DRAFT

EADP Commissioning Plan

Commissioning for Recovery from Problem Alcohol and Drug Use 2011 – 2014

DRAFT FOR CONSULTATION

This plan sets out how Edinburgh Alcohol and Drug Partnership (EADP) proposes to commission services to support people with alcohol and drug problems to achieve recovery. The draft plan explains the priorities and outcomes we are seeking to achieve, and sets a framework for future service planning.

We particularly want to hear from the following groups of people:

- current and recent service users, their carers and families
- providers of services to people with alcohol and drug problems
- commissioners and other strategic decision makers
- members of the public.

The Commissioning Plan will have an impact on services provided for people with problem alcohol and drug use. This includes services provided by both the voluntary and statutory sector.

Responding to the consultation
You can comment on this draft plan by completing the online survey at www.edinburghadp.co.uk

Or by printing off and completing the survey in Appendix 1 and posting it to:

Freepost RSSG-UUEB-SEJZ
EADP
Level 1/7
Waverley Court
4 East Market Street
EDINBURGH
EH8 8BG

The deadline for comments is 21st October 2011

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1. Introduction

Welcome to the first draft of the Commissioning Plan for recovery from problem alcohol and drug use 2011-2014.

This plan proposes outcomes and priorities for people over the age of 18 with problem alcohol and drug use, their children and other family members, significant others and carers.
A separate plan will be developed setting out commissioning intentions to support those under the age of 18 to address their problem alcohol and drug use.

Q: What is the purpose of the EADP commissioning plan?

A: The plan describes the principles, priorities and outcomes for services to support **more people achieve a sustained recovery from problem alcohol and drug use**. It sets the framework for the future planning of alcohol and drug services.

Organisations involved in commissioning these services include the City of Edinburgh Council, Capital City Partnership, NHS Lothian and Lothian and Borders Police.

Q: What is Commissioning?

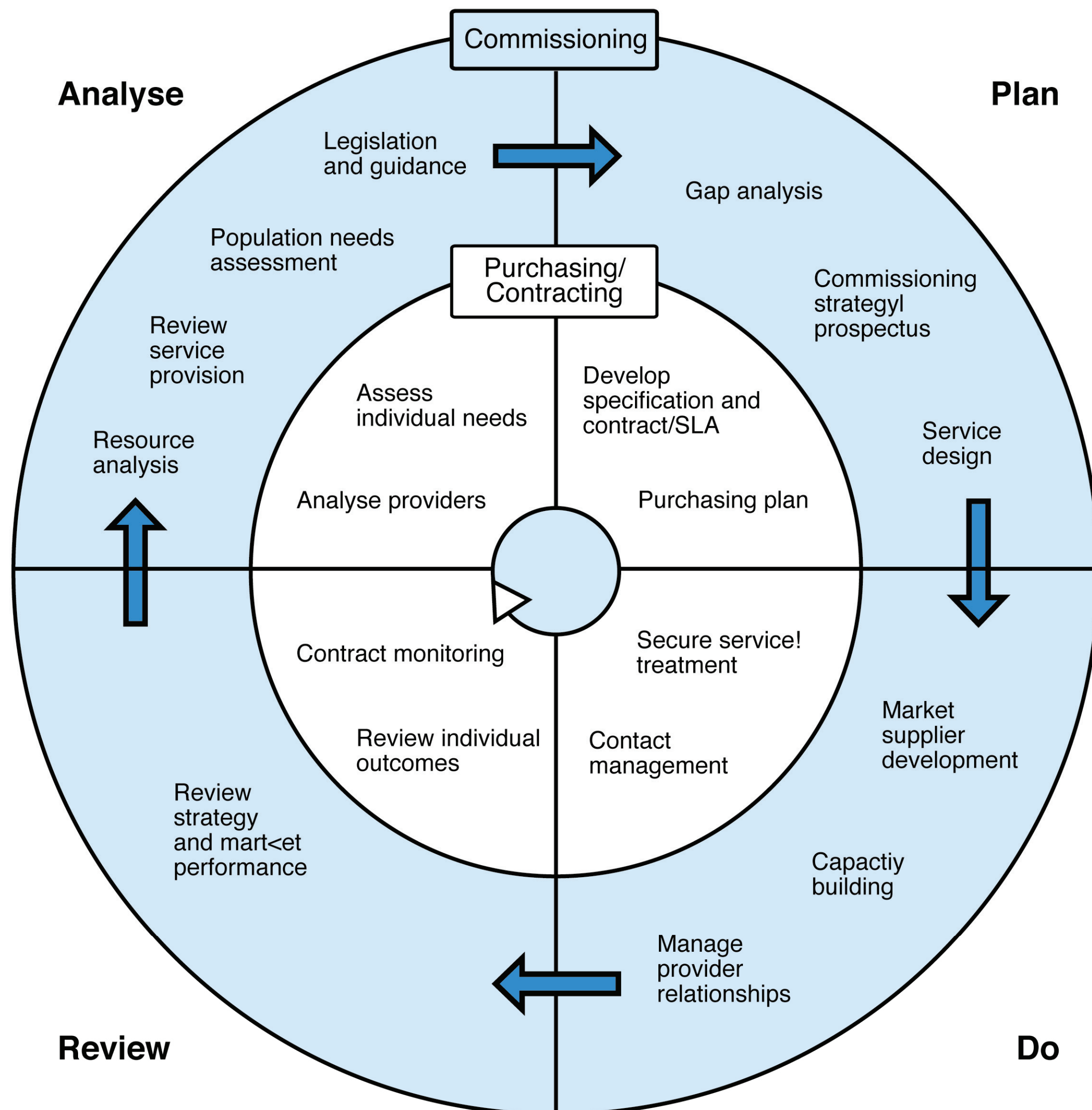
A: A good definition of commissioning is:

> "the term used for all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these into place."

Commissioning is a specialist activity undertaken by those people who are required to make decisions about investing in services. For adult treatment and recovery services in Edinburgh this is managed by the EADP Joint Commissioning Group which reports directly to the EADP Executive Group and into the Edinburgh Partnership.

The commissioning model below in Figure 1 has been taken from the Social Work Inspection Agency's (SWIA) 'Guide to Strategic Commissioning' (2009). EADP will use this cycle to plan and develop services.

Figure 1: Commissioning Cycle and Key Activities



Q: What difference will the commissioning plan make to current service delivery?

A: The commissioning plan sets out how EADP will improve outcomes for service users by developing a recovery oriented system of care and increasing the **efficiency** and **effectiveness** of services across Edinburgh.

