

Multi-agency inspection

Substance Misuse Services in Grampian 2007

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Acknowledgement

We wish to thank everyone who assisted us during this multi-agency pilot inspection. We received a warm welcome from everyone we met and we are grateful to them for the time and effort they took to assist us. We particularly appreciate the way the local co-ordinators provided us with support and information throughout the inspection.

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Social Work Inspection Agency

Evaluations

The multi-agency inspections for community care services have adopted the SWIA six-point scale. In this multi-agency inspection of services for substance misuse, the inspection team has for the three Action team areas provided an evaluation for each of the six areas for evaluation, as set out in Appendix 2: model for the multi-agency inspection in Grampian.

The evaluations apply to collaborative working between health and social work services within the partnerships. For this reason, they may differ from the evaluations in the SWIA performance inspections. There are no evaluations given to a single agency, or in Chapter 7, which considers Grampian-wide issues.

The evaluation scale

| Level | Definition | Description |
|---------|----------------|---|
| Level 6 | Excellent | Excellent or outstanding |
| Level 5 | Very good | Major strengths |
| Level 4 | Good | Important strengths with some areas for improvement |
| Level 3 | Adequate | Strengths just outweigh weaknesses |
| Level 2 | Weak | Important weaknesses |
| Level 1 | Unsatisfactory | Major weaknesses |

The report format

We collected a very large amount of information during the inspection. This report cannot do full justice to all that we learned. Instead it draws out the main themes about collaborative working, backed by selected examples.

Except where the inspection team is expressing an opinion, the report is written in the past tense, as it states the position at the time of the inspection. Where we use quotes from individuals, they represent opinions we heard widely expressed, not just one individual's views.

The report uses the following words to describe numbers and proportions when we quote findings from our surveys or from our file reading exercises:

Almost all = over 90%

Most = 75-90%

Majority = 50-74%

Less than half = 15-49%

Few = up to 15%

The term 'social work services' covers both social work and social care services, either directly provided by the councils or commissioned from the independent sector.

Multi-agency Inspections

In recent years, the NHS in Scotland and local authorities have responded to significant challenges and changes. There have been substantial improvements in health, social work and social care services which have delivered better outcomes for people who misuse substances and their families.

In all public services we are making a shift from top-down, target-driven performance management to more self-improving systems built around the needs of individuals. Increasingly, collaborative working between health, social work, social care agencies and other partners such as the police will make a significant contribution to improved services. The overall aim of collaborative working is to give people the best and safest care possible.

Multi-agency inspections support this improvement in several ways. This first pilot multi-agency inspection of substance misuse services focuses on the way that the agencies in Grampian work together, rather than on specific services. In doing so, it promotes collaborative working by highlighting good practice, and making recommendations where change or improvements are needed. It demonstrates to people who use services that joint working can assist them to improve their lives. It makes sense to service providers who want simpler and less burdensome review, inspection and regulation.

The model and methodology for the multi-agency inspections have been developed by the Social Work Inspection Agency (SWIA), the National Health Service Quality Improvement Scotland (NHS QIS), and the Care Commission. Each has different ways of working but all have an identical focus in assisting agencies to give people the best and safest care possible.

This report gives an overview of collaborative working between health and social work services provided in Grampian.

We fully appreciate the co-operation and assistance of Aberdeen City, Aberdeenshire and Moray councils, NHS Grampian, and Grampian Police which have participated in the first pilot inspection of substance misuse services. In particular we are grateful to people who use services, carers, staff and managers who played an active role in the inspection process.

Alexis Jay
Chief Inspector
SWIA

CHAPTER 1

Introduction

1.1 Aberdeen City

Home to a population of 202,370, Aberdeen City covers 186 square kilometres. The population density is 1,089 people per square kilometre, making the city one of the most densely-populated authorities in Scotland. The population has decreased by 4.2% since 2000, while overall Scotland's population has decreased by 0.4%. The unemployment rate in Aberdeen City is 1.5% – this is lower than Scotland as a whole (3.1%). Eighty two percent of working age people in Aberdeen City are economically active. This is higher than the Scotland average of 79.5%. The employment rate in Aberdeen City is 78%. This is higher than the Scotland average of 75%. Working age people account for 66% of all people in Aberdeen City. This is higher than for Scotland as a whole.

Aberdeen is a thriving, cosmopolitan port in the North-east of Scotland. Built at the mouth of two major Scottish rivers, the Dee and the Don, the Granite City owes its distinctive appearance to the famous, locally quarried and widely exported, building material. Traditional industries such as fishing and farming still flourish in and around the city but Aberdeen's buoyant modern economy is fuelled by the oil industry, earning the city its epithet as 'Oil Capital of Europe'.

1.2 Aberdeenshire

Aberdeenshire has a population of 235,440, and covers an area of 6,313 square kilometres, making it the sixth largest authority in Scotland. The population density is 37 people per square kilometre. The population of Aberdeenshire has increased by 3.6% since 2000, while Scotland's has decreased by 0.4%. The unemployment rate in Aberdeenshire is 1.5 – this is lower than Scotland as a whole (3.1%). Eighty four percent of working age people in Aberdeenshire are economically active. This is higher than the Scotland average of 79.5%. The employment rate in Aberdeenshire is 81%. This is significantly higher than the Scotland average of 75%. Working age people account for 62% of all people in Aberdeenshire. This is lower than for Scotland as a whole.

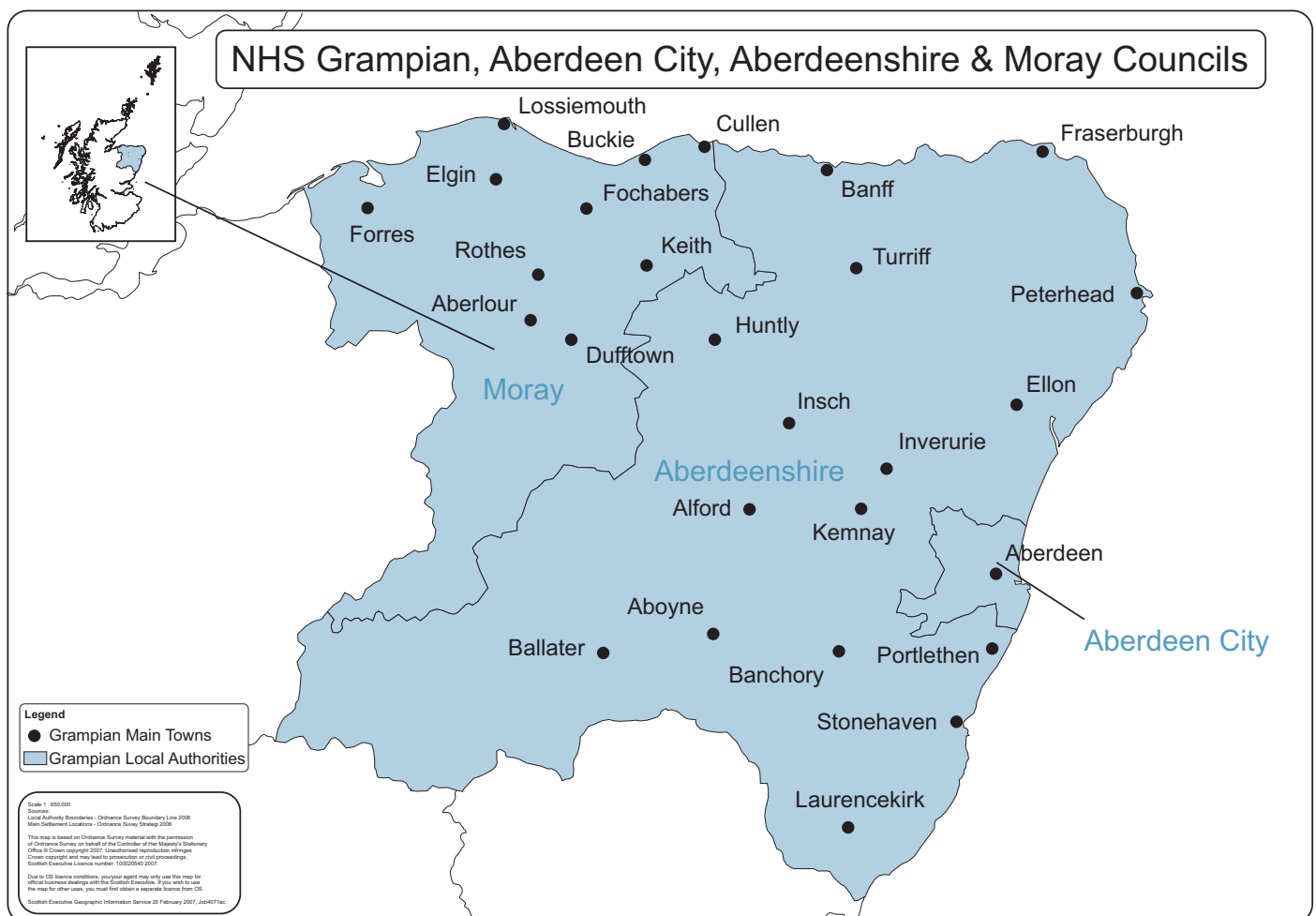
The major towns are Peterhead (17,891), Fraserburgh (12,116), Inverurie (11,060), Stonehaven (10,794), Westhill (10,054) and Ellon (9,465). Aberdeenshire is predominantly a rural area. Traditionally it has been reliant on agriculture, fishing and forestry but in the last 30 years oil and gas industries and the service sector have boomed, contributing to rapid population growth. Population is predicted to increase by 8% by the year 2024, and the proportion of people aged 65+ to rise by 11% over the same period. There has been considerable development (including new housing), two thirds of which has been within a 20-mile radius of Aberdeen City.

1.3 Moray

Moray has a population of 88,120, and covers 2,238 square kilometres. The population density is 39 people per square kilometre. The population has increased by 3.7% since 2000, while overall, Scotland's has decreased by 0.4%. The unemployment rate in Moray is 2.4% – this is lower than

Scotland as a whole (3.1%). Eighty two percent of working age people in Moray are economically active. This is higher than the Scotland average of 79.5%. The employment rate in Moray is 78%. This is higher than the Scotland average of 75%. Working age people account for 61% of all people in Moray. This is lower than for Scotland as a whole.

Most people in Moray (almost 60%) live in the main towns of Elgin, Buckie, Forres, Keith and Lossiemouth. Moray includes the fishing towns in the north such as Buckie and Lossiemouth; the agriculturally-rich Laich of Moray and the main town of Elgin; the Spey Valley, home to world-renowned food processors such as Walkers and Baxters; and the highlands of the south which form part of the Cairngorms mountain range. Moray's natural advantages have seen it develop major revenue earning industries such as whisky distilling, food processing and tourism.



1.4 NHS Grampian

NHS Grampian has three Community Health Partnerships. Each partnership is strategically aligned to the three Grampian councils, Aberdeen City, Aberdeenshire and Moray.

1.5 Drug and Alcohol Action Teams

There are three DAATs in Grampian, one for each of the three local authorities, Aberdeen City, Aberdeenshire and Moray. The structure of each DAAT is in appendices 3, 4 and 5 and the composition of each DAAT is within each of the following chapters.

Drug and Alcohol Action Teams (DAATs) were set up by the Scottish Office in 1995 and are the strategic partnerships responsible for implementing the national drugs and alcohol strategies at a local level. There are 22 in Scotland. They are comprised of key partners who have the capacity to represent or influence the agencies at the forefront of tackling drugs and alcohol misuse. These include health boards, local authority departments (social work, education, housing, etc.), the police, Scottish prison service, the voluntary and private sector, and representatives from the local community and service users and carers. DAATs should link with other strategic partnerships including Community Planning Partnerships, Community Safety Partnerships, Community Health Partnerships and the emerging Community Justice Authorities. The DAATs were the focus of a stocktaking exercise by the Scottish Executive, the report of which was published in the summer of 2007.

Aim, Scope and Nature of Inspection

2 Pilot multi-agency inspection of substance misuse services in Grampian

2.1 Background

The Scottish Executive's Drug Treatment and Rehabilitation Review, published on 27 October 2004, recommended an external audit of drug and alcohol services to provide an independent overview of service quality, service delivery and integration of the range of local providers. In order to fulfil this commitment, the Ministers for Justice and for Health and Community Care asked SWIA, in partnership with others, to develop a multi-agency inspection framework in order to inspect services for people who misuse drugs and people with alcohol problems. This would cover services provided by local authorities, health and the voluntary sector and would be informed by the findings of the Care Commission.

2.2 Working group

In order to progress this inspection, SWIA convened a working group to develop the inspection framework and methodology for a pilot inspection in 2006. In addition to our partner inspectorates and quality assurance bodies, the working group included representation from health, local authorities, Scottish Executive policy interests and voluntary sector organisations representing service users and Drug and Alcohol Action Teams. The involvement of service users was central to this inspection.

2.3 Purpose of inspection

The overall purpose of the inspection was to establish to what extent substance misuse services were helping the people who use them to make positive changes in their lives.

Scope and unit of inspection

SWIA and its partners inspected services for adults with drug or alcohol problems. We addressed harm reduction, abstinence, recovery and routes out. We also looked at the links between these services and the welfare of dependent children, offending behaviour and mental health. The inspection covered a range of services provided by local authorities and health, and services commissioned or purchased from the voluntary sector.

It was agreed that the unit for inspection would be the Action Team area.

2.4 Identification of pilot area

In identifying a pilot area for this inspection, we wanted to achieve an urban/rural mix and significant prevalence. In addition, we tried as far as possible to take account of other inspection activity taking place at the same time. We chose Grampian and approached the Action Teams for their consent. We were delighted that the Grampian Action Teams responded so positively. This was a pilot inspection and we will be actively seeking feedback about the process.

2.5 Inspection partners

SWIA's key partners in this inspection were NHS QIS, the Care Commission and HMle. We made full use of information and intelligence held by our partners, in particular, inspection findings from the HMle inspections of services to protect children and the Care Commission's inspections of relevant care homes and support services.

The inspection team consisted of inspectors from SWIA, the Care Commission, Her Majesty's Inspectorate of Constabulary, inspectors with social work and health backgrounds, including two GPs, one senior nurse, one consultant psychiatrist, one pharmacist, people who used services and a carer.

2.6 Inspection model

The inspection model focused on the outcomes for people who use services and their families and the overall approach was one of continuous improvement. The model is based around six key questions and is similar to the SWIA performance inspection model, but was adapted for multi-agency use and the particular issues relating to substance misuse services. It also takes account of the Scottish Executive's quality standards for substance misuse services. Appendix 2 sets out the model.

2.7 Inspection process and timeline

The inspection process began with formal notification to senior officers. It then fell into three main phases.

Phase One

This phase involved the collection of a large amount of information from a variety of sources including:

- a range of existing information provided by the DAATs about substance misuse services in Grampian (such as strategic and business plans, partnership arrangements, guidance and protocols, range of services, performance information, etc.);
- the Action Teams' own self-evaluation of substance misuse services in Grampian, which was provided through the Self Evaluation Questionnaire;
- peer research into the views of people who use substance misuse services in Grampian;
- questionnaires to staff, carers and stakeholders; and
- analysis of a sample of case files across sectors.

Phase Two

The information collected during phase one was analysed and was used to inform the fieldwork phase of the inspection. The inspection team spent two weeks in Grampian meeting with services users and carers, staff at all levels, elected members and stakeholders as well as visiting services and observing practice.

Phase Three

All of the evidence was collated into a published inspection report. Performance against each of the key questions in the inspection model was graded using a six-point scale.

The inspection of substance misuse services in the Grampian area, given its complexity, posed some problems.

Because the focus for this inspection was Action Team areas, we have evaluated each Action Team area, in Chapters 3, 4 and 5, according to our Performance Improvement Model (PIM). We have placed as much information as possible into each Action Team area to give as full a picture as possible. We have not reported on Grampian-wide issues using this model and have therefore not evaluated Chapter 7.

We were not able to break down the health file reading or health staff survey into Action Team areas. We have therefore reported on them in Chapter 7 in the section on NHS Grampian. The peer survey was conducted as a Grampian-wide survey, and is reported on in the chapter on Grampian-wide issues, but we were able to disaggregate some data into Action Team areas, and these data are reported in section 2 of each of the Action Team chapters.

CHAPTER 3

Aberdeen Joint Alcohol and Drug Action Team Area

Action Team: The Action Team is known as the Joint Alcohol and Drug Action Team or JADAT. The team meets quarterly and the membership of 27 includes health (7), local authority officers (5), elected members (2), prison (1), police (2), voluntary sector (1) Alcohol/Drugs and HIV Forum (2) Procurator Fiscal (1) and JADAT staff (3). At the time of the inspection the team was chaired by the Director of Corporate Planning for NHS Grampian but plans were being progressed to appoint an independent chair to be employed on a part-time basis. There were 4 themed sub-groups, each chaired by a key stakeholder.

The JADAT was supported by a team leader, 3 development officers, a health improvement officer and an information officer.

3.1 Key Outcomes

In Aberdeen we found some evidence of attempts by the JADAT to promote and progress an outcomes-focused approach to the development and delivery of services. However, we considered that these attempts were under-developed against the backdrop of long-standing problems with capacity. Nonetheless, there was sufficient evidence of improvement in positive outcomes to merit an evaluation of ADEQUATE on this measure.

Prevalence profile

During 2005-06, Aberdeen reported to the Scottish Drug Misuse Database (SDMD) there were 516 new people seeking care and treatment. This figure was a decrease on figures for the four previous years. We know that the City had seen a year-on-year increase in the number of people seeking specialist addiction intervention. The numbers of people accessing shared care methadone had increased by more than 10% a year for the previous three years and numbered approximately 1200 per year at the time of inspection. Aberdeen City had five Community Pharmacy Needle Exchanges, five outreach services and one fixed base enhanced needle exchange. Between them in 2005-06 they distributed 623,469 needles with a return rate of approximately 70%. A report in 2003 indicated that Aberdeen had a prevalence rate of opiate and benzodiazepine use of 2.03%, while the Scottish average was 1.84%. It also had the highest rate of injecting and a higher incidence of psychostimulant use than elsewhere in the country.

There were over 600 people on the waiting list for the Substance Misuse Service (SMS). While approximately 40% of these were being prescribed methadone by their GPs, we were concerned that those in this group had not had an assessment of their needs made. In the most recent National Drug Treatment Waiting Times Information Framework Report, 23% of people referred were offered an assessment appointment within 21 days of being referred. Aberdeen used prioritisation criteria to fast-track those who were at particular risk, including pregnant women, and families with children were prioritised. Young adults with no dependents who were injecting drugs but not seen as high risk, could wait up to two years for assessment. The JADAT was aware that this was not acceptable.

It was harder to obtain reliable data on people accessing help for alcohol misuse than for drug misuse. Adults with alcohol problems were waiting for services from the statutory sector but we were told by voluntary alcohol counselling services that they could see people within 21 days of referral. Alcohol counselling services attracted self-referrals more than other addiction services.

The figures for under-age drinking exceeded the national average on a number of key measures. Between 2003 and 2005 the number of children referred to the Reporter on substance misuse grounds almost doubled, while national figures dropped. The JADAT informed us that one possible reason for this increase was the proactive referral to the Children's Reporter by the Grampian Police Youth Justice Management Unit (YJMU) of any offences where alcohol or drugs are featured

Performance profile

Performance data on outcomes was being developed. The information which follows on performance relates to the priorities set by the Scottish Executive as well as emerging evidence of progress on planning and delivering services with a focus on measurable outcomes.

Each Action Team produced an annual Corporate Action Plan (CAP) which set out how it had addressed the priorities set by the Scottish Executive and local initiatives and developments for the forthcoming year. Performance monitoring based on these priorities had contributed to slow progress in developing a focus on outcomes in the planning, development and delivery of substance misuse services.

Although it was not obligatory to develop a local strategy as well as a CAP, Aberdeen had such a plan for 2005-09. The strategic objectives of the local plan mirrored the national priorities and committed the Action Team to some local objectives. The strategy focused on activity and outputs rather than outcomes.

The CAP acknowledged that waiting times for assessment continued to be a problem, but reported that 82% of clients received treatment within 14 days once an assessment had been undertaken. The JADAT also reported it had exceeded its most recent target of 56 new clients, with 176 accessing substitute prescribing. This figure rose to 222 by the end of the reporting year (Scottish Drug Misuse Database p.11). The serious concern was about the unacceptably high number of people – over 600 – waiting for treatment, some of whom may have had to wait for up to two years to be assessed by SMS. At the time of the inspection an audit of waiting lists was in progress, as the Action Team wanted information about the make-up of the list, for example those who might be engaged with other services, including prescribing from their GP, whilst waiting for assessment by SMS. During the inspection we were advised that “names were dropping off already”.

Culture, change and communities

The JADAT used a range of indicators to measure its performance against the national priority to reduce the percentage of adults exceeding weekly sensible drinking limits. The JADAT had a

Binge Drinking Harm Reduction Task Group which was progressing a number of targeted awareness-raising initiatives, often linked to the community safety partnership. Despite the positive impact of individual initiatives, evidence presented on various measures did not point to an overall reduction in the incidence of harm-related binge drinking.

There was no percentage target relating to the national priority to reduce drug and alcohol related crime and the evidence on a range of offences between 2003 to 2006 did not suggest an overall reduction. Police activity in relation to stop and search had increased during the period but the impact on the volume of illicit drug seizures had been mixed.

Prevention, education and young people

The local target of developing a drug and alcohol strategy aimed at young people was being developed behind schedule as a result of staffing difficulties. The intention was to have outcome objectives consistent with the Integrated Children's Services Plan, which ranged from pre-birth support and protection measures through to youth justice. During a three year period Aberdeen had a number of strategic imperatives in relation to children and substance misuse relating to Getting Our Priorities Right, the results of Pregnancy and Midwifery research, and the rising number of children being referred to the Reporter on the grounds of substance misuse. The development of the strategy had been unduly protracted. Aberdeen should progress this strategy as a matter of some urgency.

The JADAT supported a number of inter-agency initiatives concerned with ante-natal and early years care when children were born to mothers who misuse substances. We were pleased to see that these brought together statutory services with the voluntary sector. The JADAT partners needed to clarify the respective roles of staff. Moreover, we found evidence from other stakeholders that social work capacity to offer support to pregnant substance misusing women and their babies was variable and sometimes insufficient. This service was undergoing a review at the time of the inspection.

The most recent figures showed that there had been an increase in the numbers of children on the child protection register as a result of parental substance misuse. We were also advised that the Families First service was running into difficulties in meeting demand and that this was also the case with the part-time maternity post attached to a voluntary sector agency.

The JADAT had commissioned Robert Gordon University to map services for children to inform wider integrated children's services planning. The JADAT Children and Young People's sub-group had subsequently identified a gap in dedicated provision for children who misuse substances.

Initiatives in relation to Hidden Harm and Getting Our Priorities Right had resulted in a Grampian-wide "Framework for Reducing the Harm" guidance, inter-agency information-sharing protocols in the city, as well as "Children at the Centre" training for social work staff.

There is a national target concerned with reducing hazardous drinking by young people. The JADAT had used the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) to set a baseline for levels of drinking by young people in Aberdeen City and these showed that Aberdeen was matching or exceeding national trends. There was no recent data to enable performance to be compared as the most recent survey was undertaken in 2004 and information was only available on a Scotland-wide basis. However, the JADAT undertook two local surveys in 2005-06, one in Torry and one in Kincorth which revealed very high levels of drinking among 14-15 year olds. These surveys provide a good baseline to measure the impact of a number of actions assigned to the Torry Neighbourhood Youth Team for 2006-07.

Provision of support and treatment services

The CAP figures for 2005-06 suggested that, in most of the services commissioned through the JADAT, the target of a year-on-year increase of 10% of drug misusers in contact with services had been met. The number reported to be accessing the primary care methadone shared care scheme had risen in the same period by 25% [CAP]. The CAP also listed the main public sector and commissioned services and the numbers of 'active clients' for the last two years. This provided a much more accurate picture of actual numbers in contact with services and the JADAT had rightly taken the decision to include alcohol services even though these were not included in the national priority or target. The differences in the figures between the two years varied from service to service and it was too early to draw significant conclusions. However, this represented a step forward in systematic reporting from the various agencies delivering services and we consider this should be built on when developing outcome-related performance measures.

Aberdeen reported uncertain results regarding the national target to increase the numbers of drug misusers successfully completing treatment. Between 2004 and 2006 there was a significant reduction in the number of unplanned discharges from a high of 37% to 14%. Planned discharges had also decreased by 29%, however, which suggested longer-term engagement with services. Bearing in mind what we know of the journey of drug users through services and the improved outcomes where contact is longer, this seems to be a positive response

The Integrated Community Drug Rehabilitation Service (ICDRS) had reported a 70% retention rate of people who use services for the last two years in succession. We noted that the ICDRS had identified a series of output measures such as health gain through core fitness measures, improving social networks of non-drug using associates, and people who use services reporting less anxiety. It was intended to build on this progress with the appointment of a well-being worker from the summer of 2006 to support people who use services into mainstream activity. This service reported that 60 service users had engaged in employability or training programmes in each of the last two years and that the retention rate of referrals it made to Progress 2 Work rose to 85% in 2005-06.

Good practice example – progress 2 work

Progress 2 Work is a scheme funded by Job Centre Plus which aims to help support people, including recovering drug users, into work and employment opportunities. The scheme is delivered in partnership with Aberdeen Foyer, Aberdeen Cyrenians and APEX, in conjunction with the Community Rehabilitation Service. The scheme supported well-stabilised drug users to take up training and employment as part of a rehabilitative programme. Of the 73 people who started the scheme in 2005-06, 96% had positive outcomes in relation to training, education and employment.

We found the ICDRS to be a good example of a service developed with very clear expectations with regard to outcomes, where different agencies or disciplines contributed to the overall package of treatment and support. The evaluation of the service in 2005 revealed issues around clarity of role between the different agencies, and a lack of focus on rehabilitation. The promotion of recovery and routes out of services had been re-asserted as goals of this service.

Performance summary

The CAP was very active during 2005-06 and had set out a challenging agenda of key actions for 2006-07. Most of these had timescales and leads identified, the latter being individuals, sub-groups or agencies. However the measurable outcomes still related largely to inputs and process measures, e.g. numbers and completions of plans, rather than being outcome based.

Aberdeen's self-evaluation questionnaire acknowledged that while the JADAT gathered a lot of information about performance on an ad hoc basis, there was no corporately agreed means of demonstrating outcomes across the spectrum of provision. It was an area "where all services had struggled". Senior management in the statutory sector acknowledged that they were still measuring inputs and processes. In contrast, the voluntary sector expressed concern that they had become too focused on outcomes and were being required to provide a lot of information for different commissioners and stakeholders which detracted from direct work with service users. However, there was no real consensus in the voluntary sector about re-defining outcomes to make them more meaningful.

Recommendation 1

A recommendation on outcome and performance measures applicable to all three Action Teams is made in Chapter 6.

In 2006 the JADAT appeared to have made efforts to progress measuring outcomes, but the over-riding impression was of too many impact measurement tools and initiatives and a lack of a clear strategic direction. The JADAT intended to address the failure on the part of service providers to use outcome measurement pro-formas through commissioning arrangements.

During the local authority and voluntary sector file reading we found evidence that the circumstances of people who used services had improved in 60% of cases in Aberdeen City. In 64% of these cases, the improvement in circumstances could mostly or to a greater extent be attributed to effective social work services. In 52% of the cases where the individual's circumstances had improved, this could be attributed mostly or to a greater extent to effective collaboration between services. In nearly half of cases where there was no perceived improvement, the lack of effective collaboration was at least partly attributable.

3.2 People Who Use Services, Staff and Other Stakeholders

Aberdeen had a number of plans to ascertain the experience of service users in order to inform service development. There was a considerable gap between these plans and practice at the time of the inspection. We found that staff expressed high levels of job satisfaction and key to this was the belief that their service made a positive difference. We were particularly concerned about the continued impact on the community of the scale of unmet need as measured by the numbers of people on waiting lists for assessments for treatment services.

We considered that Aberdeen performed to an ADEQUATE standard on this measure.

Experience of people who use services, their families and carers.

Peer research was the primary means by which we engaged with service users during the inspection and we interviewed 157 people across Grampian. The broad findings are reported in Chapter 7. We found it more difficult to identify carers and met with a very small number living in Aberdeen, or who had experience of services in Aberdeen.

