Appendix I

WEST DUNBARTONSHIRE
COMMUNITY PLANNING PARTNERSHIP

West Dunbartonshire Alcohol & Drug Partnership

A Strategy to reduce the harmful effects of alcohol and drugs and promote recovery

2011 - 2014

West Dunbartonshire Alcohol and Drug Partnership

Alcohol & Drug Strategy: (Draft 4) 2011 – 2014

August 2011

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FOREWORD

The West Dunbartonshire Alcohol and Drug Partnership (ADP) Alcohol and Drug Strategy 2011 – 2014 has been developed in partnership with all key stakeholders including those who represent the wider community of West Dunbartonshire and those who access support from our local alcohol or drug services.

The aim of this strategy is to enable the ongoing delivery and monitoring of local services which are reflective of locally identified need. Already, we have made substantial progress in delivering the priorities identified at both local and national levels i.e. evidenced a substantial growth in local recovery capital, and increased delivery of community based detoxification and rehabilitation services.

Of particular note is the establishment of a "radical", approach to the overprovision of licensed premises. That Overprovision Policy, which is encompassed within the West Dunbartonshire Statement of Licensing Policy, is being held up as an example of good practice nationally and has already been successfully tested when it enabled the refusal of an expansion to alcohol shelf space within a local supermarket.

However, while we recognise local success and innovation where we can, we must also continue to rise to the challenges that the effects of alcohol and drug misuse continue to present across West Dunbartonshire.

This strategy therefore reaffirms the approach that will be taken to deal with the complex issues associated with the misuse of alcohol and drugs.

Ultimately, our aim is to reduce the adverse effects that drugs and alcohol have on the social and economic health of individuals and communities in West Dunbartonshire and to enhance and improve the confidence of all local residents that alcohol and drug misuse is being addressed comprehensively by all local agencies.

The West Dunbartonshire Alcohol and Drug Strategy 2011 – 2014 should be viewed as an "organic" document which should be used to plan, monitor and shape the delivery of person centred services which are reflective of identified need.

The Commissioning Strategy for Alcohol and Drug Services 2011 - 2021, attached as Appendix 10, projects how that local need may develop, and will form the basis on how future service delivery is shaped.

In closing may I, once again, offer my thanks to the partners who assisted in the development of this Strategy, and ask for your continued support in developing and delivering local services which may be challenging, but which are centred on the needs of our communities, our clients and those who offer ongoing support for them in achieving sustained recovery from drug or alcohol problems.

Keith Redpath
Chair
West Dunbartonshire Alcohol & Drug Partnership

Executive Summary

Introduction

The West Dunbartonshire Alcohol and Drug Partnership's aim is, through efficient and effective partnerships with key stakeholders, to reduce the harmful effects of alcohol and drugs and promote recovery.

This Strategy is designed to ensure a needs-led approach to the planning, delivery and monitoring of local addiction services and has been developed in conjunction with the West Dunbartonshire Commissioning Strategy 2011 – 2021 (Appendix 1).

The document evidences the level of need both locally and nationally and establishes Local Improvement Targets (LITs) linked to National Core Outcomes (NCOs) to deal with the complex issues associated with alcohol and drug misuse.

The Strategy's action plan, which is split into 'Prevention' and 'Recovery' sections, has been developed in partnership with a variety of key stakeholders and sits alongside and is linked to, other local and national strategies. The Strategy will be reviewed on a six-monthly basis to ensure specific actions are being delivered and evolving to meet changing need, service provision or policy requirements.

By working in partnership it is envisaged that the harmful effects of alcohol and drugs on individuals, families, friends and indeed whole communities will be reduced. Ultimately, the West Dunbartonshire ADP vision is for a local community where alcohol and drug misuse is being addressed and all residents feel healthier, happier and safer.

Local Need

The importance of Alcohol and Drugs Partnerships conducting a needs assessment has been highlighted in a number of national reports. Locally, the identification of priority areas has been taken forward in partnership with key stakeholders who have also been involved in the development of a Commissioning Strategy for West Dunbartonshire (Appendix 1).

In 2009 there were an estimated 6,090 people living with alcohol or drug-related problems in West Dunbartonshire. Of that number an estimated 1,601 have problems with drug misuse and 4,489 (6% of the population aged 15 – 64) live with problems associated with alcohol misuse. *(Estimating the National and Local Prevalence of problem Drug Misuse in Scotland, August 2009 and Alcohol Statistics Scotland 2009).*

In mid 2010 the "General Registrar for Scotland" indicated that the population of West Dunbartonshire had fallen to 90,570; of that number 60,554 were aged 15 – 64. It is estimated therefore that there are currently 4,668 individuals aged 15 – 64 living with problems associated to alcohol or drugs. Three thousand six hundred and thirty three (6%) have problems with alcohol misuse and 1,035 (1.71%) are living with drug misuse problems.

West Dunbartonshire is ranked as the second highest area in Scotland for drug misuse (*Drug Misuse Statistics Scotland* 2009) and had the third highest alcohol-related death rates in the UK *(Office for National Statistics 2007).*

A 2008 audit by West Dunbartonshire Social Work Department identified the wider impact substance misuse has on children and young people.

The audit found addiction was a factor in half of all cases held by Children and Families Teams; 72% of all cases held by Criminal Justice Teams and for 61% of accommodated children and young people.

Service Delivery

Local alcohol and drug services and supports have, and will continue, to be provided using a tiered approach. This ensures a Care Pathway exists to meet the needs of anyone affected by alcohol or drug misuse.

Tier 4 – Specialist inpatient/residential care
Tier 3 – Community based specialist drug and alcohol assessments and care planned treatment and care
Tier 2 – Brief psychosocial interventions, harm reduction
Tier 1 – Information and advice, screening and onward referral.

Addiction services are being developed with a "needs-led" ethos which is centred on the client and not the service.

Annual service user surveys combined with focus groups, integrated care planning, the establishment of integrated teams across Social Work & Health and ongoing service level agreements and partnership working with voluntary sector organisations offer clients choice and access to a raft of holistic services relevant to individual need.