It is important to acknowledge that many professionals and services are already providing a high level of recovery-focused care and treatment. However, the current network of services in Edinburgh is complex and based on a model of care that does not fully support recovery. There are improvements identified by service users, commissioners and service providers that need to be made to the system to improve outcomes for service users.

Q: Which service users will be affected by the changes in the EADP commissioning plan?

A: The main people who will benefit from the improvements that will be made through this commissioning plan are those over the age of 18 who have alcohol and/or drug problems and who live in the City of Edinburgh. There will also be significant benefits for their children, carers, other family members and communities.

2. Vision Statement

2.1 Our vision is that **more people achieve sustained recovery from problem alcohol and drug use.**

2.2 EADP defined recovery from problem alcohol and drug use in its strategy as “a process through which an individual is enabled to move on from their problem alcohol/drug use, towards an alcohol/drug-free life as an active and contributing member of society.”

2.3 Recovery will mean different things at different times to individuals and families as they move away from problem alcohol and drug use. Consequently it is useful to think about recovery as a series of principles. The Centre for Substance Abuse Treatment has avoided the idea of consensual definition in favour of a series of principles which reflect the broad understanding of recovery in EADP. These are:

- there are many pathways to recovery
- recovery is self directing and empowering
- recovery involves a personal recognition of the need for change and transformation
- recovery is holistic
- recovery has cultural dimensions
- recovery exists on continuum of improved health and wellbeing
- recovery emerges from a process of healing and self-redefinition
- recovery involves addressing discrimination and transcending shame and stigma
- recovery is supported by peers and allies
- recovery involves rejoining and rebuilding a life in the community
- recovery is a reality.

2.4 EADP recognises that the definition of recovery is not restricted to levels of alcohol/drug use. It encompasses those who are abstinent and those who are in methadone-assisted recovery, those who have achieved controlled drinking, amongst others who no longer use problematically.

2.5 Recovery is defined in the context of people’s lives and therefore applies to individuals, their families and communities.

Question 1

Do you agree with this definition of recovery?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1 - Strongly disagree

Do you have any comments?

3. Strategic Context

3.1 EADP launched its citywide strategy to address the impact that alcohol and drug use has on individuals, families and communities in February 2011. The vision outlined in the strategy is that **Edinburgh promotes a healthy and responsible attitude to alcohol and is a city where recovery from problem alcohol and drug use is a reality**. This is supported by three high level outcomes:

EADP Strategy High Level Outcomes
Children, young people and adults' health and wellbeing is not damaged by alcohol and drugs.
Individuals and communities affected by alcohol and drugs are safer.
More people achieve a sustained recovery from problem alcohol and drug use.

3.2 The strategy reflects the two national strategies to address alcohol and drugs:

- ***Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*** (2008)[1]
- ***Changing Scotland's Relationship with Alcohol: A Framework for Action*** (2009)[2].

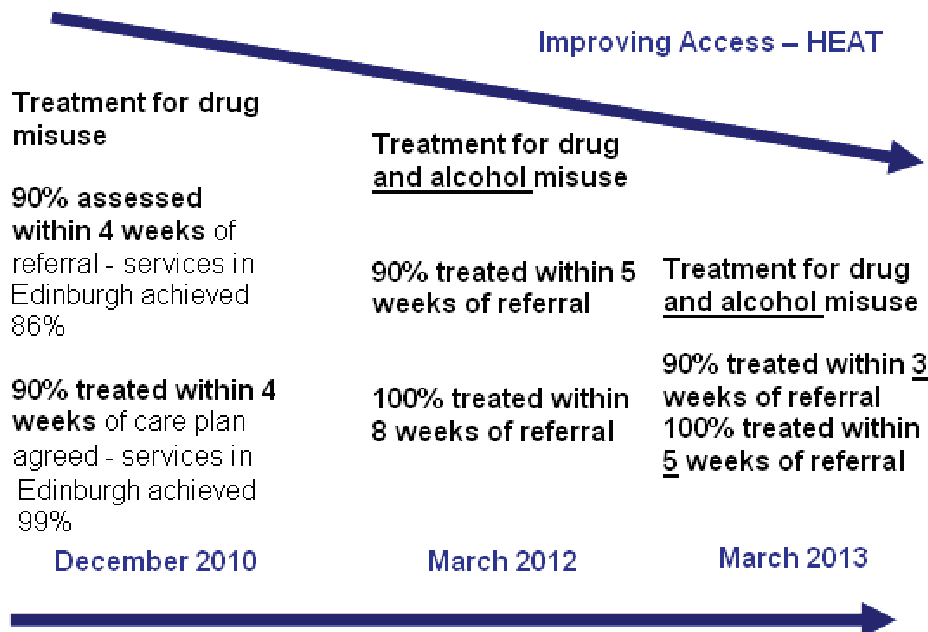
3.3 *Road to Recovery* sets out a shift in treatment policy, making recovery the central part of all aspects of treatment and support for those with drug problems. This includes affecting cultural change within treatment and other services used by those with alcohol/drug problems, to raise the aspirations of service users to move towards a more stable lifestyle as a contributing member of society.

3.4 The strategy also places significant emphasis on reducing the impact that parental drug and alcohol use has on children. It prioritises intervening as early as possible to prevent harm and identifying and responding more fully to the needs of children.

[1] Scottish Government (2008) Road to Recovery: A New Approach to Tackling Scotland's Drug Problem http://www.scotland.gov.uk/Publications/2008/05/22161610/0
[2] Scottish Government (2009) Changing Scotland's Relationship with Alcohol: A Framework for Action available at http://www.scotland.gov.uk/Publications/2009/03/04144703/0

3.5 *Changing Scotland's Relationship with Alcohol* sets out a whole population approach to reducing alcohol related problems. The main objective of the strategy is to reduce alcohol consumption across the population; this will in turn reduce the number of alcohol related problems. The strategy sets out a focus on prevention as well as recovery. Evidence suggests that the most effective alcohol policies to reduce consumption are controls on price and availability, drink driving laws and brief interventions (World Health Organisation 2005).

3.6 **Improving access to alcohol/drug treatment and support** is a priority for Scottish Government and there is a challenging target which all services need to achieve over a three year period set out below.



3.7 The EADP commissioning plan shares the following principles with the City of Edinburgh Council's draft Commissioning Strategy for Care and Support 2011-2016.