This section includes some findings from the peer research specific to Aberdeen, as well as findings from observed practice and our meetings with service users and carers during field work.

Slightly more than half the service users we met with used services in Aberdeen. In addition to responding to multiple-choice questions, 57 made evaluative comments about their experience of substance misuse services in the area. These comments have been grouped in the following table.

| | |
|--|-----------|
| Those who were complimentary about the quality of services | 18 |
| “Cannot fault anything within service” “Basically I think the service I receive is excellent” | |
| Those who singled out the quality/qualities of staff | 11 |
| “Key worker is excellent, without her I wouldn’t have made it” “My key worker has been brilliant...she gives me good advice” | |
| Those who commented favourably on inter-agency working | 3 |
| “If it wasn’t for the three services....I would not be halfway to where I am today” | |
| Concerns about access to services | 18 |
| “Not a lot of services, or if there are they are not well advertised” “Disgusted I had to wait three years for a methadone script because I wasn’t a priority...I was suicidal” “Lack of citric acid is a really big problem for me....can’t always get it at the shops or pay for it” | |
| Those who made negative comments about services | 4 |
| “Alcohol users receive a second class service compared to drug addicts” “Should be more user involvement” | |
| Those who had a negative experience of inter-agency working | 3 |

Fieldwork meetings with service users

Service users we met with were very positive about the substance misuse services they were receiving.

There was a general consensus that drug users on a substitute prescription were treated with dignity at pharmacies. It was acknowledged by senior staff that more needed to be done to involve service users in decision making around their care. Aberdeen University was to undertake a user preference study.

Most people we spoke to were also positive about other health services, although access to dental treatment, substitute prescribing and perceived increased risk associated with injecting because of decision by NHS Grampian not to include citric acid in needle exchange packs, were all raised as concerns.

Service users spoke particularly highly of the main service they were involved with, whether or not they identified this as part of a wider inter-agency package of treatment and support. The

importance of good working relationships with a ‘constant’ was clearly very important, whether a GP or a key worker in a statutory or voluntary agency.

An integrated Drug and Alcohol Service Assessment and Review form being rolled out across Grampian had the potential to quality assure services from a user’s perspective. It contained a number of review/exit questions which attempted to elicit their satisfaction with the service received. However, there were no mechanisms in place at the time of the inspection for routinely collating and reporting on answers.

The Action Team had made plans to improve the collating of service user’s views and their place in informing planning and development strategies. On the whole, voluntary sector agencies seemed to be exceeding the rather modest commissioning expectation that they have “Service Suggestions and Complaints” in place. We saw service user groups influencing service delivery and had evidence that Aberdeen had undertaken surveys of service user’s views.

The file reading results also showed good practice across statutory and voluntary organisations with regard to the sharing of information from worker to service user. Similarly, in over 90% of cases it was clear from the file that the views of service users were taken into account in care planning processes.

Experience of carers

All of the carers we met with in Aberdeen who used carer support services had found out about them as a result of a family member seeking help, and the carer having played a role in this. One in particular was clear that when his adult child had approached a service for help, the agency had invited him to be part of the help provided. Others spoke of their frustration at being perceived in this light, in what they felt was the absence of consideration of their needs. They all derived support from their involvement in carer support groups. Agencies in the voluntary sector, both drugs and alcohol, facilitated or hosted such groups.

We met with a carer who felt that she had had to fight for services for her son for many years. Problems resulting from his substance misuse were exacerbated by a medical condition, but she considered that there had been a very poor assessment of how these would impact on each other. She was supported throughout by her GP but felt frustrated that specialist health and social work services could not join up to properly support her son.

Recommendation 2

There is a recommendation for all three Action Teams about the involvement of users and carers in developing services in Chapter 6.

Experience of staff

We received seven responses from nine staff employed by Aberdeen City council substance misuse services. This number of responses was too small to provide statistically robust results, and the results were indicative only.

Of those who responded, the survey results for local authority staff in Aberdeen City were very positive but the picture was something of a mixed one in that both written comments in the survey and complaints and concerns expressed during the fieldwork sometimes contradicted these results.

Most respondents agreed that they enjoyed their work and felt that the work they did made a positive difference to reducing the harm associated with substance use and made a positive difference to the lives of people who used services and their families and carers. The survey results pointed to key motivators being in place – working in partnership with people who use services, their families and carers to achieve agreed goals; being clear about what they were expected to achieve in their job; and having regular training and development opportunities, often being involved in training and sharing good practice with staff from other services. The majority of staff agreed morale had been good in their team for the previous six months.

Partnership working

The results from questions relating to partnership working were positive.

| | AGREE | DISAGREE |
|--|-------|----------|
| Effective partnership working by all agencies represented on the Action Team has improved outcomes for service users | 100% | 0 |
| My team has a good relationship with health professionals | 86% | 14% |
| I participate in regular multi-agency/disciplinary meetings | 86% | 14% |
| In multi-disciplinary teams, all staff can access the records of people who use our services | 71% | 29% |
| My team sign-post people to appropriate services | 100% | 0 |
| Where more than one service is involved, they join up around the needs of service users | 100% | 0 |

In circumstances where adult service users had parenting responsibilities, all seven respondents agreed their team or service was proactive in the sharing of information for assessment purposes. Nearly all agreed that teams worked effectively with social work child care services where there were parenting/child protection concerns. This indicated that staff were aware of their obligations in this regard. However, in our local authority file reading for Aberdeen City (12

files) we found no initial assessments of the impact of parental substance misuse on the children where there were children in the household.

We were concerned about this and consider that managers should make sure that staff are familiar with Getting Our Priorities Right and the local guidance published in 2006 on the inter-agency sharing of information on children affected by substance misuse in Aberdeen.

Some respondents expressed concerns about how accessible their particular service was, with only three of the seven respondents agreeing it was easy for people to get access to the services their team provided, and about gaps in the range of services available. However, it was clear that staff felt that those who did manage to access the service achieved positive changes as a result. All seven respondents agreed that their team promoted recovery and routes out for people who use services.

All 7 staff who responded agreed they understood the role of the JADAT and most agreed the JADAT had effectively communicated its plans for substance misuse services in the Aberdeen area. However around half of the staff who responded disagreed that there was top-level commitment in health, social work and the voluntary/independent sector to work together to improve substance misuse services.

Around half of staff who responded disagreed substance misuse services were highly valued by elected members and by the NHS board.

Impact on community well-being

The self-evaluation questionnaire characterised this area as one “where there were a number of tensions”, mostly resulting from communities – either geographic or of common interest – being frustrated by or attempting to circumvent resource constraints in substance misuse services, particularly drug treatment services. These could be communities of interest making a case for fast tracking to certain services, or by-passing the Action Team to apply for funding for an initiative or project. The self-evaluation questionnaire made reference to heightened tensions when development funding was available. We found evidence that such tensions did exist. While we found some evidence of steps being taken to proactively engage with communities on these issues, for instance in relation to the planning of new accommodation, these were not systematic.

We found widely acknowledged gaps in relation to engaging with the public on substance misuse services, on capacity building within communities, and the development of services to ameliorate adverse consequences for those communities. Local authority services had been in a protracted process of radically re-structuring their service delivery model into three neighbourhoods. A key objective was to put the information and the services in place to offer maximum responsiveness to local needs. It was acknowledged that substance misuse could lose out to those issues which seem to preoccupy the public more, particularly environmental

factors. The 2004 household survey included data on reported neighbourhood disturbances involving drug or alcohol use. The rate for Aberdeen was marginally higher than the national average. The Action Team should re-engage with communities to ascertain the scale of the perceived problem and where best to deploy resources.

Aberdeen was using much of the same material – DVDs, board games – as elsewhere for awareness raising with young people on substance misuse issues. All school nurses were trained to use these materials, to complement the role of youth project and youth justice staff attached to schools. Schools routinely received drugs awareness input from the police and from a local voluntary sector agency. The management of alcohol-related incidents was to be made explicit in substance incident policy currently dominated by drugs.

Strategically, the Action Team was linked to the regeneration and community safety strategies. We were told that bringing the strategies together to develop more effective approaches required further work. While we found that there had been an over-emphasis to date on developing individual projects rather than sustainable capacity building, we were impressed by the reported impact of some of these initiatives. These included the work being done with young people, particularly in schools, and also those identified by police as being engaged in offending or anti-social behaviour which was substance misuse related.

We found that community safety planning and activity yielded positive evidence of strategic co-ordination and performance. The JADAT had set up a Criminal Justice and Community Safety sub-group, which worked at the interface of the Corporate Action Plan and Community Safety Plan. There had been a number of different strands of an overarching strategy to promote community well-being through the management of the night-time economy in the city centre. These strands included information and education, encouraging public houses to act responsibly to discourage irresponsible drinking, and practical public order measures such as marshals to help with ensuring that people had safe transport means to get home. Targets in respect of these had been met and these initiatives were to be extended. However, Aberdeen city centre had the highest number of public order offences in Scotland. We were told that senior police officers were concerned that too many licensed premises were partly to blame for this situation.

3.3 Key Processes

Aberdeen was in the process of a major redesign of services for people with substance misuse problems to improve their journey through the services. Steps were being taken to integrate services, and the ICDRS was having some success in providing a joint service, but other initiatives for integration were largely still at the planning stage. The integrated assessment and review tool was being used by some of the agencies, but not by all.

We consider Aberdeen's performance in this area to be ADEQUATE.

The journey of the service user and family through services

There was a useful “Guide to Services” for alcohol, drugs and sexual health in Aberdeen and Aberdeenshire. Aberdeen had a range of leaflets about the JADAT and about individual services. Information was also available on a JADAT website and websites run by Drugs Action and AACS. There was also a Helpline.

We found access to substance misuse services in Aberdeen to be varied. People seeking substitute prescribing services through their GPs were referred to nurses from the Fulton Clinic. Some GPs were content to prescribe methadone once the service user had been stabilised while others would not take back service users until CPN support had been identified. Some GP practices had CPNs attached to them while others did not. We were told that re-design plans had been developed to address this.

Waiting lists for CPN support from the Fulton Clinic were long. The Integrated Community Drug Rehabilitation Service (ICDRS), a partnership of four voluntary sector services, Aberdeen City Council Social Work Services and the NHS, as commissioned, only took referrals from SMS and had regular referral meetings. However, this represented only a part of substance misuse services. The other main commissioned voluntary sector services took a mixture of self-referrals and referrals from other agencies, including GPs and social work care managers. Those working solely with people with alcohol problems tended to have predominantly self-referrals. Referrals to some individual voluntary sector services also came from the Helpline, especially from sex workers and oil industry workers.

The percentage of people seen in under 21 days from referral to initial appointment dropped between 2004-05 and 2005-06, with particular problems in Drugs Action, with a 69% drop, and SMS GP services with a 57% drop. The CAP noted that “overall Aberdeen City is still faced with a bottleneck of people waiting to access services, particularly primary substitute prescribing”. Waiting lists varied from service to service. We were told in a GP focus group that there was a wide variation in waiting times between practices depending on whether they were linked or not to SMS through the shared care scheme. Patients were known to de-register with non-linked practices and become “homeless” to jump the queue.

Waiting lists for the various services were currently being reviewed to exclude any ‘double counting’ of people who may have referred themselves or been referred to another service in the meantime and were now in receipt of a service. We were also told that revenue funding was available for the appointment of three additional nurses to SMS as part of the plans for an Integrated Care Planning and Stabilisation Service. Their appointment had been delayed due to lack of identified interim accommodation.

Aberdeen was looking to the proposed Integrated Care Planning and Stabilisation Service, as part of an overall redesign of drug treatment services, to solve their capacity problems but we did not see clear enough evidence that this would suffice. The appointment of additional staff should take a significant number from the waiting list but the throughput of substance misuse services was small and demand was therefore likely to grow each year.

The plan to tackle capacity issues on an ongoing basis appeared to centre on the expectation that the ICDRS would extend, prescribing would expand, and that the role of the new service would be to stabilise clients who would then be passed to GPs for continued prescribing and ICDRS for other services. We saw no evidence of plans to extend ICDRS nor to expand prescribing and could not see how either would impact on initial referral rates to the Integrated Care Planning and Stabilisation Service.

Recommendation 3

Concerted action should continue to be taken to reduce waiting times and lists. As well as addressing capacity, Aberdeen should further consider redesign of services and set short-, medium- and long-term targets to reduce waiting lists.

Frontline staff told us that efforts would always be made to see people at least once as soon as they were referred. There was a standard protocol for prioritising referrals, but it was used with some flexibility to ensure that young single men were seen and were not always at the bottom of any list. Workers tried to keep in touch with clients by phone when they were on a waiting list. After two appointment letters with no response, people might be removed from the list (but not if they were under 18), though there seemed to be some flexibility about this.

All of the agencies delivering substance misuse services in Aberdeen City had their own files. We read 55 social work and 54 voluntary sector files. NHS Grampian conducted an internal audit of 88 of its Substance Misuse Service files, but this sample size was not sufficient to allow analysis at Action Team level. The results from the health file reading are discussed in Chapter 7.

We found that all of the social work files and three-quarters of the voluntary sector files contained an assessment. Seventy seven percent of social work files contained an integrated assessment while this fell to 12% for voluntary sector files. Forty six percent of the assessments in the voluntary sector files were rated as weak or unsatisfactory, while 75% of the social work assessments were rated as good, very good or excellent. Seventy nine percent of the social work and voluntary sector files had a care and treatment plan or equivalent and in 60% of cases this was being reviewed at regular intervals which reflected the level of need and risk. However, in cases where risk to the service user or others in the household was identified, only four of the 24 relevant files contained an up to date risk assessment and risk management plan.

Multi-agency and multi-disciplinary working and integrated, person-centred care

There was a Joint Future management structure in place for substance misuse services, with a single manager, co-location of social work care managers and SMS staff, and the development of specialist GPs. ICDRS was co-terminus with GP practices.

Aberdeen City JADAT had received additional funding from the Scottish Executive to set up an integrated drugs services. However, at the time of our visit only the ICDRS could be described as operating in an integrated way. SMS staff, the specialist substance misuse social workers and ICDRS were using the latest draft of the integrated assessment and review form and it was a requirement to access Phoenix Day Care. The other commissioned voluntary sector providers had their own systems and expressed some misgivings about the integrated assessment and review form. Although there had been extensive consultation on, and revision of the form, they felt it was unwieldy and of much less relevance to alcohol than drugs. The JADAT planned for the integrated assessment and review form to be rolled out to all agencies, and commissioned services will be expected to use it as a condition of their service level agreements.

Recommendation 4

A Recommendation on assessments and risk assessments applicable to all three Action Teams is made in Chapter 6.

There was no shared IT system across the agencies. This hindered information sharing. Consent to share information was evident in significantly more social work files (67%) than voluntary sector files (42%).

We analysed the care and treatment plans in the social work and voluntary sector files to determine to what extent they evidenced integrated care around the individual's needs. We found that in approximately one third of plans this was completely or mostly the case, in a further third it was partially the case, while the remaining third offered no evidence of this. In significantly more social work files (91%) it was clear which agencies and professionals were involved, compared with voluntary sector files (67%). In only a third of all social work and voluntary sector files was there evidence of multi-agency working with clearly stated roles and responsibilities.

We found that none of 12 relevant social work files and one of the four relevant voluntary sector files, where there were children in the household, contained an initial assessment of the impact of parental substance misuse on the children. Furthermore only one of the nine relevant social work files contained a parenting assessment, while one of the four relevant voluntary/independent sector files did, an average across the city of 15%.

Recommendation 5

A recommendation applicable to all three Action Teams on working with families where there are substance misuse problems is made in Chapter 6.

Good Practice Example

The Integrated Community Drug Rehabilitation Service (ICDRS), a partnership of four voluntary sector services, Aberdeen City Council Social Work Services and the NHS was a successful model of multi-agency working, with very clear expectations with regard to outcomes. Partner agencies worked together effectively to establish who should best deliver different parts of care plans and also positively influenced prescribing practice by SMS.

There were cross-referrals within the voluntary sector, but limited partnership working with GPs. GPs felt that there was a good working relationship between SMS and maternity services in the care of pregnant drug users.

There were multi-agency posts, such as those at ICDRS, and also a maternity post and a joint Families First service with Aberlour, focusing on early intervention. We observed a fortnightly case meeting where four cases showed evidence of good multi-agency working with all parties – SMS, ICDRS, CPNs, Foyer, etc. – communicating well with each other. There was a focus on forward planning with movement towards education or employment.

There was some confusion about how packages of care were co-ordinated – the role of care management. One view held by some staff was that there were barriers to holistic care because of difficulties of referrals within the service. There were only two social work care managers in the city. They did not attend clinical meetings at the Fulton Clinic, and we were told that nurses did not act as care managers. However, we were told that in practice there may not be any real difference between care management and co-ordination. One nurse whose practice we observed clearly saw his role as co-ordinating care packages.

Historically, services in the city seem to have developed separately, with the NHS being a provider and the local authority largely a purchaser of services. There appeared to be a consequent underinvestment in social work services. In addition the statutory bodies had independently commissioned services from the voluntary sector, with little reference to the JADAT. There was now the beginning of an integration agenda and an attempt to commission services jointly and strategically.

The involvement of, and partnership with, people who use services, their families and carers

Aberdeen City staff and managers stated that they felt they were “adequately effective in relation to work in partnership with people who use services”. Staff were required to assess and consider the views of significant others in the integrated assessment tool and “there were no reasons why staff across all services should not be applying this”. Although this aspect was not routinely or consistently performance managed, almost all of the social work and voluntary sector files we read contained evidence that the views of service users were taken into account. Eighty five

percent contained evidence that service users were invited to attend decision making meetings and reviews.

Commissioned services were required to provide user feedback as part of their service level agreement, and quality assurance measures to monitor this were in the pipeline. Service users had had some involvement in the development of ICDRS, the proposed new drug treatment centre, and needle exchanges through a service user preference study. There had also been a recent survey of women in the sex industry to inform service delivery. Some of the services provided showed a good level of service user involvement.

Inclusion, equality and fairness in service access and delivery

The two aspects of access to service delivery which particularly disadvantaged individuals were different practices in how waiting lists were managed and the variation of experiences in individual GP practices. We were told this was being addressed through the GP Enhanced Service Contract, the Commissioning Strategy and through the service redesign to establish an Integrated Care Planning and Stabilisation Service. Current contracts specified an equal opportunities approach to services. The needs of some groups, such as offenders and pregnant women, had been targeted through commissioned services.

3.4 Strategic Management and Leadership

We found that the Aberdeen Action Team faced significant and complex challenges in responding to the comparatively high levels of substance misuse problems in the city. The scale and nature of the challenges required concerted strategic leadership from the Team, but we found that capacity at the most senior membership level was limited by a combination of wide-ranging individual responsibilities, change within organisations and change within the Action Team support structure. There was a lack of knowledge and understanding of the vision for substance misuse services among staff. The planning and deployment of resources did not match the spectrum of needs linked to substance misuse. We found that the Action Team did not yet model robust performance management to service providers. We found performance in this area to be **WEAK**.

Vision

The chair of the JADAT saw Action Teams as having four purposes – direction of strategy, allocation of resources, monitoring and management of performance and governance.

Aberdeen JADAT had aims and objectives for the treatment and rehabilitation of people with substance misuse problems. The overall aim was for services to move from being delivered on a 'functional' basis to being constructed around a central multi-disciplinary care process with three key objectives: stabilisation, moving on and moving out. Specific aims included the stabilisation or detoxification of individuals. The ultimate goal was to help them stabilise or become drug/alcohol free. Other aims included reducing the risk of the spread of blood-borne viruses,

improving the holistic health of individuals (mental health was specified), reducing involvement in criminal activity, improving people's personal, social and family functioning and helping people to move on through education, employment and housing opportunities.

We found a lack of consensus in Aberdeen about the vision for substance misuse services. Many staff we spoke to were either unaware of the vision, felt there was no shared vision, or that they had not been involved in shaping it. Some said that different agencies held different views about the way forward. The voluntary sector expressed concern about the lack of transparency of decision-making in the JADAT, particularly with regard to the allocation of resources. This had led to a lack of trust, and confusion about the role of the JADAT and its members. Some continued to see the JADAT as a forum for bidding for money rather than a forum for joint strategic planning and development of services. We considered that this limited its effectiveness, and the JADAT and its members should clarify their respective roles and responsibilities.

Staff we spoke to in focus groups from across the agencies felt that there was poor communication between the JADAT and front line staff and that their knowledge and experience was not taken into account in service planning and development. They were unaware of major developments, e.g. the new Community Alcohol Team. The Action Team chair recognised this.

Aberdeen City JADAT had two elected members and they were well informed about substance misuse services. However, other elected members were less aware of the JADAT or of the overall strategy for substance misuse in the city. The council had set up an elected members group called the Alcohol and Drug Task Group. It had a small budget of £50k per annum which it distributed to small local groups based on reports from officials. However, the councillors were not aware of where this fitted with the JADAT's strategic overview.

Aberdeen City Council had recently undergone an extensive re-organisation with the aim of delivering services on a multi-agency neighbourhood model. As a result of the re-organisation, responsibility for delivering on substance misuse objectives rested with several senior strategic posts in the council. The Head of Planning and Policy for Services to Adults had overall responsibility for planning and the Chief Social Work Officer (CSWO) had specific statutory duties but no operational responsibilities. The re-organisation had led to a gap in key council representation on the JADAT, which required to be filled. The Chief Executive saw substance misuse as one of the eight priority areas for the Council. We think that if the Council is to be effective in delivering on this priority, they will need to make sure that they have relevant senior management representation on the JADAT.

Joint planning and development of services

Aberdeen's Community Plan (2001) prioritised "reduction of drug and alcohol use and the associated acquisitive crime" and stated it was a key goal. The plan made no specific reference to alcohol, but drugs were mentioned under Health and Social Care and under Safety. There

were no specific targets under Health and Social Care, but actions included the DAT (now the JADAT) taking forward the drugs strategy, providing a spectrum of services from education and prevention to treatment and rehabilitation and raising public awareness of the risks of transmission of infection among drug injectors. Under 'Safety' there was a specific target to increase drug seizures by 25% by 2005 and to establish a DTTO scheme in 2001.

The most recent update on the Community Plan (2003-05) set out a number of key priorities for 2005-06 including the further development of Joint Future to include joint drugs and alcohol services. The update stated that detailed targets in relation to drugs and alcohol were contained in the Joint Health Improvement Plan (JHIP) which was set to become the Health and Social Care Action Plan. Targets for 2005-06 included reducing drugs/substance misuse/dealing, along with a reduction in underage drinking. There were links to alcohol misuse in the plans for safer streets with recognition of the role of alcohol fuelled violence. The JHIP (2006-08) made a number of strong statements about the need to reduce the impact of substance misuse on communities. The CAP was set out around the Scottish Executive's national priorities. The Children and Young People's sub-group of the JADAT acted as a sub-group of the Integrated Children's Services Planning structure.

Although there were links between the high level strategic plans, there was room for greater alignment of strategies, especially in the light of the stated move towards neighbourhood service delivery.

Recommendation 6

There is a recommendation on strategic links applicable to all three Action Team areas in Chapter 6.

User and carer involvement in the strategic planning process was piecemeal. The chair of the Alcohol and BBV Forum attended JADAT meetings, and AVCO, which represented voluntary sector carer forums, also had a seat on the JADAT. The JADAT had supported initiatives at a service level to consult people using services on 'what works/worked' when developing services. Drugs Action had a forum for people using services, called Unite. They told us they had the opportunity to meet with the JADAT and had advised them that counselling services were urgently needed alongside methadone maintenance.

Commissioning arrangements

The JADAT had recently undergone restructuring and had put commissioning and performance management high on its agenda. Traditionally Aberdeen City Council had been a purchaser of substance misuse services rather than a provider. In order to make sure that future services for substance misuse were commissioned in line with the overall strategic direction, the JADAT was in the process of introducing a new joint commissioning strategy. It had plans for a pooled

budget and a single point for service commissioning for drug and alcohol treatment and rehabilitation services (both statutory and non-statutory) in the city.

The new joint commissioning strategy was aimed at improving commissioning from the voluntary and independent sectors but NHS Grampian and the council were expected to adhere to the same principles of best value, standards and performance management. The strategy proposed putting in place an annual commissioning cycle led by an assessment of needs. Commissioned services would have a single contract and all commissioning of substance misuse services would take place through this structure. The JADAT would establish broad strategic objectives, and its Treatment and Support Services Sub Group would identify commissioning intentions based on these. The Joint Future Commissioning Team would then be responsible for selecting providers.

Council and health commissioning staff would undertake contracts, monitor compliance and feed performance information back to the JADAT. The JADAT would not support short term or pilot projects although they were exploring an Innovation Fund to enable projects which were part of a wider development and which generated learning to be supported. Currently services were commissioned in different ways and outcomes were not specified. The JADAT planned to review all its existing service level agreements in line with the new strategy.

We were encouraged by the plans which the JADAT had set out for the new commissioning strategy but we had concerns. Firstly, we were told that the council had just advertised for a Commissioning Strategist with a commissioning team to sit under the CSWO and it was not clear whether this would be a joint post with health.

In addition, there was a need for the JADAT to review the existing balance of services as well as commissioning arrangements. We found no clear rationale for the current balance of services or evidence that it was based on identified need. It was therefore not possible to say if this presented an appropriate range of service diversity or opportunistically developed services with duplication and gaps.

Recommendation 7

The JADAT should review the balance of services in Aberdeen to make sure they meet the current identified need in the city.

Range and quality of services

Aberdeen's substance misuse service was based at the Fulton Clinic and consisted of one consultant psychiatrist, two staff grade doctors, and 24 nurses, with two social work care managers attached. The health staff prescribed and detoxified, while the social work staff assessed and care managed and referred to residential rehabilitation. The CPNs held sessions in

the majority of GP practices, including the Homeless Practice, as well as a number of specialist drug misuse clinics for target groups such as criminal justice, ante and post-natal services. A variety of voluntary organisations provided counselling, support and help in moving on. A Community Alcohol Team was planned.

A service to respond to the needs of psycho-stimulant drug users, INCITE, was set up in Aberdeen in 2003 as a pilot, with Scottish Executive funding. This funding came to an end in 2005, and the JADAT continued to support the project until 2006. Drugs Action, where the project was based, were to continue to support the project until May 2007. At the time of the inspection an evaluation of the service had been carried out, though not published. The JADAT was to put together a psycho-stimulant strategy to develop services to psycho-stimulant users.

The recently developed commissioning strategy was aimed at helping to address the opportunistic development of services. Some of the gaps in services identified by service users, staff and elected members, in our questionnaires and during the fieldwork, included residential rehabilitation, information about available services, the need for more preventative and throughcare services and counselling in localities. No alcohol detoxification was available in the community.

The JADAT's self-evaluation questionnaire identified a need for the dedicated social work resource to be increased and this was confirmed by senior staff on our visit. We considered there might be some tension about the strategic direction for the council into neighbourhood structures. The Council and the JADAT would have to work together to develop an appropriate balance of centralised and neighbourhood services

Aberdeen had faced difficulties over the years, due to the pressure of demand for drug treatment services. In order to address the current waiting list and capacity problems, the partner agencies had invested capital of £2.7 million for the construction of a new building to house the integrated drugs service in the city. Plans for a site had been agreed but planning permission had yet to be obtained and senior staff informed us it was unlikely to be open in less than three years. In the meantime they were setting up temporary accommodation and had identified premises. The aim was for every referral to pass through the same initial point for assessment. Stabilisation was the goal for health and social work services, while the voluntary sector (through the ICDRS) provided rehabilitation and routes out.

There were also plans for a Community Alcohol Team with a doctor, three nurses, two social work care managers and two voluntary sector support workers. The Joint Future Management Structure for Drug Services was being adapted for the implementation of Alcohol Services. Two voluntary sector service providers, with support from JADAT, NHS Grampian and Aberdeen City Council, were undertaking a merger to form a new organisation, Alcohol Support Ltd. Staff and other stakeholders we spoke to during our visit seemed less aware of the plans for the Community Alcohol Team than for the Integrated Care Planning and Stabilisation Service.

We remained concerned that senior SMS staff were unable to articulate a clear long-term plan to address capacity issues, particularly of initial drug stabilisation services.

