people who have been working in services for many years.

Additionally, interviewees were concerned about the amount of talk there is around the subject of recovery and the fact that this is rarely translated into action. Staff seemed to feel there is no real leadership from 'the top' with regards to the implementation of this agenda and that this is why very little has been achieved to-date.

On another note, stakeholders said that in order to promote recovery it is important to address the issues that underlie substance misuse within our society such as poverty and deprivation, mental health issues and so on.

Another concern raised by interviewees relates to the HEAT targets and the fact that these may be compromising patient care, and in turn, people's potential to 'recover' successfully, since targets tend to reduce the quality of care.

5.3.7 Views on Future Investment

Stakeholders were asked to rate the following three points in order of importance as to where they would like to see future investment go:

- Expanding the range of interventions provided
- Increasing capacity of services
- Improving the quality of services

A few of the stakeholders indicated that they felt these three points are so closely related that it would be difficult to identify one above the others as a priority. However, the majority of interviewees across all regions, felt that 'increasing capacity' was most important concern - closely followed by 'improving the quality' (as most stakeholders said that in general services were already of a reasonable quality) - and lastly 'expanding the range of interventions provided' (since there is a large number of different services in existence).

A number of stakeholders made comments regarding the areas where future investment might be beneficial.

Several people said they wished to see more investment being focused on promoting a 'recovery agenda' in Edinburgh, as stakeholders felt very little, if anything, has been done to move service provision in this direction. This included the vast majority of stakeholders commenting that investment needed to be focused on developing 'ongoing support services' (relapse prevention, self-esteem work, positive engagement, and related group work) and 'aftercare services', that regularly follow-up with their clients in order to review their progress.

It was also highlighted by a number of people that there should be regular mandatory reviews for substance misusers on substitute prescribing, especially methadone. At the moment this is not the case, with General Practitioners frequently issuing methadone scripts, without properly reviewing patients - in turn, this is preventing clients from moving towards reduced dosages. Stakeholders repeatedly emphasised that this issue needs to be urgently addressed.

It was felt that there is a need for serious investment in mental health services. The vast majority of stakeholders commented that current provision was highly inadequate and that this has very serious consequences, especially since the prevalence of dual diagnosis amongst substance misusers is so very high.

Additional comments are summarised below.

- More local investment is required in order to address the needs of substance misusers who are parents and the impact this has on the quality of life of their children.
- The issue of providing funding for 'crisis intervention services', as well as 'drop-in clinics', was also raised by several stakeholders as an important area.
- The need to develop a system to monitor individual client outcomes was highlighted as being important. The Christo Scale is utilised by ELCA and was one suggested method.
- The need for an agreement over how to develop and implement an 'electronic patient case record' that could be accessed and utilised by all services throughout the Lothians and within the City of Edinburgh.
- An IT system to needs to be developed to provide a Lothian-wide network for prescribing services.

5.4 Key Findings – Stakeholders' Views

- In light of the positive regard for the LEAP facility and the concerns raised in terms of a lack of local alternatives, stakeholders considered that there was potential benefit in looking to expand the range and capacity of local rehabilitation services.
- The perception of stakeholders was that there was limited provision of detoxification services in the city. However this appears to be contrary to recent developments within inpatient and outpatient NHS drug and alcohol detoxification services.
- There is a lack of psychological services provision within addictions across the city, especially with regard to the management of clients with complex needs.
- Many stakeholders commented that the provision of housing support to this client group requires to be reviewed as it is not currently meeting their needs effectively.
- Interviewees state that the current level of Needle Exchange services (or Injecting Equipment Provision) is satisfactory to meet the needs of this client group.
- There is a need to develop a suitable scheme for managing people who are drunk and incapable in the city. This would require multi-agency input and an identified key individual to take this forward.
- Although supportive of DTTOs and support for prisoners and ex-prisoners, stakeholders felt that more structured aftercare needs to be put in place to prevent recidivism.
- The management of parasuicide requires to be considered as a multi-agency responsibility. This should involve police and acute hospital staff as well as community-based alcohol and drug services.
- There were a lot of concerns raised about the reconfiguration of 'Hype' because the majority of interviewees stated that this was an excellent service. Stakeholders hoped any changes would not decrease the quality of this service and so reduce the standard of care for young people within Edinburgh.
- There is a lack of clarity regarding the management of people with mental health problems as well as drug or alcohol problems. This was raised by a number of stakeholders as a matter of priority.
- It was felt by many stakeholders that the concept of recovery may well be known to senior staff involved in commissioning and planning but that these needed to be clarified to all staff working in services.
- Finally, whilst many stakeholders welcomed the HEAT target on waiting times there was a concern that this may result in a higher throughput with insufficient aftercare.

CHAPTER 6: STAFF CONSULTATION

6.1 Introduction

This chapter sets out the information provided by staff of drug and alcohol services in Edinburgh. An online questionnaire was sent to all service staff in February 2010. A total of 138 completed surveys were received, and the responses were entered into SPSS for analysis. Of the responses received, the staff represented twenty-one services, namely: CDPS, LEAP, ELCA, BCC, HRT, Crew, APS NHS, SHC, CHAI, NEDAC, LTP, DRT, HYPE, CP, CARS, SACRO, RI, MTP, SEDAC, AP and ALNS. A thematic analysis was conducted on responses to the two open-ended questions.

The table below demonstrates the number of staff who represented each of the services given above. Of the 138 respondents, eight did not provide the name of the service that they represented.

Table 6.1: Number of participants representing each service

Service	Number of participants who represented service
CDPS	18
LEAP	10
ELCA	21
BCC	10
HRT	9
Crew	9
APS NHS	8
SHC	6
CHAI	6
NEDAC	5
LTP	5
DRT	5
HYPE	4
CP	3
CARS	3
SACRO	1
RI	2
MTP	2
SEDAC	1
AP	1
ALNS	1

6.2 Statement Ratings

Each member of staff was asked to rate their agreement with a set of 17 statements. These statements were derived from the QUADS[126] standards manual for alcohol and drug treatment services and then mapped against the National Quality Standards for Scotland[127]. Respondents were asked to rate the extent to which they agreed with each statement on a five-point scale: Strongly Agree – Agree – Don't Know – Disagree – Strongly Disagree. For the analysis, ratings were scored from 1 (strongly disagree) to 5 (strongly agree). Table 6.2 below demonstrates the 17 statements and the percentages of participants who rated between one and five on the scale of agreement.

Table 6.2: Staff agreement ratings by percentage

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
We treat everyone equally no matter what their race, gender, disability, age or belief system.	**67.2**	26.3	2.9	2.1	1.5
We clearly explain our confidentiality policy to service users.	**60.6**	35	2.2	2.2	0
We let service users know about other services that might be useful to them.	**56.9**	40.9	1.5	0.7	0
Service users are made to feel safe and comfortable when they attend this service.	**55.1**	38.4	2.9	3.6	0
We provide good health advice and information, and help service users to find health providers (e.g., GP, dentist, optician)	**49.7**	37.2	8	5.1	0
We help me to make service users' situations better.	46.1	**47.4**	5.8	0.7	0
The assessment we give helps service users to work out what their problems are and what they could do about them.	44.5	**45.3**	6.6	3.6	0
We are good at working together with other services.	43.4	**47.1**	6.6	2.9	0
When we receive a referral the application is dealt with quickly.	**40.9**	**40.9**	9.5	8.7	0
We are good at finding ways to keep improving the service we provide.	37.3	**46.7**	13.1	2.9	0
We tell service users how to make a complaint if they are not happy.	37.2	**55.5**	5.8	1.5	0
We are good at adapting when service users' needs change.	33.4	**51.4**	8.7	5.8	0.7
We provide enough information about our service to help service users decide whether to come along	31.4	**55.5**	5.8	6.6	0.7
Service users find it easy and convenient to get to our service.	26.3	**48.2**	13.9	10.1	1.5
We help service users to get ready for work, training or volunteering.	22.3	**57**	12.6	8.1	0
We allow service users' families/partner/carers to let us know what they need.	14.5	**37**	23.9	22.4	2.2
Service users get to have a say in how the service should be run.	8	**37**	26.8	25.3	2.9

[126] Alcohol Concern & SCODA (1999). *Quality Standards Manual for alcohol and drug treatment services*. SCODA Publications, London.

[127] Scottish Government (2006). *Quality Standards for Substance Misuse Services in Scotland*. Edinburgh: Scottish Government.

The table above indicates that the majority of staff who participated in the study positively regarded the services that they represent. Most of the statements (n=15) garnered over 75% positive responses. In particular, the statements with which the staff most strongly agreed with related to: clearly explaining confidentiality policy to service users; informing service users of other services; equal treatment; and, making service users feel comfortable when attending services.

However, there were several aspects of service provision which were considered less highly among the staff. Around 28% disagreed that service users get a say in how services should be run; similarly around 25% of staff did not agree that services allow the families/partners/carers of service users to inform them of service user needs. Around 12% felt that service users do not find it easy and convenient to get to their respective services.

In eight cases, over ten respondents (7%) stated that they 'did not know' about a specific aspect of the service. These were:

- Service users get to have a say in how the services should be run (26.8%).
- We allow service users and families/partners/carers to let us know what they need (23.9%).
- Service users find it easy and convenient to get to our service (13.9%).
- We are good at finding ways to keep improving the service we provide (13.1%).
- We help service users to get ready for work, training or volunteering (12.6%).
- When we receive a referral the application is dealt with quickly (9.5%).
- We are good at adapting when service users' needs change (8.7%).
- We provide enough information about our service to help service users decide whether to come along (8%).

Whilst it is not possible to conclude why individuals rated these statements this way, perhaps services should be aware that these are areas which may need further exploration.

6.3 Qualitative Comments

Respondents were asked "If there was one thing about the services you could change, what would it be?" One hundred and twelve (81%) respondents provided a response while the other 19% provided no answer.

The responses focussed around ten key issues. The table below lists these issues along with the number of people who felt that these needed to be tackled.

Table 6.3: Issues for change suggested by respondents

Issue	Number who suggested change	Percentage who suggested change
Expand service facilities	21	19%
Venue/Building of Service Issues	18	16%
Time Issues/Open hours	18	16%
Resources/Funding Issues	12	11%
Staff Issues	11	10%
More user involvement	9	8%
Distance/Client access to service	9	8%
Aftercare Issues	5	4%
More communication with GPs/Health Policy/other Networks	5	4%
More evaluations and monitoring	4	4%

It can be seen that the staff felt most strongly about expanding the facilities that their service provided. They also felt strongly about venue issues and time issues. The nature of their responses can be seen below:

6.3.1 Expand Service Facilities

'It would be good to provide a longer-term case management service for people for complex needs.'

'We would be able to have more clients on the programme.'

'Increase the capacity of consultation rooms.'

'Increase the range/variety of services we provide.'

'Open-ended counselling'

'Would like to see introduction of more nurse facilitated groups, i.e. relapse prevention, anxiety management, etc. Also Carer Support Groups or one-to-one service.'

'Easily understood website/leaflets detailing our services.'

6.3.2 Venue/Building Issues

'Make the office/counselling spaces more attractive, comfortable for service users (and staff).'

'A new building allowing us to match our growth to our environment.'

'Relocate to a more appropriate building to operate our service from.'

'Better more suitable premises - current premises not fit for purpose. Also no disabled accesses.'

'The building is unfit for purpose.'

'The building is absolutely terrible working conditions not suitable for staff and clients and has been an ongoing problem.'

'The venue - not suitable structure but a good position within the city.'

6.3.3 Time Issues/Open hours

'Reduce waiting time for patients.'

'I suppose the one thing I would change is wait-list times for entry to services so that our service user population have access to wider resources.'

'The long waiting list. It would be better if we were able to take on more clients and a faster rate. But this would require more workers.'

'I would like it if we were able to open an additional evening for our men clinic or had the facilities to test in the outreach settings.'

'Opening hours. 9 to 5 most of our patients rarely make app before 10.00 a.m.'

'A drop-in service geared more towards this client group may be more successful in engaging genuinely motivated clients. Afternoon or evening slots may be more client-centred.'

Table 6.3 also shows that staff felt quite strongly about funding/resource issues, staff issues, distance/client access issues and having more service user involvement. The nature of their responses can be seen below:

6.3.4 Funding/Resource Issues

'Ideally there would be more money coming into the project in order to allow for the opening of new posts and the better accommodation of service users.'

'To receive long-term funding.'

'Additional resources, as over a period of time it has meant that limited resources has restricted development as front line staff are unable to ensure profile is maintained.'

'More resources. We are particularly short of admin time and basic equipment such as a reliable printer/photocopier.'

'That funding could be more long-term - This would help the service to plan strategically and this in turn will benefit clients.'

6.3.5 Staff Issues

'Extra staffing.'

'More staff to give staff more time to offer more appointments in local areas.'

'Increase in budget for staffing the team, (including more male staff), so that our response corresponds to the "window" of opportunity for assessment and support to potential clients ready to make changes.'

'Increase staff to reduce waiting times.'

'More staffing resources therefore lower waiting times.'