- services to be outcomes focussed, personalised and offer choice
- self-management and the promotion of well-being, independence, recovery and living and dying well
- carers will be supported as equal partners in the provision of care
- **consultation and engagement**
- equality and equity of access
- best value framework for all services, which ensures value for money and quality services for service users

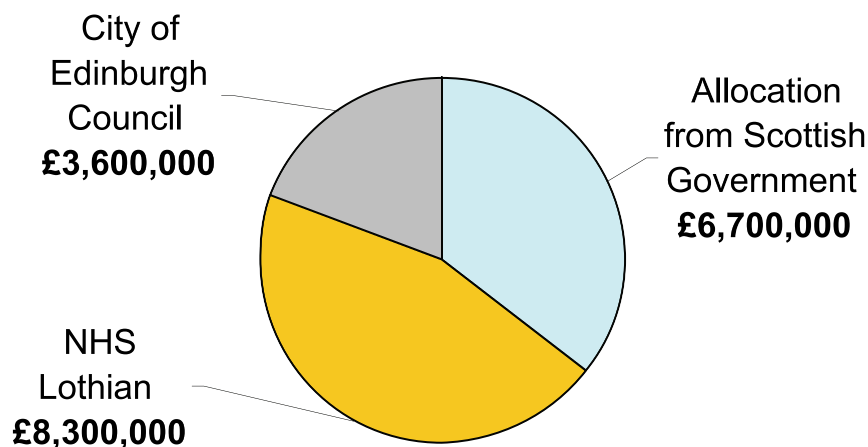
- supporting and engaging providers/market stimulation
- assessment of benefit and risk in service redesign
- promoting community benefit and sustainability.

EADP intends to place a particular focus on **consultation and engagement** with service users and their carers in the design and development of services.

4. Resources

4.1 The main funders of alcohol/drug treatment and support services are NHS Lothian and the City of Edinburgh Council (CEC). In addition to this, Scottish Government funding is allocated to Edinburgh to be spent in partnership through EADP. Decisions over investments are made in partnership through the EADP Joint Commissioning Group.

4.2 Over £18 million was spent in Edinburgh in 2010/11 on treating and supporting people with problem alcohol/drug use. The following pie chart summarises the allocation from the main sources:



4.3 This can be broken down to demonstrate how the funding is used.

- About **£4 million** is spent on services provided by 3rd sector organisations like ELCA (Edinburgh & Lothian Council on Alcohol), NEDAC (North Edinburgh Drug Advice Centre), Simpson House and Circle Harbour.
- Almost **£6 million** is spent on NHS alcohol/drug services including the Ritson Clinic, Locality Clinics, the Community Drug Problem Service (CDPS) and the Alcohol Problem Service (APS), LEAP (Lothians & Edinburgh Abstinence Programme), and the Harm Reduction team.
  (The Ritson Clinic, LEAP and the Harm Reduction Team are Lothian-wide services.)
- About **£2.4 million** is spent every year on substitute prescribing. This includes the cost of the drugs and payments to pharmacies for supervision.
- About **£840,000** is paid to GPs to provide an enhanced service for people with drug misuse.
- **£4.5 million** is spent on services provided by the City of Edinburgh Council. This includes the Drug Testing and Treatment Order (DTTO) Team and the Drug and Alcohol Referral Teams.

5. Challenges and Outcomes

5.1 The main challenge within this commissioning plan is to meet the demand for services within the future resources that are available. Addressing alcohol and drug use remains a national priority and this has been reflected in unprecedented levels of investment over the previous five years. However it is accepted that all public sector organisations will continue to be under severe budget pressures over the coming five years and this will impact on services for people moving into recovery. Existing services will need to become more efficient and more effective in helping people.

5.2 Fewer jobs and lower incomes, welfare reform to the benefits system and a shortage of affordable housing choices in the city will present a clear challenge to support people move into sustained recovery. Innovative and new approaches will need to be developed as will closer and more integrated arrangements for the commissioning and delivery of services.

5.3 Within this context the local and national policy sets out a shift from an approach built solely on the principles of harm reduction, to one which must also encompass principles of recovery. This will require a shift in ways of working, levels of service provision, the relationship between service providers and planners, and service users.

5.4 The supporting outcomes of the EADP commissioning plan are:

- More people will access treatment services so that 50% of people with drug problems and 20% of people with alcohol problems who need treatment recieve it. This is in line with recognised good practice. Not everyone with problem alcohol/drug use will need to access treatment as some will not be in a situation where treatment will be of benefit and others will not require the support of treatment to move into recovery.

- More people complete treatment and support programmes.

- More people move into recovery.

Question 2

Do you agree with the supporting outcomes proposed for the Commissioning Plan?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1 - Strongly disagree

Do you have any comments?

5.5 In the past success measures for alcohol and drug treatment services have tended to focus largely on outputs, such as waiting times, or numbers in treatment. To reflect changes in other areas of care EADP intends to commission services on an outcome based approach. This means that services will be measured against the outcomes that they achieve with service users (their effectiveness) as opposed to outputs (their productivity)

5.6 Commissioning services on an outcome basis will mean that there will be less emphasis on prescriptive service standards in commissioning and more focus on measuring the effectiveness of positive changes in people's lives. Effectively this means that the responsibility for managing and designing services within a regulated environment sits with service providers within the voluntary, public and where appropriate private sectors, as opposed to commissioners. (It will be the responsibility of service providers to engage service users and their families in this process.) In this context the role of the commissioner is to facilitate and support the management and design process.

Question 3

Do you agree that there should be a stronger emphasis on outcomes and the responsibility for service design should sit with service providers rather than commissioners?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1 - Strongly disagree

Do you have any comments?

5.7 Whether or not EADP seeks to move to outcome based commissioning, it is looking to set outcomes for services working with people with problem alcohol/drug use. Outcomes need to reflect the breadth of the definition of recovery and focus on the key changes in behaviour that help people to achieve sustained recovery from problem alcohol and drug use.

5.8 It is proposed that following outcomes will be applied to help measure the positive effect and achievements that services deliver with service users:

- a reduction in risk taking behaviour related to overdose and blood borne viruses
- a reduction in dependence on drugs or alcohol
- the controlled use of drugs or alcohol

- a reduction in criminal activity including re-offending
- sustained employment
- ability to access and sustain appropriate settled accommodation
- improved mental and physical health, and wellbeing
- improved relationships with family members, partners and friends
- the capacity to be a caring and effective parent
- ability to maintain a broader social network with those in recovery.

Question 4

Do you agree that these are the right outcomes to measure sustained recovery from problem alcohol/drug use?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1 - Strongly disagree

Do you have any comments?

6. Understanding of Local Need

6.1 Predicting future need is a less exact science than commissioners and service providers would wish. It typically uses a combination of population projections and local information on presenting need to create a profile. This section sets out a summary of the alcohol/drug related need within Edinburgh as identified by needs assessment reports. Much of the findings are from the EADP Needs Assessment 2010 (available at www.edinburghadp.org.uk).