Residential detoxification and rehabilitation

Aberdeen did not have a residential resource for drug users but did have a dedicated homeless resource. The one residential service for people with alcohol problems also accommodated four designated places as an alternative to police custody.

The 2006 Care Commission inspection report on this service noted that a number of recommendations from the previous report had yet to be fully addressed. These were areas of critical importance to the safe running of the service, including accident recording and medication handling. A former recommendation had been strengthened to a requirement in the more recent report.

There was an unresolved issue about the up-grade of the accommodation to offer the choice of single rooms and en-suite facilities. The service had recently been re-structured to amalgamate with the advisory and counselling service. Discussions were on-going about the future configuration of the residential service, stalling progress on the up-grade.

This service was subject to joint commissioning. Contract compliance monitoring should include an obligation on the service provider to feed back any recommendations and requirements arising from an inspection report. It then becomes a shared responsibility to ensure that necessary steps are taken to address these with the timescales committed to in the action plan. These obligations required to be tightened up in Aberdeen.

Quality assurance and continuous improvement

Aberdeen City Council accepted that their performance management needed to improve. JADAT staff agreed that this was also so for the JADAT, and told us there was no performance management framework. However, they were setting local implementation targets in relation to the integrated service and shared care programme. Information collected through the use of the integrated assessment and review form could be used to help measure performance outcomes. In addition, performance against Corporate Action Plan objectives was reported at JADAT meetings through a traffic light system.

Management information

Aberdeen's SEQ stated "we have inadequate information systems in place in relation to IT and having systematic reporting from a practice, operational management and strategic level". It also noted that the NHS SMS had no systems in place other than paper records, making management information such as missed appointments, outcomes and other performance information un-reportable. Information from GP activity and Community Pharmacy was collected

but not used systematically in the management of care. Individual providers had their own range of systems. They were developing a system for monitoring outcomes at a service level. Outcomes from the assessment tool were monitored monthly, and the ICDRS routinely collected quantitative information on numbers attending.

Recommendation 8

There is a recommendation for all three Action Teams on management information in Chapter 6.

3.5 Partnership Working

We found that joint working varied. Partners were not able to commit the time necessary to chair the JADAT. We recognised the difficulties involved for agencies in taking on this responsibility, but it raised questions about the priority given to the commitment to partnership working in Aberdeen at a strategic level. The recent re-organisation in the Council had also created a hiatus in representation. Voluntary organisations often felt excluded from decision-making processes. There had been only slow progress in moving to pooled budgets and the deficiencies in the contracting system were just beginning to be addressed. We therefore considered performance in this area to be **WEAK**.

Partnership arrangements

Senior officers in Aberdeen City Council were positive about the good well-established working relationships with other agencies, the strength to resolve problems and the energy and enthusiasm devoted to developing joint strategies for better services. In particular we heard about how the police had adjusted their command structure to reflect the new service delivery neighbourhoods.

However there were mixed views among stakeholders about partnership arrangements in the city. For instance, some felt that partnership working had been affected by the major organisational change in the Council as senior experienced staff had left, some of whom chaired the JADAT sub-groups. Some voluntary sector organisations were frustrated at not being equal partners and felt excluded from key decisions. Initiatives tended to be single agency based with the exception of the ICDRS and the proposed Integrated Care Planning and Stabilisation Service.

Although JADAT meetings were well attended, some spoke of a lack of continuity of membership and existing members did not feel able to take on the role of chair. The lay chairperson, once appointed, would be accountable to the chair of the CHP committee and the Chief Executive of the local authority. It would be the lay chairperson's job to manage the partnership working.

ICDRS had a well developed service structure and positive working relationships among its four partner organisations. There was a Management Protocol for partner agencies and the service coordinator met regularly with the chief executives of the partner agencies.

GPs generally felt partnership working arrangements with them were not adequately supported at a strategic level although they sometimes existed for individuals. Some felt strongly about the fact that they had not received the support from the Fulton Clinic that they believed they had been promised in the enhanced care contract.

The proposed Integrated Care Planning and Stabilisation Service was to be overseen by the Joint Futures Service Management Team. This included providing direct operational management on behalf of NHS Grampian and Aberdeen City Council to the service. A joint paper/case file system, joint policies, procedures, programmes and activities for working with service users, joint performance measures, quality assurance, evaluation and reporting systems, joint staff training and appraisal systems, jointly agreed financial reporting mechanisms, managed service level agreements and implementation of the move towards single shared accommodation as well as ICT solutions for integrated working were all part of this package.

Development and review of joint policies, procedures and protocols

The JADAT chair believed there had been a real partnership approach to the implementation of GOPR through the Children's sub-group. *Working with Children and Families Affected by Substance Misuse in Aberdeen City: Interagency Guidelines, July 2006* was available in draft. Voluntary sector front line workers thought that 'Getting Our Priorities Right' had been responded to positively across the city. It had increased good practice between the people who used services, drug agencies and child care social work.

The Fulton Clinic had a practice of no home visits by nurses to drug users, as this was not seen as a good use of resources, given the demand for treatment. One member of staff told us that that this practice was based on a view that it was dangerous for staff. However, evidence could not be provided for this, and this was not a practice followed by health staff in other parts of Grampian. We were told that if deemed clinically appropriate, a home visit would be organised by the team. Risk should be assessed on an individual basis, following clear protocols.

Recommendation 9

The Fulton clinic should review its practice on home visiting by nursing staff to ensure that risk is assessed on an individual basis, and that resources are deployed effectively, based on clear agreed criteria. The assessment tool in use may be helpful.

Recruitment, deployment and development of staff

We were informed by nursing managers in the Fulton Clinic that all nursing staff in the SMS had responsibilities for both drug and alcohol services. A senior manager in the SMS said that all posts were advertised on a 75% drugs/25% alcohol basis. Staff were recruited to work in either drugs or alcohol, and the 75/25 split was notional, to ensure that if there was a requirement to cover clinics at short notice, staff would have a working knowledge of each other's remits. Managers suggested some staff still worked with historical remits. In our view staff should be supported to develop their remits and skills in line with the requirements of the service. We consider the fact that staff were allowed to continue working unchallenged with outdated remits and that managers seemed unaware of what their staff were doing indicated weaknesses in line management. Voluntary organisations tended to have separate drug and alcohol remits for historical reasons.

The lead nurse and other senior nursing staff received their supervision through fortnightly senior nurse meetings and G grade staff had appraisals once or twice per year. Junior nursing staff were managed by the senior nurses. There was a psychotherapist to whom all staff could go to discuss clinical or personal matters in confidence. This was not mandatory but it was encouraged. The clinical nurse managers met occasionally with the psychotherapist to discuss themes which had emerged.

Social work care managers did not attend the team meeting at the Fulton Clinic, and were managed separately from health staff by the Team Manager, Joint Future Mental Health and Substance Misuse. Much of the role of the specialist social work staff seemed to be to undertake assessment for residential rehabilitation, including running preparation groups. We were told that the original rationale for having only two specialist substance misuse social workers was that other care managers would undertake less specialised substance misuse work. Senior council staff acknowledged that this decision needed to be reviewed and that direct provision needed to be increased. We thought it important that this decision was undertaken in the context of a review of the balance of services. Recruitment generally was difficult as salaries were higher in Aberdeenshire.

Recommendation 10

Aberdeen City Council should review the level and role of its specialist substance misuse social work service in the context of a review of the balance of substance misuse services across the city.

Although staff told us that training opportunities were available we found that access to training in the city for staff was uneven. Some had minimal training while others were undertaking accredited courses costing several hundred pounds. Some staff said there were courses

available but it was difficult to access them when the service was short-staffed. Drugs Action staff felt they were encouraged to go on courses but other city staff did not share this view. Many staff said they would benefit from accredited cognitive behavioural therapy and motivational interviewing courses.

SMS offered a 12-week programme for hospital and social care staff, GPs and, midwives where they could spend one day a week at the Fulton Clinic. This was now accredited through the university. We were told that this had helped recruitment difficulties to substance misuse services but it had the drawback of creating vacancies elsewhere in the health service, notably in mental health.

Some staff raised safety issues with the inspection team, e.g. an alcohol voluntary organisation where female staff sometimes undertook counselling alone with inadequate safety precautions, such as no panic buttons.

Joint budgeting and use of financial resources

The JADAT had recognised that current financial governance was hampered by inadequate Service Level Agreements (SLAs) and contractual arrangements. The council chief executive said there had been little progress on moving to pooled budgets as this required maintenance of two ledger systems. Progress had however been made in respect of alignment of budgets across the three new neighbourhood management areas.

However, substance misuse was being used as a 'pathfinder' for the Joint Future partnership with the aim of establishing a pooled budget. This will include Scottish Executive Action Team monies, a core amount from the JADAT, and BBV funds, plus the potential to include shared care funds, e.g. the sum allocated to pharmacists for the provision of supervised methadone which was currently held within the medical budget. The budgets to be pooled from the Council included the two social work care management posts, the purchase commissioning budget and lottery funding for substance misuse, but not the resources currently in Children's Services or Criminal Justice where governance for these will remain. NHS resources to be pooled included the SMS funding, GP and pharmacy contract funding and current commissioned services from the voluntary sector. However we saw no reports which contained agreed figures for the pooled budget and we were aware that pooling budgets was a financially complex exercise.

Aberdeen had received funding from the Scottish Executive to set up an integrated community drugs rehabilitation service, and had an underspend to 31 March 2006 in their CAP of £772,000. We were told much of this had been identified as the revenue budget for the new drug treatment and rehabilitation service and that it was underspent due to problems recruiting staff of the right calibre and a lack of accommodation for these staff. We were told that lack of accommodation was a serious issue. According to senior SMS staff, it would be at least three years before any new-build was complete, and at the time of the inspection, planning consent had not been

granted. We were concerned that there seemed no sense of urgency about tackling this problem and that, as we identified in the previous section, there seemed to be no long-term plan to address capacity.

The Aberdeen Joint Alcohol and Drug Action Team (JADAT) submitted its Corporate Action Plan (CAP) for 2006-07 to the Scottish Executive in May 2006 and received feedback on the CAP in October 2006. Our review of Section F of the CAP, which gives details of drug and alcohol direct spend by partner organisations, noted the following:

- Drug Specific Spend – £2,176,000 of Scottish Executive funding had been made available to the JADAT during the period 1998-99 to 2005-06. The 2005-06 funding and actual spend had not been identified separately by the JADAT. In addition, a further £2,781,000 of funding was available from partner organisations of the JADAT for 2005-06. Some financial information in relation to this category was outstanding.
- Alcohol Specific Spend – £392,000 of Scottish Executive funding had been made available to the JADAT during the period 2004-05 to 2005-06. The 2005-06 funding and actual spend had not been identified separately by the JADAT. In addition, a further £480,000 of funding was available from partner organisations of the JADAT for 2005-06. Some financial information in relation to this category was outstanding.
- Combined Drug and Alcohol Specific Spend – there was £105,000 of Scottish Executive funding made available to the JADAT for use in 2005-06. In addition, a further £257,000 of funding was available from partner organisations of the JADAT for 2005-06.

Recommendation 11

There is a recommendation on financial issues for all three Action Teams in Chapter 6.

3.6 Capacity for Improvement

The evaluation of capacity for improvement is based on three key factors: demonstrable improvements in outcomes for people who use services, quality assurance and performance management, and the effectiveness of leadership at all levels in health and social work services.

Aberdeen had a serious problem in relation to the large waiting list for people to gain access to prescribing services, and waiting lists for some other services. Plans to resolve this were at an early stage and we did not have confidence that the JADAT and its constituent members had strategies in place to address this quickly. Services for the treatment and rehabilitation of people who misuse substances were in the process of a major redesign. We recognised improvements in developing some aspects of an integrated service, but there was still some

way to go for there to be an integrated service for the city. Changes in the structure of the Council services, particularly the place of social work in planning and service delivery, and proposed changes in the leadership of the JADAT, as well as uncertainty about the timescale for important new developments such as the Integrated Care Planning and Stabilisation Service, added to uncertainty about the future of substance misuse services in the city. Attempts to develop performance management of services were also at an early stage.

Factors which would underpin and support positive change were identified. It was clear that senior staff in the Aberdeen area were aware of much that needed to be done to improve services, and had begun to initiate a major redesign of services. There was evidence of improving outcomes for those in treatment. The appointment of a team leader for the JADAT team, the beginnings of joint commissioning, the good start made at integrated working by ICDRS, and the recognition by social work that more specialist social work staff were needed, were all promising. The capacity for improvement was therefore ADEQUATE.

Aberdeenshire Alcohol and Drug Action Team Area

Action Team: The Action Team in Aberdeenshire is known as the Alcohol and Drug Action Team or ADAT. The team meets quarterly. The membership of 27 includes health (7), local authority officers (6), local authority elected members (2), police (2), prison (1), voluntary sector (1), Forum (3), Licensed Trade (1), ADAT (4). There are three forums in the shire, which cover North, South and Central areas and which are all represented at team meetings.

There are four sub-groups: Care and Treatment, Children and Young People, Criminal Justice, and Education and Prevention and Community Safety.

The team is supported by a Co-ordinator, two development officers and an information officer.

4.1 Key Outcomes

The ADAT had introduced a number of measures to promote outcome-focused practice and to commission and develop services on this basis. This was work in progress and there were occasions when the emergent evidence was not clear or robust enough at the time to support a firm judgement.

The balanced nature of evidence to date led to an evaluation of ADEQUATE on this performance measure.

Prevalence profile

Aberdeenshire had seen a steady increase in the number of residents seeking treatment, although there had been a levelling out over the period from 2004-06 at just over 500 people seeking help for specialist drug services. Nevertheless, the latest figures suggested that, at 1.10% of the population known to have problematic drug use, this was still well below the Scottish average of 1.84%. There had been a gradual increase in the number of service users describing a history of illicit drug use of 10 years or more. The figure for 2005-06 was 61% in respect of service users with an average age on presentation of 26 years. This had implications for the development of youth-focused services. Opiate dependency was the most common presenting problem. The waiting list of around 60 compared to an active caseload throughout substance misuse services of 855. Some people from south and central Aberdeenshire received clinical intervention in Aberdeen. Despite NHS Grampian and ADAT efforts to roll out the integrated service model from the north of the shire there were no such services available in central and south, and Aberdeen is more convenient to travel to than Fraserburgh.

Percentage figures from 2004-05 on 13-15 year olds who reported using illicit drugs, showed that 11% of 13 year olds and 31% of 15 year olds reported that they had been involved in drug use, an increase on the 2002 SALSUS figures. There had been a very slight increase in the number of referrals to the Reporter on the grounds of substance misuse between 2003-05.

There had been a sharp increase in the number of neonatal discharges where maternal substance misuse had been a concern, and an increase in the numbers of children on the child protection register where substance misuse was a major contributing factor.

With regard to alcohol problems, the figures for adult alcohol consumption across Grampian were similar to the Scottish average. The figures on patterns of under-age drinking showed that young people in Aberdeenshire exceeded Scottish averages on a number of key measures. The contact rate with GPs for alcohol problems was reported as 14 per 1000 of the population in 2004. This compared favourably to the national figure of 24.3.

Performance profile

In common with the other Action Teams, performance data on outcomes was being developed. The information which follows on performance is in relation to the priorities set by the Scottish Executive as well as emerging evidence on progress on planning and delivering services with a focus on measurable outcomes.

Aberdeenshire ADAT exceeded its performance contract with the Scottish Executive for 2005-06 relating to new clients, with 419 entering treatment [SDMD 2006 p.11]. Between 2004 and the end of 2005 Aberdeenshire saw a reduction in the percentage of people who were seen for assessment within 21 days of being referred, from 26% to 23%. During the inspection we were told by a senior officer that 95% of people were now seen within four weeks of referral. Once assessed, there was an improving picture of treatment being in place within 14 days.

We found waiting lists were regularly reviewed and generally well managed, subject to the disparities that existed between the north and other parts of the shire. In the north, the first letter which was sent to people explained the reason for any delay and signposted them to the local voluntary sector service in the mean-time. No equivalent service existed in south or central Aberdeenshire.

Culture, change and communities

The ADAT had used its 2002 Adult Lifestyle survey to set out a baseline for the number of adults exceeding weekly sensible drinking levels. However, as this had not yet been repeated there was no more recent information by which to measure performance. The planned 2005-06 activity outlined in the CAP alluded to awareness raising, engagement with community forums, and health fairs in schools to target parents, but was vague on outputs and on measurable outcomes.

Aberdeenshire measured its performance in relation to drug and alcohol-related crime through numbers of a range of offences and police actions, some directly related to substance misuse and others not. There had been an increase in drunkenness offences but much of the performance information appeared to indicate an overall increase in drug-related crime and also police stop and search activity.

Management of social work criminal justice addiction services for Grampian was located in Aberdeenshire. The Aberdeenshire CAP was the only one of the three to note specific targets for this intervention, including increasing numbers being supported by criminal justice addiction workers.

Prevention, education and young people

Aberdeenshire figures on under-age drinking patterns exceeded the Scottish average figures on a number of key measures. We found some indications that Aberdeenshire was attempting – with variable success – to address the challenge of effective engagement with young people. A dedicated Children and Substance Misuse post had been made permanent, while a youth project previously contracted to deliver drug-focused interventions was re-launched in 2006 as a substance misuse initiative.

Planned activity in this area had stalled because of staff capacity problems. Nevertheless, the evidence from the CAP and our fieldwork suggested that the approach taken in Aberdeenshire was strategic, partnership-centred and sustainable. The emphasis was on capacity-building with those people and for those organisations, who had most day-to-day involvement with young people, such as Community Learning workers, youth workers and families. This was complemented by research-based projects targeting staff working with children at risk or hard to reach, for instance children's home staff and outreach workers.

Concerns about reported rises in the number of neonatal discharges led to Aberdeenshire conducting a training needs analysis for this group. They also took a decision to review the role of NHS Grampian Improving Health staff in schools and in the community, to develop their remit to respond to prioritised concerns.

Aberdeenshire used SMR 24 and SALSUS data as performance measures for the target to reduce the proportion of under 25s reporting illegal use of drugs. Numbers of under 25s reported as new clients in SDMD 2006 was 151, a dramatic increase on the 2004-05 figure of 66. There was also a markedly higher incidence of service users in their mid-twenties reporting substance misuse of 10 or more years standing. We saw very good examples of youth services which engaged with young people on a range of health and lifestyle issues but there were reports that they needed stronger links with treatment services. Their perception was that the waiting times were longer than the official data suggested.

Provision of support and treatment services

The national priority to increase the number of drug users in contact with treatment and care services has been met by the ADAT. Moreover, they had reduced waiting times and the percentage of unplanned discharges. Figures on drug misusers successfully completing treatment showed an increase from 33 for the year 2004-05 to 50 for the first nine months of the 2005 financial year.

These figures were encouraging but did not identify the extent of the disparities which existed between the north of the shire and south and central. We heard from senior staff that they were very conscious of the need to redress the balance of accessible services across the shire.

The ADAT had purchased or commissioned services from voluntary and independent providers. It had taken steps to ensure value for money, in that it sometimes commissioned part of a service which was primarily delivered for the city in the city. This was true of drug and alcohol service providers who had posts or sessions assigned to the shire, either on an outreach basis or attached to a particular base. This could be problematic when the main contract was under threat, as with the INCITE project for psychostimulant users. We also heard from some rural service users that they would rather access specialist services in the city to protect their anonymity.

The ADAT had secured temporary funding for three employment workers to engage specifically with people who had a history of substance misuse. The most recent figures showed that this project had some success in attracting referrals and translating those into personal development and health improvement gains. Within a year, 20 people had moved into full employment. We were told that the success of this project had exceeded expectations and, as a result, the workers were being prioritised by the Care and Treatment sub-group for permanent funding.

Performance summary

Overall, the CAP demonstrated considerable activity for 2005-06 and identified timescales and leads for all of the actions for the coming year. The measurable outcomes were often process measures. However, one of the actions was to produce outcome measures for all services by December 2006.

Aberdeenshire's self-evaluation questionnaire stated that the ADAT had developed a corporate approach to performance monitoring of drugs and alcohol treatment services. This was partially supported by our inspection findings. The key players in the ADAT and sub-groups all demonstrated a consistent understanding of the role and relationship between strategic and operational outcomes, and how the ADAT structures and processes were applied to monitor and report on progress.

However, there were evident deficits in management information systems which limited or slowed such processes up, and inconsistent IT systems across agencies, or unsophisticated systems within some agencies resulted in data for audit purposes being manually collected and harmonised. We were told that a recent survey of service users had attempted to capture how useful the service they used had been and the specifics of the difference made. These results were not available at the time of the inspection.

We also found that appropriate links were made between high-level strategic planning documents such the Joint Health Improvement Plan and Community Plans, but documentary evidence supplied by the ADAT on periodic reporting on treatment outcomes failed to set these in a strategic context, either in relation to national or local targets, or to inform strategic planning.

Evidence of progress on the ADAT's five current strategic objectives of quicker access to services, increased number of individuals starting treatment, improved retention in treatment services, decreased unplanned discharges and increased planned discharges was encouraging. There was increased access to services, people were experiencing health and lifestyle gains from their engagement with services, and the positive impact of the employment development workers had exceeded expectations.

The common shortcoming in outcome reports was the lack of context. In the absence of information concerning outcome targets, it was impossible to determine whether the outcomes were achieving or exceeding expectations, or falling short on a particular measure such as value for money.

Regarding individual gains resulting from engagement with substance misuse services, the local authority had begun employing the Cristo impact tool, which can assist in sustaining motivation and focus on progress towards outcomes for both service user and worker.

There were strong and consistent signs that the ADAT and service providers shared a commitment to achieving effective performance on demonstrating outcomes for service users, but the means of evidencing this must now move to a higher level of harmonised reporting and performance management.

Recommendation 1

There is a recommendation on outcome and performance measures for all three Action Teams in Chapter 6.

In 69% of cases from the local authority and voluntary sector file sample the individual's circumstances were seen to have improved. Effective collaboration between services was considered to be a significant factor in this improvement in only 15% of voluntary sector files, but in 49% of local authority cases.

4.2 People Who Use Services, Staff and Other Stakeholders

In Aberdeenshire, people who used services were generally positive about their experiences, and some support for carers was developing. The staff survey results were mixed. We found staff to be positive on the whole in our meetings with them. Aberdeenshire faced significant challenges regarding the impact of substance misuse on comparatively small communities. The evidence varied as to how well they had engaged in addressing the concerns of communities whilst engaging with them in decision-making around the provision of services. We consider that Aberdeenshire performed to a GOOD standard in this measure, demonstrating important strengths.

Experience of people who use services, their families and carers.

This section includes some findings from the peer research specific to Aberdeenshire, as well as findings from observed practice and our meetings with service users and carers during field work. We found it more difficult to identify carers, and the experience of those related here cannot be assumed to be typical.

Thirty one of the 36 service users who took part in the peer research made evaluative comments about their experience of accessing and using services. These can be roughly grouped as follows:

| | |
|--|-----------|
| Those who were complimentary in general terms about services | 6 |
| “I think this service is one of the best I have experienced” | |
| “I’ve been lucky to get the service I get” | |
| Those who singled staff out for particular praise | 6 |
| “It’s quite a dangerous job for staff and they should get more credit for what they do” | |
| “Staff have given me more support than my family” | |
| Those who had experienced good inter-agency working | 2 |
| “I am very impressed with the whole package” | |
| Those who were concerned about access to services | 11 |
| “One thing that gets to me is the lack of services and the waiting lists” | |
| “We need the needle exchange to be open longer and access to prescribing” | |
| Those who felt professional attitudes were unhelpful | 6 |
| “There is a big problem with GPs in the area. They do not want to give addicts any help” | |
| “The health centre attitude to drug addicts is terrible” | |
| “The health service should be a bit more tolerant” | |

Fieldwork meetings with service users

Service users we met with were very positive about the services they were receiving. Some told us they would not have known how to go about accessing specialist services if the services had not come to them following court appearance. Some service users told us about long waits for substitute prescribing.

In our observed practice sessions we were impressed with the extent to which service users seemed to be fully engaged in decision-making around their care in treatment. This was confirmed by them in subsequent discussion. They spoke highly of the main service they were engaged with and we found more frequent instances when service users were clear that their key worker/care co-ordinator actively sought input from other agencies or mainstream resources, to support a comprehensive care plan.

All of the service users felt that they had achieved some positive changes as a result of their engagement with services.

There had been a recent survey of service users views on services but the results were not available at the time of the inspection.

Experience of carers

In common with what we heard from carers in Aberdeen, carers in the Shire had taken a long time to seek support after it became evident that the person they cared for had a dependency problem. In smaller towns they felt exposed to recognition and possible speculation if they were seen to pick up information about support in a public setting.

A web-site had been developed for the area, which was affiliated to the national carers group. However, the reported means by which carers had found out about help was one of two family support groups. We understood that one had been disbanded. The group we attended was supported by two local authority facilitators.

Experience of support within the group was extremely positive but there had been varied experience of their involvement in assessment and care planning processes in respect of the person they cared for.

Recommendation 2

There is a recommendation for all three Action Teams about the involvement of users and carers in developing services in Chapter 6.

Training opportunities relating to substance misuse were opened up to carers. We heard from one carer about his experience of attending a conference funded by the group and finding that he was the only non-professional there. There was also access to alternative therapy training through the group, and a carer had been trained in a particular technique, which the carer was then able to use to therapeutic effect with the person they cared for.

Experience of staff

We received 25 responses from staff employed by Aberdeenshire Council substance misuse services, a 78% response rate of the total number of staff.

Motivation and satisfaction among staff were high. We had evidence that staff enjoyed the work they did. Managers spoke very highly of staff and the survey results indicated that nearly all staff who responded felt valued by their managers and well supported in situations where they may have faced personal risk. The majority agreed morale had been good in their team for the previous six months. Staff, including administration staff, spoke positively about training and development opportunities available to them.

Staff expressed some frustration about inadequate staffing levels in some services or teams, temporary contracts rather than permanent ones, and time spent on paperwork rather than direct contact with service users. The area which staff were most concerned about, however, was gaps in services and the implications for those with substance misuse problems unable to get the help they needed. Common themes were that staff felt they were doing their level best in a difficult field, and some exasperation that strategic bodies like the Scottish Executive and the ADAT seem unable to address resource issues systematically and sustainably.

“We did get exhausted sometimes as problems were very often life or death.”

“Waiting list was too long, there were limited staff to deal with the desperation people were in at times.”

(Quotes from staff survey)

Most of the 25 respondents in our survey agreed that more effective collaborative working between all the agencies represented in the Action Team structure had resulted in improved outcomes for service users. Aberdeenshire achieved the highest rating in the file reading results for partnership working appropriate to the needs of service users. Some partnerships were perceived to be working better than others.

Partnership working

| | AGREE | DISAGREE |
|---|-------|----------|
| Effective partnership working by all agencies represented on the Action Teams has improved outcomes for service users | 83% | 17% |
| My team has a good relationship with GP practices | 60% | 40% |
| I participate in regular multi-agency/disciplinary meetings | 78% | 22% |
| In multi-disciplinary teams, all staff can access the records of people who use our services | 31% | 69% |
| My team sign-posts people to appropriate services | 100% | 0 |
| Where more than one service is involved they join up around the needs of service users | 77% | 23% |

Concerns were expressed in our focus groups about weak partnership links with mental health services.

Almost all of the 20 staff who responded to the question agreed that where service users had parenting responsibilities, their team was proactive in sharing information and engaging in joint assessments with all relevant agencies. A similar number felt that they worked effectively with social work child care where there were parenting/child protection concerns. However, the file reading results highlighted the need for improvement in this critical area. Only 4 of 11 files contained an initial assessment where there were children living in the same household.

All 25 of the staff who responded agreed the service provided had a positive impact on the lives of service users and their families and their team promoted recovery and routes out for people who use services.

It was noteworthy that half of the 20 staff who responded to the question disagreed that their working conditions were expected to improve over the next 12 months.

Around half of the staff who responded agreed that substance misuse services were highly valued by elected members and by the NHS Board. Most of those who responded agreed that there was top level commitment from health, social work and the voluntary sector to work together to continually improve services.

Impact on community well-being

In its self-evaluation, Aberdeenshire presented a very positive picture of its performance on this measure which was not wholly supported by the findings from the inspection. While we found evidence of good strategic planning and structural links, we heard from senior staff and from community representatives that the strategic focus had been skewed towards drugs when the

problems confronting them were mainly concerned with alcohol. In fact, the most recent figures suggested a comparatively low rate of reported neighbourhood disturbances related to substance misuse.