6.3.6 Distance/Client Access Issues

'Not all clients find it easy to get to the clinic - so maybe we should look at ways to improve attendance.'

'To increase further the amount of clients who attend the service for treatment.'

'I think some clients could be seen in locations closer to their home. I think for some clients it may improve their level of engagement.'

'Access to building and more rooms available.'

'Improve accessibility - many of our counselling rooms are up flights of stairs without lifts.'

6.3.7 More Service User Involvement

'Better user involvement in service design and delivery.'

'I would like more service user involvement. I feel that this is not given enough consideration and priority within the service.'

'Empower user involvement to meaningfully engage as an equal partner in developing and shaping service/ treatments/ support provided.'

'More user involvement.'

Examples of some of the other issues that the staff felt that were important to be changed are:

6.3.8 Aftercare Issues

'I would like to add a detoxification service and offer better aftercare.'

'I would like to see an aftercare programme introduced into our existing system.'

'I would like to be able to provide an aftercare service that could create stability for a service user moving back into the community.'

6.3.9 More Communication with GPs/Health Policies/Other Networks

'To work more closely with the formation and exploration of health policy in Scotland.'

'Greater involvement with other organisations, e.g. networking.'

'Formal provision for outreach.'

'Closer links and support from GPs.'

6.3.10 More Evaluations/Monitoring of Staff

'More evaluation to see if we are doing what work and within evidence-based practice.'

'I would like more staff supervision and senior members of staff employed to remove wide gap.'

'I would also like monitoring of our service to be more precise and guidelines to be put in place and taken more into consideration.'

Staff were asked if there was anything else that they would like to say about their service. Sixty-eight (49%) of the respondents chose to answer this open-ended question, the majority (74%) of whom gave positive responses regarding their services. The nature of these responses can be seen below:

'Very proud to work within an innovative, easy-to-access service.'

'I believe that our service fills necessary gaps for our service users.'

'We provide a robust service that is welcomed by clients and absolutely crucial.'

'One of the best aspects of our service is the insistence on quality and on an ethical and non-discriminatory approach.'

'Great service, well-maintained and monitored.'

'I feel very proud to work for [this service], I feel we are a passionate and very professional service, always looking to review and improve our service.'

'I think we make a valuable contribution in enabling service users to achieve long-term change in all aspects of their lives.'

'There is a high standard of professionalism and training. It is secure and safe for clients.'

'We have a very good team who pull together and are committed to service users' needs.'

'I feel that our service has a number of dedicated, professional and knowledgeable staff.'

'Provides a safe, welcoming service with good information available regarding other services.'

However, 18 respondents felt that there was room for improvement in areas such as 'funding', 'location', 'time spent with clients', 'resources' and other issues. The nature of their comments can be seen below:

'Less time on paperwork, protocols, care plans, audits, activity data, etc. and more time with patients/clients.'

'The quality of our service is often compromised by the lack of specialist quality resources in the community.'

'It is very disappointing that this service and others are having their funding cut BEFORE the needs assessment is completed.'

'Need more resources and recognition for what we are doing.'

'We would benefit from 'outside' supervision.'

'Increase in partnership working across statutory and non-statutory services for patients with drug and alcohol problems.'

'Clinics closer to the clients might enhance attendance numbers.'

'Funding for external evaluation would support service to continue to improve.'

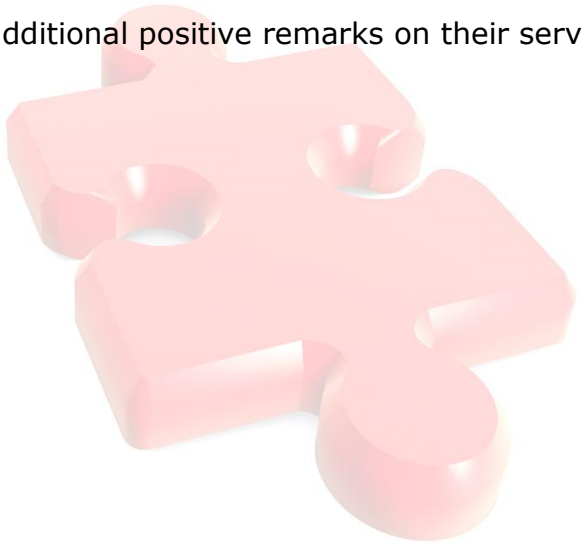
'Not enough funding for staff development or upgrade of counselling rooms or provision of tea/coffee/water for clients.'

'Our service requires additional resources - e.g. training + career opportunities.'

'New premises - counselling rooms - access – needed.'

6.4 Key Findings – Staff Consultation

- One hundred and thirty-eight questionnaires were completed and submitted by the staff that represented twenty-one drug and alcohol services in Edinburgh.
- The staff generally felt positive about the facilities their services provide. They felt strongly that their services are good at assisting clients in accessing and engaging with their service. They reported that they were explaining confidentiality policies clearly to the service users, as well as providing clients with information on other services that may be useful to them. The large majority of staff also reported that they tell service users how to make a complaint if they are not happy.
- However, there were some aspects of services which did not gain such positive feedback and may require some attention. Staff did not feel strongly that service users get to have a say in how services should be run. A quarter of respondents did not agree that service users could get to their services easily. Furthermore, half of respondents felt that service users' families, partners or carers were not involved in planning their care and 55% did not agree that service users get to have a say in how services should be run.
- Time was raised as an issue of concern by staff, as were funding and the location of their service.
- The majority of staff provided additional positive remarks on their services.



CHAPTER 7: SERVICE USER CONSULTATION

7.1 Service Users

7.1.1 Method

A short, simple survey form was created to assess the views of service users about the services they attend in Edinburgh. Copies of the survey were made available to patients visiting the service, along with a 'ballot-box' for them to post completed forms.

As an incentive to participate, respondents were offered the chance to be entered into a prize draw for a £50 shopping voucher. In order to allow entry into the draw but still maintain anonymity, a detachable slip was provided on each form for participants to write down their contact details.

Boxes and forms were provided to 22 main alcohol and drugs services in Edinburgh, and responses were received from 16 of them, namely: NEDAC, HYPE, TPS, SACRO, SHC, CARS, AOE, CP, BCC, RI, LEAP, HRT, CDPS, SW (DRT), ELCA, CHAI. Boxes were available for approximately six weeks, after which point, the questionnaires were posted back to the research team by the service.

A total of 249 completed forms were received within the study period, and the responses entered into SPSS for analysis. A thematic analysis was conducted on responses to the two open-ended questions. A further 25 completed forms were received in the four weeks after the last cut-off date for analysis. These are not included in the quantitative analysis but were rapidly appraised to ensure that the points raised in the qualitative section of the questionnaire were included in the final analysis. One thousand questionnaires were distributed between the services across the city; this represents a 27.4% return rate.

Table 7.1: Number of users in contact with service and responses received from each service

Service	Number of people in contact with service	Number of responses received
NEDAC	184	19
HYPE	-	10
TPS	130	23
SACRO	-	1
SHC	78	25 (+1*)
CARS	24	7
AOE	20	1 (+2*)
CP	135	6
BCC	17	6
RI	22	11
LEAP	66	19
HRT	60	13
CDPS	820	52
SW(DRT)	84	6
ELCA	179	26 (+22*)
CHAI	105	13

*received after deadline

7.1.2 Statement Ratings

Service users were asked to rate their agreement with a set of 17 statements. These statements were derived from the QUADS[128] standards manual for alcohol and drug treatment services and then mapped against the National Quality Standards for Scotland[129]. Respondents were asked to rate the extent to which

[128] Alcohol Concern & SCODA (1999). *Quality Standards Manual for alcohol and drug treatment services*. SCODA Publications, London.

[129] Scottish Government (2006). *Quality Standards for Substance Misuse Services in Scotland*. Edinburgh: Scottish Government.

they agreed with each statement on a five-point scale: Strongly Agree – Agree – Don't Know – Disagree – Strongly Disagree. For the analysis, ratings were scored from 1 (strongly disagree) to 5 (strongly agree). Table 7.2 below demonstrates the 17 statements and the percentages of participants who rated between one and five on the scale of agreement.

Table 7.2: Service user agreement ratings

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	No Answer
Services have clearly explained their confidentiality policy to me	**60.7**	33.7	2.8	0.8	0.4	1.6
The services treat everyone equally no matter what their race, disability, age or belief system	**58.3**	31.7	7.6	0.8	0	1.6
The services I use have helped me to make my situation better	**55.9**	36.5	4.0	1.2	0.8	1.6
I feel safe and comfortable when I attend services	**55.5**	37.3	2.8	2.4	0.8	1.2
When I was referred, my case was dealt with quickly	**49.5**	36.1	4.8	6.0	2.8	0.8
The staff have given good health advice and information, and helped me find health providers (e.g. GP, dentist, optician)	**43.2**	42.3	8.1	4.0	0.4	2.0
They let me know about other services that might useful to me	43.0	**46.2**	4.8	3.6	0.4	2.0
Services have been good at helping when my needs change	**43.0**	42.6	9.6	3.2	0	1.6
The assessment I was given helped me to work out what my problems were and what I could do about them	**43.0**	42.6	8.8	2.8	0.4	2.4
The information I was given about services helped me to decide whether to come along	39.0	**47.0**	8.8	2.8	0	2.4
I have been told how I can make a complaint if I am not happy	34.6	**42.2**	11.2	10.0	0.8	1.2
The services I use are good at working together with each other	33.3	**37.8**	22.1	2.4	0.8	3.6
I find it easy and convenient to get to substance misuse services	29.8	**45**	9.6	9.2	3.2	3.2
They are good at finding ways to keep improving the service they provide	28.9	**44.2**	23.3	0.8	0.4	2.4
The services have helped me to get ready for work, training, or volunteering	24.9	**32.2**	24.5	12.4	2.4	3.6
My family/partner/carer was allowed to let the services know what I need	17.8	28.5	**31.3**	10.8	2.0	9.6
I get to have a say in how services should be run	17.4	31.3	**35.3**	11.6	2.0	2.4

The table shows that all statements received over 90% of responses. The statement which received the least responses was 'my family/partner/carer was allowed to let the services know what I need'.

As illustrated in the table, the majority of service users who participated in the study positively regard the services they use or have used in the past. All the statements garnered 45% or more positive responses. The statements with which service users most strongly agreed related to confidentiality, equal treatment, improving situations and safety and comfort. Over 94% of the service users felt that the services had clearly explained their confidentiality policies and more than 90% felt that services had made their situations better. Over 90% also felt safe and comfortable when attending services. In addition, 89.9% of service users felt that the services treated everyone equally no matter what their race, disability, age or belief system. It is also notable that over 85% of service users felt that their cases were dealt with quickly.

However, there were several aspects of service provision which scored less highly among service users. Around 15% of service users felt that services had not helped them get ready for work, training, or volunteering. Similarly around 13% of service users felt that they did not have a say in how services should be run and their families had not been allowed to let services know what they needed. Notably, 12.4% disagreed that services were easy and convenient to get to and an additional 10.8% felt that they have not been told how to make a complaint if they are not happy.

In five cases, over 20% of respondents stated that they 'did not know' about a specific aspect of the service. These were:

- I get to have a say in how services should be run (35.3%).
- My family/partner/carer was allowed to let the services know what I need (32%).
- The services have helped me to get ready for work, training, or volunteering (24.5%).
- They are good at finding ways to keep improving the service they provide (23.3%).
- The services I use are good at working with each other (22.1%).

Whilst it is not possible to conclude why individuals rated these statements this way, perhaps services should be aware that these are areas which may need further exploration. In particular, service users seemed to disagree most with the statement 'the services have helped me get ready for work, training, or volunteering' which also received 24.5% 'don't know' ratings. The statement which received the least responses 'my family/partner/carer was allowed to let the services know what I need' received 12.8% 'disagree/strongly disagree' ratings and 21.3% 'don't know' votes.

7.1.3 Qualitative Comments

Service users were asked "If there was one thing about the services you could change, what would it be?" Ninety three (37%) respondents provided no answer. Sixty four (26%) respondents stated that nothing needed to be changed and that they were happy with the current facilities.

The other 92 (37%) respondents indicated areas which they felt could be improved or had not worked well with them. The nature of these other responses is shown in Table 7.3 below.

Table 7.3: Issues for change suggested by respondents

Issue	Number of responses (n=92)	% of responses
Time Issues	23	25%
Increase session time/more out hours	19	20.7%
Transport/Distance Issues	13	14.1%
Increase activities to bring together individuals in same situation	8	8.7%
Improve Communication	8	8.7%
More Staff	2	2.2%
More Aftercare	2	2.2%
Other Issues	17	18.5%

It can be seen that service users felt most strongly about time issues; this included shorter waiting times to be referred and quicker access to services. The nature of these responses can be seen below.

<u>Time Issues</u>

'Time between first seeking help and actually getting it is far too long.'

'Be dealt with quicker instead of waiting months for treatment.'

'The waiting list to initially get seen was too long.'

'Quicker waiting list.'

'The referral time from GP to here was excessive, I think more should be done to cut down waiting times.'

The table shows that 20.7% of respondents felt that session times should be increased and there should be more out of hours provision. The nature of these comments can be seen below.