6.2 **Prevalence** - It is estimated that there are 22,800 people in Edinburgh with dependent drinking. Alongside this there are 5,202 people with problem drug use (using heroin and / or benzodiazepines only).

6.3 Of those who reported heroin use in Scotland for 2008/09, 52% reported using through injecting while Edinburgh had a 45% injecting rate. 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%.

6.4 64% of individuals reporting heroin use in Edinburgh were under the age of 25. This is higher than the Scottish average of 51%. The male to female gender ratio in Edinburgh is 60:40 across all services. This is similar to national norms (67:33 alcohol and 70:30 drugs).

6.5 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 an alcohol-related diagnosis reduced by 32% between 2004 and 2007.

6.6 **Children Affected by Parental Substance Use** - The rate of drug related maternities in Edinburgh is reported as almost twice the national average. This is issue of concern and EADP commissions a specialist service that brings together maternity services, health visiting and alcohol and drug treatment. This issue remains a significant problem, however there is consensus amongst professionals that Edinburgh has a longer history of reporting these maternities that comparative areas. Around a third of drug and alcohol users in contact with services in Edinburgh have at least one dependent child.

6.7 **Other Related Issues -**

- About half of service users are thought to have mental health problems of varying degrees of severity.
- About 15% of service users are employed, in contrast to 77% employment in Edinburgh generally.

7. Summary of Existing Service Provision

7.1 Services for people with alcohol and drug problems are currently commissioned against the Four Tiers Model as identified in the National Treatment Agency document Models of Care (2006)[3]. This model outlines the interventions that it is best practice to commission and provide in each local area, the range of settings in which these are normally provided and the competence or level of treatment skills and training which is normally required. It does this against a tiered model of delivery outlined below.

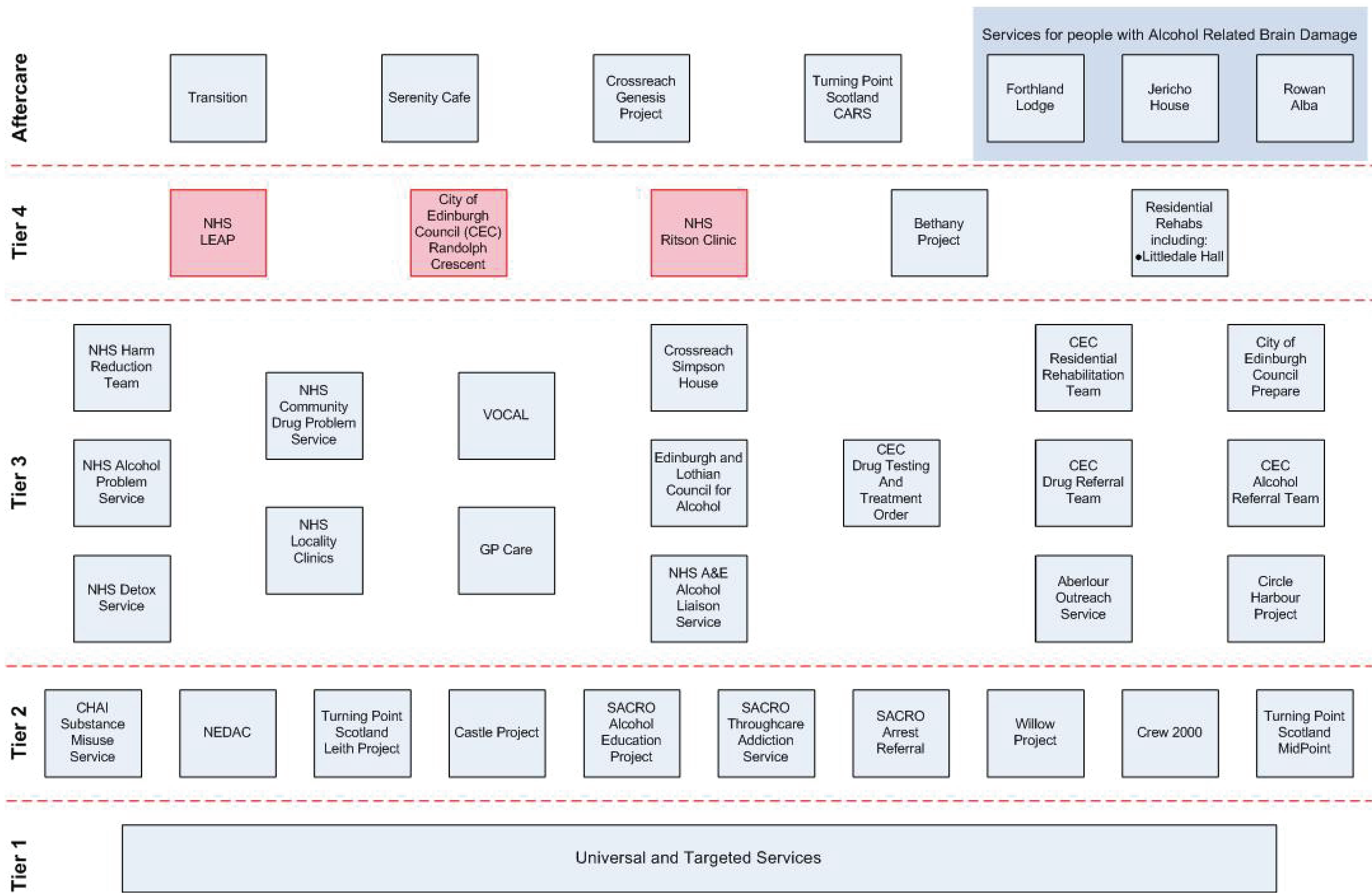
Tier 4 – Residential treatment and support services
Interventions include provision of residential specialised drug treatment, which is care planned and care coordinated Settings include dedicated inpatient or residential alcohol/drug units or wards and residential rehabilitation units.
Tier 3 – Community based care planned treatment and support services
Interventions include provision of community-based specialised alcohol/drug assessment and coordinated care planned treatment, specialist liaison and pharmacological interventions. Settings include specialist drug services including outreach services. Tier 3 interventions may be delivered alongside Tier 2 interventions. This work may be based in primary care settings (shared care schemes and GP-led prescribing services).
Tier 2 – Low threshold access services
Interventions include provision of drug-related information and advice, triage assessment, referral to structured alcohol/drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare. Settings include specialist alcohol/drug services including outreach services. Tier 2 services do not need to be provided separately from tier 3 services.
Tier 1 – Universal services
Interventions include provision of alcohol/drug-related information and advice, screening and referral to specialised drug treatment. Settings would include general healthcare settings (e.g. liver units, antenatal wards, Accident & Emergency and pharmacies), or social care, education or criminal justice settings (probation, courts, prison reception) where the main focus is not alcohol/drug treatment.