There was little evidence to show that the ADAT had taken steps to engage with communities on substance misuse issues beyond those driven by national targets. While there was reference to the local press being invited to ADAT meetings, it was not clear whether this formed part of a corporate approach to community engagement, and if there were any feedback mechanisms from this.

We heard from staff that there had been neighbourhood resistance to substance misuse services being developed in their area. However, there was no evidence of those services, or those which were currently being developed or re-designed, being the subject of proactive community engagement early in the planning stages. We were advised that these concerns had quickly subsided when the services had been operating for a while without incident, but this does not address the central issue of effective community engagement. It was suggested that there was a particular need to engage with communities which had been associated with relatively high levels of substance misuse problems, where whole communities could feel stigmatised by the association.

Both senior management and elected members felt that there needed to be a re-balancing of substance misuse resources to reflect the fact that public fears about drug use were being allowed to mask far larger-scale problems with alcohol misuse. It was alcohol-related disturbance which adversely impacted on the communities they represented. The issue of increasing prevalence in relation to underage drinking was a particular source of concern, along with that of problematic parental drinking. These were areas that the ADAT were focusing on as outlined in the current Corporate Action Plan.

Example of Good Practice

We visited a youth project in small community in Aberdeenshire. The service model was a generic one, offering education on alcohol, drugs and safer sex, and we considered that the prevention work was a good example of responding to the realities of young people's lives. There was evidence of good links with all services in the community, including the local GP practice, the pharmacy and the police. The emphasis was on social inclusion activities, and the development of personal confidence and social skills.

Community planning consultations in Aberdeenshire resulted in the identification of three community safety priorities, of which reducing the problems arising from substance misuse was one. It was not clear to us how this was being taken forward with communities affected by the issues. The Community Safety Strategy Group was represented on the Criminal Justice sub-group of the ADAT and vice versa.

4.3 Key Processes

While services were patchy across Aberdeenshire and in the centre and south in particular, the integrated service in the north was well developed, and there was evidence of good integrated working among statutory and voluntary staff. We consider Aberdeenshire's performance in this area to be GOOD.

The journey of the service user and family through services

There was a useful Guide to Services for alcohol, drugs and sexual health in Aberdeen and Aberdeenshire, and individual services produced leaflets. Local community pharmacists also had details of substance misuse services. However, a recent local survey of service users identified the need for improved information about services available.

The health and social work staff at the Kessock Clinic were line managed by their own agencies but described themselves as an integrated team. We found evidence of joint weekly referral meetings and monthly meetings to discuss issues such as policy as well as evidence of integrated care plans. There were also good relationships with local voluntary agencies. Although staff in central and south Aberdeenshire also described good inter-agency relationships, they were not able to work in as integrated a manner as staff in the north and expressed frustration about this. Barriers to greater integration included lack of suitable shared accommodation bases and there was a plea for a resource like the Kessock Clinic to be available in central and south. All health and social work staff used the integrated assessment form but the voluntary organisations did not.

Seventy five percent of referrals to the integrated substance misuse service at Kessock Clinic were from GPs, while the majority of referrals to voluntary sector services such as Northern Horizons and AACS were self-referrals.

Waiting times to enter drug and alcohol services varied throughout north, central and south Aberdeenshire, but were reported to be reducing, and Aberdeenshire ADAT was taking active steps to address this issue. Staff told us that the north used an NHS Grampian/Council priority scoring system, but south and central did not, and "worked on generally agreed priorities". In the north the aim was for people to be on the waiting list for no longer than 12 weeks, whereas in the south, where there were 24 people on the waiting list when we visited, they may have had to wait for 6 months for a service. People on the waiting list were given information about other services for which there was little or no waiting list. For people who needed detoxification and rehabilitation we were told there could be additional delays until vacancies became available and funding secured. After two appointment letters to which there had been no reply, people were discharged from the waiting list.

There was general agreement among staff that this system was a product of the Scottish Executive requirement to reduce waiting lists. Some were unhappy about the inflexibility while

others expressed the view that intervention was more likely to be successful if service users were motivated to attend. New referrals on the waiting list received a letter copied to the Community Substance Misuse Service team, who sometimes provided additional support, and the GP. One of the voluntary organisations wrote to everyone on the waiting list every two weeks and offered telephone support with a named worker.

While it was generally accepted that chaotic substance misusers with children required priority attention, staff agreed that there were risks in not assisting single young men who were unsupported, unemployed and had a poor quality of life, who could easily drop to the bottom of any waiting list. Teams told us that they would try to include some young men among priority cases. Other high risk groups which had low priority were liberated prisoners not on methadone.

All of the agencies delivering substance misuse services in Aberdeenshire had their own files. We read 62 social work and 24 voluntary sector files. NHS Grampian conducted an internal audit of 88 of its Substance Misuse Service files, a sample size not sufficient to allow analysis at the Action Team level. The results from the health file reading are discussed in Chapter 7.

We found that almost all of the social work and voluntary sector files contained an assessment. Seventy percent of social work files contained a single shared assessment but none of the voluntary sector files did, as the voluntary sector services did not currently use the integrated assessment form. Sixty seven percent of the social work assessments were rated as good or better, 22% rated adequate and 11% weak or unsatisfactory. Only 14% of the voluntary sector files were rated as good or better, 59% were rated adequate while 27% were rated weak or unsatisfactory. Eighty seven percent of the local authority files had a care and treatment plan or equivalent but this fell to half of voluntary sector files. In cases where risk to the service user or others in the household was identified, only 19% of the relevant social work files contained an up to date risk assessment and risk management plan while the figure was 40% for the five relevant voluntary sector files.

Recommendation 4

A recommendation on assessments and risk assessments applicable to all three Action Teams is made in Chapter 6.

The health members of the integrated team did not work with significant others unless the service users wished it, while the social workers did. There was a group in Banff for families affected by drugs or alcohol, and there was a plan to begin one in Peterhead. They also offered one-to-one work with significant others, including when the drug or alcohol user was not involved with the service. This service was also available in central and south Aberdeenshire.

AACS offered one-to-one cognitive behavioural therapy (CBT) and some family support, focused on lifestyle, budgeting and welfare rights.

Example of Good Practice

Aberdeenshire employed three Employment Development Officers (EDOs), although the posts were currently time-limited due to funding. The EDOs encouraged recovering substance misusers to access various schemes and projects to promote a more organised lifestyle, and connected them to mainstream services such as further education and leisure. Support workers encouraged, accompanied and helped people to keep appointments. Obtaining work experience, however, was very difficult. All staff interviewed spoke highly of the Employment Development Officers and their impact.

Multi-agency and multi-disciplinary working and integrated person-centred care

Aberdeenshire seemed to have made good progress in developing integrated care. There were joint multi-agency guidelines for information sharing, although only 60% of the social work and voluntary sector files we read contained evidence of consent to share information.

We analysed the care and treatment plans in the social work and voluntary sector files to determine to what extent they evidenced integrated care around individuals' needs. We found that 74% of the social work care plans completely or mostly evidenced integrated care and 26% did so only partially or not at all. However, only 31% of the 13 voluntary sector care plans we saw completely or mostly evidenced integrated care while 69% offered partial or no evidence of this. In 95% of social work files it was clear which agencies and professionals were involved while the figure for the voluntary sector was 67%. In 72% of social work files there was evidence of multi-agency working with clearly stated roles and responsibilities but this figure fell to 26% for the voluntary sector.

The ADAT commissioned an evaluation report on GOPR, and this report stated “there has been a change of focus for the majority of agencies, and this has led to challenges for staff in taking a more child-centred approach in their practice” and “the requirement to gather information about the children of service users was well understood by staff”. However, we found that only a third of the 11 social work files and none of the four voluntary sector files where there were children in the household contained an initial assessment of the impact of parental substance misuse on the children. Managers and staff interviewed had some concerns about consistent practice in parenting assessments, a concern we shared from our file reading, where only one of the 16 social work and voluntary sector files where there were children in the household contained one. There was, however, a full-time child care post attached to the Integrated Substance Misuse Team in the north of Aberdeenshire.

Recommendation 5

A recommendation applicable to all three Action Teams on working with families where there are substance misuse problems is made in Chapter 6.

Frontline workers from statutory and voluntary organisations seemed to work well together to deliver integrated services. Although integration seemed to be better evidenced in the north of Aberdeenshire than in the centre and south, these teams were good examples of integrated working without integrated management. CPNs were based in some GP practices, but not in all of them. We attended a quarterly meeting of the Central Aberdeenshire Alcohol, Drugs and HIV Forum (one of three in the shire) whose purpose was to inform the ADAT what was going on locally, and ensure local agency involvement. The Kessock Clinic in Fraserburgh held integrated weekly staff meetings to review cases, consider discharges and look at new referrals, which were prioritised using a points system. Joint assessments were undertaken and service users could attend multi-agency case conferences. Users of services we spoke to agreed that they thought services worked well together to help them.

The involvement of, and partnership with, people who use services, their families and carers

The three drug and alcohol forums in Aberdeenshire encouraged service users to take part in their activities, and stakeholder days had been held for information and feedback purposes. Service user feedback was built into the integrated assessment process and managers felt staff were becoming more comfortable with the integrated assessment form. Sometimes they left it with service users between appointments so that they could complete some of it themselves. They had tried different ways of involving people in their own assessments. This was confirmed from the file reading where virtually all of the social work and voluntary sector files we read contained evidence that the views of the service user were taken into account. Eighty one percent of social work files and 59% of voluntary sector files contained evidence that the service user was invited to attend decision making meetings and reviews.

The ADAT was looking at ways of collecting information from the assessment form to use in the planning of services. Treatment services were developing service user satisfaction data collection. In the integrated service they had just completed a cross-Aberdeenshire service user evaluation.

Family support groups were beginning to be established in Aberdeenshire and sustained over time. A member of the Aberdeenshire carers group represented carers on the Drug and Alcohol Forum. However, involvement of users and carers still had some way to go, with service users reporting that they did not feel involved in strategic planning or service development. The peer research conducted by SWIA may have given some impetus to this process.

Inclusion, equality and fairness in service access and delivery

As stated previously, services across Aberdeenshire varied, with the north being seen as being better served than central and south. Of particular concern was the lack of access to GP prescribing services, with key areas of Aberdeenshire having no GPs prepared to be involved in the enhanced care scheme, notably Peterhead, Inverurie and Stonehaven. Some outreach rural services and home visits had been developed where geography was an issue in accessing

services. Carers interviewed reported a “post-code lottery” in the response and support they received when they sought help.

4.4 Strategic Management and Leadership

Staff and stakeholders stated the ADAT provided a clear vision for developing services for people with alcohol and drug misuse problems. Joint commissioning arrangements were seen to be good, and the range and quality of services was particularly good in the north, but the south and central parts of the county were somewhat behind the north in provision. The ADAT had begun the process of collecting information to improve performance.

We found performance in this area to be GOOD.

Vision

During our visit, staff and other stakeholders we spoke to stated there was a clear vision for substance misuse services in Aberdeenshire. Staff and managers of substance misuse services said there was a clear direction of travel, although at times they found the pace of developments frustrating and they felt constrained by Scottish Executive funding.

The main overall priority for funding in the ADAT’s Corporate Action Plan (CAP) was increasing the capacity of treatment services to achieve:

- Quicker access to treatment;
- Increased numbers of individuals starting treatment;
- Improved retention in treatment services;
- A decrease in unplanned discharges; and
- An increase in planned discharges.

Elected members on the ADAT were knowledgeable about the substance misuse agenda. Those we spoke to were clear that the three major priorities requiring attention were young people, a greater emphasis on tackling alcohol misuse and addressing “local service deprivation”. They also said that the ADAT should be more accountable to the local authority in terms of its performance reporting and monitoring arrangements and that it should be better linked with the community planning structure.

Joint planning and development of services

Aberdeenshire’s second Community Plan (2006) had five themes, and drugs and alcohol were included under community well-being. There were no alcohol or drug-related objectives under this theme nor was the ADAT CAP listed under the key strategies. However, there was an indicator for community safety which was about reducing the number of alcohol and drug-related offences. There was a link to the Community Safety Strategy 2005-08 which had a

priority theme of tackling problems arising from substance misuse. The first key task in the Aberdeenshire Community Safety Partnership Action Plan 2004-05 was to 'positively affect alcohol and drug misuse' and the ADAT was identified as the lead agency. The stated outcome measures were:

- reducing admissions to A&E for excess alcohol consumption;
- reducing the misuse of alcohol and drugs;
- a reduction in levels of violent crime;
- a reduction in referrals to the Children's Reporter; and
- an increase in 'Good Citizen' inputs and youth diversion schemes.

No specific targets were set but it was intended to measure outcomes by counting numbers.

Alcohol and drug misuse is an issue that cuts across many areas of Local Authority activity and needs to be included in a number of different strategic and action plans. In Aberdeenshire we saw alcohol and drugs featured in the community plan and the community safety partnership action plan. However, whilst the ADAT was mentioned in the latter we thought there needed to be a better relationship between the objectives in the ADAT's corporate action plan and the community planning process.

Recommendation 6

There is a recommendation on strategic links applicable to all three Action Team areas in Chapter 6.

Commissioning arrangements

The ADAT set the broad strategic objectives in Aberdeenshire whilst the Care and Treatment sub-group was the main planning and commissioning body. At the time of the inspection Aberdeenshire Council outsourced 53% of its services including some substance misuse services. Some negotiations had been undertaken jointly with health. One service provider stated that Aberdeenshire provided good contracts and contrasted this with one year funding in other areas. However, staff commented that funding decisions could take a long time even when the money was available through the Scottish Executive and this was a cause of frustration. There was some evidence that outcome setting in service level agreements could be improved.

Range and quality of services

Aberdeenshire health and social work services were delivered by 11 CPNs based at the Kessock Clinic at Fraserburgh and a Community Substance Misuse Service comprising a team manager, a senior social work practitioner, five care managers and two support workers based in Fraserburgh, Peterhead and Banff. The staff complement in central and south Aberdeenshire was

1 service manager, 4.5 care managers and 2.9 support workers. There was also a criminal justice addiction team. This team was composed of a team manager, a social worker and a throughcare support worker based in Peterhead and Strichen. The primary voluntary provider was the Turning Point service “Northern Horizons” in Peterhead, although Aberdeenshire shared some of the voluntary services with Aberdeen.

Resource constraints in the face of increasing demand for services had prompted a review of service provision to try to ensure that all services were being utilised to maximum effect. Substance misuse care management processes had been refined to ensure that qualified social workers focused on assessment and complex intervention, while more regular contact and support was provided by support workers.

Resources were being targeted efficiently, in that some posts were part-time and there were also part-contracts with voluntary sector services from the city. These measures allowed localised access to substance misuse services. The challenges of providing services in rural areas whilst not exposing service users to stigma were referred to throughout the inspection, and were found to be particularly acute in south and central areas.

Aberdeenshire had recently agreed to fund specialist GP sessions to help address the gaps in prescribing services in some areas. However, as there had been no recruitment or identification of a location for the post, the ADAT had just agreed to recruit a doctor on an SMS staff grade and space had been identified in Huntly and Portlethen. There was also a lack of needle exchanges, particularly in central and south Aberdeenshire.

Recommendation 12

Aberdeenshire should continue to take steps to develop services in the south and central area of the county to the standard of those in the north, based on identified need.

There was an independent provider of both alcohol and drug rehabilitation in Aberdeenshire and one supported living service for alcohol. Aberdeenshire tended to use these facilities. These services are subject to regulation and inspection by the Care Commission, although the supported living service had only recently been registered and there were no published inspection reports. The most recent 2006 inspection report on the independent provider contained no requirements and one recommendation. It was noted that the recommendations in the previous report had been addressed, and there was a reference to a comprehensive audit of the service having been conducted by an officer of the local authority the previous year. The report included very positive feedback from service users.

Quality assurance and continuous improvement

Aberdeenshire substance misuse services had recently sent out 300 questionnaires to people using their services. A third of them had been returned. Most responses were positive and made a number of constructive suggestions for improving services. Criminal justice had exit questionnaires although the return rate tended to be poor.

We were told that the issue of measuring performance outcomes had been discussed by the ADAT. Services had reflected on this discussion and then agreed that the integrated assessment and review form would be the tool for services which used it and Christo would be the tool for those who did not. The pilot of the assessment form for this purpose was at an early stage. However, the framework contained a scale of 1 to 10 for each part of the service user's life, e.g. health, family and addiction. Services were asked to record these scores at the initial assessment and then again at the person's review. This should give an indication of progress in each of the areas.

We attended an event organised by the Aberdeenshire BBV Forum which provided a good opportunity for networking and sharing of good practice across the area.

Example of Good Practice

The ADAT & North Alcohol, Drug and HIV Forum conference. We sat in on a conference, attended by a number of agencies, one of a series over a 10-month period, which had involved the police, specialist services and a theatre company in making presentations. The conference was fully interactive, and included a series of workshops. There were a number of display stands with information on agencies available to delegates.

Management information

The ADAT stated that a waiting times database was well established across all treatment services, who were reporting on service inputs and outputs on a quarterly basis. Administrative staff at the Kessock Clinic recorded referral, waiting list, caseload, discharge and re-referral information on electronic databases. They acknowledged that this could be improved. They were also hampered by the system 'crashing' regularly as there were inadequate telephone lines. The further development of outcome data was an ADAT priority for 2006 and 2007.

Recommendation 8

There is a recommendation for all three Action Teams on management information in Chapter 6.

4.5 Partnership Working

We found that while Aberdeenshire's structures were not integrated, there was evidence that partners worked well together to provide a service to people with substance misuse problems. Aberdeenshire had taken a lead in the development of policies and practices for children in families where there was substance misuse. The ADAT was in the process of reviewing how funding streams were being used. We considered performance in this area to be GOOD.

Partnership arrangements

Aberdeenshire had less formal integration of both strategic and operational structures than Aberdeen City and Moray. Despite separate accountability arrangements, most of the people we spoke to said the ADAT worked well, although they acknowledged this depended on the ability of key individuals to work together. The ADAT was linked to the CHP through the Chair, which rotated among the main agencies. The police were not members of the CHP but could be co-opted on when it was their turn to Chair the ADAT to maintain this link.

The Chief Executive of the local authority described good relationships with health. However, some staff said that health dominated decision-making about substance misuse services. They stated that effective partnership working was sometimes hindered by a lack of transparency about the decision-making process and there was a lack of ability to take account of external influences. Aberdeenshire elected members also described good partnership working in the area, although they acknowledged there was "still some way to go" to get everything in place. They described good links with the NES CPC and using the Community Justice Authority to enhance links with the police and prison services, which they felt to be crucial for substance misuse services.

Development and review of joint policies, procedures and protocols

Aberdeenshire used Grampian information sharing policy and protocols across agencies. Integrated drugs and alcohol services were well established in North Aberdeenshire, and the use of integrated assessments, information-sharing, joint care plans and case reviews had been agreed and implemented.

Aberdeenshire had an operational protocol between the Criminal Justice Addictions Team, Supervised Attendance Order Workers and APEX.

Aberdeenshire had led the implementation of GOPR in Grampian. Training had taken place for GPs and health visitors, speech and language therapists and school nurses, as well as staff from other services such as housing. There had been limited success in involving GPs.

Recruitment, deployment and development of staff

We were not made aware of any significant recruitment or retention issues in Aberdeenshire. Some staff, however, complained that there were too many short term contracts. Staff in central and south Aberdeenshire expressed frustration at not being able to achieve greater integration on a par with their colleagues in north Aberdeenshire. Nonetheless managers and staff appeared to be a stable and motivated group. All the work of the public agencies in Aberdeenshire was with both alcohol and drugs.

There was a GOPR training and familiarisation strategy for staff, headed by a named officer. Voluntary sector staff whose service covered more than one Action Team area felt that the shire had had the most systematic and inclusive approach to this. The measures may have been effective in raising awareness and forging connections with child care workers, but it should be noted that these were not reflected in the file reading results. There was a commitment in the CAP to report on progress and improve implementation of GOPR in the spring of 2007.

Staff were satisfied with their training and continuing professional development opportunities. These included team days, which were seen to be valuable, STRADA courses, the post-graduate course at Paisley University and multi-agency training days, one of which the inspection team attended. There had been a recent development day which involved training for all staff in motivational interviewing. Staff also described informal learning from working in a multi-disciplinary team. Joint training on GOPR and Hidden Harm had been offered to all staff. Staff suggested that more joint training would be valuable. Social work staff training needs were identified through the council's appraisal system and supervision with line managers. The Aberdeenshire ADAT was undertaking a training needs analysis. Staff were generally satisfied with their supervision arrangements. Turning Point staff described good staff policies, review and appraisal systems and excellent opportunities for continuing professional development.

Joint budgeting and use of financial resources

The ADAT was currently reviewing how the money for substance misuse services was being used and attempting a breakdown of all of the funding streams.

We understood that health and social work budgets for drugs and alcohol treatment were not pooled but had been aligned/shared between ADAT agencies. The budget for alcohol rehabilitation had historically been both separate from and larger than the one for drugs rehabilitation. The service managers hoped that from April 2007 there would be one budget for both. Aberdeenshire jointly commissioned a number of services through the Care and Treatment sub-group of the ADAT, but the SEQ stated that "all new resources for drugs and alcohol treatment services have to be agreed by the ADAT".

The Aberdeenshire ADAT submitted its Corporate Action Plan (CAP) for 2006-07 to the Scottish Executive in April 2006 and received feedback on the CAP in November 2006. Our review of

Section F of the CAP, which gives details of drug and alcohol direct spend by partner organisations, noted the following:

- Drug Specific Spend – there was £568,000 of Scottish Executive funding made available to the ADAT for use in 2005-06. In addition, a further £1,049,000 of funding was available from partner organisations of the DAAT, £527,000 from Aberdeenshire Council and £522,000 from NHS Grampian for 2005-06.
- Alcohol Specific Spend – there was £288,000 of Scottish Executive funding made available to the ADAT for use in 2005-06. In addition, a further £603,000 of funding was available from partner organisations of the DAAT £426,000 from Aberdeenshire Council and £187,000 from NHS Grampian for 2005-06.
- Combined Drug and Alcohol Specific Spend – there was £6,000 of Scottish Executive funding made available to the ADAT for use in 2005-06. In addition, a further £694,000 of funding was available from partner organisations of the DAAT, £583,000 from Aberdeenshire Council, and £111,000 from Lloyds/TSB grants for 2005/06.

In 2005-06 the total expenditure incurred was £3,128,000 against the total funding available above of £3,208,000, resulting in an underspend to 31 March 2006 of £80,000. No particular reasons were given for the underspend. £862,000 of this spend was from Scottish Executive allocation and £2,266,000 in contributions, largely from health and council partners. In addition, the total projected spend for 2006-07 was estimated at £3,575,000.

Recommendation 11

There is a recommendation on financial arrangements for all three Action Teams in Chapter 6.

4.6 Capacity for Improvement

The evaluation of capacity for improvement is based on three key factors: demonstrable improvements in outcomes for people who use services, quality assurance and performance management, and the effectiveness of leadership at all levels in health and social work services.

The ADAT had introduced measures to begin to promote outcome-focused practice and to commission and develop services on this basis. Services in the central and south of the area had some way to develop to reach the standard, quantity and quality of those in the north. We found examples of good integrated working, strategic leadership and partnership working. Staff and managers agreed there was a clear vision for services. Joint commissioning was being developed through an Action Team sub-group. Attempts had been made to obtain the views of service users about services, and services for carers were more developed than in the other two Action Team areas. The ADAT was in the process of developing agreements on spending of drugs and alcohol money. Aberdeenshire has a GOOD capacity for improvement.

Factors which will underpin and support change were identified. These included the model of integrated working identified in the north of Aberdeenshire, which could be rolled out across the central and south, and good strategic leadership, as well as the beginnings of joint commissioning practice.

Moray Drug and Alcohol Action Team Area

Action Team: The Action Team in Moray is known as the Drug and Alcohol Action Team or DAAT. The DAAT meets quarterly. The membership of 21 includes local authority staff (6), local authority elected members (5), health (3), integrated post (2), prison (1), police(1), Forum (1), Licensed Trade Association(1).The team was chaired by the Director of Community Services for Moray Council.

There was one sub-group and a local forum.

The team was supported by one full-time and one part-time officer. At the time of the inspection, a Drug and Alcohol Development Officer post was vacant.

5.1 Key Outcomes

In both written submissions and in discussions during fieldwork, Moray staff recognised that they had very limited evidence to support outcome-focused practice. The limited nature of this evidence, together with the concerns about the practice which we found in both the file reading and fieldwork, led us to conclude that Moray performed to a WEAK standard on this measure.

Prevalence profile

A prevalence study published in 2005 estimated that Moray had a prevalence rate of problem drug use of 0.66% of the population, well below the national average of 1.84% There were 98 new people with substance misuse problems who presented to specialist addiction services, mostly in relation to opiate use. The active caseload was just over 300 across the range of services, including Progress 2 Work. There were two Elgin-based services which accounted for 90% of these 'new cases'. While we were told by staff that there was a culture of 'elastic capacity' to prevent people having to wait to be assessed for services, there were difficulties in accessing substitute prescribing and Moray had not met targets to reduce waiting times.

The contact rate for people going to their GP for help with an alcohol problem was 14.9 per 1000 of the population, considerably lower than the national figure of 24.3. for the same period. The rate of alcohol-related offending was close to the national average, with a slightly higher incidence of drink driving.

Under-age drinking patterns were comparable to the Scottish average and did not indicate particular concerns. Numbers of young people referred to the Reporter on substance misuse grounds remained in single figures from 2003 to 2005.

Performance profile

In common with the other Action Teams, performance data on outcomes was being developed. The information which follows on performance is in relation to the priorities set by the Scottish Executive as well as emerging evidence on progress on planning and delivering services with a focus on measurable outcomes.

According to the CAP, Moray did not meet its target in its 2005-06 performance contract with the Scottish Executive relating to numbers of new clients accessing the direct access service by March 2006, as there were delays in setting up this service, which began in June 2006.

Culture, change and communities

Moray set up a three-year jointly funded information post in 2006 to focus on sensible drinking campaigns. This post was concerned with co-ordinating all prevention and early intervention work. The information and communication functions of the post were to include press releases following DAAT strategy meetings.

In the most recent CAP, Moray DAAT measured its performance in reducing binge drinking by using numbers of drunkenness offences. These had reduced by over a third in the last three years. However, this measure did not distinguish gender, unlike the national target, nor did it relate to the incidence of adults exceeding weekly drinking levels. The DAAT should take steps to remedy these shortfalls and set clear targets regarding mainstream population drinking patterns.

Regarding the national priority to reduce drug and alcohol related crime, Moray used comparative figures over time on a range of offence types. Drink driving offences had fallen, while Misuse of Drugs Act offences had increased slightly.

Prevention, education and young people

In 2005 the Action Team and the Community Safety Partnership commissioned a needs assessment in relation to harmful drinking by young people. The subsequent report recommended that services should be developed specifically for young people, rather than an add-on to adult services. Funding had been made available to provide this service.

We heard good reports about the use and the value of a mobile information bus. This toured the rural areas and attracted an average of over 2000 young visitors per year. Workers distributed information materials and conduct a range of workshops. 'Before' and 'after' evaluations suggested increased knowledge and awareness of issues and risks associated with substance use. The DAAT had also supported a number of consultation events with young people, although we did not find evidence that this had influenced the development of services in the area.

Operation Avon was the DAAT, Community Safety and Grampian Police commitment to a series of discrete initiatives focusing on under-age drinking hot spots. Eighteen such initiatives resulted in the police referring 30 young people with problematic use to services for young people. The perceived success of this joint venture for individual young people and for the community, had resulted in a continuation through to 2007, with more visible partnership working on the ground.

In view of these promising developments it is disappointing that Moray provided no hard information on performance in its CAP relating to the national priorities to reduce hazardous or at

risk drinking by children and young people. Indeed, the figure quoted in relation to under 16s being admitted to hospital following alcohol misuse, suggested that this was not an improving picture. Moreover, the figures quoted in relation to child protection registration were not set in any comparative or policy context.

The failure to gather this information to inform performance management was a source of concern, and the DAAT must take steps to set the above information and initiatives within such a framework.