Increase session time/more out hours

'Later opening hours as I work.'

'Being able to phone when in crisis over phone for counselling.'

'I think it would be a good idea to consider weekend and evening opening hours as this would help people who work and also people with children.'

'Programme could be longer than 12 weeks.'

'Increase time of session.'

Some of the comments relating to transport and distance issues are given below.

Transport/Distance Issues

'Possibly change location as a bit out of the way.'

'To provide travel expenses to and from service for people on benefits.'

'Just to have it closer to where I live.'

'Where it is situated.'

'I would like bus fares.'

The table shows that 8.7% of the respondents felt that they would like to have more activities to bring together people who are going through the same experience as them. Some of these comments are:

'More meetings with other people in the same situation.'

'Possibly more outings with group.'

'More shares from recovering alcoholics and addicts would be good.'

Similarly, 8.7% also felt communication between the service and themselves could be improved. The nature of some of these comments can be seen below.

'Sometimes a lack of communication.'

'I would like to be listened to better.'

'Letters for appointments sent out too early, a text reminder would help.'

'I would like to be told in ample time before my key worker is changed.'

Two people felt that there could be more staff and another two people felt that more aftercare should be available to them.

Service users were further asked if there was anything else that they would like to say about their experiences with substance misuse services. One hundred and six (43%) respondents chose to answer this open-ended question. Twenty (8%) respondents stated that there was nothing else they would like to say about the services. Forty nine (20%) respondents provided positive responses regarding their experiences of treatment provision. The nature of these responses can be seen below.

'They were of immense benefit to helping me on the road to recovery.'

'Amazing service... have a brilliant worker who has gone above and beyond call of duty to help me.'

'This service has a lot to offer their clients... they do a great job!'

'My experience has been exceptional.'

'Without this service I wouldn't be here today.'

An additional nine (4%) respondents felt that they could benefit from having more of the same type of services. However, the remaining twenty eight (11%) respondents felt that services could be improved in some way. It was notable that the most prominent improvement suggested by the respondents was to have more information about the services available in their area. The nature of their responses can be seen below.

'Don't know any local services but would like more information.'

'There to be more information on where to get help.'

'There is not enough joined up thinking between agencies.'

'Some doctors have bad attitudes towards drug users.'

'Need more staff and decent facilities.'

'There should be more drug workers available for young people.'

'Doctors give out methadone and valium too easily.'

7.1.4 Services Used

Participants were asked to select which of the drug and alcohol services available in Edinburgh they had used or use at present. Table 7.4 below demonstrates the numbers of individuals who indicated that they had used a particular service.

Table 7.4: Numbers of respondents using drug and alcohol services

Service	Number of responses	% of responses
CDPS	123	49.4
GP	49	19.7
HRT	45	18.1
LEAP	37	15.7
NEDAC	36	14.5
ELCA	35	14.9
SHC	26	10.4
TPS/Midpoint	25	10
APS	24	9.6
SWAT	24	9.6
DTTO	20	8.0
CHAI	20	8.0
CP	18	7.2
RI	11	4.4
Crew	10	4.0
HYPE	10	4.0
DRT	7	2.8
CARS	7	2.8
BCC	6	2.4
SACRO	4	1.6
AOE	3	1.2

AA	2	0.8
HOP	2	0.8
Street Work	2	0.8
NA	1	0.4
CA	1	0.4
WESA	1	0.4
WEAG	1	0.4
HP	1	0.4
GC	1	0.4
SEDAC	1	0.4

7.1.5 Service User Focus Groups

A total of four focus groups were conducted within the City of Edinburgh with service users. These sessions lasted on average for a period of approximately one hour and information sheets and consent forms were distributed to all clients prior to the commencement of the consultation process. The venues were LEAP (n=6), CDPS (n=6), Bethany Christian Trust (n=12) and CHAI (n=8) [where n is the number of participants in attendance]. Two members of the Figure 8 research team attended each session, and all participants were given a £10 shopping voucher at the end, as a 'thank you' for taking part. The focus groups were conducted in March and April 2010 and a number of key issues were explored as outlined below.

Services within the City of Edinburgh

The services that the clients were aware of or had utilised within Edinburgh were as follows:

- Alcohol Problem Service (APS)/Ritson Clinic at the Royal Edinburgh Hospital,
- Community Drug Problem Service (CDPS),
- Harm Reduction team (HRT),
- Lothian Edinburgh Access Project (LEAP),
- Needle Exchange,
- Circle,
- Pre-Pare,

- CHAI,
- Castle Project,
- Substance Misuse Service,
- Simpson House/Sunflower Garden,
- Transition,
- Pink Ladies,
- Crew,
- ELCA,
- Homeless Outreach Project/Edinburgh Access Centre,
- Criminal Justice Services,
- Turning Point Leith,
- SACRO Offenders Service,
- Bethany Christian Trust,
- Narcotics Anonymous (NA),
- Cocaine Anonymous (CA),
- Alcoholics Anonymous (AA), and
- assistance from General Practitioners.

Views on accessibility to services and waiting times

- Overall, the clients felt that services are not well advertised and they hear about services primarily through '*word of mouth*'.
- The service users recognised that it is important to be proactive in seeking help. However, they emphasised that '*you need to be in the right frame of mind*' and when your life is driven by addiction this is very difficult.
- A suggestion about the best way to ensure those with addiction problems get the right information about services was that more information could be provided by people with experience of addiction themselves – '*more people that have actually been through it and know what they are talking about*'. Service users felt this would give the information more credibility and get people to listen.
- With regards to Alcoholics Anonymous (AA), service users feel there is a need to change how it is promoted as there is a lot of stigma and clichés associated with it, which can put people off attending. Since the organisation provides an excellent service and perhaps more forms of assistance than people might initially realise, this is an issue that needs to be addressed.

- In terms of services for young people, participants said that the majority of services are aimed at adults, and this makes it very difficult for people to obtain help.
- Some service users said that people seem to get a lot of information about addiction services when in prison. However, participants commented that this means that people really have to '*hit rock bottom and get to a place that you really don't want to reach*' before getting the right information about how to access help.
- Participants stated that sometimes addicts commit crime so that they can get given a '*court order*' to gain access to treatment more quickly.
- Accessibility to services and waiting times appear to vary and can sometimes be very long.

Potential improvements to services

- Clients felt that they would like to see more of the following:
    - Staff
    - Aftercare and relapse prevention services
    - Information on side effects for different forms of treatment
    - Detoxification facilities
    - Rehabilitation facilities, especially for women with children
    - Services for young people
    - Services for those with non-opiate addictions (such as cocaine and cannabis)
    - Services for those with families
- There is a need to ensure that services that do not primarily deal with substance misuse issues (GPs, Criminal Justice, Social Work, A&E for example) have better links with drug and alcohol services.
- Some service users argued that there is a need to raise more awareness about the difference between problem drinking and alcoholism.
- Difficulties in accessing services were attributed to:
    - Long waiting lists,
    - Lack of information being available about services, and
    - Lack of availability of services due to lack of funding.

GP consultations

- GPs do not tend to review clients' treatment options - often substitute prescriptions are re-issued without consultation.
- In general, GPs tend not to explore the issues that are important to drug and alcohol users and seemed to be lacking in their understanding of addiction.
- The above points influence client progression through treatment and recovery.
- Not all GPs will deal with substitute prescribing, so there is often a waiting time to get into initial treatment. By the time the client is able to access treatment, they may not necessarily to ready to make that step forward anymore.

Services to assist with moving on from substance misuse

- The services that clients are aware of to help them move on include:
  - NA / CA / AA
  - 12-step fellowships
  - Recovery Network
  - Transition
  - LEAP aftercare group (offers stability, connection, support)
  - APEX
  - Supported accommodation from Edinburgh City Council
- Service users stated that there is a lack of aftercare support – or they are certainly not aware of there being much available.
- Service users' experiences of working with housing officers from the Council were not positive, they felt they had been pressurised into accepting accommodation they were not happy with or had not received sufficient support.
- Clients need more help with building up their self-esteem - this would give service users the confidence they need to go out and take up other options.
- Service users stated that the job centre offers different forms of support (e.g. ILA funds for studying) but they do not advertise these options properly.
- There is a perception that the Scottish Government is concerned with getting people back into work, even when they are not ready, and that not enough emphasis is put on a 'recovery period'.
- In terms of finding employment, service users felt that it is very difficult due to the stigma attached to being an addict. They emphasised the need for more support in job centres for people in the process of recovery.

- Lack of funding was recognised as the main barrier in terms of the availability of services for people who are ready to move on.

Supported accommodation

- Members of staff working in supported accommodation provide support with budgeting and with learning how to look after yourself and live alone again.
- Service users stated that supported accommodation is the '*number one most important thing for recovery*' and it is '*like a safety net*'. They emphasised that the recovery process is very unlikely to work if you have to go and live with people who are active addicts.

Other activities

- Service users seemed to really enjoy the Serenity Café in Edinburgh, as it is a place to have a night out once a month, with other people '*in recovery'*. The fact that the place does not sell alcohol is also important as there are very few other '*dry*' places in Edinburgh for people to go.
- Recovery Fellowships offer '*fun days*' – however, service users were aware that since these are fellowship-based, they do not appeal to everyone.
- More activities for young people would be helpful.

7.2 Carers and family members

Contact was made at an early stage of the consultation with VOCAL Carers Support in Edinburgh. The research team were keen to engage with as many carers as possible and suggested conducting a focus group, as well as designing and distributing a postal questionnaire specific to the needs of carers.

Following discussion with the research team, VOCAL were of the view that a focus group would not be the desired methodology, instead requesting 15 questionnaires to be sent to a central point from which they would distribute to those that they felt would be willing and able to contribute. This was done in February 2010. By the end of April 2010 one questionnaire had been returned to the research team.

Although this data cannot be presented here as being representative of the wider carer community in Edinburgh, the research team reviewed the comments made and were satisfied that the issues raised by this carer were broadly in line with those of service users; these included concerns over length of waiting times, need for better joined-up working between services and better involvement of the family.

'[We need] doctors working with the family, keeping them informed about what medication the user is on and what is being done to detox them and get them into rehab. Not just given methadone, Valium, etc. and kept on them for years as is the case. Also more drug testing. Also as a grandparent looking after a child who is now a teenager I would like to see more help, counselling, etc. for kids of that age who may have a lot of anger or are hurting because their parents prefer the drugs to them. I feel group meetings with others of the same age and experiences would be of help to them."

7.3 Key Findings – Service Users' Views

- Two hundred and forty nine questionnaires were returned from service users across the city.
- Service users generally felt positively about the services which they were accessing. They reported that services were explaining their confidentiality policies clearly. Service users also felt safe and comfortable when they attended services, were responsive to their changing needs and the great majority of service users said that services had helped them to improve their situation.
- However, there were some aspects of services which did not gain such positive feedback and may require some attention. Service users did not feel strongly that they were involved in the way in which services were run and indicated that services were not good at assisting them to prepare for education, training or employment. Furthermore, service users did not feel that their family, partner or carer was involved in planning their care.
- Overall, the clients felt that services are not well-advertised and they hear about services primarily through '*word of mouth*'.
- Service users suggested that best way to ensure those with addiction problems get the right information about services was that more information could be provided by people with experience of addiction themselves – '*more people that have actually been through it and know what they are talking about*'. Service users felt this would give the information more credibility and get people to listen.
- With regards to Alcoholics Anonymous (AA), service users feel there is a need to change how it is promoted as there is a lot of stigma and clichés associated with it, which can put people off attending. Since the organisation provides an excellent service and perhaps more forms of assistance than people might initially realise, this is an issue that needs to be addressed.
- Waiting times were raised as an issue of concern by 9% of service users

CHAPTER 8: SUMMARY AND RECOMMENDATIONS

8.1 Overview

The purpose of this project has been to assist Edinburgh Alcohol and Drugs Partnership in meeting the recommendations of the Delivery Reform Group report (2009) by providing an assessment of current specialist drug and alcohol services, as well as a health needs assessment of local needs and gaps.

The review team sought the views of people currently using the service as well as those working within the service and a wider range of stakeholders as identified by the EADP.

Overall, the review team found all parties to be constructive and keen to engage in this process. All views were offered willingly and are assumed to have been given in good faith.

A comparative analysis was conducted on the results of the service user questionnaire (n=249) and the staff questionnaire (n=138). Both sets of answers were mapped against the National Quality standards for substance misuse services. These are set out in Appendix 4. There was a strong relationship between the positive responses (Strongly agree, Agree) of both groups. They agreed on the strengths of services and on the weaknesses.

The concluding comments of the research team are set out below and have been categorised into four main areas:

- Key challenges;
- Range of services;
- Capacity of services; and,
- Recovery communities.

8.2 Key challenges

From the evidence collected and presented in this report there are a number of key challenges that exist in terms of prevalence and need:

- Alcohol-related discharges from acute hospital settings have increased by 33% over the last ten years. These are closely associated with areas of relative deprivation.
- The rate of drug related maternities in Edinburgh is almost twice the national average.
- Estimated weekly alcohol consumption is higher in Lothian than in any other health board area.