7.2 Provision in Edinburgh is summarised in Figure 2. There are currently 16 separate commissioned organisations involved in the delivery of treatment and support to people with problem alcohol and drug use in Edinburgh[4].

[3] NTA (2006) Models of care for treatment of adult drug misusers: Update 2006 http://www.nta.nhs.uk/publications.aspx

[4] This figure does not include privately funded organisations or self help groups such as AA, NA or Smart Recovery as these are not commissioned by EADP.

Figure 2: Current Specialist Alcohol and Drug Services commissioned by the EADP



7.3 It is important to note that the services currently offered in Edinburgh have well-established systems of care linked to the evidence based good practice. Edinburgh is recognised as having developed a comprehensive range of services for people with alcohol/drug problems. As a whole the system offers a broad range of services including:

- needle exchange
- a range of psychosocial interventions in line with the evidence base including brief interventions, cognitive behavioural therapy, case management, person centred counselling
- day care programmes
- assessment and referral to residential rehabilitation
- substitute medication assisted treatment (methadone/buprenorphine prescribing) including community detox
- residential detoxification
- specialist employability services
- specialist housing services
- specialist family services
- support services for carers
- specialist services for people with alcohol-related brain damage.

EADP does not intend to reduce the level of access or current range of services available in Edinburgh.

Further information on services in Edinburgh is available at *www.edinburghadp.org.uk*

7.4 Alongside this the EADP Needs Assessment 2010 identified that generally service users felt positively about the services which they were accessing. Service users felt safe and comfortable when they attended services, and that services were responsive to their changing needs. The great majority of service users said that services had helped them to improve their situation.

7.5 However within this context the system of care was developed to meet the needs of a population of injecting drug users at a time of an HIV epidemic within this population. Over time services developed to meet need as it arose and there are many examples of where Edinburgh has developed rapid and effective responses to severe and complex alcohol and drug related problems.

7.6 While developments have generally been positive Figure 2 demonstrates that there are 32 services providing structured alcohol/drug treatment and support to people moving from problematic alcohol/drug use into recovery. This equates to 30 separate ways of accessing the treatment and recovery system. This has led some providers and commissioners to question whether people receive the right services at the right time.

7.7 Through a staff consultation in the EADP Needs Assessment 2010, it was noted that Edinburgh has a reasonable range of services at its

disposal. Concerns were raised as to whether these services 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. It is in this context that the Commissioning Plan is looking to develop an effective recovery oriented system of care.

7.8 **Primary Care** - There are 87 practices in Lothian (70% of all practices) involved in the management of treatment and care for people with alcohol and drug problems through an enhanced service agreement with NHS Lothian. In September 2010 there were over 4,000 people across Lothian receiving enhanced support from their GP for their drug misuse. This represents a significant proportion of the people in treatment in Edinburgh.

7.9 **Workforce** - The EADP Needs Assessment 2010 identified that nurses make up the largest professional group (57.45) 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 working time equivalent) and managers (16.2). The needs assessment did not evaluate the skills and knowledge base of the workforce.

[5] Numbers of staff are written in whole time equivalents

8. Gap Analysis

9.1 This section identifies the gaps in the current system of care when matched to the identified need, evidence base and policy drivers for supporting people to achieve sustained recovery from problem alcohol/drug use. In summary the gaps are as follows:

- Existing capacity does not meet the demand on treatment and recovery services.
- People receive different types and levels of service provision depending on where or how they access the system of care, despite similar levels of need.
- Linkages between treatment and support services and other services that enhance recovery are not always strong and in places capacity within some “specialist services” is low.
- There is not equity of access to psychosocial interventions that support people to detox, change behaviours and move on from problem alcohol and drug use.
- There does not appear to be a common understanding of and approach to recovery across professionals working with people with problem alcohol and drug use.
- Service users are not consistently involved in the design, development and delivery of services.

9.2 The evidence of the gaps in service provision are summarised below Question 5.

Question 5

Do you think that these are the most significant gaps within current service provision?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1 - Strongly disagree

Do you have any comments?

Gap 1:
Existing capacity does not meet the demand on treatment and recovery services.

Evidence:

- It is estimated that there here are 22,800 people in Edinburgh with dependent drinking; 6.2% are currently in treatment. There is a significant gap in levels of provision and need as good practice suggests that this should be a rate of 20%.
- Alongside this there are 5,202 people with problem drug use (using heroin and/or benzodiazepines only); 34.4% are currently in treatment. Good practice suggests that this should be a rate of 50%.

Gap 2:
People receive different types and levels of support depending on the where or how they access services. This does not appear to be wholly dependent on the needs of the person presenting.

Evidence:

- There are 30 means of accessing treatment and support
- The EADP Needs Assessment 2010 identified that the range and quality of psychosocial services are not consistent across the city.
- Professionals report different ways or levels of integrated/joint working around locality clinics. These do not appear to be based on locally identified need.
- 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. (Recommendation from EADP Needs Assessment 2010)
- Access to residential rehabilitation and detox services is perceived to be low and clarity is required on access to these services.

Gap 3:
Linkages between treatment services and other services, including mutual aid, that support recovery are not always strong.

Evidence:

- There appears to be a gap in the links between drug/alcohol treatment and recovery services and those supporting people to access employment. (EADP Needs Assessment 2010)
- The majority of respondents to staff surveys felt that joint working and information sharing could be improved between alcohol/drug services and homelessness services. (EADP Homeless Needs Assessment 2010)
- Edinburgh has not yet completed implementing the recommendations from the commitment 13 report on improving responses to dual diagnosis (mental health and alcohol/drug use problems)
- The capacity of specialist family services is low. Alongside this the delivery of interventions to improve parenting by specialist alcohol and drug services is inconsistent across the city (EADP Needs Assessment 2010).

- Few people accessing treatment reported accessing Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) to help support their recovery.
- (EADP Needs Assessment 2010)

Gap 4:
There is not equity of access to psychosocial interventions that support people to detox, change behaviours and move on from problem alcohol and drug use.

Evidence:

There is a need to ensure that a full range of evidence based interventions are 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.
(EADP Needs Assessment 2010)

Gap 5:
There does not appear to be a common understanding of recovery across professionals working within and outside of alcohol and drug services in Edinburgh.

Evidence:

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.
(EADP Needs Assessment 2010)

Gap 6:
Service users are not consistently involved in the design, development and delivery of services.

Evidence:

The following has been taken from the EADP Needs Assessment 2010 which included a consultation with 249 service users.