Recommendation 1

There is a recommendation on outcome and performance measures for all three Action Teams in Chapter 6.

Provision of support and treatment services

Moray had persistent problems with waiting times and capacity issues within treatment services. In the light of this they undertook to commission a direct access service which would serve to support people waiting to access prescribing and continue in a supportive counselling role for those on substitute prescriptions. There were a number of delays but the service opened for business shortly before the fieldwork phase of the inspection. Early signs indicated that service users saw the service as worthwhile.

Moray had met the annual target of increasing the number of drug misusers in contact with treatment services by 10%. However, over the last two years they had not significantly reduced waiting times for people entering treatment. Forty four per cent of service users now waited less than 21 days, as opposed to 42% in 2004-05. The number of planned discharges from addiction services had not changed in two years and had not been set beside unplanned discharges. It is therefore impossible to gauge whether there had been any positive change in this regard. This was another area which the DAAT had intended to address through service development plans and performance indicators, but these were not yet in place.

We found good evidence about the Progress2 Work service, which helped people to overcome barriers to employment. The numbers of service users going on to education and employment, and testimony from service users themselves, suggested that this service was making a difference their lives.

Performance summary

Achievement of the key actions for 2005-06 was patchy with many actions delayed, often because of difficulties of recruiting to posts, and rolling over to 2006-07. Planned action for 2006-07 continued to be activity based and much of it was still concerned with identifying

priorities for action, research and planning. The DAAT produced a CAP 2006-07 “Key Actions” document in August 2006. This document set out actions and measures by which Moray would be judged, but it lacked specific targets. Most actions were to be measured by numbers of people accessing services and no specific timescales were identified, nor persons responsible. There was little evidence of outcomes being identified. Developing a robust system of data collection and analysis was identified as a key priority and a performance indicator task group had been set up.

The self-evaluation questionnaire acknowledged that the Action Team had some way to go to develop a performance management framework which lent itself to measuring progress against national and local targets. We would encourage the DAAT to ensure that this reflects the ‘root and branch’ scoping, auditing and planning overhaul which would be most helpful in the circumstances.

At a strategic level there were acknowledged deficits in management information systems and performance management measures to accommodate and track the setting of outcome targets. The most recent JPIAF evaluation rated Local Improvement Targets as an area requiring substantive improvement.

The new direct access service had a service level agreement which listed a number of “definite and desired” outcomes. The Christo impact tool was to be used to measure impact. A number of other services had been established in the area for some time, and had had funding extended or increased specifically because of evidence of positive outcomes. One was the employability service and another was the alcohol counselling service available in GP practices. There were, therefore, some encouraging indications about the direction of travel now being taken by the DAAT to put outcomes at the centre of service planning.

However, our over-riding concern was the absence of evidence to show that this policy extended to all services, particularly core services. Less than half of local authority files contained a recognisable care plan, less than half of service users experienced an improvement in their circumstances resulting from service intervention and just over half had been helped to access mainstream services.

Recommendation 13

The DAAT should put processes in place to ensure that all services have outcomes as a priority. This should be clearly reflected in care planning processes and staff should be supported to achieve and sustain this approach.

5.2 People who use services, Staff and other Stakeholders

The picture in Moray was a mixed one. People who used services reported positive experiences in working with staff, but access to services varied, with most services concentrated in Elgin. Staff expressed similar levels of job satisfaction as the other areas but had issues in relation to co-location of health, social work and voluntary sector staff, with groundwork needed to promote and support integration. The Moray DAAT had linked with the community safety agenda effectively on a number of ongoing initiatives which aimed to tackle substance misuse within communities. We considered that Moray performed to an ADEQUATE standard on this measure.

Experience of people who use services, their families and carers

This section includes some findings from the peer research specific to Moray, as well as findings from observed practice and our meetings with service users during field work. We did not have the opportunity to meet with any carers in Moray.

Around two thirds of the service users (20) made evaluative comments about their experience of services. These can be roughly grouped as follows:

| | |
|---|----------|
| Those who were complimentary about services in general terms | 8 |
| “Really supportive in all aspects” | |
| “Couldn’t have got to this stage without the service” | |
| Those who had a positive experience of inter-agency working | 3 |
| “These two service have changed my life” | |
| “Sometimes feels like too much involvement but glad of the help” | |
| Those who expressed concern about access to/quality of services | 4 |
| “Need help in more rural areas outside Elgin” | |
| “Would like to see staff more regularly...more support needed” | |
| Those who were unhappy about their experience of inter-agency working | 2 |
| “I understand that it was a child protection issue but my counsellor brought up things I told her in child care meetings that I had though were confidential” | |

Field work meetings with service users

The few service users we met with were not quite as positive about their experience as we found elsewhere. The main concerns were about access to services or being “passed from pillar to post”. There were concerns expressed that there were not enough services.

Pharmacies were said to provide a good service although we heard comments that supervised dispensing was not always discrete.

We observed practice where service users seemed to be engaging well in working towards agreed care plan goals. Service users subsequently confirmed that they had benefited from the intervention. We were impressed that staff readily responded to the need for some awareness raising and support work with family members, whether adults or children.

Moray had had a number of consultation events with service users, more than were evident in the other action team areas. They had also involved a voluntary organisation in work to promote user involvement.

While we did not meet with carers, Moray Council on Addictions worked with ‘significant others’ and Studio 8 were considering offering a service to carers.

Recommendation 2

There is a recommendation for all three Action Teams about the involvement of users and carers in developing services in Chapter 6.

Experience of staff

We received four responses from five questionnaires sent to staff employed by Moray Council substance misuse services. This number of responses was too small to provide statistically robust results, and the results were indicative only.

The four staff who responded to our survey agreed that they enjoyed their work. While all staff who responded agreed that the quality of service provided by their team has improved over the last twelve months, half disagreed that morale has been good over the same period.

The four staff who responded agreed the service they provided reduced the harm caused by substance misuse to people who used the service and their families and carers, made a positive difference to the lives of people who used services, their families and carers, and promoted recovery and routes out for people who used services.

Partnership working

| | AGREE | DISAGREE |
|--|-------|----------|
| Effective partnership working by all agencies represented on the Action Team has improved outcomes for service users | 100% | 0% |
| My team has a good relationship with health professionals | 50% | 50% |
| I participate in regular multi-agency/disciplinary meetings | 100% | 0% |
| In multi-disciplinary teams all staff can access the records of people who use our services | 0% | 100% |
| My team sign-post people to appropriate services | 100% | 0% |
| Where more than one service is involved, they join up around the needs of service users | 100% | 0% |

Four staff who responded agreed they had been involved in training and sharing good practice with staff from other services. However, half disagreed that they had a good working relationship with GPs practices, health professionals, social work, housing, other council services, local voluntary organisations or local independent organisations. There was some disagreement from staff who responded to our survey that they worked in partnership with people who use services, their families and carers to achieve agreed actions in personal plans.

Moreover, staff who responded disagreed that all staff could access all the records held on people who use services. Health staff completed single shared assessments but social work staff did not. There was uncertainty as to whether social work managers or health staff would have access to their staff's health files. Considerable support from senior management in both health and social work will be needed to harmonise policies and procedures and integrate staff.

However, where service users had children, all staff who responded agreed that their team was proactive in sharing information and engaging in joint assessments with all relevant agencies. In addition, they all agreed their team worked effectively with social work child care services where there were child protection or parenting concerns. In the six files we read where there were children living in the household, half did not contain an initial assessment of the impact of parental substance misuse. There were 38 files where it was considered by inspectors that the service user was vulnerable to abuse or exploitation or posed a risk to others. Only one contained an up-to-date risk assessment.

One of the issues which staff felt strongly about was a perceived shortage of social work staff, including administrative support, and a more general feeling of being under-resourced. Only half of the staff who responded agreed they could manage their workload within their contracted

hours. The issue of suitable and sufficient premises for individual and group work was also raised.

All four staff who responded agreed that they had a good understanding of the role of the DAAT and that the Action Team had effectively communicated their plans for substance misuse services in the area. They agreed that these plans and targets reflected local needs. They also agreed that there were effective planning structures which involved all stakeholders, including people who use services, their families and carers. This was consistent with our findings about the comparatively greater level of consultation in Moray.

All four staff who responded agreed that substance misuse services were highly valued by local elected members and by NHS board members.

Impact on community well-being

We found evidence that there were a number of co-ordinated activities concerned with community engagement and with community safety in Moray. These corroborated the information supplied in both the self-evaluation questionnaire and the Corporate Action Plan that these were areas where there had been a number of successes in progressing these agendas.

The Mobile Information Bus used to disseminate positive health information to young people across a large rural area appeared to be very well used and popular with young people, and workers in the field regarded it as a very worthwhile initiative. We also heard about the work of detached youth workers in engaging on issues of substance use prevention and harm reduction.

It was made clear to us in several fieldwork meetings that Moray worked hard at engagement and consultation. The DAAT had commissioned a voluntary sector agency to develop community engagement and find meaningful and sustainable ways of ensuring that the voice of substance users, was heard in planning processes. A Development Day had taken place and work was ongoing on the action plan resulting from this.

There seemed to be regular consultation events which were open to the general public, as well as publicity campaigns on specific aspects of substance misuse, often as part of national awareness drives. Neighbourhood forums had recently been established to feed into community planning processes and these, together with Patient Participation Forums, were attended and supported by officers and elected members. The DAAT was going to collaborate with Community Safety and Health Improvement on a Drug Communication Plan.

For their part, elected members spoke with some confidence about promoting community well-being through their involvement in co-ordinated strategic planning bodies.

As part of the remit of the recently established direct access service in the centre of Elgin, staff provided information to any member of the public. They aimed to be responsive to emergent

trends and would develop specific support initiatives with particular communities of interest, such as family members, if this emerged as an unmet need.

The DAAT was committed to supporting the Community Safety Plan, and appeared to have taken this commitment further than the other Action Teams, in that performance measures between this plan and the DAAT strategic plan were to have a single harmonised system of performance reporting.

In 2005-06 there were 18 joint operations with police to tackle alcohol-fuelled anti-social behaviour by young people. This resulted in a number of referrals to specialist services, and confiscation of alcohol from under-age drinkers resulted in a referral from the police to social work. Between 2002-04 there was an upward trend in underage drinking reports by the police and a reduction in 2005 was tentatively attributed to the impact of these initiatives, but this has not continued into 2006 and therefore required a re-think. There was clear evidence that the DAAT was actively engaged in and supportive of the Community Safety Partnership in examining the way forward.

5.3 Key Processes

The appointment of a single manager for health and social work staff to an integrated service gave some cause for optimism that joint working might improve. However, the differences in the use of assessments among the three parts of the service, and the relationship of the Moray Council on Addiction (MCA) to the integrated service will need to be addressed, as well as the involvement of GPs, before the service could truly be described as integrated. It was suggested to us that our findings on the weaknesses in the files on sharing of information were not indicative of the quality of the relationships between staff and services. However we did not see clear evidence that this was the case.

We consider that Moray performed to a WEAK standard in this area.

The journey of service users and their families through the service

Moray provided a good range of leaflets in their advance information, but we were uncertain how available they were to the general public and potential clients and families. The Studio 8 direct access service had literature available and could signpost people on to other services. The pharmacy in Elgin dispensing methadone only allowed their company's leaflets to be on display. There was a service directory of addiction services in Moray, and a Moray drug telephone line.

Example of Good Practice

Moray has a direct access service, Studio 8, to help people into the services, offering literature on drugs and services, signposting to other services, one-to-one support and group sessions. This service had recently opened, but seemed to be providing quick access to services for users.

At the main office of the Moray Drug and Alcohol Team, situated at one end of Elgin High Street, there was no external sign for the service, and one sign was propped up on the floor, only visible through two sets of glass doors. While the service was described as “integrated”, it had two parts. The social work part comprised a team of three, one of whom also had senior social worker responsibilities for the other two, and a criminal justice social work addiction worker, located separately. The team was half a post short and had had no administrative support for the previous six months. The health part of the integrated service comprised four community psychiatric nurses (CPNs). The voluntary organisation, Moray Council on Addictions (MCA), with two paid counsellors and 25-30 voluntary counsellors, was located in the same building.

Referrals came directly to the individual services, and “ambiguous” referrals were discussed at a weekly meeting of the three services. Eligibility criteria to the three services was not co-ordinated. One concern was that individuals who requested voluntary sector provision received this without an assessment as to whether or not this was appropriate. A senior manager described “varying degrees of integration in the way each team works and accepts referrals” but said that protocols and ways of working together were being developed.

Neither social work nor health staff operated waiting lists for their services. However, social work staff indicated that the policy of allocating all referrals had resulted in high caseloads and that they needed to consider creating a waiting list. CPNs also told us that they had worked hard to get the waiting list down but that they now took on too much. They thought that if they only provided services in line with the protocols on priority, then young males would not get a service. One young man had been seventeenth on the waiting list for 18 months. They therefore operated a separate waiting system for these service users. MCA did not have a waiting list for assessment, but service users might have to wait for a volunteer counsellor to start work with them.

In recognition of the importance of alcohol misuse among young people in Moray, the local hospital automatically referred young people admitted due to excessive alcohol misuse to the social work team. Parents were sent a letter telling them that a social worker would visit. If there was no response after two or three attempts at contact, then no further action was taken. This is an interesting initiative, but it was unclear how effective it was at responding to the problems of these young people.

Separate files were kept by social work, health, and voluntary sector staff. We read 66 social work and 30 MCA files. NHS Grampian conducted an internal audit of 88 of its SMS files, but sample size was not sufficient to allow analysis at Action Team level. The results from the health file reading are discussed in Chapter 7.

We found that only 32% of the 97 social work and voluntary sector files contained an assessment, although the voluntary sector performed significantly better than social work in this regard. Of the 32 files which contained an assessment, over half were rated as weak or inadequate. Only 3% of these 32 files contained a single shared assessment although in all eight

of the relevant files, a specialist assessment had been completed if this was appropriate. Only just over a third of the 97 files read in Moray contained a care and treatment plan or equivalent. The care plans that we read had very few clear targets or objectives of intervention. Only 28% of social work and voluntary sector files contained evidence of regular review of the care plan. Links to other services, especially Criminal Justice, were not always recorded. We found some cases with children involved which were closed because of failure by parents to keep appointments, but there was no clear recording about discussion with childcare workers about this or about any continuing monitoring of the parents' misuse of substances and any risk to children. This was confirmed by an observed practice. It was evident from these files that while social workers and nurses had a positive working relationship, their roles were very separate.

There was no evidence of risk to or from service users being routinely recorded, although one worker in an observed practice interview described a good induction about risk assessment. Only 2% of the 44 relevant social work and voluntary sector files where risk to the service user or others in the household was identified contained an up to date risk assessment and risk management plan. NHS Grampian had a Primary Care Trust Care Plan and a Home Visit Risk Assessment, and we had sight of an Alcohol Detoxification Care Plan, but they did not seem to be integrated with other care plans. Health staff had had basic awareness training about child protection, and MCA staff supervising volunteers would ask questions about, and record numbers and ages of children in the family.

Recommendation 4

A Recommendation on assessments and risk assessments applicable to all three Action Teams is made in Chapter 6.

Multi-agency and multi-disciplinary working and integrated person-centred care

The health staff in the integrated service dealt mainly with detoxification and methadone, the social work team prioritised families, particularly if there was risk to children, and the MCA worked mostly with individuals and significant others.

Staff spoke of good informal information sharing, weekly meetings, co-location, and the recent appointment of a single manager for health and social work staff as positives. We recognised that the team had only recently been set up and so it might be unrealistic to expect it to be functioning as a fully-integrated team. However, we found little written evidence of joint working to ensure effective referral mechanisms, effective shared assessment of needs and risk, or integrated care planning and review.

The social work team did not use the integrated assessment form, but nurses did. The tool was not available electronically and as there was no possibility of a shared health and social work IT

system, it was not possible to share information in this way. There was some confusion in Moray as to whether a final draft of the form had been agreed. Documentation was therefore not harmonised and there seemed to be no systems for shared assessment of needs, which could lead to duplication. There was no standardised care plan. None of the voluntary sector files we read contained care plans which showed evidence of integrated care around the individual's needs and in 80% of the care plans in social work files this was either only partially evident or not evident at all. While service users had regular contact with specialised staff there was no evidence of this being co-ordinated.

Staff felt that appropriate information was shared between social work, health and MCA staff and that service users were clear about this. For instance, issues in relation to possible child protection concerns could be raised at the weekly meeting and these cases could be referred to the social work children and families team, with the addiction team retaining work with parents on their substance misuse. However we did not find consistent evidence of this from our reading of the case files. Only MCA had a written consent form to share information once a person started to attend their service and this information was evident in 90% of the case files we read. Only 41% of the social work files contained evidence of consent to share information. We found that half of the six relevant social work files and none of the five relevant voluntary sector files where there were children in the household contained an initial assessment of the impact of parental substance misuse on the children. Furthermore only one of the six relevant social work files and none of the five relevant voluntary sector files where there were children in the household contained a parenting assessment.

Recommendation 5

A recommendation applicable to all three Action Teams on working with families where there are substance misuse problems is made in Chapter 6.

The recently appointed manager of the integrated team was responsible to the Mental Health Joint Manager, but governance arrangements for health staff were less clear. We were told that they were line managed by the integrated team manager, a social worker, but received professional support from the clinical nurse manager. Staff felt that currently these arrangements lacked clarity.

In 80% of social work and voluntary sector files it was clear which agencies and professionals were involved. However, in only 35% of files was there evidence of multi-agency working with clearly stated roles and responsibilities, although the figure rose to 51% for the social work files alone. Only 3% of the 31 voluntary sector files contained evidence of multi-agency working with clearly stated roles and responsibilities.

There seemed to be a good relationship between GPs and specialist services in Moray, but some GPs had a limited view of their role, that of issuing methadone prescriptions. We were told by

front line workers that only two GPs were signed up for enhanced methadone prescribing, and the rest would continue with existing patients but not take any new ones.

In response to enquiries, the Studio 8 direct access service was about to start offering sessions to carers. We were unclear if they had liaised with MCA, who saw significant others, about this initiative.

Elected members we met were positive about the provision of multi-agency work, underpinned by the strength of their Community Planning Partnership (CPP), but accepted that difficulties in IT systems and confidentiality were hampering progress.

The involvement of, and partnership with, people who use services, their families and carers

The Drug, Alcohol and BBV Forum had very little representation from service users, though some individuals did attend occasionally. Alcoholics Anonymous, Alanon and the Princess Royal Trust were regular attendees. A development day run by the Forum came to the conclusion that “user involvement requires further work”. They were conducting a survey.

The integrated assessment form had been designed to support the participation of the service users in their assessments, with care plans signed by the user, and the one observed practice we undertook supported the view that this was in place in part.

Seventy nine percent of the social work and voluntary sector files we read contained evidence that the views of the service user were taken into account in this process but only 43% contained evidence that they were invited to attend decision making and review meetings. Performance in the latter was significantly better in the social work files. None of the 30 voluntary sector files read contained evidence individuals were invited to attend these meetings. However this may be due to a lack of any explicit reference to such meetings in MCA's cases recording materials. In just under half of the relevant 17 cases in Moray, there was evidence the needs of the carer had been identified. However, in only two of these cases was there evidence that the carer been offered a carers assessment, and in six cases was there evidence that the needs of the carers were being addressed. Overall, we think that there was scope for improvement in this area. More consistent use of the integrated assessment form would offer a framework for ensuring service users were fully involved in their own assessment and care planning.

Inclusion, equality and fairness in service access and delivery

The directory of services was to be reformatted in other languages, but there were no formal plans to engage people from different ethnic groups. There were, however, interpreter services available.

It was clear that Moray was in the process of trying to make the service more accessible through the Studio 8 project, and that because of the rural nature of the area, staff in service were prepared to do home visits where appropriate. The GP counselling service delivered by MCA

was also available in various GP surgeries. The involvement of GPs varied however, and addiction services were still focused primarily on Elgin. The office of the Drug and Alcohol Team was not accessible for disabled people.

5.4 Strategic Management and Leadership

The restructuring of the DAAT, with an Implementation Group emphasising the need to deliver change, and the leadership provided by the chair and vice chair of the DAAT, had resulted in greater drive and momentum. The improvements from this were beginning to be seen, though there was still some way to go. We therefore found performance in this area to be **ADEQUATE**.

Vision

Moray had recently re-structured its Action Team in response to an extensive consultation with stakeholders. There was a Strategic Drug and Alcohol Action Team and an Implementation Group. The former comprised chief officers from the partner agencies and six local authority elected members, and set the strategic agenda, while the latter comprised heads of service and was responsible for translating the strategic priorities into actions. Neither body had representation from people using services although this had been discussed. It was too early to judge how successful the restructuring would prove. However, most of the staff and other stakeholders we spoke to during the inspection felt that there was a clearer direction for substance misuse services and greater drive from the current DAAT Chair. The vision, aims and values for the DAAT had recently been revised at the time of our inspection, to enable a more comprehensive review of joint policies, procedures, protocols and guidance.

There were plans to base the DAAT Drug and Alcohol Development Officer and the Community Safety Drug and Alcohol Information and Prevention Officer with the integrated health and social work team with the intention of helping bridge planning and operational issues.

Moray DAAT had a strategy which set out its mission statement and its five key aims and objectives which were:

- Prevention through education;
- Equity of access to and provision of services across Moray;
- Promoting consultation, involvement, advocacy and public information;
- Combating alcohol and drug related crime; and
- Developing clear strategies through good information and effective communication.

Joint planning and development of services

The DAAT was linked to the community planning structure through the Community Health and Social Care Partnership, covering adult services, primary and acute care. There was one Community Health Partnership committee which was also the theme group for health and community care for the community planning structure. There were clear strategic links between the DAAT's Corporate Action Plan and Moray's Community Plan. Although there were no explicit links between the CAP and the Service Development Plans of individual agencies, the Community Service Department of Moray Council had the integration of substance misuse services as a key priority for 2006-07 in its Service Improvement Plan. Senior representatives of partner agencies were members of the DAAT's strategic or implementation group. For example, the General Manager of Moray's Community Health and Social Care Partnership and the Integrated Manager for Mental Health and Substance Misuse (with overall responsibility for drug and alcohol services in Moray) sat on the Strategic Group, while the planning lead in the Community Health and Social Care Partnership sat on the Implementation Group. Six Moray elected members, chosen for their strategic responsibilities for social work, education and health for example, sat on the Strategic Group.

Given the size of the population of Moray, links among the various strategic planning mechanisms in Moray appeared to be largely through cross-representation of individuals. These arrangements seemed to have been deliberately constructed and were largely felt to be effective by those involved.

Moray's second Community Plan (2006-10) had seven key themed areas. Alcohol and drug misuse was mentioned as a key health improvement area in 'Achieving a Healthy and Caring Community' but drug and alcohol misuse mainly featured under 'Achieving a Safer Community', as the responsibility of the Community Safety Partnership. The DAAT and its strategy were referred to, and the priorities were identified as reducing under-age drinking, and driving under the influence of drink or drugs. The objectives for reducing substance misuse for the next five years related to young people, their families, and wilful fire-raising resulting from substance misuse. These same issues were largely the focus of the substance misuse project which was part of Moray's Community Safety Strategy 2005-08. This Strategy stated that tackling substance misuse was one of its four main aims.

Recommendation 6

There is a recommendation on strategic links applicable to all three Action Team areas in Chapter 6.

The DAAT Development Officer was a member of the Community Safety Steering Group, the Community Safety Co-ordinator was a member of the DAAT Implementation Group and there was a Substance Misuse Task Group. However, the Moray Service Improvement Priorities for Children, Families and Criminal Justice (March 2006) taken from the Community Services Improvement Plan contained nothing in relation to substance misuse. This was surprising given the high profile of GOPR and Hidden Harm.

The Moray DAAT had recently conducted an extensive consultation involving a wide range of stakeholders including service users. This had influenced recent changes. Staff told us that their involvement in strategic planning and development came through the Forum. The DAAT Chair admitted that it had been difficult to secure the involvement of service users and carers in the Forum and their views had instead been sought through consultation exercises. In the past these had not been acted on but the most recent one resulted in the setting up of the new direct access service.

Commissioning arrangements

NHS Grampian funding for the commissioned substance misuse services in Moray came centrally from the Board and they were still in the process of discussing disaggregating funding to Moray. Moray Council was about to undertake a review of the commissioning of services through the voluntary sector. The DAAT had been developing commissioning processes, and thought that the effectiveness of the process was evidenced in the commissioning of the direct access service, with clear expectations in relation to performance and outcomes.

The inspection team had difficulty in accessing the records of one of the main voluntary sector service providers in Moray. Although this issue was resolved, we think that both health and the local authority should review their service level agreements with this organisation to make sure it is contractually obliged to allow access to their records for the purpose of contract monitoring and external inspection. The main barrier appeared to have been their policy on and guarantees of confidentiality to their service users. The organisation will require the support of the local authority to review this policy to make sure that it protects service users while still facilitating external scrutiny of the organisation.

Recommendation 14

Health and social work commissioners should examine contractual arrangements with providers to ensure that contracts include clear statements that they have appropriate access to their files.

Range and quality of services

Moray faced significant challenges in providing the range of services required because of the extensive and rural nature of the area. Substance misuse services were concentrated in Elgin, although we did hear from service providers that the DAAT was flexible about providing funding for services to go to the service user.

Studio 8 was funded for one year from £182,000 received from the Scottish Executive after the Drug Treatment and Rehabilitation Review. The service aimed to “offer easy initial access, assessment and onward referral for members of the public who were experiencing difficulties with their own or someone else’s alcohol use”.

The GP Counselling Service, delivered by the Moray Council on Addictions since 2003 in GP practices throughout Moray, and jointly funded by the local authority, provided an important local service to people with drug and alcohol problems.

Moray had two voluntary sector initiatives to support people back into employment: Moray New Futures was a partnership initiative which was not confined to people misusing substances, although the majority of those referred had drug or alcohol problems; and Progress 2 Work was specifically for former users or those on a treatment programme and extended into Aberdeenshire. It always exceeded minimum targets set by funding bodies, 40% of people in the project last year being placed in employment or training and 60% of those sustaining the placement for more than 13 weeks.

Example of Good Practice

Progress 2 Work was specifically for people recovering from drug and alcohol problems. New Futures (not specific to substance misuse although former service users made up a significant number of their clients) offered packages of support to help people move on, including counselling, activities, career advice, educational opportunities and chances to gain qualifications in for instance computers, food hygiene, fork lift truck driving. This approach seemed very positive and was spoken highly of by service users we met who were in touch with this project. It was also a partnership initiative and staff worked across the two projects. The integrated team manager hoped to create a full-time throughcare post within the team.

There were no specialist GP posts in Moray. However, the head of SMS informed us that there had been recent progress. Following a meeting, Moray GPs had agreed to prescribe if the consultant (shared with Aberdeenshire but based at the Fulton Clinic) visited regularly and a specialist GP was employed. There was no proper inpatient unit for treating people with drug or alcohol problems in Moray. There was also very little affordable housing, which was an important issue for people misusing substances.

There was no residential provision in Moray and no resources allocated to it in the most recent Corporate Action Plan. Staff were of the view that resources were better concentrated on developing the spread and intensity of community support available within the area.

Services in Moray had developed opportunistically. As a result some felt there was a proliferation of some services, gaps in others, and a lack of co-ordinated service development. Following on from the reorganisation at strategic level, the task for Moray was to identify the need for services, critically examine the range and roles of existing service provision across the agencies in order to identify gaps and duplication, and build a range of services which would operate in a way which met current and future anticipated needs. This may identify a need for new services but it may be that there is a need for current services to deliver in different ways to respond to identified need.

Recommendation 15

Moray should follow up its review of strategic and operational structures with a fundamental review of need and develop services and staff accordingly.

Quality assurance and continuous improvement

Developing a robust system of data collection and analysis was identified as a key priority in the DAAT CAP. However, this was still at an early stage and performance indicators through which services would report to the DAAT were being worked on by a task group of the Implementation Group. There were no internal quality assurance procedures for the team and these needed to be put in place. This issue required to be clarified quickly. Moray Council on Addiction kept an electronic record of referrals and standard letters were sent out. A paper file was set up only if someone using the service was seen by a counsellor.