It is also essential that those who access our services are encouraged to have a say in the strategic planning and delivery of local services. To ensure clients are able to play that pivotal role the Future of Addiction Services Team (FAST) was established in 2007. With support from the ADP, via a service level agreement, FAST's aim is to sign-post individuals to the range of services available to support them through their own or someone else's problems with drug or alcohol misuse.

Representatives from FAST sit, as key stakeholders, on the ADP and are involved in the key decision-making processes surrounding the ongoing planning, delivery and monitoring of local services.

Workforce Development

In December 2010, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) issued a joint statement supporting the national development of the drug and alcohol workforce.

Workforce development occurs within the Scottish context of a shift in government policy with the focus being on recovery which takes into account the long-term nature of behavioural change with the goal of an enhanced quality of life, not just the cessation of problematic substance use.
A recovery perspective means behavioural change is central to services, with the need to consider the evidence base for effective ways to promote, initiate, and maintain behavioural change.

Licensing

The Licensing (Scotland) Act 2005 requires all Scottish Licensing Boards to produce a Licensing Policy Statement detailing the extent to which the Board considers the overprovision of either licensed premises generally, or a particular description of licensed premises specifically, exists within any identified locality.

The legislation requires Licensing Boards to take a pro-active position on overprovision and to identify those localities where it would not propose to grant new licenses or license premises of a particular description. The guidance to the legislation also highlights the importance of "robust and reliable evidence" in formulating a view on overprovision.

West Dunbartonshire is ranked second in Scotland in terms of the number of licenses per 10,000 population, just behind Glasgow.

In November 2009 ADP representatives offered to facilitate an evidence-gathering process to collate data on the issue of overprovision.

Primary data came from Police (reflecting incidents and crime reports correlating to alcohol misuse), Health (alcohol-related deaths and alcohol-related and attributable hospital patients) and Fire Service was reviewed both at Council ward level and, where viable, at intermediate data zone level.

The data was presented to the West Dunbartonshire Licensing Board and members subsequently agreed a Licensing Policy statement which detailed overprovision of specific licensed premises in 18 out of 21 sub-localities in West Dunbartonshire. These included vertical drinking establishments (pubs and hotels where the bar facilities are not ancillary to the accommodation or dining); nightclubs; off-sales and supermarkets.

Accountability

This Strategy has been developed in line with local and national priorities and establishes 14 Local Improvement Targets (LITs).

These 14 local indicators were developed in line with the *National Outcomes for Community Care* and, more directly, to align with the national drug and alcohol strategies i.e. the *Road to Recovery* and *Changing Scotland's Relationship with Alcohol: A Framework for Action* and with West Dunbartonshire's Single Outcome Agreement.

While no specific local targets were set by the Scottish Government subsequent guidance made it clear that local strategies would fit with:

- National Objectives
- HEAT (Health Improvement, Efficiency, Access and Treatment) Targets
- Local Single Outcome Agreement targets.

1. West Dunbartonshire Alcohol and Drug Partnership: Our Vision Statement/Aim

1.1 Vision Statement

The West Dunbartonshire Alcohol and Drug Partnership's vision is for a local community where alcohol and drug misuse is being addressed and all residents feel healthier, happier and safer.

1.2 Aim

The West Dunbartonshire Alcohol and Drug Partnership's aim is, through efficient and effective partnerships with key stakeholders, to reduce the harmful effects of alcohol and drugs and promote recovery.

2. Making Sense of "The West Dunbartonshire Alcohol and Drug Strategy"

2.1 Developing the Strategy

This Strategy has been developed in a way that will enable, in conjunction with the West Dunbartonshire Commissioning Strategy 2011 – 2021 (Appendix 1), the ongoing facilitation of needs led planning, delivery and monitoring of local addiction services.

With strong links to national delivery measurements this Strategy will identify local need, actions and enable delivery of both local and national priorities. Although the action planning element of this Strategy document is split into 2 distinct sections i.e., "Prevention" and Recovery, within these sections issues relating to the other areas identified within the Delivery Reforms Toolkit like Children Affected by Parental Substance Misuse, Enforcement and Availability are addressed as appropriate.

The Substructures sitting beneath the ADP mirror that split. However, other specific groups have been established to ensure that issues like child protection and client involvement are central to the planning and delivery of a needs led approach to service delivery.

"The Strategy" establishes the approach that will be taken across West Dunbartonshire to deal with the complex issues associated with the misuse of alcohol and drugs. It has been developed in partnership with a variety of key stakeholders and sits alongside, and cross fertilises, other local and national strategies. Through these links it is envisaged that the harmful effects of alcohol and drugs on individuals, families, friends and indeed whole communities will be reduced. Ultimately, the West Dunbartonshire ADP vision is for a local community where residents feel healthier, happier and safer.

The Strategy will be reviewed on a 6 monthly basis, with initial planning taking place at the end of the financial year (ideally in quarter 4 i.e. January - March), and a midpoint review taking place in the middle of the year (ideally in quarter 2 i.e. July - September). This should enable partners to track delivery of specific actions and how they should evolve to reflect changes in service provision, local need or policy requirements. It should also enable timely input to budget forecasts and planning.

The Strategy takes on board the work of the Scottish Government, particularly in relation to the development of the 7 Core Outcomes, and the requirement for ADP's to acknowledge the findings contained in recently published documents like the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) Essential Services Working Group Report***; "Quality Alcohol Treatment and Support 2011"***, the ***"Prison Health Needs Assessment for Alcohol Problems"***, and ***"Monitoring and Evaluation of Scotland's Alcohol Strategy. Setting the Scene: Theory of Change"***.

It is worth noting that the detail and layout of this Strategy document has changed slightly from the first version which was ratified by the ADP in January 2010. There may be further changes ahead as a result of the development of firmer guidance, the establishment of core outcomes, and the ongoing development of performance indicators.

2.2 An Outcomes Approach to Planning

In ensuring that this document is accessible, a brief description of the planning tool used in this planning document, is noted below:

- "Review/Plan – Monitor/evaluate success/Analysis/Identification of need"
- "Output – What we need to do/change"
- "Action – How we will do/change it"
- "Input – What resources do we need to enable delivery of our action/s"
- "Outcome – What will be produced or has changed as a result of our action."