- Service users did not feel strongly that they were involved in how services were run. Furthermore, service users did not feel that their family, partner or carer was involved in planning their care
- 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.

9. Service Provision – Improvements

10.1 Existing services have worked well to achieve important outcomes for people with alcohol and drug problems. This includes significantly reducing the number of people at risk of contracting blood-borne viruses such as HIV/Hepatitis C, reductions in drug/alcohol related crime, improvements in health and wellbeing and quality of life. However challenges still remain. The national and local policy direction to focus on recovery requires change in the way that services are delivered.

10.2 This section of the Commissioning Plan identifies areas where we can build on successes by improving service delivery.

Ensuring people receive the right services at the right time

10.3 As has been noted EADP is working with services to reduce waiting times for treatment and support services, so that by 1st April 2013 no one will wait longer than 3 weeks between referral and treatment start. This presents a significant challenge within the current system of care as services maintain their own waiting lists and peaks in demand for particular organisations can have significant impact on when people can access services.

10.4 Consequently EADP is proposing that a single means of accessing treatment and support is developed across all alcohol and drug services. It is envisaged that this approach will involve:

- A single referral form / set of information required at referral.
- A single shared assessment that can be completed by any competent worker within the service system and lead to the service user starting treatment in the right service.
- A single case allocation process. This means that the assessment and case allocation process is likely to require a case allocation meeting with attendance from medical, social work and voluntary sector staff before the right service can be identified for the service user.

10.5 The single means of access will not necessarily look to reduce the number of referral points into the system of care. Organisations would continue to be able to accept referrals from a range of sources, however a consistent and joined up approach will ensure that people receive the right service at the right time no matter where they access the system.

10.6 This approach will be supported by the development of clear and well advertised access criteria for all services across the system.

10.7 Where possible EADP intends to reduce the administration required to support the referral process. Consequently it is looking to roll out the drop-in clinic model of access that already exists in North East

Edinburgh, in the place of an appointment based system. This means that clients can drop-in to services to receive an assessment and access treatment as opposed to attending at a specific time.

10.8 It is anticipated that in the majority of cases this will improve access and reduce waiting times for treatment and support services. However it is recognised that certain groups of people will not be able to access a drop-in due to child care, chaotic lifestyle and other personal issues, consequently alternative arrangements will be needed for certain groups. This will include appointment based home visits and joint assessments where they are deemed appropriate.

Question 6
Do you think that a single means of access would ensure people receive the right services at the right time within the required timeframes?
5 - Strongly agree 4 - Agree 3 - Neither agree or disagree 2 - Disagree 1- Strongly disagree
Do you have any comments?

Providing Coordinated Care

10.9 People with alcohol and drug problems are likely to have other significant problems to address in their lives. This might include difficulties with relationships, housing problems, mental health issues and lack of opportunity within the employment market. People are likely to prioritise addressing these problems at different stages in their recovery journey at a time and a level which suits their capacity to recover. Consequently coordinated care is a central part of a recovery oriented system as it supports individuals to access the services they need across the spectrum of support services to move on and into sustained recovery.

10.10 It is recognised that recovery should be self directing and empowering and where possible service users should be supported to coordinate their own care. EADP is proposing the following principles for all services to ensure that care is coordinated:

10.11 **A clear structure to the service system** – There needs to be an appropriate number of organisations involved in the delivery of alcohol and drug treatment and support services, if care is to be coordinated. There are currently 32 different services, managed by 16 organisations delivering treatment and support services in Edinburgh. Unnecessary

barriers for service users can be created when there are too many service providers with separate contracting/service requirements working to deliver care.

10.12 The system of care will need an appropriate number of providers accountable to EADP, based on the range of services offered. Alongside this there will need to be multi-agency approaches to service delivery, including co-location of services and joined up approaches to deliver outcomes. EADP is proposing that a reduction in the number of services accountable to the partnership will improve care coordination.

Question 7

Do you think that a reduction in the number of organisations accountable to EADP to provide services will improve care coordination?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1- Strongly disagree

Do you have any comments?

10.13 **Outcome driven services** – This requires services to be focussed on achieving a set of outcomes with service users. Once service users have achieved these outcomes they will need to be supported to move into other programmes or services that can help them to address the other issues in their lives. Services or programmes will need clear access and exit criteria which are well advertised to service users and other service providers.

10.14 It is accepted that access and completion of a programme will not always be a linear process. Some people will need to access services more than once and others may need to access more than one service at one time to get the support they need to move into sustained recovery.

10.15 The outcomes selected and services provided will need to reflect the broad range of need, levels of motivation and capacity to move into sustained recovery amongst people with alcohol and drug problems. Consequently the range of services offered will reflect the outcomes that service users are looking to achieve.

Question 8

Do you agree that outcome driven services will improve care coordination?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1- Strongly disagree

Do you have any comments?

10.16 **Appropriate multi-agency arrangements** – Arrangements will need to be developed between services to coordinate people's care where the timing of the delivery of particular services is deemed crucial to achieving identified outcomes. In many instances this can be coordinated through written protocols and agreements.

10.17 However there will be instances where multi-agency panels will need to be set up. Panels will need to be set up to manage the following:
- community detox for complex clients
- residential detox
- residential rehabilitation.

Question 9

Do you agree that we need multi-agency panels in these instances?
5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1- Strongly disagree

Do you have any comments?

10.18 **Care Coordinator** - Some service users will require a care coordinator to support them to access the range of services that they need to address problem alcohol/drug use. This will be due to the level of complexity of the response that is required from services to meet their immediate needs.

10.19 Vanderplasschen (2009) suggests that the model selection for care coordinators should be determined by the range of community based services that are already available, the objectives of the system of care, the target population and any available empirical evidence.

10.20 In the Edinburgh context care coordinators are seen as providing a combination of the **Generalist Model and the Assertive Community Treatment Model**[6] dependent on the level of need of the individual. The role of the care coordinator will be to provide an ongoing assessment of need, referral and support to access appropriate services. It is not anticipated that care coordination will last from the start of treatment to maintenance of sustained recovery. Where possible care coordination should be time-limited.

10.21 The inclusion and exclusion criteria for accessing a care coordinator has yet to be agreed and needs to be developed by commissioners, service providers and service users.

Question 10

Do you agree with the model of care coordination being proposed?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1- Strongly disagree

Do you have any comments?

10.22 **The role of alcohol and drug services** - Sustained recovery is dependent on people making changes in their lifestyle and social functioning as well as changes to their social identity. Alcohol and drug treatment and support services have a clear role to play in supporting people to stabilise their housing situation, improve their employment prospects and broaden their social networks where this is needed to support recovery.