- Around a third of drug and alcohol users in contact with services in Edinburgh have dependent children.
- About half of service users are thought to have mental health problems.
- About 15% of service users are employed, in contrast to 77% employment in Edinburgh generally.

8.3 Range of Services

The majority of stakeholders, service users and service providers agreed that Edinburgh has a reasonable range of services at its disposal however concerns were raised as to whether these were being used most appropriately or effectively and whether the types of service that have served the city in the past can adapt to the future needs.

Drug and alcohol services in Edinburgh provide a range of medical and psychosocial interventions for people with drug and/or alcohol problems. These are predominately delivered in one-to-one settings; groupwork and working with couples or families is rare and is provided by relatively few services.

The evidence collected from a range of sources identifies a number of specific gaps in service provision including;

- designated place of safety;
- non-pharmacological interventions;
- services for helping people move on to training and employment;
- systematic response to individuals who experience both mental health problems and substance misuse;
- services for families;
- services for under 18s;
- residential rehabilitation.

8.3.1 Designated place of safety

One of the objectives of this piece of work was to give consideration to patterns of late-night, hazardous binge drinking and associated issues of public disorder resulting from city centre evening and late night entertainment/hospitality venues, to determine service requirements. Throughout the consultation and evidence gathering these issues have not ranked highly either in terms of identified need or perceived gaps in services. While it is the case that levels of weekly alcohol consumption in Lothian are higher than other health board areas the rates of drunkenness offences recorded by Lothians and Borders Police was lower than all other police constabulary areas in Scotland.

Nevertheless the issue of providing a place of safety for people who are drunk and incapable remains an ongoing problem. There is currently no provision within the city other than police custody which has been recognised as a gap and has been the subject of funding applications to Scottish Government in the past. While it appears logical to pursue avenues of funding to provide facilities similar to Albyn House and Beechwood House (Appendix 4) stakeholders also put forward two complementary suggestions which are worthy of note. Firstly, Crew 2000 have significant experience in managing situations with large numbers of people under the influence of drugs and alcohol e.g. dance events at Ingleston, T in the Park, and could contribute this expertise to discussions on the management of alcohol-induced public disorder in the city centre. Secondly, there are now Street Pastor projects running in Perth, Inverness and Glasgow city centres. The Street Pastors mission statement is to provide an "Interdomination reponse to neighbourhood problems; engaging with people on the streets and in night-time venues to listen, dialogue and offer practical help and solutions."[130] Although these have not yet been evaluated there is evidence from Street Pastor projects running in England that they provide a number of benefits[131].

8.3.2 Non-pharmacological interventions

In common with many areas of Scotland, concerns were raised about the over-reliance on substitute prescribing in drug services and a general lack of structured therapeutic activity across substance misuse services in general. Specifically, therapies such as counselling, cognitive behavioural therapy and social skills training are of proven benefit but not widely practiced.

The use of counselling as part of a combined treatment along with methadone maintenance shows more improvements and faster and greater improvements than methadone treatment alone.[132]

The review of the effectiveness of treatments for alcohol problems conducted by Raistrick, Heather and Godfrey (2006) cites the *Mesa Grande* study which is an ongoing systematic review of the effectiveness of different treatments for hazardous and harmful alcohol consumption, ranking the effectiveness of 48 different treatment modalities[133]. Eight of the top ten rated therapies internationally are counselling or cognitive behavioural interventions. These are

[130] www.streetpastors.co.uk

[131] Johns N, Squire G, Barton A (2009). Street Pastors: From Crime Prevention to Re-Moralisation. Papers from the British Criminology Conference, Vol 9: 39-56.

[132] McLellan AT, Arndt I, Metzger D, Woody G, O'Brien C (1993). The effect of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, 269, 1953-59.

[133] Raistrick D, Heather N, Godfrey C (2006). Review of the effectiveness of treatment for alcohol problems. (National Treatment Agency for Substance Misuse, London).

brief interventions, motivational enhancement, community reinforcement, self-change manual, behavioural self-control training, behavioural contracting, social skills training and marital therapy.

From the information provided by service managers it appears that only a small minority of agencies provide counselling delivered by accredited staff, supported by counsellor supervision. Many service providers stated that they use counselling skills or a counselling approach, neither of which would be considered to be a structured therapeutic process.

Given the emphasis placed on a recovery orientated system of care and concerns expressed by a number of stakeholders, service providers and service users about the lack of planning and provision of services for non-opiate users, more emphasis should be placed on developing a range of effective interventions to complement substitute prescribing.

8.3.3 Moving on to Training and Employment

The *Road to Recovery* emphasises the importance of helping people with drug and alcohol problems to access appropriate training and education opportunities[134].

Service users and stakeholders identified this as a gap in services, one which could conceivably result in people remaining in treatment services longer than necessary.

The examples of initiatives contained in the *Road to Recovery* (p25-26) highlight how existing services are working together to provide opportunities for people who are ready to move on.

It was noted by stakeholders and service providers that the action points set out in the *Road to Recovery* had not been translated into action locally. There was a strong view from providers that future service development and resourcing should be recovery focused.

8.3.4 Services for people with mental health problems and substance misuse

In December 2007, the Scottish Government published *Closing the Gaps, Making a Difference*[135] which sets out guidance on the management of people with mental health problems and substance misuse. Little evidence was found of the development of local protocols for implementing this guidance in Edinburgh. It

[134] As 53

[135] Scottish Government (2007) *Mental Health in Scotland: Closing the Gaps - Making a Difference: Commitment 13,* Edinburgh: Scottish Government

was noted that there is a 'Commitment 13' group which had been meeting initially but had not met for a long time. A number of service managers stated that this had now been re-established in the form of two sub-groups; one concerned with the re-provision of services off the site of the Royal Edinburgh Hospital and the other focussed on inter-agency working. Given the relatively high rates of co-morbidity (between 1:2 and 1:3), and the concerns raised by stakeholders and service providers regarding the management of parasuicide, greater emphasis should be placed on the importance of developing such joint working arrangements.

8.3.5 Services for families

There is no available data that measures or monitors the number of family members affected by an individual's drink or drug use. In that respect the need is not quantified and can only be estimated. The gap analysis in chapter 4 suggests that there are around 20,000 people with alcohol dependence in Edinburgh and 5,000 problem drug users. Circle and Aberlour Outreach provide services for around 90 families. The Sunflower Garden at Simpson House provides support for the children of drug using parents.

ELCA can also provide support in terms of meeting the needs of individual family members who are affected by someone else's drinking. VOCAL carers support provides a source of mutual support for carers and kinship carers.

The current emphasis on recovery includes the re-integration of the drug user (or drinker) into family and community networks. This type of work will require current services to challenge their own practices, in terms of the over-dominance of one-to-one treatment, and develop new ways to respond to this need.

8.3.6 Services for Under 18s

The situation regarding the re-provision of drug and alcohol services to young people under the age of 18 remains unclear. There are over 10,000 young people aged 16-17 in Edinburgh[136]. Many stakeholders raised concern regarding the re-structuring of HYPE and whether there will be sufficient resource to meet the needs of this population.

One important aspect to consider in defining the shape of the re-provision is the benefits found by Midlothian Young People's Advice Service (MYPAS), the Corner Project in Dundee and Crew 2000 in Edinburgh of having a 'shop front' location where young people can access a range of services from advice and information to counselling and support.

[136] As 12

8.3.7 Residential facilities for detoxification and rehabilitation

Stakeholders, service providers and service users welcomed the addition of LEAP to the spectrum of services offered within the city. Another recent addition has been the increase in availability of in-patient beds at Royal Edinburgh Hospital for drug and alcohol detox. However there was a perception and a concern that these additional resources had come at the expense of the inpatient beds at the Links Project and the facility to access and fund out-of-area residential rehabilitation. There were additional concerns that since the closure of Brenda House there is now no rehabilitation facilities for mothers with young children.

A moratorium on the provision of community and residential detoxification and rehabilitation may help to address many of these concerns and allow service providers, service users and families an opportunity to discuss and contribute to this issue. Ultimately it is for Edinburgh Alcohol and Drugs Partnership to ensure that there are a range of options available within and outwith the city to meet the individual needs of service users.

8.4 Capacity of Services

The issue of capacity has been addressed in Chapter 4. At present it appears that there is insufficient capacity within the system to meet the current demand – as evidenced by waiting times. Moreover the difference between capacity and need is much greater than the difference between capacity and demand. There are a range of reasons why people who are alcohol dependent will not seek treatment at this time, as set out in Chapter 1. This raises the question, *"What provision is required to provide a reasonable level of access to the range of services provided?"*

The information provided to the review team from stakeholders, service managers, staff and service users suggests that there is a need to increase the capacity of drug and alcohol treatment services. The gap analyses and benchmarking in chapter 4 provide a measure of the extent to which current provision meets need, both identified (demand) and unidentified.

Logically, the next question to be addressed is, *"Where should these additional resources be deployed to meet the needs?"* There is a clear consensus from all evidence sources that the current treatment provision element of services is relatively better resourced than the aftercare element. Similarly there is agreement on the need to focus attention on routes into services, ensuring that there is a range of interventions available across the city to help people self-manage their drug or alcohol problem or provide assistance to them prior to engaging with current service provision.

8.5 Recovery Orientated System of Care

The *Road to Recovery* sets out a number of key action points aimed at promoting recovery. These include:

- To set up a Drug Recovery Network to promote and support the concept of recovery among local partners, service providers and people with problem drug use.
- An appropriate range of drug treatment and rehabilitation services to promote recovery, from all types of drug use, not just opiate dependency, which is based on local needs and circumstances, must be available in each part of Scotland.
- Better integration of medical treatment with wider range of services such as social care, housing, mental health, education and training, to enable people to recover.[137]

The evidence provided by service users and staff in Edinburgh clearly suggests that, on the whole, service users and their families are not well involved either in decisions about their own care and treatment or in providing input into how services should be designed and delivered.

The development of recovery-orientated systems of care has been developed in U.S.A. Professor William White is regarded across the world as one of the key figures in substance misuse recovery. He is currently working with Figure 8, Dr David Best and Professor Michael Gossop in reviewing the international research evidence on recovery and applying this to the Scottish context. The following passage is an excerpt from this work and describes how services need to adapt to fit into a wider, longer-term network of social support.

"The acute care (AC) model of specialised addiction treatment has measurable positive effects when compared to no intervention or alternative non-specialised interventions, but these effects vary widely by programme, counsellor, and population served. Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilised to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a local, regional or national treatment agency but a macro level organisation of a community, a state, or a nation. The model that White[138] has outlined is based on the idea that 'strategic recovery champions' will work to shift not only the attitudes of individual professionals, and the practices in specialist services, but that overall treatment systems (such

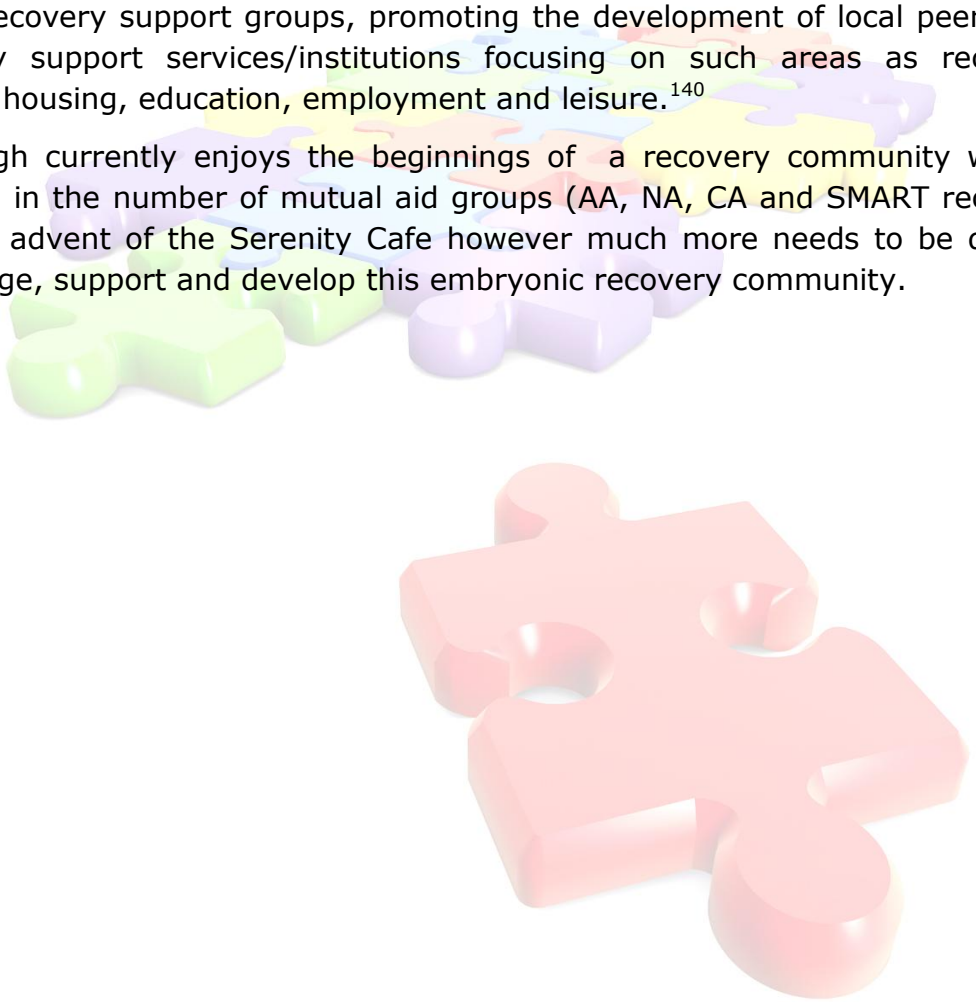
[137] As 89, page 71

[138] White, W (2008) *Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices,* Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioural Health and Mental Retardation Services

as the ADPs in Scotland) will be re-structured over time to be recovery-oriented in the sense that the ethos of the system will be around client empowerment and choice, and the distillation of hope for individual, family and community recovery." [139]

Recovery community building encompasses activities that nurture the development of cultural institutions in which persons recovering from severe alcohol or drug problems can find relationships that are recovery-supportive, natural (reciprocal), accessible at times of greatest need (e.g. nights and weekends) and potentially enduring. Recovery community building activities include cultivating local recovery community (advocacy) organisations and peer-based recovery support groups, promoting the development of local peer-based recovery support services/institutions focusing on such areas as recovery-focused housing, education, employment and leisure.[140]

Edinburgh currently enjoys the beginnings of a recovery community with an increase in the number of mutual aid groups (AA, NA, CA and SMART recovery) and the advent of the Serenity Cafe however much more needs to be done to encourage, support and develop this embryonic recovery community.