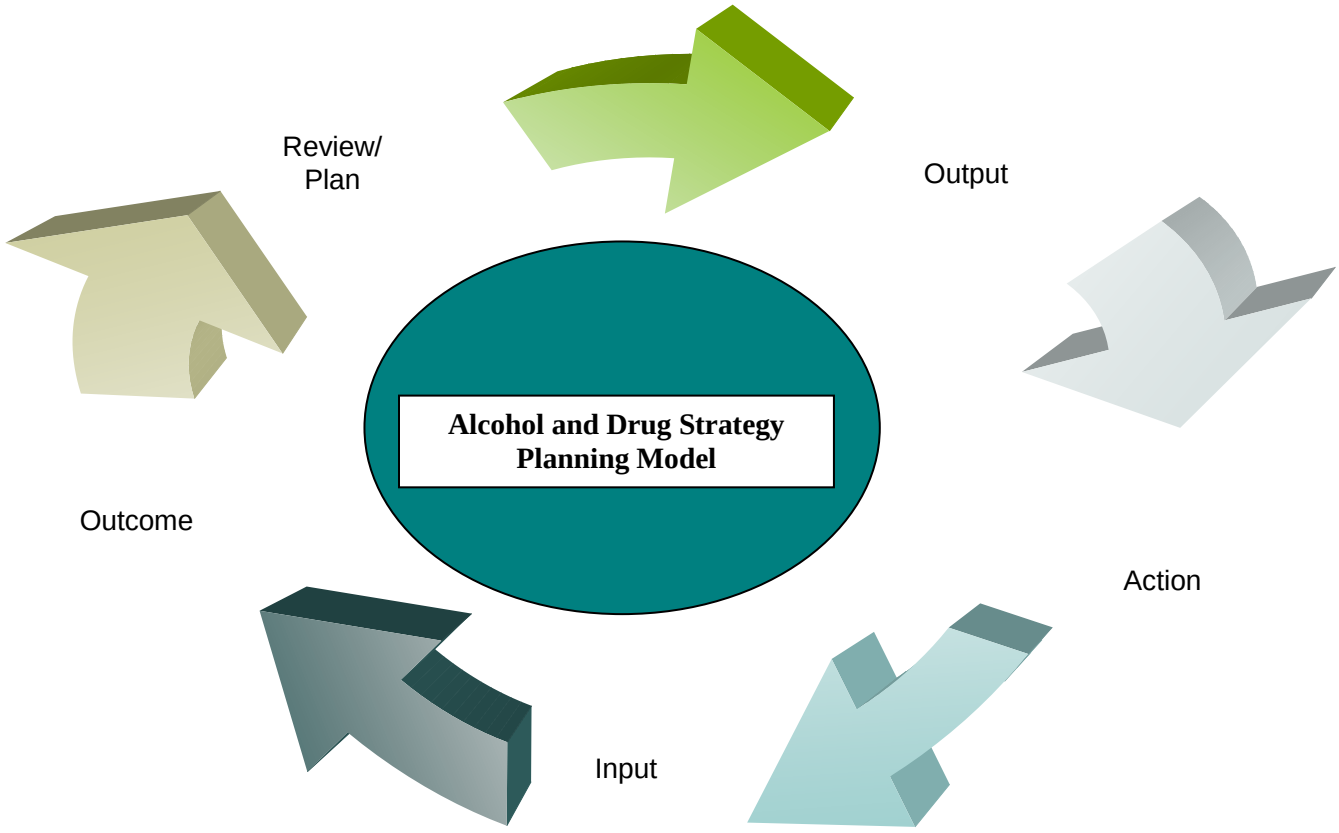


Diagram 1

Further explanation can be found in the headings of the planning table. Although not specifically taken from the LEAP Planning Model, review of this tool would also provide additional clarity if required. Action Numbers/Local Improvement Targets – for ease of reference each action will have both an Action, Local Improvement Target (LIT) number and will make reference to the appropriate National Core Outcome (NCO).

Recently, Scottish Government has supported the use of the "Outcomes (Weavers) Triangle" it is therefore envisaged that this will be the tool used to identify, plan and measure delivery of local need. (See Appendix 3).

3. Identifying Need

The importance of Alcohol and Drugs Partnerships conducting a needs assessment has been highlighted in a number of national reports including those produced by the Delivery Reform Group.

Locally, the identification of priority areas has been taken forward in partnership with key stakeholders. This has proved to be an efficient and effective way in which to encourage ownership from all partners and to enable the identification of resources to facilitate delivery of those priority actions.

Although, there is no one tool currently being used by all ADP areas, most have developed scoring mechanisms to ensure that the priorities identified are appropriate to the needs of not only the key partners in delivering their own planning priorities, but are also linked to the needs of those living with either their own or someone else's problems with drug or alcohol misuse.

More recently, via the development of the West Dunbartonshire Commissioning Strategy, those key stakeholders have not only been involved in the planning and review of the Alcohol and Drug Strategy but have also participated in ongoing Commissioning meetings which have enabled greater sharing of information and direction of resources to fill gaps and meet identified need.

3.1 Local Need

West Dunbartonshire is ranked as the second highest area in Scotland for drug misuse (*Drug Misuse Statistics Scotland* – 2009). A national prevalence study by Glasgow University showed a rise in problematic drug misuse between 2000 and 2006 (among 15-64 year olds), from 2.14% of the population to 2.61% (***Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland – 2009***).

The picture for alcohol misuse presents an equally challenging concern. With the third highest alcohol related death rates in the UK ***(Office for National Statistics – 2007),*** West Dunbartonshire has a long way to go in tackling alcohol misuse.

The population of West Dunbartonshire as reported within the 2001 census was 93,388 in mid-2008 the population had reduced to 90,940 and in 2009 that figure had dropped to 90,920 with a further reduction in mid-2010 to 90,570 *"General Registrar for Scotland". Of that number* 60,554 (63%) are aged between15 – 64, 4,668 (7.71%) individuals within the 15 – 64 age range are currently living with problems associated with drug or alcohol addiction.

Of that number 1,035 (1.71%) have problems with drug misuse and 3,633 (6%) have problems associated to alcohol misuse

3.2 Children and Young People

Local findings from a 2008 audit by West Dunbartonshire Social Work Department raises significant concerns about the wider impact substance misuse is having on children and young people. The audit found that addiction was a factor in:

- 50% of all cases held by the Children and Families Teams
- 72% of all cases held by the Criminal Justice Teams
- 61% of accommodated children and young people.