Management information

Moray's SEQ identified that "Health and local authority computer systems were unable to communicate with each other, therefore having a negative effect on the sharing of information". Historically, different members of the DAAT gave separate reports on levels of activity and trends. A single reporting mechanism for health and social work was planned, and it was hoped that the new integrated service would help in the development of this single data collection system. Statistics were gathered from the police, health, etc. but were not sufficiently analysed to feed into and plan future activity.

Recommendation 8

A recommendation on management information applicable to all three Action Teams is made in Chapter 6.

5.5 Partnership Working

Partnership working in Moray varied. We found evidence that health integration at strategic level could be improved, and housing could play a stronger role, but there was positive support for the DAAT from the council, and a senior council official chaired the DAAT. Work was beginning to strengthen the links between strategic and operational levels. The development of the integrated team and its relationship with the local voluntary providers will be an important factor in the future of partnership working. Joint budgeting was an area for improvement. We found performance in this area to be ADEQUATE, with strengths just outweighing weaknesses.

Partnership arrangements

Many people we spoke to were positive about the recent change in the leadership of Moray DAAT and saw an improvement in partnership working as a result. Health did not seem to be as fully engaged as other partners in community planning and DAAT meetings. However, there were good relations with the police, and elected members in Moray were positive about partnership working in the area. Education seemed well integrated with the Implementation Group which was chaired by the Community Learning and Development Manager and we found good links between the DAAT and the integrated children's service partnership. Housing were not engaged in the Moray DAAT. According to the chief housing officer, the Council were finding it difficult to engage on the overlapping issues when there were large parts of the agenda which did not overlap, but she suggested themed groups could feed into the implementation group and DAAT. A recent consultancy report had highlighted that substance misuse issues were not being sufficiently addressed at a strategic level within the homelessness strategy.

AA and AI anon were members of the Moray drug and Alcohol and BBV Forum and we attended a meeting where there was good representation from a range of agencies.

The chair of the Moray DAAT saw the priority as strengthening the links between strategic and operational levels. This was being taken forward in a number of ways including co-location of strategic and operational staff. The example quoted was the Moray Drug and Alcohol Team which was co-located with a recently appointed manager for both health and social work staff. However, as set out earlier in the report, this team was not yet operating in a fully integrated way.

Development and review of joint policies, procedures and protocols

We saw a review undertaken by Moray DAAT of the policies and procedures of local voluntary sector, NHS and social work service providers, although this was undated. There was an action plan to address gaps, which encouraged organisations to share good practice.

As yet there appeared to be no joint working policies and procedures in relation to the new integrated team. This should be addressed as a matter of urgency. There was a policy on automatic referral to social work and the police of any drug-related incidents in schools and to social work of any under-age drinking incidents.

Recruitment, deployment and development of staff

The integrated drug and alcohol service in Moray had three drug and alcohol social workers, one of whom was senior and had responsibility for the other two and therefore a reduced caseload. There were four CPNs and a nursing assistant. It was intended that the team would also include the DAAT development officer, a post which was currently vacant, the drug prevention officer, and an administrative post, also unfilled at the time of the inspection. It was intended to review the structure in 18 months. The criminal justice addictions worker was part of the Criminal Justice Team but line managed through Aberdeenshire. This was part of the Grampian-wide service set up to respond to a Scottish Executive initiative to give priority to substance misuse services for those who became involved in crime. There was also a part-time criminal justice social work post linked to Inverness prison, which was lottery funded until April 2007, and an exit strategy was currently being examined. The integrated team manager planned to create a permanent throughcare post.

Staff in the drug and alcohol team appeared to have a high degree of autonomy. While this might be expected with experienced staff, the findings of our case file audit suggested that there were deficiencies in practice which needed to be urgently addressed. Supervision would be one way of ensuring this.

The Drug and Alcohol Team in Moray carried out a high number of home visits. While this was important to ensure the service was accessible in a rural area, it may not always be the best use of resources. Moreover, the lack of a patch-based system for staff meant that much time was taken up in travel. The team recognised this.

Recommendation 16

Roles, responsibilities, and accountability in the integrated team should be clarified and joint working policies and procedures put in place.

Moray's specialist cover for drugs was provided from Aberdeen and we saw little evidence of good working links between this and the GPs in Moray, who perceived it as remote.

Moray DAAT produced a training issues paper in September 2006 following an inter-agency development day. This recognised the need for a training needs analysis, training plan and identified budget. Staff in Moray spoke positively about training opportunities. Child protection training was mandatory and STRADA courses were available, although some staff felt these were quite basic. More staff would like the opportunity to undertake a 12-week accredited course at Robert Gordon's University. There were time and travel constraints to attendance at conferences. The integrated team manager acknowledged the need for a staff training plan for the team and that training may have been neglected due to cost and time issues. Housing staff could access

drug and alcohol training through the DAAT. STRADA had undertaken a review of training in early 2006 and a number of courses had been planned as a result of this.

Joint budgeting and use of financial resources

The Moray SEQ stated that “the Moray DAAT has found this area problematic and has only recently been able to access many of the budget figures and resources which underpin this area of work”. Moray DAAT had an aligned rather than a pooled budget for substance misuse services. Moray was to conduct a corporate review of voluntary and private sector funding through the appointment of a project co-ordinator for a 12-month period. Moray felt that they did not get a fair financial settlement from NHS Grampian, although there were additional contributions on the ground in staff and kind.

The Moray Drug and Alcohol Action Team (DAAT) submitted its Corporate Action Plan (CAP) for 2006-07 to the Scottish Executive in May 2006 and received feedback on the CAP in October 2006. Our review of Section F of the CAP, which gives details of drug and alcohol direct spend by partner organisations, noted the following:

- Drug Specific Spend – there was £108,000 of Scottish Executive funding made available to the DAAT for use in 2005-06. In addition, a further £184,000 of funding was available from partner organisations of the DAAT for 2005-06, £65,000 from NHS Grampian and £119,000 from the local council.
- Alcohol Specific Spend – there was £123,000 of Scottish Executive funding made available to the DAAT for use in 2005-06. In addition, a further £31,000 of funding was available from partner organisations of the DAAT for 2005-06, all of this from NHS Grampian.
- Combined Drug and Alcohol Specific Spend – there was £190,000 of Scottish Executive funding made available to the ADAT for use in 2005-06. In addition, a further £245,000 of funding was available to partner organisations of the DAAT for 2005-06, £127,000 from the local authority and £118,000 from other sources.

In 2005-06 the total expenditure incurred was £672,000 against the total funding available above of £881,000, resulting in an underspend to 31 March 2006 of £209,000. The main reasons given for the some of the underspend related to the late award of contracts, recruitment difficulties and sickness absence. Of the actual spend, £257,000 was from Scottish Executive resources and the remainder contributed by health and the council. In addition, the total projected spend for 2006-07 was estimated at £1,133,000.

Recommendation 11

There is a recommendation on financial arrangements for all three Action Teams in Chapter 6.

5.6 Capacity for Improvement

The evaluation of capacity for improvement is based on three key factors: demonstrable improvements in outcomes for people who use services, quality assurance and performance management, and the effectiveness of leadership at all levels in health and social work services.

Moray should develop their performance management to enable them to measure progress. Despite the appointment of a single manager for the integrated service, Moray has some way to go to deliver a service that is truly integrated, as at present, the links are informal and a quality assurance and governance process is needed. The recently opened direct access service, Studio 8, had the potential to offer easier access for service users. The restructuring of the DAAT, the commitment of the chair and vice chair, and the enthusiasm of local councillors gave optimism for clearer direction for substance misuse services, but it was too early to be clear about the impact these changes might have. We found the capacity for improvement to be ADEQUATE.

Factors which will underpin and support positive change were identified. They included the restructuring of the DAAT, with clear leadership, the involvement of local councillors, the beginnings of joint commissioning, and the introduction of the collection of some performance management information, as well as the development of services such as Studio 8, the GP counselling service and the employment and training initiatives.

Recommendations Which Apply to all Three Action Teams

Recommendations about several issues of some importance applied to all three Action Team areas. These were outcome and performance measures, the involvement of users and carers, children affected by substance misuse, the use of integrated assessments and risk assessments, strategic links, financial arrangements and management information. These recommendations did not necessarily apply to all three teams equally, but we considered them important enough and general enough to recommend that all three teams take action on them. Benefit might be gained from Action Teams working together on these issues. They are listed below.

Outcome and performance measures

The Scottish Executive has set a number of national priorities for Action Teams, some of which have specific targets, not all of which are outcome based, for example reduction in waiting times and numbers of drug misusers in contact with services. Each Action Team has a performance contract with the Scottish Executive, and we have commented on their performance in relation to this in previous chapters, most of the information for which was drawn from the self-reporting in the CAPs and the Drug Misuse Scotland database. We found it difficult to provide an independent evaluation of performance in relation to key outcomes across all three areas as the quality of performance information was not good, a position recognised by the Action Teams themselves. Many performance indicators were process or output rather than outcome based, and gaps in information hampered the making of meaningful comparisons over a number of years. The replacement of SMR 24 with SMR 25 in April 2006, which improved collection of information on clients attending drug services, and in time for follow up information on clients' drug use and other circumstances, further complicates matters in the short term.

All three Action Teams were aware of the need to define and agree a set of outcome measures. We invite them to consider developing a set of shared outcomes and performance measures across NHS Grampian and Grampian Police as well as a set of local outcomes and performance measures to reflect local priorities.

Recommendation 1

All three Action Teams should continue the work they are doing to develop and agree local outcome and performance measures and develop systems for collecting and analysing information to monitor performance against them. They should do so jointly rather than independently. The Scottish Executive should work with Action Teams to develop appropriate local outcome and performance measures.

Involvement of users and carers in developing services

While involvement of service users varied in the three areas, generally they did not feel engaged in developing services which would help them. The Forums are one way in which their role might be strengthened. Carers were noticeable by their absence in most planning processes, perhaps in part because of their reluctance to be identified, but their involvement should be encouraged.

Recommendation 2

NHS Grampian and the three Action Teams should review the role of users and carers in developing services, and create ways in which they can become more involved. The Action Teams should review the role of users and carers in the Action Teams and Forums.

Integrated assessments including risk assessments

We found that while the integrated assessment and review form was in use by many health and social work staff, this was not true of all, and not true of most voluntary organisations staff across the three Action Team areas. There was some concern about the length of the document and its relevance to alcohol services, and indeed to voluntary sector services, some of whom said they would not use it. It would undoubtedly benefit service users for an integrated assessment framework to be in use across substance misuse services, and consistent and universal use of the assessment form would provide a useful tool to inform performance and future service planning. We have expressed concerns about risk assessment in previous chapters, and it is important that the form includes a section on risk assessment, that staff in all agencies are trained in its use, and its use is monitored.

Recommendation 4

All three Action Teams and NHS Grampian should ensure that the integrated assessment and review form for substance issue is rolled out across Grampian, that it is used by both health and social work staff, and that voluntary organisation providers are also brought on board. This tool should include a risk assessment section, and use of this should be monitored carefully.

Children affected by substance misuse problems

The three Action Teams, and the NESPC had developed a useful document, 'A Framework for Reducing the Harm to children affected by parental drug or alcohol problems', and staff we spoke to in all agencies seemed to be aware of the importance of this issue. However, in our file reading we had concerns that staff were not always assessing the impact of parental misuse on children and appropriate action was not always taken when problems were identified.

Recommendation 5

All three Action Teams should ensure that staff who work with families where there are children are trained in screening for the impact of parental misuse on children, and in collaborative assessment procedures where this is necessary. This should be monitored by senior staff managers to ensure any risk to children is identified and appropriate action taken.

Strategic relationships

We recognise the difficulties partners have in connecting strategic developments in the field of substance misuse through the agencies and the plans these agencies develop individually and in partnership. DAATs have particular problems in relation to the accountability of constituent members. One senior staff member told us that “the Action Team works by persuasion”. Another spoke of “the myriad of circles and interactions”. Other senior DAAT members spoke of the lack of clear guidance from the Scottish Executive on the role of DAATs and of how they were often reacting to directives from the Scottish Executive, with a variety of funding streams, sometimes short term, to contend with. At the time of our inspection the Scottish Executive stocktaking exercise was still in progress. The DAATs were also in an environment where CHPs had recently been introduced, influencing the health component of substance misuse policy and services. Some local authorities, such as Aberdeen, were restructuring services such as social work education and housing, which have a significant part to play in responding to the needs of people with substance misuse problems.

NHS Grampian, the three CHPs, the three local authorities and the three Action Teams have to work together closely to deliver improvements in substance misuse services through the implementation of the various plans, such as CAPs, Community Plans, Community Safety Plans and Health Improvement Plans. While all three Action Teams were working to develop integrated planning and service delivery, we found that the three Action Teams had some way to go to be able to deliver on these. Consideration should be given to formal and agreed reporting mechanisms from the Action Teams to NHS Grampian, the CHPs and the local authorities.

Recommendation 6

All three Action Teams should continue to work to develop and improve strategic links through relationships between strategic planning groups and the integration of substance misuse issues into appropriate plans. Reporting mechanisms from the Action Teams to the partner authorities should be agreed.

Management information

The three Action Team areas identified the difficulties in gathering and sharing information which could be used to improve joint performance. Different IT systems and reporting mechanisms contributed to this. All three Action Teams had recognised the importance of developing better management information systems, but had some way to go to providing effective systems.

Recommendation 8

All three Action Teams should continue to develop management information systems to enable the appropriate sharing of information and the joint identification of performance information and unmet need. This information should be used to inform key planning and decision-making processes in the Action Teams.

Financial management

The three Action Teams differed in their approach to the collection and presentation of financial information, and there were inconsistencies, even in their submissions in their CAPs. These differences made it difficult to monitor effectively the use of funds by each Action Team. We did not have the capacity to examine this complex issue in detail, but all three Action Teams recognised the need to improve joint financial governance, including the need to clarify contractual arrangements with the voluntary sector, which provides many of the services, particularly in Aberdeen. They had already begun to take steps to do this.

Recommendation 11

The three Action Teams should continue to review their financial governance and put in place processes to enable them to improve their capacity to monitor and review spending on substance misuse in their areas.

Conclusion – The three Action Teams operated separately, and for many issues this was entirely appropriate. However, they should take the opportunity to use the above recommendations to work together in areas where we have expressed concern about the need for improvement in all three Action Team areas. One way to improve joint working would be for Action Team chairs and co-ordinators to meet regularly to discuss areas of common concern and learn from each other's problems and successes.

Overview of Grampian-wide Issues

- NHS Grampian
- Drug-related Deaths
- Grampian Police
- Social Work Criminal Justice Substance Misuse Services
- The Role of Voluntary and Independent Sector Providers
- Feedback from Service Users and Carers

7.1 NHS Grampian

Summary – NHS Grampian

We recognise the difficulties in delivering a service to people with substance misuse problems across three Action Team boundaries. NHS Grampian committed resources to substance misuse services and took an active part in the Action Teams and sub-groups. However, we had concerns about the lack of a strategic overview for health substance misuse services, and the broad remit of senior managers, leaving them little time to devote to substance misuse issues. We noted that NHS Grampian were reviewing some of these arrangements. Health staff have a crucial role to play, working with partners, in the delivery of services to people with substance misuse problems. We had concerns about the inconsistency of governance of staff, and the lack of clarity of roles and responsibilities of some staff, particularly nurses. There were significant gaps in the geographical coverage of some important health services, particularly substitute prescribing, pharmacy services and needle exchanges in rural areas.

7.1.1 Policy, strategic planning and management

Substance misuse was identified as a cross-cutting strategic priority for health improvement and community planning across all three Action Team areas, and featured in current documents such as “Healthfit”, Joint Community Care Plans and Community Safety within the wider community planning agenda.

As might be expected, most strategic planning for substance misuse took place in the three Action Team areas rather than at Grampian level. However, a number of senior staff in NHS Grampian and in partner agencies acknowledged that more strategic planning and leadership was needed at a Grampian level to target resources more effectively. NHS Grampian did not have an over-arching strategic framework for substance misuse services. We found that there was insufficient capacity at strategic level to focus on substance misuse services. We were of the opinion that this contributed to inconsistencies in standards of service delivery and deficiencies in performance management across the three Action Team area by health or in partnership with other services.

A senior manager of NHS Grampian acknowledged the need for a Grampian overview of the need for and balance of substance misuse services to enable resources to be targeted where they were most needed. He also recognised the usefulness of a Grampian-wide drug and alcohol strategy, but saw limited scope to develop a local vision due to the agenda being set at a national level, and the individual Action Teams being responsible for driving the local vision.

NHS Grampian contributed significantly to the three Action Teams. At the time of our inspection, two of the three Action Teams (Aberdeen and Aberdeenshire) were chaired by senior NHS Grampian managers, and attendance at meetings of the Action Teams was good, apart from Moray, where involvement was more limited.

There were no clear reporting mechanisms from the Action Teams to NHS Grampian or the three local authorities. This is not uncommon where multi-agency partnerships are set up with a strategic planning remit, but the main partner agencies continue to be accountable for the bulk of the funding. The Chief Executive of NHS Grampian informed us that a mechanism to performance manage the Action Teams through the CHPs was needed as links between the Action Teams and the CHPs were currently in need of strengthening.

We noted the recent development of the Clinical Effectiveness and Reference Group for Addictions (CERGA). The findings from the inspection suggest that further groundwork on the base-line position of services, as well as the authority and objectives of the group, would be of value in providing a framework which would allow this group to drive continuous improvement. We noted the existence of the blood-borne viruses' strategy and commend the NHS Board on the progress made on the hepatitis screening and immunisation programme. We also welcomed the emergent harm reduction guidance. However, these should form part of a comprehensive strategic framework, to reflect the prominence detailed in the above reports.

The strategic lead for substance misuse sat with the Head of Strategic Planning, who also chaired the Aberdeen JADAT. Both he and other senior managers acknowledged the difficulty of committing the appropriate time within an extensive remit to focus on strategic planning for substance misuse, or indeed, to fulfil the role of JADAT Chair to the extent he saw necessary. A decision had been made to advertise for an independent chair of the JADAT.

Recommendation 17

NHS Grampian should ensure that Action Team partners are clear about its strategic intentions.

Structurally, the Substance Misuse Service was located within the mental health directorate which was Grampian-wide, but was hosted by the Aberdeenshire CHP. Some thought was being given to moving substance misuse services out of the mental health directorate and into the

CHPs. Operational responsibility lay with the general manager for mental health services who was also the Clinical Director for the Specialisms Directorate. His managerial portfolio included nine other services. He directly managed all of the health services based at the Fulton Clinic in Aberdeen. This senior manager while operationally involved with this service, was directly involved in the joint commissioning of services in the Action Team area in which he was based.

We were concerned that the extremely wide and diverse responsibilities of these two important posts limited the capacity of the post holders to devote time to substance misuse services. We recognised that proposed changes to the management of substance misuse services were being considered with the intention of improving the situation.

A senior nurse managed nursing staff in both the City and the Shire and was based at the Fulton Clinic. In Moray, a joint manager had been appointed to manage nurses and social workers. The post-holder was a social worker and was managed by the General Manager for Mental Health. We found the level of delegated authority in Moray to be unclear, with some nurses uncertain about governance arrangements. This was one instance of differences in arrangements or expectations where we were unable to obtain clear evidence from senior management as to the systems in place to ensure sound governance. The last comprehensive audit was undertaken in 2003, and a further audit was planned, but the health file reading for Grampian NHS did not provide evidence of nurses' case files being routinely audited.

We recognise the difficulty for NHS Grampian in delivering services across three Action Team areas, and that given the differing needs and circumstances in each area, different practices may develop. However, we were concerned that the practices of staff in health were not equitably managed and governed across the three areas, to ensure that standards of practice were consistent.

We did see good examples of integrated health and social care service delivery which left service users feeling that they had benefited from the enhanced experience, but we had concerns about the following:

- 'Partnership' arrangements between GP practices and SMS nurses which varied widely in the extent to which they constituted joint working. We were told that some GPs referred initially to SMS for assessment and stabilisation and took patients back once this had been achieved, while others did not take them back, but 'hosted' SMS sessions at their practice. We also heard that some GPs would refer to SMS but because they knew from experience, especially in the city, that this could mean months or years of waiting, they would begin prescribing in the meantime. Others would not institute prescribing.
- In some instances the contact between the patient and the GP could be very limited. We heard that a nurse could see the patient, conduct tests, counsel and write a prescription, leaving the doctor to sign it. A recent review of alcohol counselling made available in GP

practices in Moray revealed that the most common concern raised by patients was not in relation to the service but the lack of any communication from the GP once they had made the initial referral.

- Non-clinical service providers were frustrated and concerned that people using services could not get access to prescribing services as some local GPs had not engaged in substitute prescribing, leading to what was described as a “post code lottery”, and certainly resulted in inconsistent provision of services across Grampian.
- Nurses and their managers were sometimes unclear about whether nurses worked only with people with alcohol problems, or drug problems, or with both, and if both, then what percentage of their time should be spent with each. Historically these had been separated and a gradual change had been encouraged. There was also confusion about whether nurses co-ordinated care packages in conjunction with social work colleagues, and differences in practice in the three Action Team areas about when nurses would undertake home visiting.
- Discrete professional groups, such as pharmacists, reported that they had near daily contact with drug users on substitute prescriptions but some felt quite isolated and ‘out of the loop’ in their ability to contribute to the care and treatment decision-making process. Others reported a more positive experience.

We therefore had concerns about governance issues in the area of substance misuse. There seemed to be no formal reporting mechanism to the NHS Board which set out the schedule for performance monitoring against targets and standards specific to substance misuse services. We were aware of the structural arrangements within the board to oversee governance, but could find no one in authority who could tell us about clinical governance priorities in respect of substance misuse. In the context of marked variations in practice across the field, we believe that these differences undermine best practice and limit best value from integrated models of care and treatment.

In this regard we found parallels with the NHS QIS report on Clinical Governance and Risk Management Arrangements, which stated that “... corporate decision-making and arrangements for local implementation at NHS Grampian appeared reliant on individuals’ relationships, rather than on systems and clear lines of accountability”. (2005)

Recommendation 18

NHS Grampian should develop clinical governance arrangements for substance misuse. They should be supported by guidance, standards of performance and reporting requirements.

We have highlighted issues about joint working in the chapters on the Action Team areas. At this point we draw attention to the fact that people had markedly different experience of partnership working within health and with health colleagues.

7.1.2 Treatment Options and Capacity

Substitute prescribing

Methadone was almost exclusively the substitute prescribed for opiates. We found comparatively rare examples of alternatives being used, either on an individual basis or as part of a pilot.

All three Action Team areas faced challenges in the number and geographical spread of GP practices with enhanced contracts in respect of substance misuse services. This shortage was not unique to Grampian. The problems of GP prescribing have been growing increasingly acute over many years, especially in Aberdeen, and we did not find evidence that these problems had been the focus of strategic planning processes across NHS Grampian. We were aware of current plans to introduce salaried GPs with this prescribing role to relieve pressure in at least two areas.

We were told by senior health managers that the problem with the enhanced contracts was that they were “just not that attractive to GPs”. We could not find evidence of any consideration of what would make the contracts more attractive. Quite apart from the financial incentives which have featured elsewhere in Scotland, the GPs we spoke with expected a significant level of support from the Substance Misuse Service and were clear that where this was consistently delivered it worked very well, to the benefit of all concerned.

We heard from doctors that engaging with drug users in particular could be fraught with difficulties. GPs we spoke to had experienced problems of difficult behaviour from some patients. It was clear also, however, that some had worked alongside patients and other agencies to achieve rehabilitation through gradual reduction in methadone dosage. They reported that it was the exception rather than the rule that patients achieved this goal. The picture was much more commonly one of long-term maintenance and some doctors expressed the view that they felt ‘backed into a harm reduction corner’.

The expectations of the enhanced contract, apart from prescribing medication and providing testing, are that doctors demonstrate continued development through training, and act as a knowledge resource to colleagues. NHS Grampian had a calendar of training, and GP practices closed one half day a month for training purposes, but both GPs and pharmacists told us that it could be difficult to find the time or the locum cover to allow them to attend some training events.

Moray had not made any improvements in increasing access to prescribing services. National targets on identifying and reporting on new clients in 2005-06 were not met.

Aberdeenshire had increased access to treatment services, reduced waiting times and increased the number of planned discharges and people moving on to employment or further education. The main concerns were the disparities within the area. Services were concentrated in the north, including an integrated Substance Misuse Service, while it had proved difficult to bring GP practices in central and south Aberdeenshire on board with shared care.

Aberdeen had increased access to services and had a high percentage of GP practices signed up to enhanced contracts for drugs, but the overall capacity had been unable to keep pace with the demand for prescribing.

Additional staff resources for prescribing are only part of the solution. We remained concerned that senior SMS staff were unable to articulate a clear strategic workforce and development plan which would avoid perpetuating this bottle-neck.

Recommendation 19

NHS Grampian should increase its efforts to promote enhanced contracts, and provide support to GPs in order to develop more equitable services across Grampian.

Alcohol

Staff involved in substance misuse throughout Grampian reported that alcohol did not have the same public and political profile and developments had lagged behind drug services. Services in Aberdeenshire and Moray were provided to help both alcohol and drug misusers, while those in the city were largely separate. Staff we interviewed had to be prompted to include alcohol in our discussions, as the assumed focus was on drug use. There were plans in Aberdeen for a Community Alcohol Team with a similar structure to the combined SMS/ICDRS (Integrated Community Drug Rehabilitation Service). Management acknowledged that the development of this service had caused some consternation in the voluntary sector in particular, but provided evidence that there had been extensive consultation. For its part, the voluntary sector cited this as an example where consultation and conclusions did not seem to progress in a transparent sequence.

People with co-existent mental health and substance misuse problems

As identified in the Scottish Executive report, “Mind the Gaps”, substantial proportions of people who misuse substances also suffer from mental health problems. Despite the fact that substance misuse sat within the mental health directorate, we were told very little about policies or services for the care and treatment of people with co-occurring substance misuse and mental health problems, as set out in “Mind the Gaps”. We heard from many sources that it could be very difficult to access psychiatric care for people who presented with depressive or anxiety-related conditions while they had a substance misuse problem. This appeared to depend on the practice

of individual consultants. The availability of services for assessment, treatment and support was often described as a lottery, depending substantially on individuals. We heard about the development of a working group in one of the areas to look at what the barriers were to effective engagement with the “Mind the Gaps” agenda were, but discussion with management in the same area revealed that these difficulties persisted. This is an issue which requires a health-led strategic response across all three areas, and it is concerning to find no clear evidence of the impact of “Mind the Gaps” for people with co-existing mental health and substance use problems.

Recommendation 20

NHS Grampian should review strategy and service delivery for people with co-occurring substance misuse and mental health problems in the light of the objectives and recommendations in “Mind the Gaps”. Clinical leadership and pathways of care should be clarified.

Children affected by substance misuse problems

We found a more positive picture in relation to the impact of initiatives to improve services to children affected by substance misuse problems such as Getting Our Priorities Right and Hidden Harm. The health file reading results showed that in 71% of cases where children were living in the same household as the patient, there was an initial assessment of the impact of the patient’s substance misuse. The integrated assessment form employed set out data, analysis and any necessary action. From the staff survey, 90% of health staff agreed that their team was proactive in the sharing of information for assessment purposes when patients had children. Ninety seven per cent of staff believed they worked effectively with social work child care colleagues when child protection issues arose. We have referred to this issue in each of the Action Team area chapters.

7.1.3 Pharmacy services

Ninety seven of the 127 pharmacies in Grampian offered supervised consumption of methadone and 12 offered a needle exchange service. The intention was to increase needle exchange and to ensure better geographical spread by targeting areas which did not provide a service. A recent survey of people using services on the content of needle exchange packs had led to some changes, but the decision not to include citric acid was commented on by staff across the sectors and by people using services in our surveys and in our fieldwork.

We heard conflicting accounts of the access to dispensing arrangements for substitute prescriptions in pharmacies. Pharmacists in some areas thought that they were the sole local provider of dispensing services, or GPs thought that access was virtually dependent on one very sympathetic pharmacist, while NHS Grampian reported that there were 300 dispensing spaces

available in the city alone. This suggested the need for more robust information and communication systems.

All three Action Team areas experienced challenging issues in respect of access to substitute dispensing services for drug users. The pharmacists we met with during our fieldwork had different approaches and attitudes regarding their work with drug users, but some had clearly gone out of their way to provide a discrete and sensitive service.