[139] Excerpt from forthcoming review of evidence of Recovery (Scottish Government, 2010)

[140] White, W (2009b) 'The Mobilization of Community Resources to Support Long-Term Addiction Recovery', *Journal of Substance Abuse Treatment,* Vol. 36, No. 2, pp146-58

8.6 Recommendations

The recommendations set out below are drawn from the evidence of current practice with regard to the range and capacity of alcohol services in Edinburgh compared to the research and guidance referred to throughout this report. These are presented for the consideration of the EADP and their partner organisations.

1) Edinburgh ADP should look at ways to reduce alcohol related hospital admissions, targeting those people who live in areas of where admissions are higher. This might include the better targeting of treatment services and/or public health campaigns.

2) Given that the rate of reported drug related maternities is twice the national average, Edinburgh ADP should ensure that the Prepare service and other treatment services are adequately resourced and targeted to work with this group of women and their families.

3) Edinburgh ADP should look further at the need for services to manage people who are drunk and incapable. This includes providing a place of safety as well as looking at ways to reduce the numbers of people who binge drink to this extent. Approaches to this issue would need to include the Licensing Board, the Police, Services for Communities, Children and Families, The Scottish Ambulance Service, NHS Lothian and key members of the voluntary sector. The ADP may also want to consider developing and/or reviewing initiatives such as the Street Pastors Projects which appear to have been successful in other cities.

4) There is a need to ensure that a full range of evidence based interventions is available to meet the identified needs of alcohol and drug dependent people across the city. Greater emphasis needs to be placed on the development of psychological and psychosocial interventions such as structured counselling, cognitive behavioural therapy and social skills training.

5) There appears to be a gap in the links between drug/alcohol treatment and recovery services and those supporting people to access employment. The ADP should ensure that drug/alcohol treatment and recovery services are identifying their clients' / patients' employment related aspirations and needs as well as looking at strengthening the links between education, training, volunteering and employment services and treatment / recovery services. Further thought should also be given to developing opportunities for people in recovery to access employment.

6) Given the prevalence of dual diagnosis the ADP should prioritise implementing the recommendations and good practice guidance contained in *Closing the Gaps* and support the development of multi-agency protocols and pathways for people with mental health and substance misuse problems. This would include an appraisal of the training needs of staff working across these areas.

7) Further work is needed to identify the numbers of children affected by a parent's problem drug/alcohol use. This may require joint working between Children and Families and Drug/Alcohol Treatment Services. Alongside this further work is needed to develop clear care pathways for pregnant women,

parents with problematic drug/alcohol use and their children so that the needs of these people can be met at both a family and individual level.

8) There are almost 3000 people attending alcohol and drug services in Edinburgh yet there is a disproportionately low level of work with couples, families and carers. Further work is required to identify a range of measures to complement the existing provision in the city.

9) Further exploration as to the level of re-provision of drug and alcohol services for young people under the age of 18 is required. As the re-structuring of HYPE was taking place during the needs assessment no judgement of the extent to which the new provision will provide the range and capacity of services required can take place.

10) Further work is needed by the ADP to identify the need for residential detoxification and rehabilitation. Forthcoming guidance is expected from the National Treatment Agency in England on identifying the need for residential services which may be adapted to fit the Scottish context. Services will then need to be developed by the ADP to meet this need.

11) There needs to be a clear and well publicised pathway in place for people to access residential detoxification and rehabilitation. This should include criteria for access as well as support pathways post discharge.

12) Evidence from the gap analysis, as well as the existence of waiting lists suggests that there are challenges in terms of the capacity of services to meet the need. This may be due to an under-resource in terms of alcohol and drug treatment provision or due to the cost-effectiveness of the current treatment system. Evidence based on the national prevalence study points to a need for more services for men however no such gender distinction should be made on any additional resource put in place. The ADP should look at ways of making the current treatment system more cost effective so that capacity can be increased; further to this the ADP may need to increase investments in treatment services to meet any further short-fall in capacity.

13) A recovery oriented treatment system should be dynamic and offer pathways for service users to move through the service system as they progress in their recovery. This movement not only suggests progress for individuals but also suggests that there is throughput within the system. The ADP should ensure there is a clear pathway which identifies routes into, through and out of treatment and recovery services and should set up arrangements to monitor the throughput within the system.

14) The ADP should map the existing provision of self help services such as AA/NA/ SMART and identify ways to support the development of self help to ensure that it is an integrated part of the treatment and recovery system.

15) The planning and development of services should be built around the ambitions of service users and their families within a recovery-orientated system of care. Developing services in this way will provide benefits to people who use the service but will also help develop community based mutual aid and peer support networks, thereby enhancing the ability for people to move on from services. Consequently the ADP should develop a clear framework for how

service users and their families should be involved in the delivery, development and commissioning of drug/alcohol services.

16) The ADP should have a role in facilitating the development of recovery communities within Edinburgh to support people in their recovery.

APPENDICES

Appendix 1: List of stakeholders interviewed during the consultation phase.

Appendix 2: Profile of current service provision

Appendix 3: Provision of designated places of safety (DPOS)

Appendix 4: National quality standards for substance misuse services: Comparisons between service users and service staff

Appendix 1: List of stakeholders interviewed during the consultation phase.

Stakeholder	Position and Service
Mr Jamie Megaw	Strategic Programme Manager, NHS Lothian
Mr Jim Sherval	NHS Lothian
Ms Kaaren Haughton	Department of Social Work, Edinburgh City Council
Ms Christina Burnett	Head of Service, Children and Families, Edinburgh City Council
Mr Andrew Jeffries	Children and Families, Edinburgh City Council
Ms Cathy King	Manager, Housing, Edinburgh City Council
Mr Ronald Lancashire	Manager, Criminal Justice Services, Edinburgh City Council
Dr Fiona Watson	Clinical Lead, Alcohol Problem Service (APS)
Dr Malcolm Bruce	Consultant Psychiatrist, Alcohol Problem Service (APS)
Dr Eunice Reed	Lead Psychologist, Alcohol Problem Service (APS)
Ms Elaine Wilkinson	Senior Nurse, Alcohol Problem Service (APS)
Mr Ian Burns	Clinical Nurse Manager, Community Drug Problem Service (CDPS), NHS Lothian
Mr Jim Shanley	Service Manager Harm Reduction Team, NHS Lothian
Mr Daniel Campbell	Service Manager, North Edinburgh Drug and Alcohol Centre
Meichelle Walker	General Manager, Edinburgh & Lothians Council on Alcohol (ELCA)
Mr David Carson	Service Manager, Health Promotion
Mr Andrew McAleavey	Service Manager, Homeless Outreach
Dr John Budd	General Practitioner with Specialist Interest within Substance Misuse, Homeless Outreach, Cowgate
Dr David McCartney	General Practitioner and Manager, Lothian and Edinburgh Abstinence Programme (LEAP)
Dr David Caesar	Consultant, Accident & Emergency, Edinburgh Royal Infirmary
Dr John P Gordon	General Practitioner, Pentland Medical Centre, Currie
Mr David Crosbie	Service Manager, Leith Project, Turning Point Scotland

Mr Glenn Liddall	Service Manager, Simpson House Counselling Service
Ms Jan Williamson	Service Manager, Includem
Mr Kevin Gore	Service Manager, CHAI
Ms Beverley Hubber	Service Manager, Castle Project
Ms Maura Daly	Service Manager, Circle
Ms Paula Gaunt-Richardson	Service Manager, Hype
Mr John Arthur	Service Manager, Crew
Ms Michelle Kirkpatrick	Service Manager, Pre-Pare
Ms Margo Irvine	Service Assistant Manager, Aberlour
Mr Sean McCollum	Scottish Drugs Forum
Mr Martin Gordon	Superintendent, Lothian and Borders Police
Mr David Harvie	District Procurator Fiscal, The Crown Office and Procurator Fiscal Service
Ms Susan Clark	Licensing Solicitor, Edinburgh City Council
Mr Peter Connor	Manager, Scottish Ambulance Service
Ms Jackie Clinton	Head of Programme Outcomes, Scottish Prison Service
Ms Kimberley Campbell	Service Manager for Edinburgh, British Red Cross
Mr Colin Beck	Manager of Mental Health and Vulnerable Services in Health & Social Care

Appendix 2: Profile of current service provision

Table 3.1: Service users in Edinburgh Drug and Alcohol services – by age (%)

Service	Under 15 years	15-24 years	25-34 years	35-44 years	45-54 years	55-65 years	65+ years
NEDAC	0	15	35	29	16	4	1
HOP	0	15	54	20	9	0	2
TPS	0	7	45	30	13	5	0
Crew	0	40	40	15	5	0	0
MAS	0	3	41	43	11	2	0
SHC	0	16	46	30	7	1	0
CARS	0	12	62	22	4	0	0
AOE	0	5	66	24	5	0	0
CP	0	15	35	30	15	5	0
Circle	0	20	50	20	10	0	0
BCC	0	11	30	30	17	10	2
RI	0	10	20	50	20	0	0
LEAP	0	5	25	35	20	10	5
HRT	0	5	80	15	0	0	0
CDPS	0	30	30	20	10	10	0
APS	0	10	30	30	20	10	0
SW(DRT)	0	0	58	40	2	0	0
SW(BBV)	0	0	20	55	15	10	0
SW(ART)	0	0	0	59	20	20	1
ALS	0	2	8	23	30	25	12
ELCA	0	4	14	20	46	12	4
MEARS	0	35	40	20	4	1	0
CHAI	0	16	47	17	10	6	4

Table 3.2: Service users in Edinburgh Drug and Alcohol services – by ethnic origin (%)

Key to Table 3.2

WS – White Scottish	OSA – Other South Asian
OWB – Other White British	CH – Chinese
WI – White Irish	C – Caribbean
OW – Other White	A – African
I – Indian	BL – Black
P – Pakistani	AMB – Any Mixed Background
B – Bangladeshi	OEG – Other Ethnic Group

Service	WS	OWB	WI	OW	I	P	B	OSA	CH	C	A	BL	AMB	OEG
NEDAC	96	1	0	1	0	1	0	0	0	0	1	0	0	0
HOP	85	13	0	2	0	0	0	0	0	0	0	0	0	0
TPS*	97	1	1	12	0	4	0	0	0	0	0	2	3	0
Crew	80	12	0	0	0	1	0	0	0	0	0	1	1	5
MAS	98	0	0	2	0	0	0	0	0	0	0	0	0	0
SHC	83	7	1	2	0	0	0	0	0	0	1	1	4	1
CARS	85	9	0	2	0	0	0	0	0	0	0	0	4	0
AOE	100	0	0	0	0	0	0	0	0	0	0	0	0	0
CP	80	15	0	0	0	0	0	0	0	0	0	0	5	0
Circle	80	10	0	0	0	0	0	0	0	0	0	0	10	0
BCC	90	10	0	0	0	0	0	0	0	0	0	0	0	0
RI	75	25	0	0	0	0	0	0	0	0	0	0	0	0
LEAP	95	0	1	1	1	0	0	0	1	0	0	0	1	0
HRT	80	20	0	0	0	0	0	0	0	0	0	0	0	0
CDPS	90	0	0	0	0	0	0	0	0	0	0	0	0	10
APS	90	0	0	0	0	0	0	0	0	0	0	0	10	0

SW(DRT)*	90	0	0	0	0	0	0	0	0	0	0	0	0	0
SW(BBV)*	75	10	0	0	0	0	0	0	0	1	10	0	0	0
SW(ART)	95	0	0	0	0	0	0	0	0	0	0	0	0	5
ALS	90	5	2	2	0	1	0	0	0	0	0	0	0	0
ELCA	41	54	1	3	0	0	0	0	0	0	1	0	0	0
MEARS	95	0	0	0	1	0	0	0	0	0	0	2	1	1
CHAI	90	6	0	2	2	0	0	0	0	0	0	0	0	0

* Percentages were provided by Service Managers and do not always add up to 100%.