The Scottish Government has acknowledged concerns and developed initiatives and policies to address the issues. Some of these have been primarily focused on addiction, such as ***Tackling Drugs in Scotland: Action in Partnership*** *(1999)* while others such as ***For Scotland's Children: Better Integrated Children's Services*** *(2001);* reflect addiction as an emerging issue affecting young people, children and families.

The focus on the welfare of children and young people is also clear in *'**For Scotland's Children', published by the Scottish Executive in 2001***. This document called for better integrated working between all agencies to ensure better outcomes for young people, children and families, particularly the most vulnerable groups of children. The national audit and review of child protection, *"**It's everyone's job to make sure I'm alright"*** emphasised that the responsibility for protecting children lay with every agency, not only those providing services to children and families, but also to adults who have the care of children.

The publication of *Getting Our Priorities Right* and *Hidden Harm* sought to highlight the issues for the particularly vulnerable and significant number of children affected by parental alcohol and drug misuse. We know that several agencies can have contact with substance misusing parents and their children in relation to either the needs of the adults or the needs of the children. It is important that there is good communication and joint working between and within agencies to provide effective support to families and to ensure that children are protected.

Prevention, early identification and intervention are priorities, particularly in meeting the needs of children and young people. Service intervention at an earlier stage can enable successful treatment than if the intervention occurs following a longer period of entrenchment, when the young user becomes an older, more chaotic user with a much wider set of needs and less motivation. This view is held up by the ***NTORS*** (National Treatment Outcome Research Study) and ***DORIS*** (Drug Outcome Research in Scotland) findings.

3.3 Confirmed Numbers

A number of sources exist to look at actual individuals with substance misuse problems. In preparing an allied report on the needs of young people, a working group undertook a "snapshot" survey of substance misuse service use in West Dunbartonshire in 2006 (see Chart 1 below). The review, as a snapshot of service use at a given date, identified 118 young people (under 21) receiving a service.

Of these, 84 were using a Tier 2 or Tier 3 service. Personal identifiers (initials, gender and date of birth) were used to avoid double counting.

Chart 1

Young People's Alcohol and Drug Services Audit - 2006		
Service	**Tier**	**Number of Service Users at Point of Survey**
Youth Justice	1	13
Children & families, inc. Group Work	1	21
Alternatives	2	43
DACA	2	32
General Practitioners	2/3	No returns. Following selected visits, none identified.
Lomond Drug Problem Service	3	0
Lomond Alcohol Service	3	0
Social Work – Addiction Services	3	2
Clydebank Community Addiction Team	3	7

As noted in the snapshot above, the majority of young people were using DACA (Dumbarton Area Council on Alcohol) or Alternatives, the two voluntary sector providers. These organisations were able to provide an annual throughput, to accompany the snapshot. For DACA in 2006/07, there were 134 referrals, with a 44% attendance (59 -individuals with a primary alcohol problem). Over the same year, Alternatives worked with 48 individuals (these were individuals with a primary drug problem, although some did also misuse alcohol).

A more recent review (March 2007) was undertaken to complement the snapshot, which looked at young people in local children's units and young people working with youth justice. Of 53 young offenders, 20 were identified as having a drug and/or alcohol problem and 4 young people in care (2 of whom directly accessed specialist services, with 2 being supported by unit staff) were also identified as having a substance misuse problem.

Drug death statistics provide us with another confirmed picture into substance misuse locally. Between January and June 2006, there were 5 young people (under 25) who died from a suspected, accidental drug overdose. This reflects a significant increase from previous years, but mirrors the national trend, with 23% of Scottish drug deaths occurring in those under 23 years of age.

3.4 Statistical Analysis of Young People's Needs

West Dunbartonshire has the sixth highest prevalence of drug misuse in Scotland and experienced a rise in problematic drug misuse between 2000 and 2006 (among 15-64 year olds), from 2.14% of the population to 2.61% (***Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland*** – 2009). The same study found, for West Dunbartonshire, 4.69% of 15 to 24 year olds are estimated to be misusing drugs. This equates, per capita, to approximately 294 young people misusing drugs.

A consultation exercise, led by Dialogue Youth through Y-Sort-It, in 2006, surveyed 188 young people (full report available). That survey identified 52 young people reporting drug/alcohol use, and of these, 12 sought assistance for their misuse.

This survey suggests up to 6% of young people in the population could seek direct assistance for their drug or alcohol use. Based upon the assumption of 6,277 young people (aged 15-19 – *West Dunbartonshire Social and Economic Profile*, 2006/2007), there could be 375 young people misusing alcohol and/or drugs and seeking specialist support.

The 2006 *West Dunbartonshire Pupil Health Survey* (West Dunbartonshire Community Health Partnership) indicated that levels of drinking increased with age and deprivation, although it remained clear that the majority of pupils reported never or rarely having been drunk.

Evidence shows that young people are exposed to drugs and alcohol as part of their culture, and many will have direct experience. For some, this leads to problematic use and the potential of longer-term misuse.

Local audits of Single Shared Assessments indicate consistently that for most adults with a current drug or alcohol problem, their first experience of misuse occurred in their early teens. Young people's misuse today remains an indicator of future service needs for the adults of tomorrow.

3.5 Adults: The Level of Need

It is estimated that there are approximately 6,090 people living with problems associated with drug or alcohol addiction. Of that number it is estimated that 1,601 have problems with drug misuse and 4,489 (6%) of the population aged 15 – 64 are living with problems associated with alcohol misuse *(Estimating the National and Local Prevalence of problem Drug Misuse in Scotland, August 2009 and Alcohol Statistics Scotland 2009).* A midyear report linked to the 2010 census has indicated a further reduction in the total population size, however, of the 60,554 aged 15 – 64 there are estimated to be 7.71% living with problems associated to drug or alcohol misuse.