There was a specialist lead for substance misuse pharmacy services who was the link with the Action Teams. Some pharmacists expressed the view that they felt isolated from wider substance misuse services. Their main interface was with the prescribing clinician and they said they would welcome more involvement through Action Team structures. We were advised that any concerns about the performance or practice of individual pharmacists would be raised with the specialist lead who would liaise with the head of SMS. There were no routine meetings between these two.

Recommendation 21

Action Teams should improve pharmacists' representation to ensure that their important role is recognised and their experience contributes to the development of integrated substance misuse services of the best quality.

An NHS Grampian audit of methadone prescribing published in 2007 confirmed our findings on a key point regarding the perception of drug users: pharmacists told us that they felt that patients with drug problems were unfairly stigmatised by colleagues from other pharmacies who chose not to get involved in dispensing and supervision. The experience of those who did, in almost 97% of cases, was that they experienced no problems with attitude or behaviour from people on substitute prescriptions. The one area which had seen a slight deterioration from previous audits was in relation to inaccuracies or miscalculations on the actual prescription.

7.1.4 Health staff

We surveyed health staff, but were unable to disaggregate their responses to the three Action Team areas. In common with the three Action Team areas, the positive results from the health staff survey were sometimes at odds with what was repeatedly reported during fieldwork, giving a mixed picture overall. We met with nursing staff, doctors (GPs and consultants) and pharmacists who had some positive things to say about partnership working in substance misuse, but exasperation from some about the number of GPs who chose not to engage with drug users and substitute prescribing in particular. We also heard from GPs who were engaged in this work that it was not altogether comfortable for them and they felt “backed into a damage limitation corner”.

Almost all of staff who responded to our survey agreed that they enjoyed their job. Where there were established shared care arrangements and where pharmacists felt they were included in the communication loop, experience on the ground was reported on favourably. It was also acknowledged that NHS Grampian provided opportunities for multi-disciplinary training. Nursing staff reported that individual supervision had appropriate priority from their line manager. They had access to a psychotherapist for confidential support, and this person then reported to the senior nurse with “themes” should any arise.

Nursing staff generally appeared to feel that the work that they did and the difference it made were key motivators. The dissatisfaction we encountered from some seemed to be related to feeling “out on a limb” and more keenly felt in a particular area where drug misuse services were perceived to be more “nurse-led”.

Ninety one percent of staff reported that more effective partnership working by the agencies represented on the Action Teams had resulted in improved outcomes for people using services. Of partnership working with other services on the ground the most positive relationships were reported to be with social work. Only a minority of health staff felt they had an effective working relationship with housing or other local authority departments, or with the independent sector. Just over half responded positively about their relationship with the voluntary sector which was a concern, given the important and substantial role of the latter across the Grampian area.

More than half of staff agreed that there were clear guidelines about the appropriate sharing of information, but even where teams were working to an integrated service model, most health workers could not access all the records of current and mutual service users. The majority of staff felt that they were proactive in sharing information for assessment purposes where service users had parenting responsibilities.

Sixty five percent of respondents in our survey agreed that morale had been good in their team for the last six months but almost half disagreed that working conditions were likely to improve in the coming year.

7.2 Drug-related Deaths

From the beginning of 2006 to mid December there were 45 confirmed and two suspected drug related deaths in Grampian: five in Moray, 14 confirmed and one suspected in Aberdeenshire, and 26 confirmed and one suspected in Aberdeen City. This was a significant increase from 2005 – almost 100% – but the 2005 figure was unusually low. Grampian has had approximately 11% of drug-related deaths in Scotland since 2001 with the exception of 2005.

We found no mechanism in Grampian for systematically reviewing drug-related deaths. We noted from the Moray Corporate Action Plan (CAP) that the DAAT was to set up a local group to review

drug-related deaths, while in the city CAP it was stated that a sub-group of the recently-established Clinical Effectiveness and Reference Group (CERGA) would in 2006-07 “review current policies and make recommendations for a comprehensive strategy for tackling drug related deaths and local implementation of the SACDM reporting into preventing drug related deaths”.

CERGA is to have a Grampian-wide remit and it would be more appropriate if this group took forward these objectives on behalf of all three Action Teams in the form of a Standing Group, consistent with Scottish Executive guidance on Taking Action to Reduce Scotland’s Drug-related Deaths.

An overhaul of current arrangements for reviewing alcohol or drug deaths where the person was known to services, was also needed. There was currently no formal procedure for examining these deaths. There was an informal arrangement where they were reported to the specialist substance misuse consultant who linked with the police, sought information from SMS about treatment status, and, if in treatment, a decision was taken with the lead clinician as to whether a critical incident review should take place. NHS Grampian was reconsidering this process following concerns raised by the Mental Welfare Commission.

Recommendation 22

NHS Grampian and Grampian Police, in consultation with Action Team partners, should establish a standing group for the monitoring and prevention of drug-related deaths and should develop formal procedures for the review of drug related deaths where the person was known to services. The three Action Teams should agree a definition of alcohol-related deaths and include those deaths with drug deaths.

7.3 Grampian Police

Strategy

Action Teams had highlighted different aspects of partnership working with the police in their Corporate Action Plans and Self-evaluation Questionnaires, and these were explored in the area chapters. It seemed clear from the evidence presented in these documents and from discussions during fieldwork, that the police were generally regarded as a good multi-agency partner in the field of substance misuse. The police described themselves as “an active consultative partner involved in the preparation of Action Team strategies”.

The force was represented on all three Action Teams and there appeared to be strong links with community safety structures, which had led to a number of joint initiatives. It was interesting to note that the majority of these joint initiatives focused on problems related to alcohol misuse as the dominant source of adverse impact on communities, although educative initiatives covered drugs, alcohol and a range of other life choice issues.

Service delivery

Grampian Police were involved in considerable joint activity with support staff from the Aberdeen Action Team to examine the feasibility of developing an assertive drug treatment programme aimed at addressing the area's most problematic high-tariff drug-using offenders. This was to be based on a service model in England, and a smaller-scale version of the same model was being considered for Aberdeenshire. This showed that initiatives were being considered across Action Team areas, although in this instance the project seemed to have stalled.

The 11 School Liaison Officers supported teachers in the delivery of personal, social, health and citizenship education. They had anti-social behaviour operations where they could identify young people who had an incipient or fully fledged substance misuse problem and refer them to an appropriate youth support service. Educational input, awareness-raising about services, and alternative activities were crucial preventative investments in which all the Action Team partners had a stake, given what we know of typical onset of problematic substance use in mid teens.

The police have a multi-faceted contribution to promoting early intervention for children and young people. As well as their direct work in schools and with youth in organised activities or on the streets, they automatically referred to child protection enquiries for domestic disputes, which commonly involved substance misuse. The re-structuring which took place in 2005 re-designated the CID lead officer post for drug misuse to the strategic Force Substance Misuse Co-ordinator, Community Partnerships, and was re-aligned to include alcohol issues. This should be helpful in adopting an overview of where and how to best deploy resources, provide greater community focus and should enable the school liaison role to be developed further.

There was a force-wide needle exchange scheme operating in all major custody suites. There were established arrest referral schemes in North Aberdeenshire and Moray, and funding had recently been granted for one in Aberdeen.

Police were represented on the Drug Treatment and Testing Order Advisory Group and staff had found that the police had been good in the passing on of information about changes in drug market conditions/added risks. Similarly, workers from a voluntary sector agency in the city working with women in the sex industry found that most police they dealt with handled issues sensitively if and when the women were the victims of crime.

There had been an increase in police activity in all areas of substance misuse in recent years, with mixed results. They had had operations specifically targeting the disruption of crack cocaine coming into the Aberdeen area. It had been known for some time that the North-east of Scotland had a disproportionate share of this particular drug problem and seizures of this drug continued to exceed the target. This was consistent with the finding that, although opiate dependency was still the dominant drug for new presentations at specialist addiction services, a third of this number presented with crack cocaine problems.

7.4 Social Work Criminal Justice Substance Misuse Services

The Social Work Inspection Agency produced a report in September of 2006 on the Northern Partnership Criminal Justice Social Work Services. The Northern Partnership consisted of the three local authorities in the Grampian area plus Highland Council. The inspection found that “there is a lack of effective joint working between the Partnership’s criminal justice addictions team and case managers in the four authorities”, and recommended that the Partnership should “review the function and operation of the criminal justice social work addictions service and the co-ordination of externally provided addictions services”. We do not intend to cover the same ground in this report, though we do comment on aspects of criminal justice addiction work in the chapters on Action Team areas. The report, however, did not cover Drug Testing and Treatment Orders, and we comment on this here.

Drug Treatment and Testing Orders (DTTO) were available in Aberdeen , Aberdeenshire and Moray. The service was staffed by an integrated team of nurses, social work and addictions staff. The service provided an intensive programme of treatment, support and rehabilitation to offenders on a court order. During the course of the fieldwork we heard very positive reports from both staff and service users about the efficacy of the service and the advantages of a multi-disciplinary approach. It was encouraging to note that the completion rate for orders was running at 50%, given that programme completion was recognised to be a critical success factor in reduced risk of re-conviction.

Our concern was centred on those who were not given the opportunity to access the service and why this was the case. The DTTO service was available to Sheriff Courts across city and shire but very few referrals for consideration of an order came from outside Aberdeen. Moreover, there had been persistent difficulties in sustaining a viable level of referrals from criminal justice colleagues in the city, despite the issue having been raised repeatedly with criminal justice management. The relationship between criminal justice social workers and addiction services was noted to be ineffective in the SWIA inspection report of criminal justice social work services in the Northern partnership, especially in Aberdeen. We understood that the partnership had therefore decided to review the city addictions service to give it a clearer remit.

Recommendation 23

Criminal Justice Social Work Services should review the current position of the Drug Treatment and Testing Orders in order to ensure that offenders and the courts have credible community-based intervention options. Any such review must include strategic partners and other key stakeholders.

7.5 The Role of Voluntary and Independent Sector Providers

The findings in this section are based on the written survey returns and file reading. Where we met with focus groups or individual staff during our fieldwork these are reported in the chapters for the relevant Action Team area.

Job satisfaction was as high for voluntary sector staff as for other sectors, while the experience of partnership working was decidedly more mixed. In the analysis of the particular issues highlighted in the survey returns, this was very much related to how they experienced being perceived by their statutory colleagues.

Almost all staff agreed that they enjoyed their job and believed that their team was successful in reducing the harm caused by substance misuse. They generally felt that they worked within a framework of clear expectations, had manageable workloads and had access to relevant training opportunities.

Almost all staff believed that skills were deployed effectively within their team. In contrast to the statutory sector, nearly half agreed that their organisation had a policy of encouraging employment applications from people with a previous history of substance misuse problems.

Eighty nine percent of staff reported that their service was easy to access, and there was 100% agreement that their team promoted routes out of substance misuse. Ninety percent of staff agreed that all service users had care plans, but in one Action Team area the figure was as low as 50%. However, this area had the highest incidence of regular reviews. Although 89% asserted that they worked with other agencies to 'wrap around' service users with complex needs, this was not borne out by the file reading results, where significantly more social work files showed evidence of partnership working than voluntary sector files.

Voluntary sector engagement in partnership working was mixed. It was a matter of concern that there was almost an even split on agreement concerning good relationships with colleagues from other agencies, notably social work and housing. Nearly half said that they did not regularly attend multi-agency meetings and more than half did not agree that there were clear guidelines in place about the sharing of information where more than one service was involved with a service user.

More than half did not agree that effective systems were in place for two-way communication between the Action Team and front-line services. Staff in the voluntary sector were significantly less likely to agree that good partnership working by all agencies on the Action Team had resulted in improved outcomes for service users.

The following were examples of written comments about what would improve services in the area:

“Better relationships with social work – more clarity about the aims of the project”;

“More accessible treatment, more GP involvement”.

These results suggest disaffection of staff in the voluntary sector. The Action Teams should take active steps to explore and to address these.

Concerns were also expressed in the written comments about disparities, including those of pay and conditions, between alcohol and drug services, with the latter resourced to pay more. The differences in the make-up of the services was quite marked, with alcohol services usually employing more unpaid volunteers than would typically be found in a drug service. This seemed to be partly evolution and partly pragmatism, the latter in the context of the national market-place.

Eighty six percent of staff agreed that ‘Hidden Harm’ and ‘Getting Our Priorities Right’ had impacted positively on the practice within their team, but this was not reflected in the file reading results. The numbers surveyed were too small to be of statistical significance but there was a lack of evidence to demonstrate that the impact of parental substance misuse was being assessed as a matter of course.

The Action Team areas had included the voluntary sector in in-house training made available through the local authority, but to different degrees and in different ways.

Risk assessment was an area which required further development and more focus in the voluntary sector. There were 21 files where it was identified that the person was vulnerable to abuse or that a person in the house posed a risk to other adults in the household, but an up-to-date risk assessment and risk management plan was present in only 19% of cases. Case files showed very little evidence of first-line manager scrutiny.

Recommendation 24

Voluntary organisations in Grampian should conduct an internal audit of all files, focusing on critical areas of parenting assessment, risk assessment and care planning processes. The Action Teams should put measures in place through contract compliance processes to monitor progress on this.

7.6 Feedback from Service Users and Carers

Service Users

To obtain the views of users of services in the three Action Team Areas, we commissioned a peer review, conducted by Scottish Drugs Forum. One hundred and fifty seven service users were interviewed and we also had a number of opportunities to observe practice and meet users in a number of different settings across the Action Team areas. The views of service users throughout Grampian are presented here.

National Quality Standards were introduced in Scotland in the autumn of 2006. On the basis of the evidence set out below, service users in Grampian perceived that services were largely being delivered in accordance with these standards. Access to services could be a problem, but once in services, service users reported that they felt safe, consulted and that the service improved their lives.

Most service users were very positive about the changes that services had helped them to make:

- Twenty eight percent reported that they had stopped using illicit drugs or misusing alcohol as a result of engaging with services and a further 59% had significantly reduced misuse. More than half attributed this outcome to effective inter-agency working.
- Self-reported outcomes for the 81 interviewees who had been involved in offending prior to attending a service were particularly positive. Sixty reported that they had stopped offending and 14 that their offending had reduced.
- One hundred and eleven of the 136 service users we spoke to who had suffered physical health problems as a result of their substance misuse felt that they had recovered or were recovering, as did all of the 109 people who reported having suffered mental health problems. In around 35% in both health categories, people felt that inter-agency working had played a significant part.
- Ninety five of the 122 who told us that they had experienced family relationship problems related to their substance misuse felt that engagement with services had benefits in repairing or improving these relationships.

It was encouraging that those who took part in the peer review spoke positively about the services they received. However, we were not able to interview people on waiting lists, of whom there were many, nor those who had dropped out of services.

Observed practice and meetings with service users yielded powerful personal testimony about the difference services had made, but by their nature what we heard was from people part-way through planned care and support and it was not possible to ascertain sustained positive change. Typical reports from service users related how services had “turned my life around”, “saved my life” or “provided much-needed respite from the chaos that had gone before”.

In 58% of the local authority and voluntary sector files read, there was evidence that the individuals' circumstances had generally improved while the figure was higher for health files.

Eighty nine of the 157 interviewees in the peer research were parents. Of these, 30 lived with their children. Of the 89, 64% reported the service they attended for their problem also offered support in their parenting role. Forty eight percent provided direct support, 12% linked to another child-care agency and 40% felt that they did not need this kind of help. Eleven percent experienced problems in accessing substance misuse services because of child care issues.

“Sometimes I couldn't get to service if my kid's off school. The workers were alright but I don't want my kid mixing with other addicts.”

“Social work helped with after-school care when I was attending service.”

Most respondents reported positive effects on their parenting abilities as a result of the help they were receiving, whether or not they had additional help with child care.

“DTTO has helped get my drug problem under control therefore I had more time to spend with my children instead of committing crime and being in prison.”

“I lost my child and was not far off finishing my life. Down to losing script. They made sure I was stable and it has made me a better parent.”

7.6.1 Access to services

Despite what we know of waiting list problems for some services, the service users we interviewed had not generally had to wait long for the main service they were receiving. The problem which was identified from the majority of comments on the subject of access, was that most did not believe the range of services was adequate for their area, and limited or delayed access to prescribing services was highlighted as a particular problem. Many commented about a lack of residential rehabilitation in the area.

The other issue which came up repeatedly in the research and the fieldwork related to information about services and concern about lack of awareness of the help available. The main source of information was reported to be GPs, which illustrated the vital role they had in referring to other services as well as providing them.

Those who told us that their involvement with substance misuse services came about through criminal justice generally felt that this resulted in speedy access to treatment services, although some expressed reservations about this.

“It was a court order so it was easy.”

“It took me to get on a DTTO to get a script and get stabilised.”

7.6.2 Involvement in assessment, care planning and reviews

The majority of service users agreed that an assessment of their needs was started within a week of their accessing the service. Almost all service users believed that the assessment reflected their needs completely or partly. A slightly lower number were positive about their own involvement in the assessment process and felt that their views were taken into account. While almost half the assessments were thought to include the views of their GP, less than one in six involved families or spouses.

Sixty four per cent of the 157 people interviewed reported that they had a care plan, while the other third did not believe they had or did not know. Three out of four who believed they did have a care plan said they attended regular meetings in this regard.

Almost all service users in the peer review reported that they were happy with the service they received and this was also true of the service users we met with during the fieldwork. In alcohol services there was a high agreement that staff had the ability to understand the problem, but only half of users of drug services rated staff as excellent in this regard. Across all services, service users were virtually unanimous that their service was sensitive to issues of ethnicity, gender, disability and sexuality. Many spoke in the warmest terms about the regard and affirmation they felt they receive from their key worker.

We heard examples of service users and carers being involved in staff selection or staff training (both of and with staff) but these tended to be exceptions, and should be examined carefully in relation to further development. These can be extremely positive experiences for all concerned if properly planned.

7.6.3 Carers

We were only able to meet with a small number of carers and therefore cannot be clear how representative their views were. We did not meet with any carers who felt that they had only good outcomes to report. In contrast to an improving health picture for service users, carers told us that their own health and sense of emotional well-being had worsened as a result of their caring role. They were unanimously of the view that their support needs were not recognised or responded to in sufficient measure to avoid these adverse outcomes.

Carers were clear that it had taken them a considerable period after problems developed for them to even think about their own need for support, rather than supporting services to care for their family member. They reported that they did not know where to go, some worried about whether their own difficulties in coping would somehow back-fire (especially if they had assumed partial or complete responsibility for the care of dependent children), and they also reported a deeply felt sense of the stigma of drug use, particularly within the family. We were given access to a recent research paper which looked at issues affecting access to support for carers in one of the Action Team areas. The findings from this small-scale study supported our own – that

people had a mixed experience of attempting to access support but felt it was extremely worthwhile once they received support.

Example of Good Practice

Family support group facilitators with whom we met had opened up training opportunities to family members. We heard from one carer of his experience of attending a conference funded by the group and finding that he was the only non-professional there. This particular carer also accessed training in therapy, funded through the group, which he was then able to use to therapeutic effect with the person he cared for.

We heard very mixed accounts from carers as to how accessible and how helpful they had found carer support services. They had also experienced different degrees of inclusion in assessment and care planning processes in respect of the person they cared for.

They spoke about the stigma felt by all members of a family when the drug problem of one member becomes known about by others. This can result in them trying to manage the problem without external support until a crisis point is reached.

Carers also reported different experiences of contributing to assessment and care planning in respect of their family member. We heard an example of a carer who supported his adult child to access a service in the city and was not only involved in the assessment process but was provided with information and encouragement regarding family support. Another carer told us of how she had had to fight for services for her son for several years. Problems resulting from his substance misuse were exacerbated by another condition, but she believed there was very poor assessment of how these would impact on each other. She felt excluded from assessment and care planning and experienced great frustration that health and social work services did not join up to support her son.

Each Action Team was supporting some form of support for carers, sometimes in-house and sometimes through commissioned services.

We were concerned that while all of the Action Teams gave us evidence of how they were improving the means by which they captured and collated service user experience, none made any such claim in respect of carers' experiences.

Recommendation 2

There is a recommendation for all three Action Teams about the involvement of users and carers in developing services in Chapter 6.

Evaluations and Recommendations

8.1 Evaluations for Aberdeen JADAT Area

| Area for Evaluation | Evaluation |
|--|------------|
| Key Outcomes | Adequate |
| Impact on People who use Services and other Stakeholders | Adequate |
| Key Processes | Adequate |
| Strategic Management and Leadership | Weak |
| Partnership Working | Weak |
| Capacity for Improvement | Adequate |

8.2 Evaluations for Aberdeenshire ADAT Area

| Area for Evaluation | Evaluation |
|--|------------|
| Key Outcomes | Adequate |
| Impact on People who use Services and other Stakeholders | Good |
| Key Processes | Good |
| Strategic Management and Leadership | Good |
| Partnership Working | Good |
| Capacity for Improvement | Good |

8.3 Evaluations for Moray DAAT Area

| Area for Evaluation | Evaluation |
|--|------------|
| Key Outcomes | Weak |
| Impact on People who use Services and other Stakeholders | Adequate |
| Key Processes | Weak |
| Strategic Management and Leadership | Adequate |
| Partnership Working | Adequate |
| Capacity for Improvement | Adequate |

8.4 Recommendations – Individual Action Team Areas

Aberdeen City JADAT

Recommendation 3

Concerted action should continue to be taken to reduce waiting times and lists. As well as addressing capacity, Aberdeen should further consider redesign of services and set short-, medium- and long-term targets to reduce waiting lists.

Recommendation 7

The JADAT should review the balance of services in Aberdeen to make sure they meet the current identified need in the city.

Recommendation 9

The Fulton clinic should review its practice on home visiting by nursing staff to ensure that risk is assessed on an individual basis, and that resources are deployed effectively, based on clear agreed criteria. The assessment tool in use may be helpful.

Recommendation 10

Aberdeen City Council should review the level and role of its specialist substance misuse social work service in the context of a review of the balance of substance misuse services across the city.

Aberdeenshire ADAT

Recommendation 12

Aberdeenshire should continue to take steps to develop services in the south and central area of the county to the standard of those in the north, based on identified need.

Moray DAAT

Recommendation 13

The DAAT should put processes in place to ensure that all services have outcome indicators as a priority of delivery and development. This should be clearly reflected in care planning processes and staff should be supported to achieve and sustain this approach.

Recommendation 14

Health and Social work commissioners should examine contractual arrangements with providers to ensure that include clear statements that they have appropriate access to their files.

Recommendation 15

Moray should follow up its review of strategic and operational structures with a fundamental review of service need and develop services and staff accordingly.

Recommendation 16

Roles, responsibilities, and accountability in the integrated team should be clarified as a matter of urgency and joint working policies and procedures put in place.

8.5 Recommendations – All Three Action Teams

Recommendation 1

All three Action Teams should continue the work they are doing to develop and agree local outcome and performance measures and develop systems for collecting and analysing information to monitor performance against them. They should do so jointly rather than independently. The Scottish Executive should work with Action Teams to develop appropriate local outcome and performance measures.

Recommendation 2

NHS Grampian and the three Action Teams should review the role of users and cares in developing services, and create ways in which they can become more involved. The Action Teams should review the role of users and carers in the Action Teams and Forums.

Recommendation 4

All three Action Teams and NHS Grampian should ensure that the integrated assessment form for substance misuse is used across Grampian, by all relevant statutory and voluntary staff Regular auditing of the the forms should take place to ensure that the risk assessment section is being effectively utilised.

Recommendation 5

All three Action Teams should continue to ensure that staff who work with families where there are children are trained in screening for the impact of parental misuse on children, and in collaborative assessment procedures where this is judged necessary. This should be monitored by senior managers to ensure any risk to children is identified and appropriate action taken.

Recommendation 6

All three Action Teams should continue to work to develop and improve strategic links through relationships between strategic planning groups and the integration of substance misuse issues into appropriate plans. Reporting mechanisms from the Action Teams to the partner authorities should be agreed.

Recommendation 8

All three Action Teams should continue to develop management information systems to enable the appropriate sharing of information and the joint identification of performance information and unmet need. This information should be used to inform key planning and decision-making processes in the Action Teams.

Recommendation 11

All three Action Teams should continue to review their financial governance and put in place processes to enable them to improve their capacity to monitor and review spending on substance misuse in their areas.

8.6 Recommendations – Grampian-wide**Recommendation 17**

NHS Grampian should ensure that Action Team partners are clear about their strategic intentions.

Recommendation 18

NHS Grampian should develop clinical governance arrangements for substance misuse. They should be supported by guidance, standards of performance and reporting requirements.

Recommendation 19

NHS Grampian should increase their efforts to promote enhanced contracts for GPs and provide support to GPs in order to develop more equitable services across Grampian.

Recommendation 20

NHS Grampian should review strategy and service delivery for people with co-occurring substance misuse and mental health problems. Clinical leadership and pathways of care should be clarified.

Recommendation 21

Action Teams should review pharmacists' representation to ensure that their important role is recognised and their experience contributes to the development of integrated substance misuse services of the best quality.

Recommendation 22

NHS Grampian and Grampian Police, in consultation with Action Team partners, should establish a standing group for the monitoring and prevention of drug-related deaths and should develop formal procedures for the review of drug related deaths where the person was known to services. The three Action Teams should agree a definition of alcohol related deaths and include those deaths with drug deaths.

Recommendation 23

Criminal Justice Social Work Services should review the current position of the Drug Treatment and Testing Orders in order to ensure that offenders and the courts have credible community-based intervention options. Any such review must include strategic partners and other key stakeholders.

Recommendation 24

Voluntary organisation providers in Grampian should conduct an internal audit of all files, focusing on critical areas of parenting assessment, risk assessment and care planning processes. The Action Teams should put measures in place through contract compliance processes to monitor progress on this.