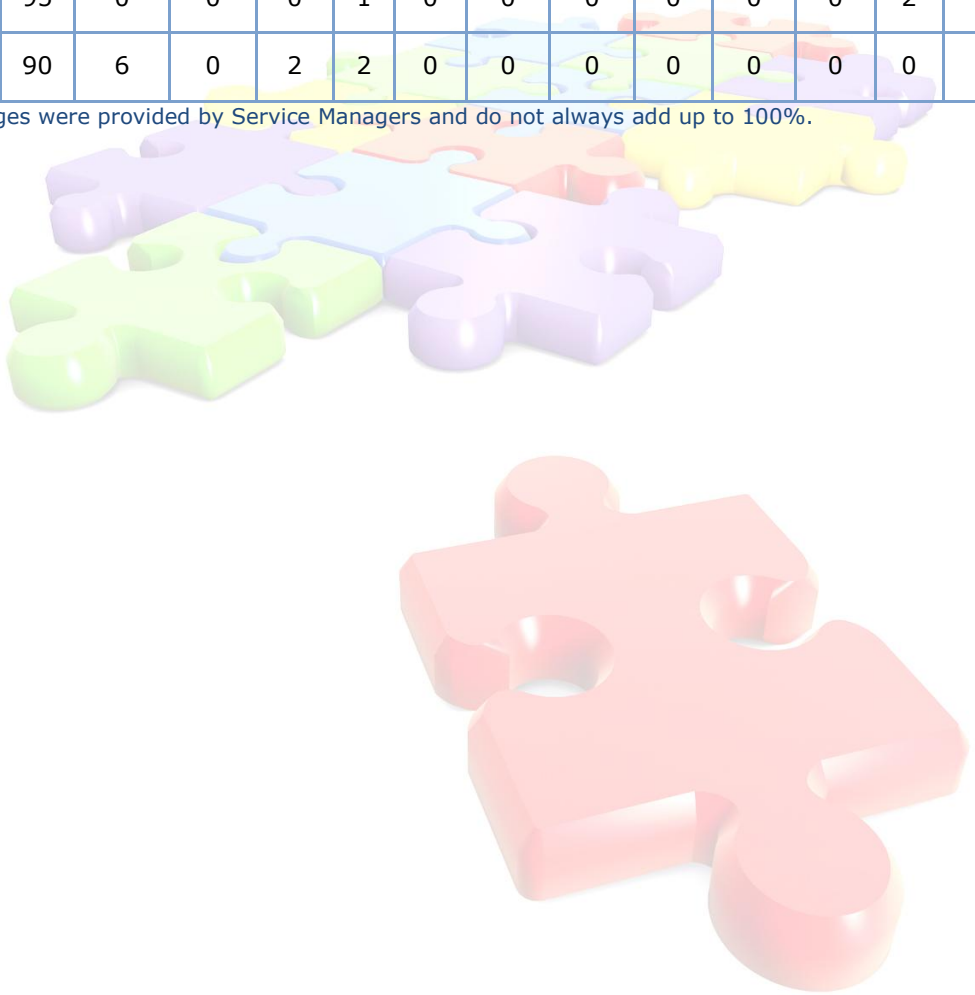


Table 3.3: Percentage of service users with dependent children in the Edinburgh-by service

Service	Service users with dependent children (%)	Estimate (Y/N)
NEDAC	31	N
HOP	5	N
TPS	32	N
Crew	40	Y
MAS	4	N
SHC	35	Y
CARS	25	Y
AOE	100	N
CP	60	Y
Circle	100	N
BCC	30	Y
RI	0	Y
LEAP	15	Y
HRT	30	Y
CDPS	40	N
APS	10	Y
SW(DRT)	30	Y
SW(BBV)	10	N
SW(ART)	20	Y
ALS	35	Y
ELCA	40	Y
MEARS	49	N
CHAI	40	Y

Table 3.4: Service users in Edinburgh Drug and Alcohol services – by economic activity status (%)

Service	Employed (paid or unpaid)	Full time education/training	Support into employment	Unemployed	Long term sick/disabled	In prison	Other
NEDAC	6	2	6	57	21	1	7
HOP	0	0	0	100	0	0	0
TPS	2	1	5	51	41	0	0
Crew	40	15	10	15	5	0	15
MAS	8	4	33	33	20	2	0
SHC	22	2	7	8	34	21	6
CARS	2	0	8	80	10	0	0
AOE	8	0	0	92	0	0	0
CP	5	0	5	80	10	0	0
Circle	10	10	10	30	40	0	0
BCC	0	0	65	0	35	0	0
RI	0	0	0	50	50	0	0
LEAP	15	0	0	65	20	0	0
HRT	10	0	0	70	20	0	0
CDPS	1	0	0	80	0	0	19
APS	10	0	0	60	0	0	30
SW(DRT)	0	0	30	50	20	0	0
SW(BBV)	10	0	1	1	82	0	6
SW(ART)	33	0	32	33	0	0	0
ALS	45	10	5	20	20	0	0
ELCA	45	1	0	32	4	7	13
MEARS	11	0	0	89	0	0	0
CHAI	5	10	20	55	5	5	0

Table 3.5: Service users in Edinburgh Drug and Alcohol services – by legal status at first contact (%)

Service	None	Case pending	DTTO	On probation/supervision order	In prison	Other
NEDAC	51	12	0	11	2	24
HOP	0	70	9	0	0	0
TPS	77	13	5	2	3	0
Crew	90	5	1	4	0	0
MAS	65	22	4	7	2	0
SHC	58	6	10	6	20	0
CARS	30	30	20	20	0	0
AOE	90	10	0	0	0	0
CP	60	20	5	15	0	0
Circle	70	0	10	10	10	0
BCC	0	30	0	8	8	0
RI	0	0	0	25	0	75
LEAP	80	10	3	7	0	0
HRT	0	20	0	0	0	0
CDPS	20	0	0	0	0	80
APS	20	0	0	0	0	80
SW(DRT)	0	0	10	20	0	0
SW(BBV)	0	0	0	5	0	0
SW(ART)	0	0	0	20	0	0
ALS	75	15	5	5	0	0
ELCA	62	10	0	20	7	1
MEARS*	0	100	3	10	0	0
CHAI	73	0	10	5	2	10

* Percentages were provided by Service Managers and do not always add up to 100%.

Table 3.6: Service users in Edinburgh Drug and Alcohol services – by accommodation status (%)

Service	Owned / Rented	Supported accommodation	Residential rehabilitation	In prison	Homeless - roofless	Homeless hostel/ Temporary /unstable accommo-dation	Other
NEDAC	89	0	0	1	1	7	2
HOP	0	0	0	0	22	88	0
TPS	75	1	0	0	1	23	0
Crew	70	30	0	0	0	0	0
MAS	87	2	2	2	0	7	0
SHC	46	9	15	20	1	9	0
CARS	90	2	0	0	0	8	0
AOE	80	0	0	0	0	20	0
CP	80	0	0	0	20	0	0
Circle	70	0	0	0	0	30	0
BCC*	0	100	100	0	0	0	0
RI	75	25	0	0	0	0	0
LEAP	14	2	80	0	3	1	0
HRT	50	20	0	0	0	30	0
CDPS	90	3	0	0	0	0	7
APS	95	5	0	0	0	0	0
SW(DRT)	70	0	0	0	0	30	0
SW(BBV)	30	70	0	0	0	0	0
SW(ART)	65	0	0	0	0	30	5
ALS*	95	5	0	0	0	5	0
ELCA	85	7	0	7	0	1	0
MEARS	75	5	0	0	3	15	2
CHAI	85	4	4	2	5	5	0

* Percentages were provided by Service Managers and do not always add up to 100%.

Table 3.7: Percentage of service users with mental health problem

Service	Service users diagnosed with a mental health problem (%)	Estimate (Y/N)
NEDAC	35	N
HOP	62	N
TPS	70	Y
Crew	40	Y
MAS	42	N
SHC	20	Y
CARS	50	Y
AOE	22	N
CP	40	Y
Circle	40	Y
BCC	66	N
RI	10	Y
LEAP	65	Y
HRT	40	Y
CDPS	100	Y
APS	100	Y
SW(DRT)	-	N
SW(BBV)	90	Y
SW(ART)	60	Y
ALS	5	N
ELCA	70	Y
MEARS	20	Y
CHAI	20	Y

Table 3.8: Service users in Edinburgh Drug and Alcohol services – by duration of service user contact (%)

Service	A single contact	Less than 4 weeks	1-3 months	3-6 months	More than 6 months
NEDAC[1]	-	-	-	-	-
HOP	0	0	45	29	26
TPS	2	3	5	25	65
Crew	20	20	20	30	10
MAS	0	2	20	28	50
SHC	38	23	19	11	9
CARS	0	3	53	24	20
AOE	0	0	5	10	85
CP	10	0	10	30	50
Circle	0	0	0	20	80
BCC	0	21	27	29	23
RI	0	0	0	0	100
LEAP	0	10	30	10	50
HRT	0	0	0	30	70
CDPS	5	5	0	60	30
APS	5	5	0	60	30
SW(DRT)[1]	-	-	-	-	-
SW(BBV)	0	0	15	0	85
SW(ART)[1]	-	-	-	-	-
ALS	37	20	20	18	5
ELCA	5	9	36	35	15
MEARS	65	5	10	15	5
CHAI	5	5	5	5	80

Table 3.9: Service users in Edinburgh Drug and Alcohol services – by reasons for closed contact %

Service	Planned Closure	Unplanned Closure	Closed for Misconduct
NEDAC	56	44	0
HOP	71	29	0
TPS	80	20	0
Crew	55	45	0
MAS	20	80	0
SHC	20	79	1
CARS	31	69	0
AOE	80	5	15
CP	40	60	0
Circle	90	10	0
BCC	38	28	34
RI	75	10	15
LEAP	60	35	5
HRT	80	15	5
CDPS	50	40	10
APS	50	40	10
SW(DRT)	40	60	0
SW(BBV)	80	20	0
SW(ART)[1]	-	-	-
ALS	85	15	0
ELCA	54	46	0
MEARS	50	50	0
CHAI	70	25	5

Table 3.10: Referral sources of services in the Edinburgh.

Service	Any Agency	Self Referral	GP	Health Professionals	Social Work	Court	Other
NEDAC	✓	✓	✓	✓	✓	✓	Family Friends
HOP	✓	✓	✓	✓	✓	×	Housing
TPS	✓	✓	✓	✓	✓	✓	-
Crew	✓	✓	✓	✓	✓	×	-
MAS	✓	✓	✓	✓	✓	✓	-
SHC	✓	✓	✓	✓	✓	✓	-
CARS	✓	✓	✓	✓	✓	✓	-
AOE	✓	✓	✓	✓	✓	×	-
CP	✓	✓	✓	✓	✓	×	-
Circle	✓	✓	✓	✓	✓	✓	Schools
BCC	✓	✓	✓	✓	✓	✓	Prisons Family members Hostels
RI	✓	✓	✓	✓	✓	✓	-
LEAP	✓	×	✓	✓	✓	✓	-
HRT	✓	✓	✓	×	×	×	-
CDPS	✓	×	✓	✓	✓	✓	-
APS	✓	×	✓	✓	✓	✓	-
SW(DRT)	✓	×	✓	✓	✓	×	-
SW(BBV)	×	✓	✓	✓	✓	×	-
SW(ART)	✓	×	✓	✓	✓	×	-
ALS	×	✓	✓	✓	✓	×	-
ELCA	✓	✓	✓	✓	✓	✓	Employers
MEARS	-	-	-	-	-	-	-
CHAI	✓	✓	✓	✓	✓	✓	Housing dept

Table 3.11: Profile of service user groups in Edinburgh Drug and Alcohol services