In 2007/08 there were approximately 2,259 new clients referred to addiction related services within West Dunbartonshire; of that number 952 (42.14%) were offered an appointment within 14 days of referral and a total of 1,659 (73.4%) were offered their first treatment within 21 days of referral *(Information Services Division, NHS Scotland).*

During 2008/09, 2,382(88.68%) of a total 2,686 new clients received their first appointment within 14 days of referral *(Information Services Division, NHS Scotland).* Two thousand, five hundred and ninety nine (96.76%) received their first appointment within 21 days of referral *(Information Services Division, NHS Scotland).*

In 2009/10 there were approximately 2,259 referrals to addiction-related services within West Dunbartonshire; of that number 2,088 (92.43%) were offered an appointment within 14 days of referral and a total of 2,226 (98.54%) were offered an appointment within 21 days of referral *(Information Services Division, NHS Scotland).*

3.6 Drug and Alcohol-Related Mortality

Deaths due to alcohol and/or drugs are particularly high, with West Dunbartonshire being recorded as having the third highest level of alcohol related deaths (per 100,000, population) in the United Kingdom.

Scottish figures indicate that West Dunbartonshire has the third highest level of alcohol related deaths in Scotland; behind Inverclyde and Glasgow City which were recorded as 2nd and 1st highest respectively.

In reported figures from the General Registrar's Office for Scotland (GRO), the number of alcohol related deaths within West Dunbartonshire for 2008 was 44; in 2009 that figure fell to 25. Taken as an average; the number of alcohol related deaths within West Dunbartonshire has decreased from the 2003 – 2007 average of 42.8 to an average of 31.8 across 2005 – 2009.

An increase in 2010 has halted the identification of either an upward or downward trend. The General Registrar Office for Scotland reported a total of 35 alcohol related deaths which across the 2006 – 2010, 5 year average, equated to 38 alcohol related deaths per 100,000 population.

The picture in relation to drugs has fluctuated over the same period with a rise in 2008 to 23 but has returned in 2009 to a total of 13 drug related deaths within West Dunbartonshire. During the same period i.e. 2005 – 2009 the average number of drug related deaths within the West Dunbartonshire area was 17.

In 2010 a slight increase was reported by (GRO) i.e. 18 drug related deaths, the 5 year average across 2006 – 2010 also increased to 18.62 drug related deaths per 100,000 population.

3.7 Needs of the Individual

Addiction services within West Dunbartonshire are being developed with a "needs led" ethos which is centred on the client and not the service. To this end annual service user satisfaction surveys *"10 Questions to a Better Service"* have been undertaken. These surveys combined with focus groups, the roll out of integrated care planning, and the establishment of integrated teams across Social Work & Health and ongoing service level agreements and partnership working with voluntary sector organisations offers clients choice and access to a raft of holistic services relevant to individual need.

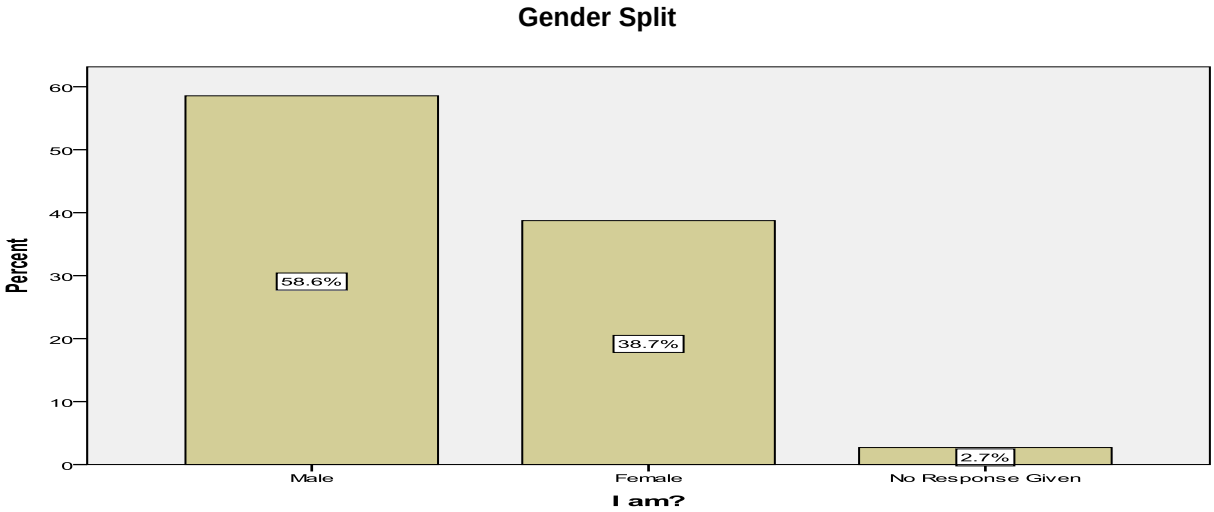
As a result of previous surveys, clients were able to identify areas where they required early access to services and additional supports at times when they felt particularly vulnerable to relapse. In response an early integration element, which enables clients to access services at the earliest possible juncture, was established as was an out of hours telephone support service i.e. The HEAR service. This operates in the evening, weekends and public holidays and is currently being expanded to include befriending support and volunteering opportunities.

This means of collecting the views of those who use local services should continue, however, we need to recognise the important role other data collection mechanisms can play in maintaining a client focussed approach to service planning and delivery.

As a snapshot, the information below provides an overview of the gender, age of those accessing services and who took part in the service user satisfaction survey during 2009/10.