10.23 Best (2010) notes that recovery relies on timely access to recovery-compatible housing, training, education and employment support and peer based recovery systems.

10.24 Consequently we will commission services that look to do the following:

- Stabilise people's housing situation and refer on to appropriate housing services.

[6] **Generalist** – characterised by close involvement / interaction between the care coordinator and individual resulting in assessment and other characteristics of care coordination happening over a period of time.
Assertive Community Treatment – consists of a "wrap around set of services" provided by the case coordinator which might include crisis intervention, skills building, counselling, family consultations and crisis intervention as well as care coordination.

- Encourage employability from day one, believing that having a job is beyond no-one. Commissioned services will work closely with the new neighbourhood hubs to be created by the Edinburgh Strategic Skills Pipeline Project.
- Support individuals as members of a family. This includes involving carers and other family members appropriately in the development of care plans and signpost to specialist support as required. Particular attention needs to be paid to the needs of children; services will work within *Getting it right for every* child to ensure that children whose parents have alcohol and drug problems have their needs met.

10.25 EADP will continue to invest in services for carers of problem alcohol and drug users. It will need to explore a number of approaches to increasing the capacity to respond to these needs by developing peer support and other volunteer based approaches.

10.26 **Strong recovery communities** - Evidence suggests that currently 58% of people with lifetime dependence will achieve lifetime recovery[7]. It is estimated that being in recovery remains a constant challenge for most people for 5-7 years. After this time people in recovery report the phenomenon of feeling “better than well”.

10.27 It is often said that both professionals and service users do not see or meet people who have moved into sustained recovery. This is partly due the distance that people in sustained recovery choose to put between themselves and their old identity as a problem alcohol/drug user. It is also due to the unintentional distance that currently exists between some treatment and support services and the recovery community (peer support or mutual aid). This is a national issue, however Edinburgh has some examples of good practice bring these areas of delivery together.

10.28 **Peer Support** - The development of peer support within treatment and support services has already started in Edinburgh. This needs to be developed to encompass all areas of delivery. The model will vary across services depending on the services provided and means of delivery. However peer supporters need to be well trained and require close supervision to ensure they keep well and maintain their own recovery as well as support others in their recovery. Research also suggests that peers should not be managed by treatment and support services, especially treatment facilities which they attended as service users, as this can cause difficulties over the role and expectations of these volunteers.

10.29 There are already good examples of how peer supporters are involved in service delivery. EADP is keen to develop this approach so those involved in peer support receive an agreed level of training an agreed

[7] Best (2010) Digesting the evidence.

supervision. There also needs to be clear roles for peer supporters within individual services.

10.30 **Mutual Aid** - There is strong evidence for the efficacy of Alcoholics Anonymous (AA), and smaller evidence for Narcotics Anonymous (NA) and Smart Recovery. Mutual aid needs be seen as a key part of the system of care for people with alcohol and drug problems and recognised as an option for some at the point of assessment. There are already a significant number of AA and NA meetings in Edinburgh; further work is needed to support the development of Smart Recovery.

10.31 Best (2010) notes that the addition of one abstinent person to a social network increases the probability of abstinence by 27%[8]. EADP will continue to support the development of an abstinence based recovery community. It will also look to facilitate the development of a methadone assisted recovery community linked to treatment and recovery services.

Question 11
Do you agree that the approach outlined will lead to strong recovery communities?

5 - Strongly agree
4 - Agree
3 - Neither agree or disagree
2 - Disagree
1- Strongly disagree

Do you have any comments?

[8] Best (2010) Digesting the evidence

10. Strategic Commissioning Intentions

10.1 This section summarises the main intentions of EADP to improve outcomes for people with alcohol and drug problems. These intentions are based on the key actions identified in the previous sections of this Commissioning Plan.

Strategic intention 1: Ensure people receive the right services at the right time by developing a single means of accessing treatment.

Strategic intention 2: Ensure that tasks and roles are matched to appropriately qualified practitioners and volunteers, leading to higher quality services and more equitable provision.

Strategic intention 3: Invest in an appropriate number of services to deliver a coordinated system of care. EADP intends to carry out a Procurement Risk Assessment on all commissioned services. This will determine the best procurement route to take in line with the City of Edinburgh's Commissioning Strategy.

Strategic intention 4: Co-locate/integrate services that will lead to people with a range of substantial needs receiving support they need to move into recovery.

Strategic intention 5: Improve access to psychosocial services which supports people to move into recovery.

Strategic intention 6: Develop a workforce that has a clear understanding of recovery and how to support people to achieve this.

Strategic Intention 7: Improve access to the range of services that support parents and their children.

Strategic Intention 8: Increase the number of people living in appropriate settled accommodation.

Strategic intention 9: Commission services that support people to engage in voluntary work or meaningful employment.

Strategic intention 10: Support the development of recovery communities which are well connected with treatment and support services.

Strategic intention 11:
Improve access to support for carers and family members to ensure their needs are met and they are better equipped to support people in their recovery.

Strategic intention 12:
Develop effective arrangements for the involvement of service users and their carers in the planning, development and delivery of services to ensure that service user's needs and aspirations are placed at the centre of their care.

Strategic intention 13:
Move to commission outcomes as opposed to services.

Appendix 1

EADP Commissioning Plan Consultation Questionnaire

The Way Forward for Drug and Alcohol Recovery

Views are being sought on how services for people with alcohol and drug problems in the capital are commissioned. The aim is to see more people benefit and achieve a sustainable recovery through, for example, a single access to treatment and support. It reflects the national strategies on alcohol and drugs.

Edinburgh Alcohol and Drug Partnership, known as EADP is consulting on their Commissioning Plan with the aim of gathering views from those who provide support and treatment, and service users.

Please read the Draft Commissioning Plan ***www.edinburgh.gov.uk/eadpconsultation*** before you respond.

Please complete the survey below and send it to:

Freepost RSSG-UUEB-SEJZ
EADP
Level 1/7
Waverley Court
4 East Market Street
EDINBURGH
EH8 8BG

For more information:

Email: hsc.eadp@edinburgh.gov.uk

Tel: 0131 529 2118

Question 1 - Vision and outcomes of the plan

Our vision is that **more people achieve sustained recovery from problem alcohol and drug use.**

Recovery is defined as: "a process through which an individual is enabled to move on from their problem alcohol/drug use, towards an alcohol/drug-free life as an active and contributing member of society."