Service	Under 16 years	16-18 years	18 years +	21 years+	Men only	Wo-men only	Both sexes	Couples	Women with childre n	Couples with children	Men with children
NEDAC	×	✓	✓	×	✓	×	✓	✓	✓	✓	✓
HOP	×	✓	✓	✓	×	×	✓	✓	✓	✓	✓
TPS	×	✓	✓	×	×	×	✓	✓	✓	✓	×
Crew	×	✓	✓	✓	×	×	✓	×	×	×	×
MAS	×	✓	✓	✓	×	×	✓	✓	✓	✓	✓
SHC	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CARS	×	✓	✓	×	×	×	✓	✓	✓	✓	✓
AOE	×	×	✓	×	×	×	✓	✓	✓	✓	×
CP	×	✓	✓	×	×	×	✓	✓	✓	✓	×
Circle	✓	✓	✓	✓	×	×	×	×	✓	✓	✓
BCC	×	×	✓	✓	✓	×	×	×	×	×	×
RI	×	×	✓	✓	×	×	✓	×	×	×	×
LEAP	×	×	✓	×	×	×	✓	×	×	×	×
HRT	×	×	✓	×	×	×	×	×	×	×	×
CDPS	×	✓	✓	✓	×	×	✓	✓	×	✓	×
APS	×	✓	✓	✓	×	×	✓	✓	×	✓	×
SW(DRT)	×	×	✓	×	×	×	✓	✓	✓	✓	✓
SW(BBV)	×	×	✓	×	×	×	✓	✓	✓	✓	✓
SW(ART)	×	×	✓	×	×	×	✓	✓	✓	✓	✓
ALS	✓	✓	✓	✓	×	×	✓	✓	✓	×	×
ELCA	×	×	✓	×	×	✓	✓	×	×	×	×
MEARS	×	✓	✓	✓	×	×	✓	✓	✓	✓	✓
CHAI	×	✓	✓	✓	×	×	✓	✓	✓	✓	✓

Table 3.12: Opening days and times of the Edinburgh Drug and Alcohol Services

Service	Opening days/times	Out of hours service
NEDAC	Monday: 9am- 4.30pm Tuesday, Wednesday and Thursday: 1pm-4.30 pm	By arrangement with individual clients
HOP	-	As required by client
TPS	Monday to Thursday: 9am - 5pm Friday: 9am-4.30pm	-
Crew	Monday to Friday: 9am-5pm	Tuesday & Thursday 5pm-7pm
MAS	Monday to Thursday: 9am - 5pm Friday: 9am - 4.30pm	None
SHC	Monday and Wednesday: 9am-9pm Tuesday, Thursday and Friday: 9am- 5pm	-
CARS	Monday to Thursday: 9am-5pm Friday: 9am- 4.30pm	None
AOE	Monday to Friday: 9am-5pm	To 8.00 pm evenings including Saturdays
CP	Monday to Friday: 9am-4.30pm	-
Circle	Monday to Friday: 9am-5pm	Flexible
BCC	Monday to Sunday: 9am-5pm	-
RI	Monday to Friday: 9am-5pm	On phone at any time
LEAP	Monday to Friday: 9am-4pm Saturday:10am-1pm	All other hours.
HRT	Monday to Friday: 12.30am-4pm	-
CDPS	Monday to Friday: 9am-5pm	-
APS	Monday to Friday 9am to 5pm	-
SW(DRT)	Monday to Friday: 8.30am-5pm	-
SW(BBV)	Monday to Friday: 8.30am-5pm	-
SW(ART)	Monday to Friday: 9am-5pm	-
ALS	Monday to Friday: 8am-5pm	-
ELCA	Monday to Thursday: 9am - 9pm Friday: 9am- 4pm	Saturday: 9am-2pm
MEARS	Monday to Friday: 9am-5pm	None
CHAI	Monday to Friday: 8am-6pm	None

Table 3.13: Profile of service access methods in Edinburgh Drug and Alcohol services

Service	By appointment	Home visits	Disabled access	Contact address required	Telephone helpline	Other (please specify)
NEDAC	✓	✓	✓	×	✓	Referrals, Information and advice service
HOP	✓	✓	×	×	×	Outreach
TPS	✓	×	×	×	✓	Duty access (drop in)
Crew	✓	×	✓	×	✓	Drop in acupuncture sessions
MAS	✓	✓	×	×	×	-
SHC	✓	×	✓	×	✓	Ramped access to the ground floor; Advice / information offered by telephone
CARS	✓	×	✓	×	×	-
AOE	✓	✓	×	×	×	-
CP	✓	✓	✓	×	×	-
Circle	✓	✓	×	×	✓	-
BCC	✓	×	×	×	×	-
RI	✓	✓	×	×	✓	-
LEAP	✓	×	✓	×	×	-
HRT	✓	×	×	×	×	Drop in sessions
CDPS	✓	✓	✓	×	×	-
APS	✓	✓	✓	×	×	-
SW(DRT)	✓	✓	×	×	×	-
SW(BBV)	×	✓	×	×	×	-
SW(ART)	✓	✓	×	×	×	-

ALS	✓	×	✓	×	×	-
ELCA	✓	×	×	×	×	Drop in service
MEARS	✓	✓	✓	×	✓	Drop in service; accompanying clients to court and to appointments with other agencies
CHAI	✓	✓	✓	×	✓	Drop in service

Table 3.14: Profile of substances treated in Edinburgh Drug and Alcohol services

Service	All	Alcohol	Heroin/opiates/opioids	Psycho stimulants	Hallucinogens	Benzodiazepines	Over-the-counter medication	Prescription medication	Solvents/ volatile substances	Other (please specify)
NEDAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	Polydrug Use
HOP	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
TPS	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
Crew	×	×	×	✓	✓	×	×	×	×	-
MAS	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
SHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	Alcohol and Drug users
CARS	×	×	✓	✓	✓	✓	✓	✓	✓	-
AOE	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
CP	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
Circle	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
BCC	✓	✓	✓	✓	✓	✓	✓	✓	✓	Gambling addiction
RI	×	✓	×	✓	✓	✓	×	×	×	-
LEAP	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
HRT	×	×	✓	✓	×	×	×	×	×	-
CDPS	×	×	✓	✓	✓	✓	✓	✓	✓	Legal highs
APS	×	✓	×	×	×	✓	×	×	×	-
SW(DRT)	×	×	✓	✓	✓	✓	✓	✓	×	-
SW(BBV)	×	✓	✓	×	×	✓	×	×	×	-

SW(ART)	×	✓	×	×	×	×	×	×	×	-
ALS	×	✓	×	×	×	×	×	×	×	-
ELCA	×	✓	×	×	×	×	×	×	×	-
MEARS	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
CHAI	✓	✓	✓	✓	✓	✓	✓	✓	✓	-

Table 3.15: Profile of service provision within Edinburgh Drug and Alcohol services

Key to Table 3.15

A – Advice and information	NE – Needle Exchange
C – Counselling	O – Outreach
D/A – Detox/Abstinence	SP – Substitute Prescribing
FS – Family Services	RC – Rehabilitation (Community)
BBV – Blood Borne Virus Services	RR – Rehabilitation (Residential)

	A	C	D/A	FS	BBV	NE	O	SP	RC	RR	Other
NEDAC	✓	✓	×	×		✓	✓	×	✓	×	✓
HOP	✓	✓	×	×	✓	✓	✓	×	×	×	-
TPS	✓	×	×	×	×	✓	×	✓	✓	×	✓
Crew	✓	✓	×	×	×	×	×	×	×	×	-
MAS	✓	×	×	×	×	×	✓	×	×	×	-
SHC	✓	✓	×	✓	×	×	×	×	×	×	-
CARS	✓	×	×	×	✓	×	×	×	✓	×	✓
AOE	✓	×	×	✓	×	×	✓	×	×	×	✓
CP	✓	×	×	✓	✓	✓	✓	×	✓	×	-
Circle	✓	×	×	✓	×	×	✓	×	✓	×	-
BCC	✓	✓	✓	×	×	×	✓	×	✓	×	-
RI	✓	✓	×	×	×	×	✓	×	✓	×	-
LEAP	×	✓	✓	✓	✓	×	×	×	✓	✓	-
HRT	✓	✓	✓	×	✓	✓	✓	✓	×	×	-
CDPS	✓	✓	✓	×	✓	✓	✓	✓	✓	×	✓
APS	✓	✓	✓	×	✓	✓	✓	×	✓	×	✓
SW(DRT)	✓	✓	×	×	✓	×	×	×	×	×	✓

SW(BBV)	✓	✓	✓	✓	✓	×	×	×	×	×	✓
SW(ART)	✓	✓	×	×	×	×	×	×	✓	×	-
ALS	✓	✓	×	×	×	×	×	×	×	×	✓
ELCA	✓	✓	×	×	×	×	×	×	×	×	✓
MEARS	✓	✓	×	×	×	×	×	×	×	×	-
CHAI	✓	✓	×	✓	✓	✓	✓	✓	×	×	✓

Table 3.16: Range of detoxification/abstinence services provided within Edinburgh Drug and Alcohol services

Service	In-patient detox	Out-patient detox	Home-based detox	Metha-done	Subutex (Buprenor-phine)	Benzodi-azepines	Dihydro-codeine	Suboxone (Bupren-orphine + Naloxone)	Other (please specify)
LEAP	✓	✓	✓	✓	✓	✓	✓	×	-
HRT	✓	✓	✓	×	×	×	×	×	-
CDPS	✓	✓	✓	✓	✓	✓	✓	✓	Anti-depressants
APS	✓	✓	✓	✓	✓	✓	✓	✓	Psycho-tropics

Table 3.17: Profile of rehabilitation and other services within Edinburgh Drug and Alcohol services

	AS*	A/C**	Drop-in sessions	Education and training	Engage peer volun-teers	Group work	Structured day programme	Other (please specify)
NEDAC	×	✓	✓	×	×	✓	×	-
HOP	-	-	-	-	-	-	-	-
TPS	×	✓	✓	×	×	×	×	-
Crew	×	×	✓	×	✓	×	×	-
MAS	-	-	-	-	-	-	-	-
SHC	×	✓	×	✓	×	✓	×	✓
CARS	×	✓	×	✓	✓	✓	✓	✓
AOE	-	-	-	-	-	-	-	-
CP	×	✓	✓	✓	×	×	×	✓
Circle	-	-	-	-	-	-	-	-
BCC	✓	✓	✓	✓	✓	✓	✓	✓
RI	✓	✓	×	×	×	×	×	✓
LEAP	✓	✓	×	✓	✓	✓	✓	-
HRT	✓	×	×	×	×	×	×	-
CDPS	✓	✓	×	✓	×	×	×	-
APS	✓	✓	×	✓	×	✓	×	-
SW (DRT)	×	×	×	×	×	×	×	✓
SW (BBV)	×	×	×	×	×	×	×	✓
SW (ART)	×	×	×	×	×	×	×	✓
ALS	-	-	-	-	-	-	-	-
ELCA	×	×	✓	✓	×	✓	×	-
MEARS	-	-	-	-	-	-	-	-
CHAI	✓	✓	✓	✓	✓	✓	✓	-

*AS-Accommodation Support **A/C-Aftercare

Table 3.18: Profile of accessibility barriers in Edinburgh Drug and Alcohol services

	Opening Hours	Waiting Times	Referral/Exclus-ion Criteria	Funding	Capacity	Distance to Service	Cost of Travel	Availability of Public Transport	Concerns about Confidentiality	Environment/ Accommodation of service	Fear for safety	Lack of childcare	Other (please specify)
NEDAC	×	✓	×	✓	✓	✓	✓	×	×	×	×	×	Territor-ialism
HOP	×	×	×	✓	✓	×	×	×	×	×	×	×	-
TPS	×	✓	×	×	✓	×	×	×	×	✓	✓	✓	No disabled access
Crew	✓	×	×	✓	✓	✓	✓	×	✓	✓	×	✓	-
MAS	✓	×	×	✓	×	✓	✓	×	×	×	×	×	-
SHC	×	✓	✓	✓	✓	✓	✓	✓	×	×	×	×	-
CARS	✓	✓	×	✓	✓	✓	×	×	×	×	×	✓	-
AOE	×	×	×	✓	✓	×	×	×	×	×	×	×	-
CP	×	×	×	×	×	×	×	×	×	×	×	✓	-
Circle	-	-	-	-	-	-	-	-	-	-	-	-	-
BCC	×	×	✓	×	×	×	×	×	×	×	×	×	-
RI	✓	×	✓	✓	✓	×	×	×	×	×	✓	×	-
LEAP	×	✓	×	×	✓	×	×	×	×	×	×	✓	-
HRT	×	×	×	✓	✓	×	×	×	×	×	×	×	-
CDPS	✓	✓	×	×	✓	×	×	×	×	×	×	✓	-
APS	✓	✓	×	×	✓	×	×	×	×	×	×	✓	-
SW (DRT)	×	✓	×	×	✓	×	✓	×	×	×	×	×	-
SW (BBV)	×	×	×	×	✓	×	×	×	×	×	×	×	All service users are Hep C or HIV Positive
SW (ART)	×	×	×	×	✓	×	×	×	×	×	×	×	-

ALS	×	×	✓	×	✓	✓	×	×	×	×	×	×	-
ELCA	×	×	×	×	×	×	×	×	✓	×	×	✓	Language Barriers
MEARS	×	×	×	×	×	×	✓	✓	×	×	×	×	Insuff-icient motivation on part of service user
CHAI	✓	×	×	✓	✓	×	✓	×	×	×	✓	✓	-

Table 3.19: Profile of staff compostion in Edinburgh Drug and Alcohol services

Service	Nurses	Support Workers	Key Workers	Social Workers	Managers	Service Co-ordinators	Administrative Officers	Addictions G.Ps	Consultant Psychiatrists	Secretarial Staff	Psychologists	Occupational Therapists	Team Leader	Pharmacist
NEDAC	-	-	-	-	1	-	1	-	-	-	-	-	-	-
HOP	1	-	-	1	-	-	-	-	-	-	-	-	-	-
TPS	0.4	-	4	-	0.6	1	-	0.5	-	-	-	-	-	-
Crew	-	-	-	-	-	-	-	-	-	-	-	-	1	-
MAS	-	2	2	-	1	1	-	-	-	-	-	-	-	-
SHC	-	-	-	-	2	-	1	-	-	-	-	-	-	-
CARS	-	-	2	-	1	1	-	-	-	-	-	-	-	-
AOE	-	3	-	-	2	-	1	-	-	-	-	-	-	-
CP	-	-	5	-	1	-	-	-	-	-	-	-	-	-
Circle	-	5	-	-	1	-	-	-	-	-	-	-	-	-
BCC	-	3	10	-	2	1	1	1	-	-	-	-	-	-
RI	-	3	-	-	1	1	-	-	-	-	-	-	-	-
LEAP	2	-	3	-	1	-	1	1	-	2	-	-	-	0.5
HRT	5	-	3	-	1	-	-	-	-	-	-	-	-	-
CDPS	15	-	-	-	-	-	4	-	2	-	1	-	-	-
APS	27	-	-	-	-	-	4	-	2	-	1	1	-	-
SW (DRT)	-	-	-	6	-	-	-	-	-	-	-	-	0.5	-
SW (BBV)	1	-	-	3	-	-	-	-	-	-	-	-	-	-
SW (ART)	-	-	-	6	-	-	1	-	-	-	-	-	1	-
ALS	2	-	-	-	-	-	-	-	-	-	-	-	-	-
ELCA	-	-	-	2	-	-	3	-	-	-	-	-	-	-
MEARS	-	-	-	0.2	-	-	-	-	-	-	-	-	0.5	-
CHAI	4	-	-	2	2	-	1	-	-	-	-	-	-	-

Table 3.20: Profile of staff compostion in Edinburgh Drug and Alcohol services cont.