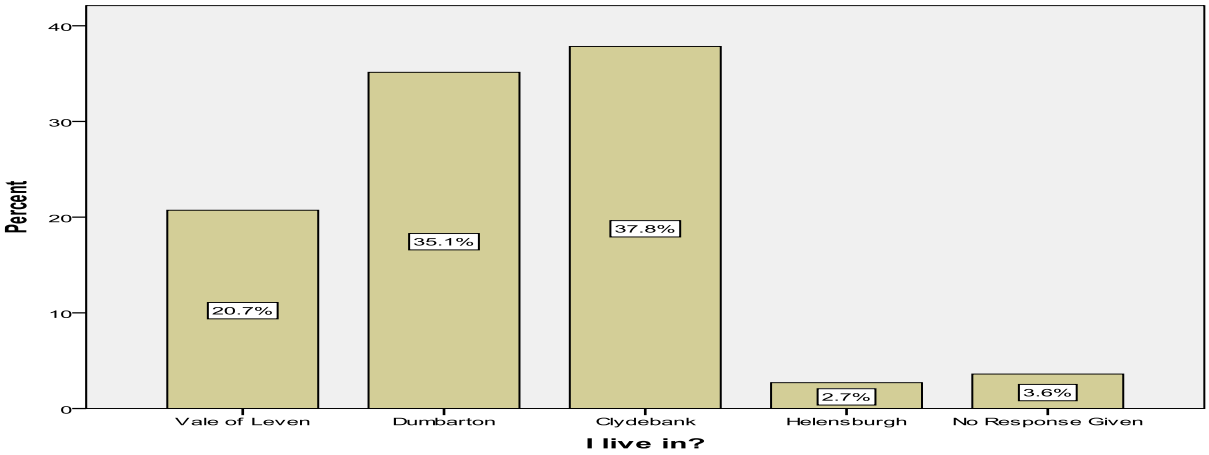
Demographics

Sixty five (58.6%) responses, across all participant service providers were from males; 43 (38.7%) were from females and 3 (2.7%) chose not to divulge their gender.



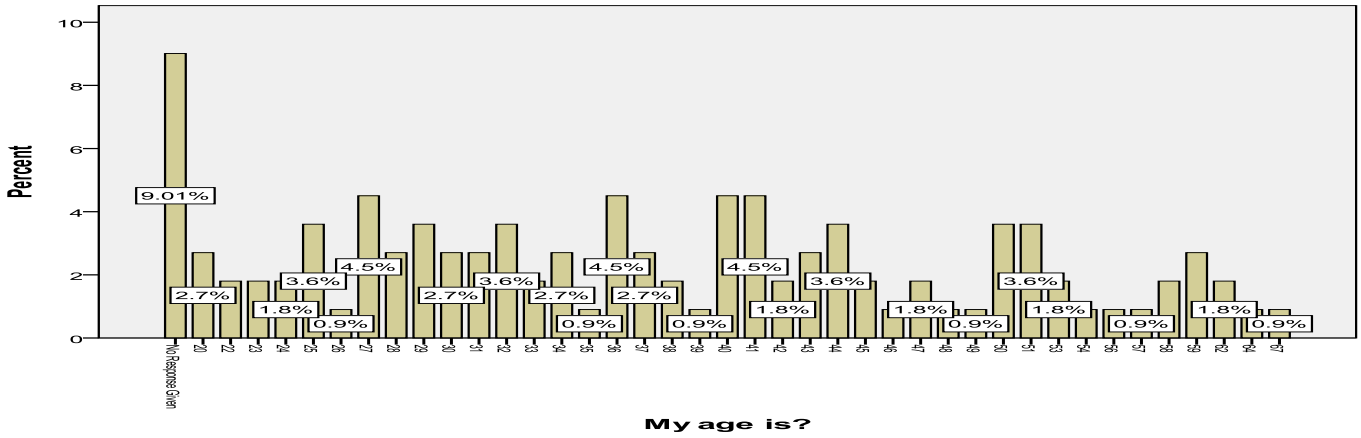
Area of Residence

Thirty nine (35.1%) lived in Dumbarton; 42 (37.8%) were from Clydebank; 23 (20.7%) indicated the Vale of Leven as their area of residence; 3 (2.7%) indicated Helensburgh as their place of residence; and 4 (3.6%) chose not to identify their area of residence.



Age of Respondents

The age range of respondents across all service providers is from 20 - 67, the youngest being 20 and the eldest 67. Ten individuals chose not to divulge their age.



This means of collecting the views of those who use local services should continue, however, we need to recognise the important role other data collection mechanisms can play in maintaining a client focussed approach to service planning and delivery. With this in mind individuals involved in the Future of Addiction Services Team (FAST) will be undertaking a series of focus groups during 2011/12.

3.8 Main Issues identified within Survey

Across all the surveys, response levels have been high, running at 40-50% return rates; a positive sign that service users have good relationships with their service providers and have a willingness to share their views regarding those services.

While some of the answers elicited as part of the questionnaire may be subjective, the results clearly indicate that the majority of service users who have participated in the Service User Satisfaction Survey are satisfied with the service that they receive from their current service provider.

When asked to comment on the "best things" about the services, people mentioned getting help to address their addiction problem; many highlighted issues associated with their own confidence and self esteem; staff were viewed positively and the ability to speak freely to either their worker or other service users was reported fairly regularly as was the diversionary element associated with regular attendance i.e. "keeps me occupied", "keeps my mind off drugs/alcohol".

When asked about the "worst things" or "things that could be improved" the majority of responses were linked to the provision of out of hours support. Service users also identified barriers to services, including transport; childcare and the lack of confidential waiting areas.

4 Client (Service User) Involvement

National policy documents like ***"The Road to Recovery"*** indicate that an individual's recovery from problems with drug or alcohol misuse is more likely to be achieved and sustained if they are at the centre of the planning and delivery of their individual care packages.

4.1 Future of Addiction Services Team (FAST)

It is also essential that those who access our services are encouraged to have a say in the strategic planning and delivery of local services. In order to ensure that clients are able to play that pivotal role the Future of Addiction Services Team (FAST) has been established. FAST membership consists of individuals who are currently, or have previously, accessed local addition services. With support from the ADP, via a service level agreement, FAST's aim is to sign-post individuals to the range of services available to support them through their own or someone else's problems with drug or alcohol misuse.

Representatives from FAST sit, as key stakeholders, on the ADP and are therefore involved in the key decision-making processes surrounding the ongoing planning, delivery and monitoring of local services.

The links with all services are maintained through the Service User Involvement Steering Group which has representation from all local service providers. This group helps to drive service user involvement across West Dunbartonshire and ensure that the voice of those not wishing to participate in a structured means of involvement is added to those of their peers.

Other means of facilitating service user involvement is ongoing within each of the service provision areas, these are not limited to, but do include involvement in interviewing for staff, sitting on the management board of the third sector organisations, having a say in how new premises are decorated. In addition, more recovery based involvement like group work; a regular monthly recovery café and weekly client-led drop in sessions are being promoted through a year-long celebration of recovery with all statutory and third sector providers in West Dunbartonshire.