The following principles reflect the broad understanding of recovery that is being proposed:

- there are many pathways to recovery
- recovery is self-directing and empowering
- recovery involves a personal recognition of the need for change and transformation
- recovery is holistic
- recovery has cultural dimensions
- recovery exists on continuum of improved health and wellbeing
- recovery emerges from a process of healing and self-redefinition
- recovery involves addressing discrimination and transcending shame and stigma
- recovery is supported by peers and allies
- recovery involves rejoining and rebuilding a life in the community
- recovery is a reality.

Recovery is defined in the context of people's lives and therefore applies to individuals, their families and communities.

Do you agree with this definition of recovery?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

June 2011

Question 2 - Challenges and Outcomes

The overall outcome of the EADP commissioning plan is for **more people to achieve a sustained recovery from problem alcohol and drug use.**

This is complemented by three supporting outcomes:

1. More people will access treatment services so that 50 per cent of people with drug problems and 20 per cent of people with alcohol problems who need treatment receive it. This is in line with recognised good practice.
2. More people complete treatment programmes.
3. More people move into recovery.

Do you agree with the supporting outcomes proposed for the Commissioning Plan?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

Question 3 - Outcome Based Approach

EADP intends to commission services on an outcome based approach. This means that services will be measured against the outcomes that they achieve with service users (their effectiveness) as opposed to outputs (their productivity).

Do you agree that there should be a stronger emphasis on outcomes and the responsibility for service design should sit with service providers rather than commissioners?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

June 2011

Question 4 - Measuring Effects and Achievements

It is proposed that following outcomes will be applied to help measure the positive effect and achievements that services deliver with service users:

- a reduction in risk taking behaviour related to overdose and blood borne viruses
- a reduction in dependence on drugs or alcohol
- the controlled use of drugs or alcohol
- a reduction in criminal activity including re-offending
- sustained employment
- ability to access and sustain appropriate settled accommodation
- improved mental and physical health, and wellbeing
- improved relationships with family members, partners and friends
- the capacity to be a caring and effective parent
- ability to maintain a broader social network with those in recovery.

Do you agree that these are the right outcomes to measure sustained recovery from problem alcohol / drug use?

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree or disagree
- [ ] Disagree
- [ ] Text

Do you have any comments?

June 2011

Question 5 - Gaps in Provision

Using the EADP Needs Assessment 2010, EADP proposes that the following are the key gaps in treatment and support services:

- Existing capacity does not meet the demand on treatment and recovery services.
- People receive different types and levels of service provision depending on where or how they access the system of care, despite similar levels of need.
- Linkages between treatment and support services and other services that enhance recovery are not always strong and in places capacity within some "specialist services" is low.
- There is not equity of access to psychosocial interventions that support people to detox, change behaviours and move on from problem alcohol and drug use.
- There does not appear to be a common understanding of and approach to recovery across professionals working with people with problem alcohol and drug use.
- Service users are not consistently involved in the design, development and delivery of services.

Do you think that these are the most significant gaps within current service provision?

☐ Strongly agree
☐ Agree
☐ Neither agree or disagree
☐ Disagree
☐ Text

Do you have any comments?

June 2011

Question 6 - Service Delivery - Improvements

Ensuring people receive the right services at the right time

EADP is proposing that a single means of accessing treatment and support is developed across all alcohol and drug services. It is envisaged that this approach will involve:

- A single referral form / set of information required at referral.
- A single shared assessment that can be completed by any competent worker within the service system and lead to the service user starting treatment in the right service.
- A single case allocation process. This means that the assessment and case allocation process is likely to require a case allocation meeting with attendance from medical, social work and voluntary sector staff before the right service can be identified for the service user.

Do you think that a Single Means of Access would ensure people receive the right services at the right time within the required timeframes?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

June 2011

Question 7 - Coordinated Care

There are currently 32 different services, managed by 16 organisations delivering treatment and support services to service users in Edinburgh. EADP is proposing that a reduction in the number of services accountable to the partnership will improve care coordination.

Do you think that a reduction in the number of organisations accountable to EADP to provide services will improve care coordination?

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree or disagree
- [ ] Disagree
- [ ] Text

Do you have any comments?

June 2011

Question 8 - Outcomes to measure recovery

Services need to be focused on achieving a set of outcomes with service users. Once service users have achieved these outcomes they will need to be supported to move on into other programmes or services that can help them to address the other issues in their lives. Services or programmes will need clear access and exit criteria which are well advertised to service users and other service providers.

Do you agree that outcome driven services will improve care coordination?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

Question 9 - Multi-Agency Panels

There will be instances where multi-agency panels will need to be set up. Panels will need to be set up to manage the following:

- community detox for complex clients
- residential detox
- residential rehabilitation

Do you agree that we need multi-agency panels in these instances?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

June 2011

Question 10 - Care Coordinator

Some service users will require a care coordinator to support them to access the range of services that they need to address problem alcohol / drug use. This will be due to the level of complexity of the response that is required from services to meet their immediate needs.

Do you agree with the model of care coordination being proposed?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

June 2011

Question 11 - Recovery Communities

EADP will continue to support the development of an abstinence based recovery community. It will also look to facilitate the development of a methadone assisted recovery community linked to treatment and recovery services.

Do you agree that the approach outlined will lead to strong recovery communities?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Text

Do you have any comments?

June 2011

About You

Are you answering this survey as an individual or on behalf of an organisation?

- ☐ On behalf of an organisation - go to Part 1
- ☐ As an individual - go to Part 2

Part 1 - Your Organisation

Please tell us:

1. Your organisation's name: ______________________________

2. How many people you represent: ______________________________

Part 2 - Personal Information

In order to help us make sure we have a range of responses from different people, we would like to have some information about individuals.

Would you like to provide this information? ☐ Yes ☐ No

Personal Details

Gender: ____________ Age: ______________________

What is your ethnicity? ______________________________

Do you consider yourself to have any of the following conditions which have lasted, or are expected to last, at least twelve months?

- ☐ 1. Deafness or partial hearing loss
- ☐ 2. Blindness or partial sight loss
- ☐ 3. Learning disability (for example, Down's Syndrome)
- ☐ 4.Learning difficulty (for example, dyslexia)
- ☐ 5. Developmental disorder (for example, Autistic Spectrum Disorder or Asperger's Syndrome)
- ☐ 6. Physical disability
- ☐ 7. Mental health condition
- ☐ 8. Long-term illness, disease or condition
- ☐ 9. Other condition, please specify: ______________________
- ☐ 10. Prefer not to answer

What religion, religious denomination or body do you belong to?

Do you consider yourself to be:

- ☐ In recovery and in treatment
- ☐ In recovery and not in treatment
- ☐ A relative / carer of someone in recovery
- ☐ Professional in the treatment / recovery field
- ☐ Other

June 2011