Abbreviations and Acronyms

| | |
|--------------|---|
| A | |
| AACS | Alcohol Advisory & Counselling Service |
| ADAT | Alcohol & Drugs Action Team (Aberdeenshire) |
| B | |
| BBV | Blood-Borne Viruses |
| C | |
| CAP | Corporate Action Plan |
| CAT | Community Alcohol Team |
| CBT | Cognitive Behavioural Therapy |
| CERGA | Clinical Effectiveness & Reference Group for Addictions |
| CHPs | Community Health Partnership |
| CPN | Community Psychiatric Nurse |
| CPP | Community Planning Partnership |
| CPS | Community Safety Plan |
| CSMS | Community Substance Misuse Service |
| CSSG | Community Safety Strategy Group |
| CSWO | Chief Social Work Officer |
| D | |
| DAAT | Drug & Alcohol Action Team (Moray) |
| DAT | Drug Action Team |
| DTTO | Drug Treatment and Testing Order |
| E | |
| EDOs | Employment Development Officers |
| G | |
| GOPR | Getting Our Priorities Right |
| GP | General Practitioner |
| I | |
| ICDRS | Integrated Community Drug Rehabilitation Service |
| ICPSS | Integrated Care Planning and Stabilisation Service |
| IDS | Integrated Drug Services |
| J | |
| JADAT | Joint Alcohol and Drug Action Team (Aberdeen City) |
| JHIP | Joint Health Improvement Plan |
| JPIAF | Joint Performance and Improvement Assessment Framework |

Appendix 1: Substance Misuse Abbreviations and Acronyms

| | |
|---------------------|--|
| M | |
| MCA | Moray Council on Addiction |
| N | |
| NES CPC | North East Scotland Child Protection Committee |
| NHS Grampian | National Health Service Grampian |
| NHS QIS | NHS Quality Improvement Scotland |
| S | |
| SALSUS | Scottish Schools Adolescent Lifestyle and Substance Use Survey |
| SE | Scottish Executive |
| SEQ | Self-Evaluation Questionnaire |
| SLA | Service Level Agreement |
| SM | Substance Misuse |
| SMS | Substance Misuse Service |
| SMR | Substance Misuse Research |
| SPS | Scottish Prison Service |
| SSA | Single Shared Assessment |
| STRADA | Scottish Training on Drugs and Alcohol |

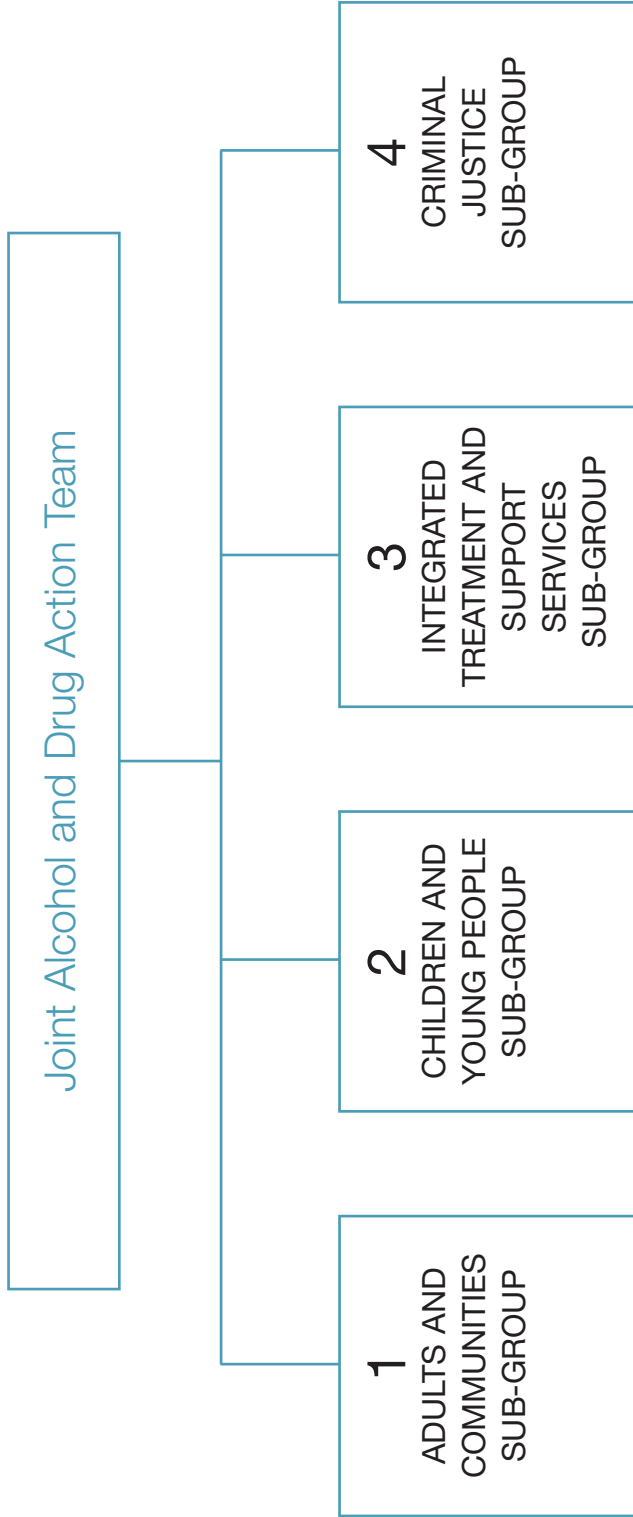
Multi-agency Inspection of Substance Misuse Services – Inspection Model

| | |
|--|---|
| <p>1. What key outcomes have we achieved?</p> | <p>1.1 Outcomes for people who use services, their families and carers</p> |
| <p>2. What impact have we had on people who use our services and other stakeholders?</p> | <p>2.1 Experience of people who use services, their families and carers 2.2. Experience of staff 2.3 Impact on community wellbeing</p> |
| <p>3. How good is our delivery of key processes?</p> | <p>3.1. The journey of the service user and their family through the service 3.2. Multi-agency and multi-disciplinary working and integrated person-centred care 3.3 The involvement of and partnership with people who use services, their families and carers 3.4. Inclusion, equality and fairness in service access and delivery</p> |
| <p>4. How good is our strategic management and leadership?</p> | <p>4.1. Visions, values and aims 4.2. Joint planning and development of services 4.3. Commissioning arrangements 4.4. Range and quality of services 4.5 Quality assurance and continuous improvement 4.6 Management information</p> |
| <p>5. How good is our partnership working?</p> | <p>5.1 Partnership arrangements 5.2 Development and review of joint policies, procedures, protocols and guidance 5.3 Recruitment, deployment and development of staff 5.4 Joint budgeting and use of financial resources</p> |
| <p>6. What is our capacity for improvement?</p> | <p>6.1 Evaluation based on the evidence in the other 5 key questions</p> |

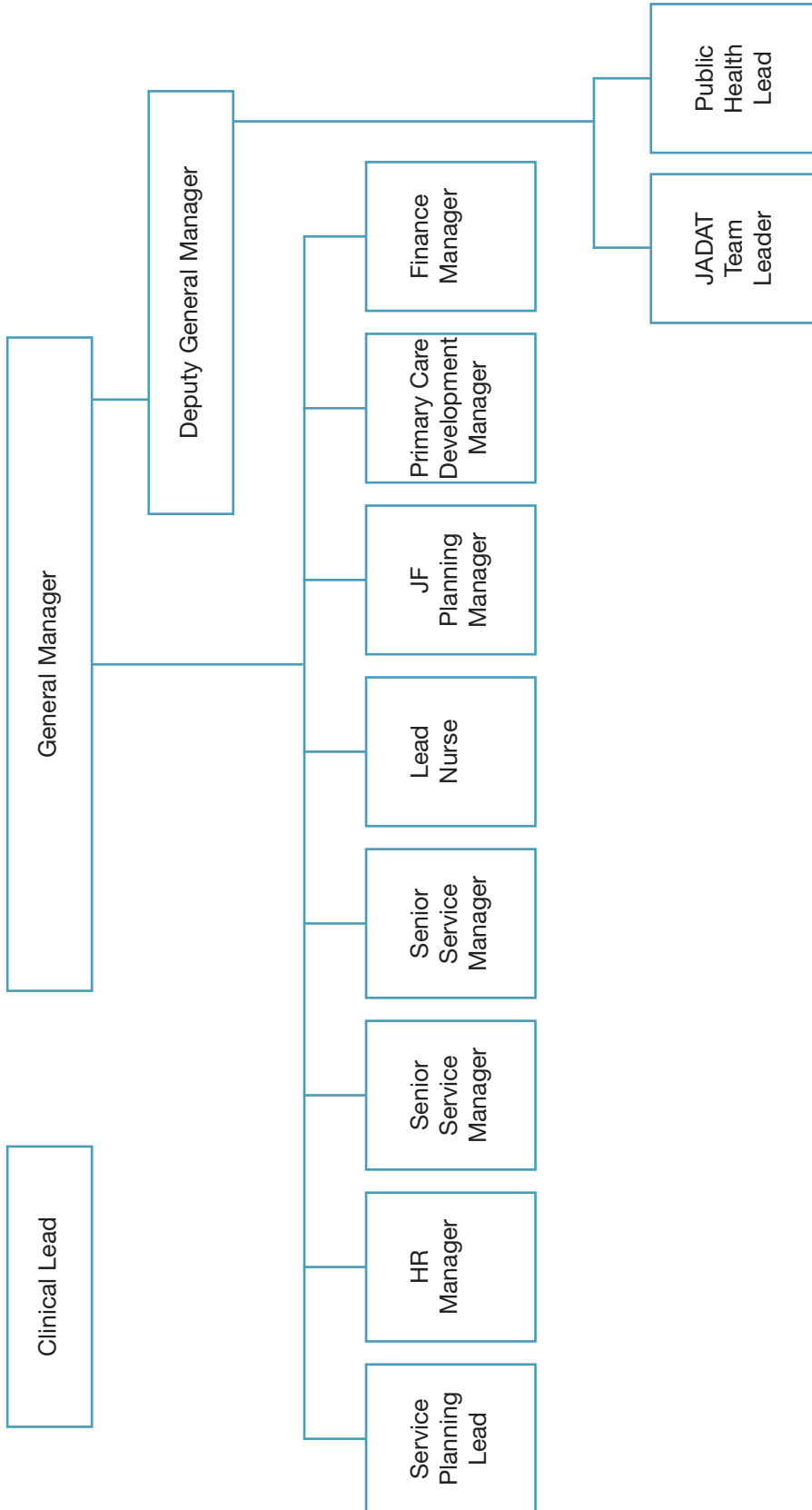
Appendix 3

Aberdeen City Structure Charts

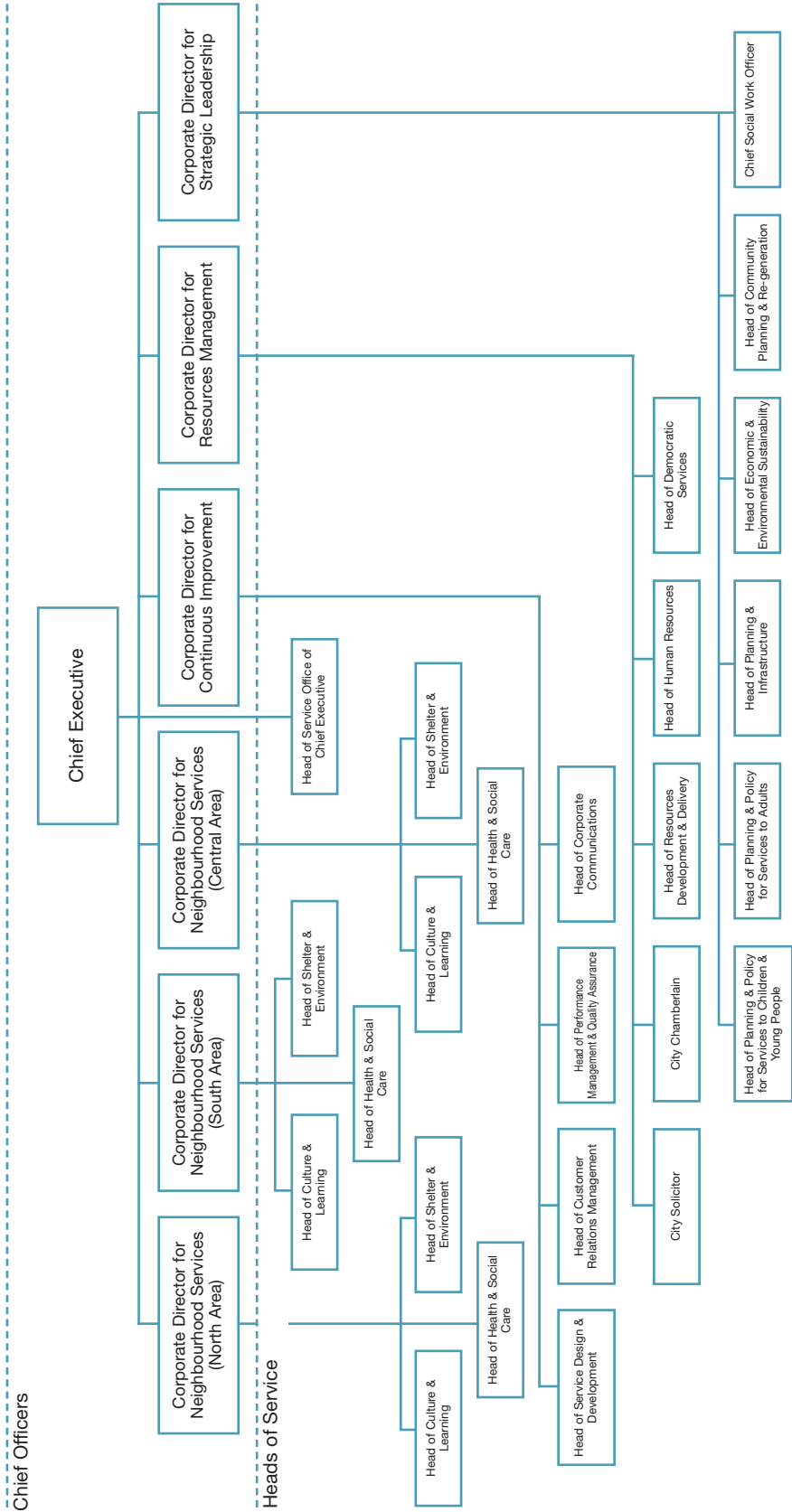
Aberdeen City – JADAT



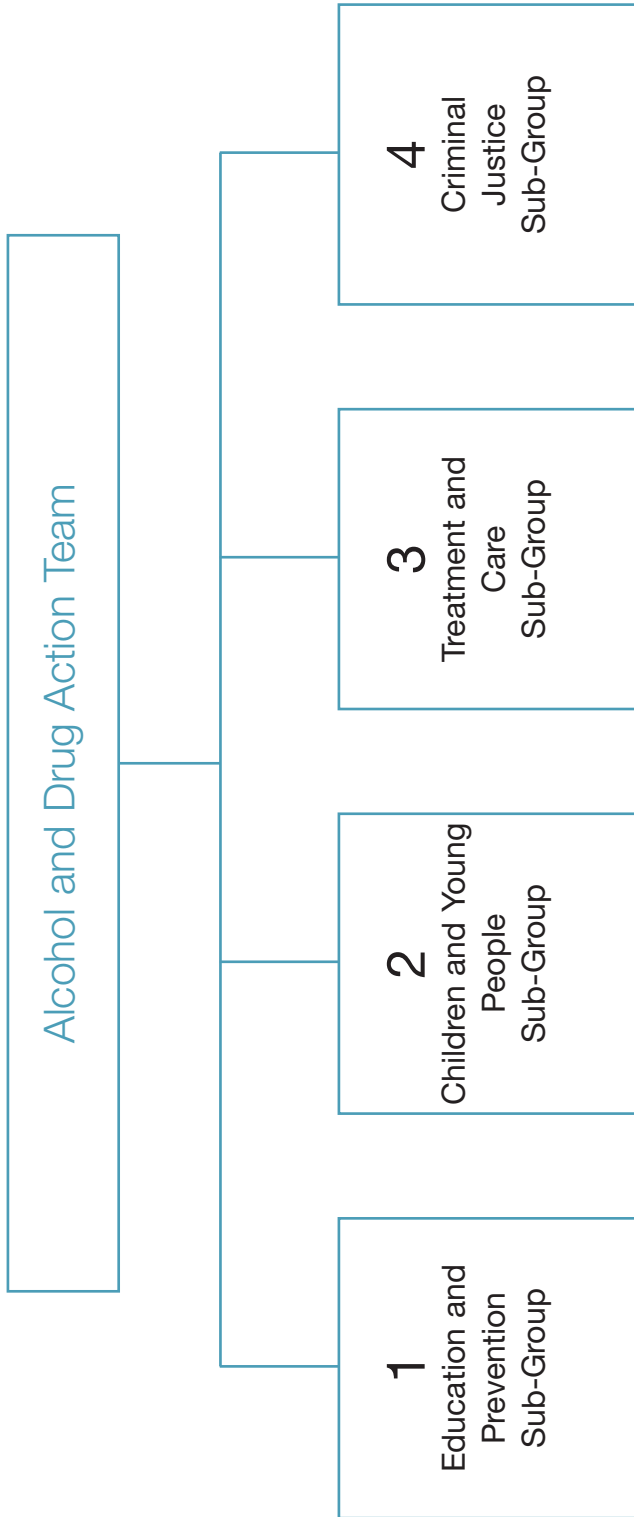
Aberdeen City – Community Health Partnership



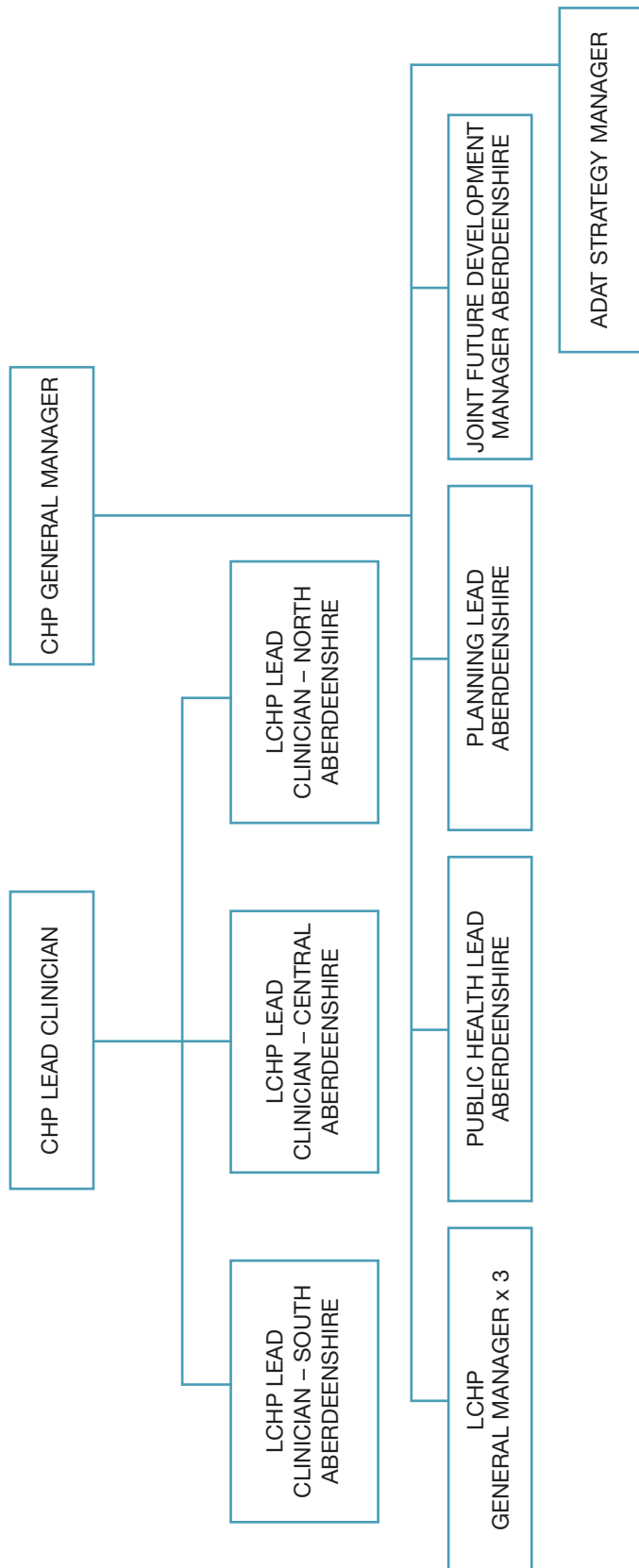
Aberdeen City Council Structure Diagram



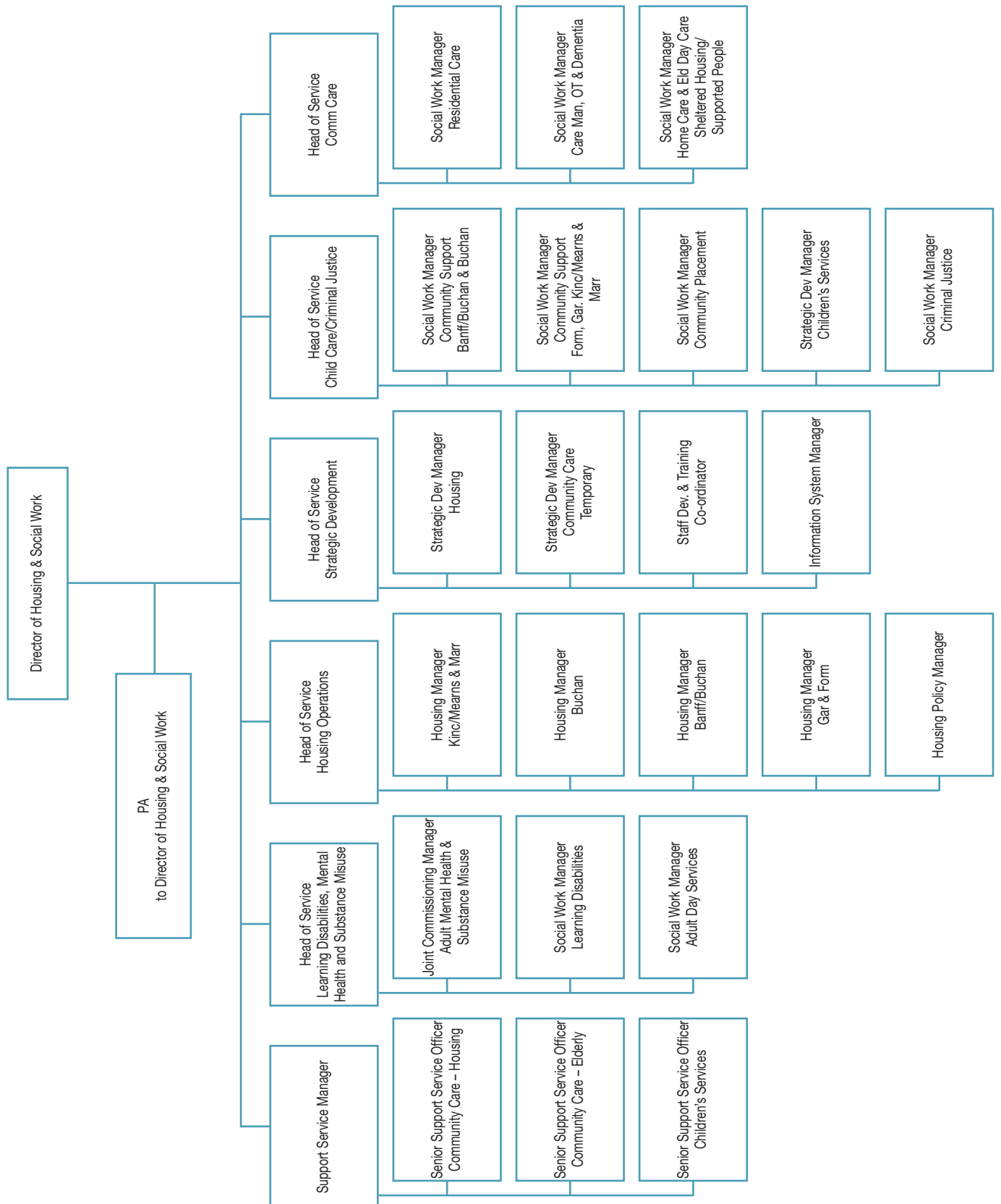
Aberdeenshire Structure Charts



Aberdeenshire Community Health Partnership



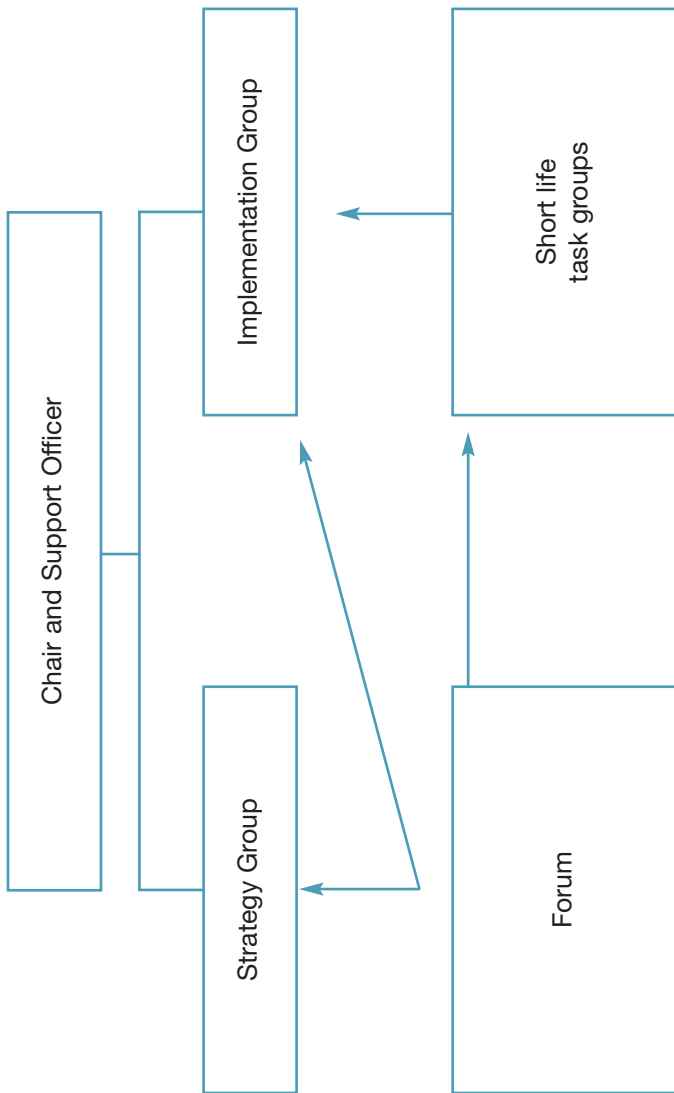
Aberdeenshire Housing and Social Work – Senior Management



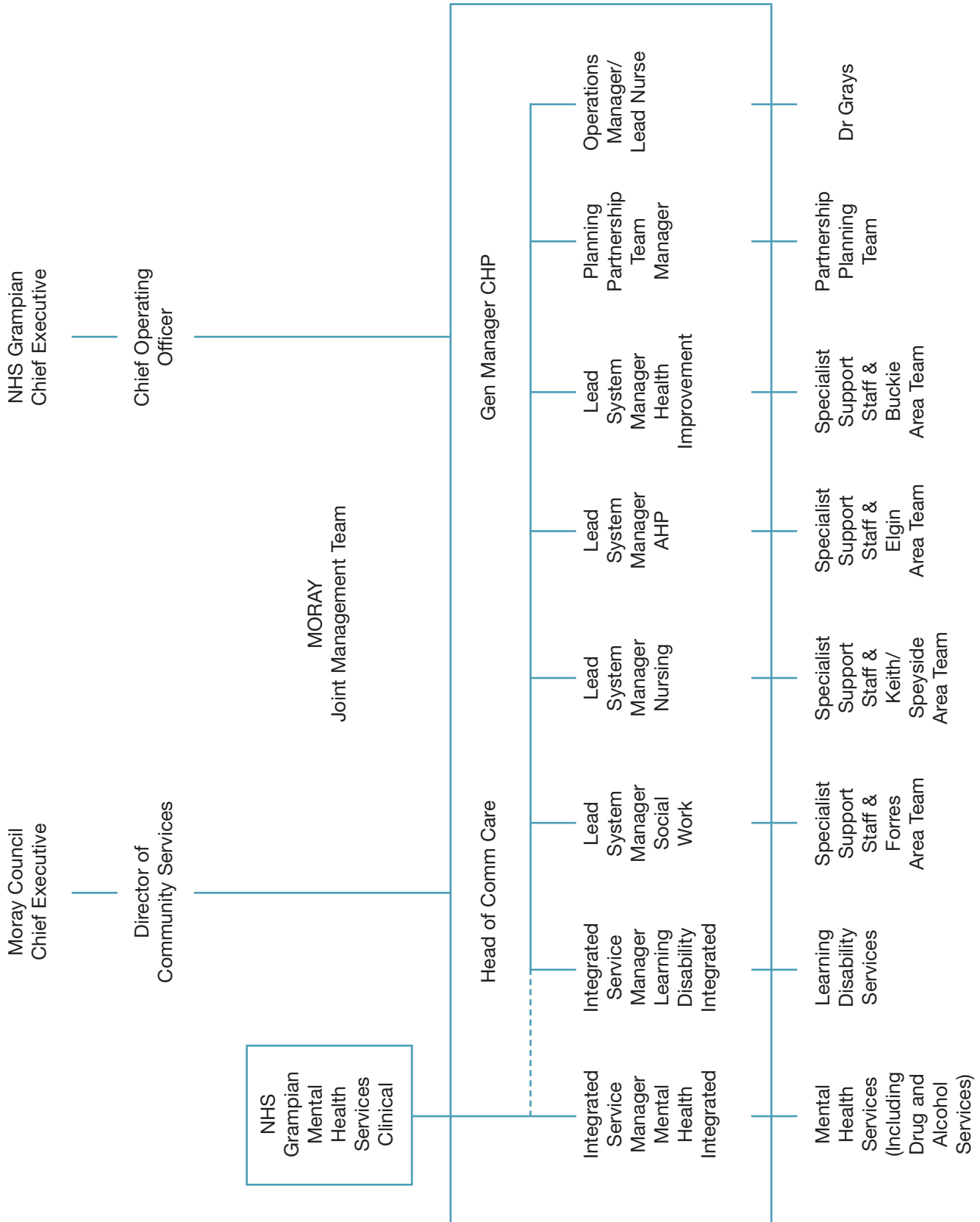
Appendix 5

Moray Structure Charts

Moray DAAT Structure



Management Structure – Moray Community Health and Social Care Partnership



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