Annual service user satisfaction surveys "10 Questions to a Better Service" have enabled the identification of perceived gaps in services and have led to the establishment of services, such as the HEAR Out of Hours Telephone Support Service, to meet those gaps.

The next Service User Satisfaction Survey is due to take place in 2011, it is hoped that with support from the Future of Addiction Services Team (FAST) that focused involvement, of those who are usually hardest to engage with, will take the delivery of needs led services to a different level.

5 Licensing

5.1 Overprovision

Research undertaken by the Greater Glasgow and Clyde NHS Public Health Department identified a strong positive relationship between outlet density and crime. The conclusion of that research, which included a review within West Dunbartonshire, indicated that decreasing outlet density will decrease the rate crime. These findings correlate closely with international studies on the links between outlet density and crime **(*The Relationship between Outlet Density and Crime in NHS GGC*, Dr Catherine Chiang, 2009).**

Health statistics present an equally concerning portrait, with West Dunbartonshire having the third highest number of alcohol related deaths in the United Kingdom.

Even acknowledging the close links between other issues of deprivation, the health of West Dunbartonshire is significantly affected by alcohol misuse.

West Dunbartonshire has the highest overall level of fire-related fatalities (18.5% of the Strathclyde total) as well as the highest level of fire-related anti-social behaviour (refuse fires, derelict building fires, deliberate vehicle or other primary fires, acts of violence against fire fighters, etc.) in the Strathclyde Region. This area also has the second highest level of house fires for the region. Alcohol is identified as the major secondary cause for most domestic fires and has a clear association with anti-social behaviour encountered by fire and rescue staff.

Section 7 of the Licensing (Scotland) Act 2005 requires the Board's Licensing Policy Statement *(West Dunbartonshire Licensing Board)* to include a specific statement as to the extent to which the Board considers the overprovision of either licensed premises generally, or a particular description of licensed premises specifically, to exist within any identified locality.

The legislation requires Boards to take a pro-active position on overprovision and to identify those localities where it would not propose to grant new licenses or license premises of a particular description.

The guidance to the legislation also highlights the importance of "robust and reliable evidence" in formulating a view on overprovision. The policy of the Board should be "expressed in such a way that interested parties are left in no doubt as to the reasons for its adoption, including the evidence upon which the Board relied and the material considerations which were taken into account."

During the meeting of the West Dunbartonshire Licensing Forum held in November 2009 representatives linked to the West Dunbartonshire Alcohol and Drug Partnership (ADP) offered to facilitate an evidence gathering process, the initiation of which was a series of meetings to collate evidence on the issue of overprovision.

As part of this process, currently available data was reviewed, at Council Ward level, and where viable, down to "Intermediate Data zones" in line with Scottish Neighbourhood Statistics. Primary data came from Police (reflecting incidents and crime reports correlating to alcohol misuse), Health (alcohol-related deaths and alcohol-related and attributable hospital patients) and Fire statistics.

Additional data, drawn from visits to licensed premises by Strathclyde Police provided further detail on the extent to which licensed premises were operating far below stated capacity. Police officers have been making routine and non-routine visits to licensed premises over several months, and recording information about the premises. The visits were made at various times during opening times and on different days throughout the week, to build a picture of occupancy levels compared with stated occupancy capacity. The information was collated and analysed between 1 September and 31 December 2009, broken down by Council Wards.

West Dunbartonshire is ranked second in Scotland in terms of the number of licenses per 100,000 population, just behind Glasgow.

This review has highlighted other indications of overprovision across West Dunbartonshire, this despite evidence that a number of pubs and clubs regularly do not operate even close to current capacity. Police reports from regular visits to licensed premises provide a consistent pattern of trade far below capacity.

The health, crime and anti-social effects linked to the relatively easy availability of alcohol are reflected in personal tragedies and the drain on public resources. A recent social care report released by the Scottish Government (*The Societal Cost of Alcohol Misuse in Scotland – 2007*) suggested a national cost on the NHS of up to £400 million per annum, of up to £350 million per annum for social care costs and nearly £1 billion in crime costs. A percentage of these costs are also reflected locally.

This data was presented to the West Dunbartonshire License Board; it was subsequently agreed that:

There was overprovision in the following types of licensed premises:

- Vertical drinking establishments
- Nightclubs
- Off-sales and local convenience stores
- Supermarkets.

It was also confirmed that there is an overprovision of these types of licensed premises in 15 of the 18 sub-localities.

The West Dunbartonshire Licensing Board's Overprovision Policy was recently tested when a local supermarket applied for an increase in shelve space linked to the sale of alcohol, this application was refused due to identified overprovision within the area.

6. Workforce Development

In December 2010, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) issued a joint statement supporting the national development of the drug and alcohol workforce. Central within that statement is an expectation that ADP's will:

- Promote agreed national learning priorities
- Identify and articulate local workforce development needs aligned with national learning priorities and develop local strategies and implementation plans to meet these needs
- Encourage multi-disciplinary and multi-sector training in generic competences to develop a shared vocabulary and understanding of alcohol and drug problems, to promote an integrated approach across services that support individuals on their road to recovery.