Service	Senior Social Worker	Clerical	Senior Practitioner	Practitioner	Resource Development Worker	Session Practitioner	Drug Worker	Alcohol Worker	Care Manager	Paid Counsellor	Voluntary Counsellor	Supervisor	Receptionist	Criminal Justice	Placement Counsellor coordinator
NEDAC	-	-	-	-	-	-	5	1	-	-	-	-	-	-	-
HOP	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TPS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Crew	-	-	1.2	1	1	2	-	-	-	-	-	-	-	-	-
MAS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SHC	-	-	-	-	-	-	-	-	-	4	9	-	-	-	1
CARS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AOE	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CP	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Circle	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BCC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
RI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
LEAP	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
HRT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CDPS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
APS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SW (DRT)	0.5	0.5	-	-	-	-	-	-	-	-	-	-	-	-	-
SW (BBV)	-	-	-	-	-	-	-	-	3	-	-	-	-	-	-
SW (ART)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ALS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ELCA	-	-	-	-	-	-	-	-	-	6	22	6	3	-	-
MEARS	-	-	-	-	-	-	-	-	-	-	-	-	-	4	-
CHAI	-	-	-	-	-	-	6	1	-	1	-	-	-	-	-

Appendix 3: Provision of Designated Place of Safety (DPOS)

Overview

There is a growing debate over the proper handling of drunk and incapable people who come into contact with the emergency services. While little data exists on the demand drunken and incapable people place on services, we do know that the impact on the police, SAS and emergency departments can be significant. SAS, for example, report that in 2007 they attended an average of 73 incidents between 1-2am on Sunday mornings, compared with the normal hourly average of 38 incidents. On Hogmanay, incidents peaked at 150 between 2-3am.[141] In addition, a recent audit of Scottish Accident and Emergency Departments found alcohol to be a contributory factor in at least 11% of all presentations,[142] while over 70% of adults presenting to emergency departments may be alcohol-related (with the majority of these being concentrated at weekends and involving young men).[143]

The demands of providing care and support to individuals who are drunk and incapacitated and who may be a danger to themselves or others can reduce the ability of emergency services to address other problems, with increased risks for those awaiting attention. In addition, police cells are inappropriate for the detention of drunk and incapable people who have no other reason to be there. There is, therefore, a need to identify more effective ways of dealing with such people.

Legal position

According to the Civic Government (Scotland) Act, 1982 (Section 50/1) any person who, while not in the care or protection of a suitable person, and is, in a public place, drunk and incapable of taking care of himself shall be guilty of an offence. Drunk and incapable people are often arrested not to protect the public but for their own safety. However, a research study into deaths in police custody[144] had suggested that officers could not and should not be expected to know how to care for drunken detainees. Many of these people may actually need a degree of low level medical care while they are 'sleeping it off'.

As part of a policy for the decriminalisation of drunkenness, the Criminal Justice (Scotland) Act 1980, introduced Designated Places of Safety (DPoS) where police could take drunk and incapable people to sober up. This legislation aims to address the futility and financial cost attached to the handling of drunk and incapable people by the police. Having a Designated Place of Safety scheme in place should have reduced the burden on the emergency services; however, in practice very few of these Designated Places of Safety were established, and to a large extent the handling of drunk and incapable

[141] Scottish Ambulance Service data.

[142] *Harmful Drinking One: The Size of the Problem,* NHS Quality Improvement Scotland. http://www.nhshealthquality.org/nhsqis/files/Alcohol_size%20of%20prob_web.pdf

[143] *Harmful Drinking Two: Alcohol and Assaults*, NHS Quality Improvement Scotland http://www.nhshealthquality.org/nhsqis/files/Alcohol_assaults_FINAL_web.pdf

[144] Home Office (1998). Deaths in Police Custody: Learning the Lessons. Police Research Series, Paper 26.

individuals has remained the responsibility of the police and ambulance services and emergency departments.

Costs of current approach

Handling drunk and incapable incidents clearly puts a demand on emergency services in terms of time and money; however, at the moment there is little data available to accurately measure the extent of this impact.

The limited data that is available shows that:

- In 2006/07, 6,664 drunkenness offences were recorded by the eight Scottish police forces, constituting 0.7% of all recorded crime[145,146].
- In 2005/06, the Northern and Strathclyde police force areas recorded the highest rates of drunkenness (28 and 21 offences per 10,000 population). While Lothian & Borders and Central police force areas recorded the lowest (2 and 4 per 10,000)[147].
- Figures uncovered under the Freedom of Information Act show that in 2006/07 more than 1,600 youngsters under 18 were arrested for being drunk and incapable in a public place. A third of those picked up by police were 15 or under[148].
- The busiest time for alcohol-related A&E presentations is between midnight and 4 a.m. on a Saturday morning. Four and a half times more patients presented during these 4 hours than at the same time during the rest of the week[149].
- One in four patients attending A&E for an alcohol-related problem had been seen for alcohol-related problems in past[4].
- The most common presenting complaint was some form of alcohol-related injury (53%) followed by intoxication (23%)[4].

Findings from the 'Cost of Alcohol Use and Misuse in Scotland' report[150] (2008) offer some insight as to the monetary costs emergency services incur in response to alcohol misuse in general (including handling drunk and incapable people):

[145] Recorded Crime in Scotland 2006/7 figures

[146] In addition, it is assumed that alcohol is a key factor in a number of other offences.

[147] ISD Scotland (2007). Alcohol Statistics Scotland 2007. Available on: http://www.alcoholinformation.isdscotland.org/alcohol_misuse/files/Alcohol%20Bulletin.pdf

[148] www.mirror.co.uk/news/topstories/2008/03/04/rise-in-children-arrested-for-being-drunk-and-incapable-89520-20339683/

[149] NHS Quality Improvement Scotland (2008). Understanding Alcohol Misuse in Scotland: Harmful Drinking, Final Report. Available on: http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/30_04_08_alcoholreport.pdf

[150] The Scottish Government (2008). Costs of Alcohol Use and Misuse in Scotland. Available on: http://www.scotland.gov.uk/Publications/2008/05/06091510/0

- It is estimated that in 2006/07 alcohol-misuse related A&E attendances cost the NHS £32 million (based on an estimated figure of 25% of all A&E attendances).
- Similarly, it is estimated that in 2006/07 the Scottish Ambulance Service spent £31.5 million on attending alcohol-misuse related incidents (based on an estimated figure of 25% of all road ambulance incidents).
- The total cost of policing attributable in response to alcohol misuse in 2006/07 is estimated at £288m (based on an estimated figure of 25% of recorded incidents in which alcohol is the critical factor).

The evidence presented above demonstrates the impact and cost incurred by the emergency services' handling of drunk and incapable individuals.

Some of the benefits to be gained from having a designated place of safety are:

- 'To reduce the impact on limited police, ambulance & health service resources at peak times.'
- 'To ensure the safety of vulnerable people by early, pro-active intervention, thus reducing the risk of them committing or becoming the victims of crime'.
- 'To encourage the reporting of previously under reported alcohol related crimes'.
- 'To reduce violence & anti-social behaviour associated with over-consumption of alcohol in the city centre'. [151]

Current service provision in Scotland

Some local provision already exists - including a protocol established between Fife Constabulary and the Scottish Ambulance Service and temporary arrangements established for large scale events, such as Edinburgh's Hogmanay. However, provision is known to be patchy.

Albyn House was opened in 1983 as the first Designated Place of Safety in Scotland. It now runs as part of *Alcohol Support* services and offers a 4-bed unit where people identified by the police as being drunk and incapable can safely sleep off the effects of intoxication. The service covers the geographical area of Aberdeen City, south to Stonehaven, west to Inverurie and north to Ellon.

Beechwood House (Inverness) was founded by the Church of Scotland and offers 8 places as a Designated Place of Safety. As with Albyn House, once clients have sobered up they are given the opportunity to move on to a hostel/rehabilitation accommodation attached to the Designated Place, where they can stay and receive support for their alcohol dependency.

[151] As 74

Appendix 4: National quality standards for substance misuse services: Comparisons between service users and service staff

In 2006, The Scottish Government produced the National Quality Standards for substance misuse services[152] It stated that these standards are expected to improve the consistency and quality of substance misuse service provision in Scotland; to form the foundation of a framework that is intended to enable service providers to examine and continuously improve their service delivery, increase accountability, and assist service commissioners to make evidence based funding decisions. Finally it stated that they will provide a benchmark for the level of quality that should be consistently reached for all services working with substance misusers.

Eight of the eleven standards have been utilised in this needs assessment to gauge the level of compatibility between the views of service users and staff working in services.

Standard Statement 1: You will be provided with all the information you need to help you decide about using the service.

Questionnaire statement: The information I was given about services helped me to decide whether to come along.		
Group	Strongly Agree	Agree
Service Users	39%	47%
Service Providers	31.4%	55.5%

Questionnaire statement: I have been told how to make a complaint if I am not happy		
Group	Strongly Agree	Agree
Service Users	34.6%	42.2%
Service Providers	37.2%	55.5%

Questionnaire statement: Services have clearly explained their confidentiality policy to me		
Group	Strongly Agree	Agree
Service Users	60.7%	33.7%
Service Providers	60.6%	35%

[152] Scottish Government (2006). *Quality Standards for Substance Misuse Services in Scotland*. Edinburgh: Scottish Government.

Standard Statement 3: You will be able to access safe, quality surroundings when engaging with the service.

Questionnaire statement: I feel safe and comfortable when I attend services.		
Group	Strongly Agree	Agree
Service Users	55.5%	37.3%
Service Providers	55.1%	38.4%

Standard Statement 4: You will be involved in a full assessment which makes sure that decisions about your care and support are based on your needs.

Questionnaire statement: The assessment I was given helped me to work out what my problems were and what I could do about them.		
Group	Strongly Agree	Agree
Service Users	43%	42.6%
Service Providers	44.5%	45.3%

Standard Statement 7: You will be able to discuss and plan your long-term support with service staff, involving your family, other organisations, services or representatives as appropriate.

Questionnaire statement: My family/partner/carer was allowed to let services know what I need.		
Group	Strongly Agree	Agree
Service Users	17.8%	28.5%
Service Providers	14.5%	37%

Standard Statement 8: You will receive quality support and care.

Questionnaire statement: Services have been good at helping as my needs change.		
Group	Strongly Agree	Agree
Service Users	43%	42.6%
Service Providers	33.4%	51.4%

Standard Statement 9: The service will work with a wide range of partners, including other services, so that your needs are met.

Questionnaire statement: The services I use are good are working together with each other.		
Group	Strongly Agree	Agree
Service Users	33.3%	37.8%
Service Providers	43.4%	47.1%

Standard Statement 10: The service you receive has been designed with you, your family and the local community in mind.

Questionnaire statement: The services treat everyone equally no matter what their race, disability, age or belief system.		
Group	Strongly Agree	Agree
Service Users	58.3%	31.7%
Service Providers	67.2%	26.3%

Standard Statement 11: Your views will be sought in order to constantly monitor the type, delivery and development of services.

Questionnaire statement: I get to have a say in how services should be run.		
Group	Strongly Agree	Agree
Service Users	17.4%	31.3%
Service Providers	8%	37%