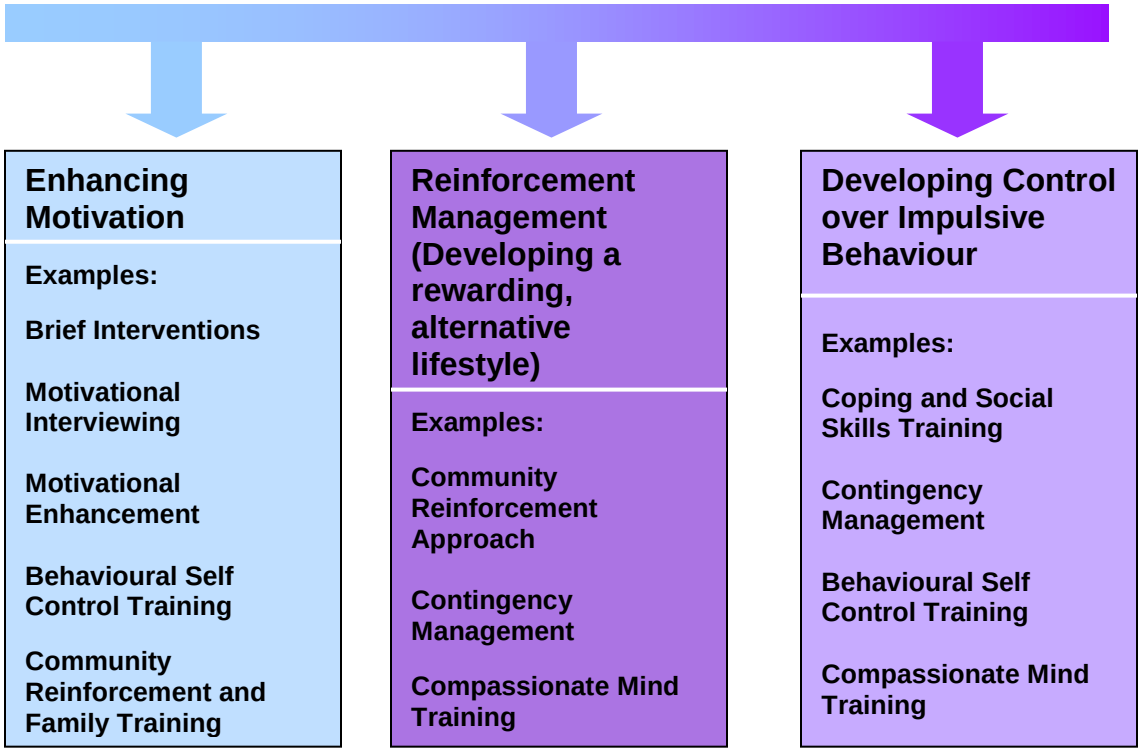
Developing our workforce occurs within the Scottish context of a shift in how we consider interventions for problematic alcohol and drug use. Previously, the emphasis has been largely limited to stabilisation and/or the development of specific treatments matched to specific problem areas at particular points in time. This approach to treatment potentially fails to take into account the long-term nature of behavioural change. The emerging focus reflected in Scottish governmental policy, is that of recovery.

The shift to a recovery perspective means a focus on the journey over time, with the goal of an enhanced quality of life, not just the cessation of problematic substance use.

A recovery perspective means behavioural change is central to services, with the need to consider the evidence base for effective ways to promote, initiate, and maintain behavioural change.

Research on effective behavioural interventions identifies three principles common to effective substance abuse treatments: motivational enhancement; developing control over impulsive behaviour; and reinforcement management. The following chart considers the three common principles listed above and matches the therapeutic focus of the interventions recommended by NICE and HTBS to each principle.

Three Common Principles of Effective Behavioural Interventions



Training programmes can be developed locally to facilitate a structured model of service delivery across multiple alcohol and drug services. Existing training programmes largely reflect these three strands, although they have not previously been articulated as such, nor have thresholds for training been established.

Further work is being taken forward by the Treatment and Support Group (a sub-group of the ADP) members of this group will be tasked with developing a Workforce Plan based upon these three strands.

7. Quality Alcohol Treatment and Support (QATS)

As indicated within the Report from the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) Essential Services Working Group: Quality Alcohol Treatment and Support (QATS) there are a total of 14 recommendations. West Dunbartonshire ADP is already delivering against all of the recommendations; a list of those recommendations are noted below.

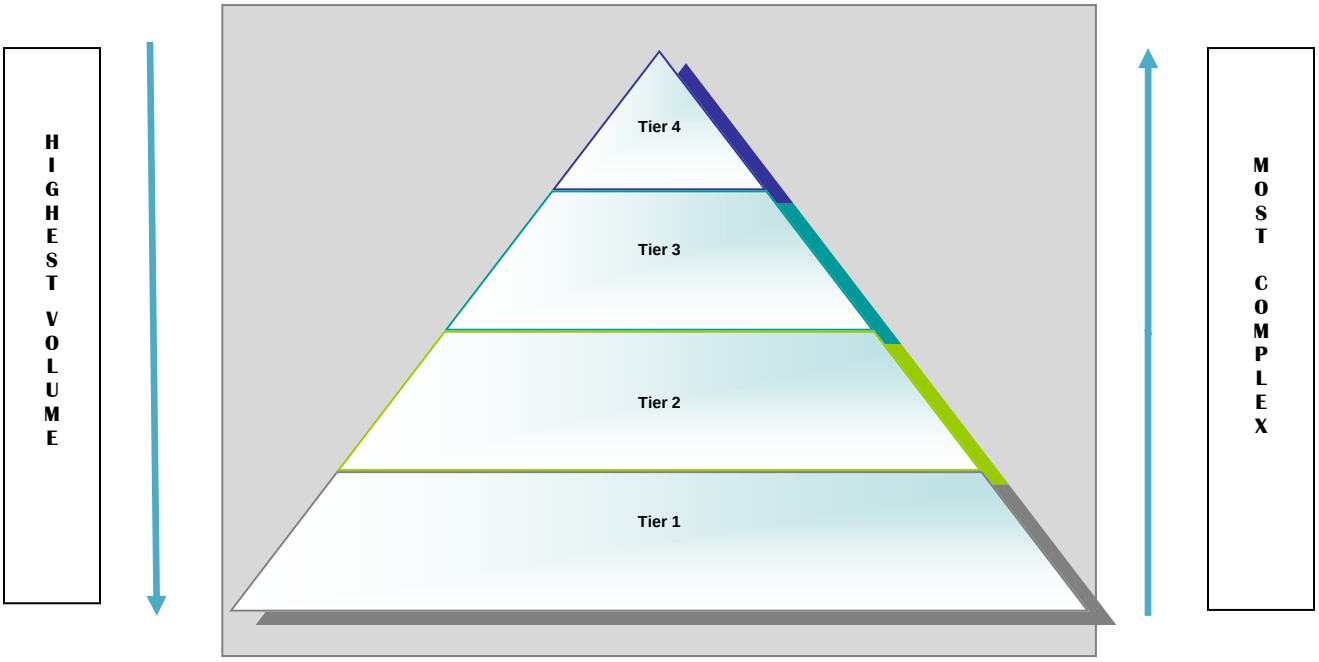
1. Local services should be based on a "stepped care" approach, within the tiered model as set out in the Alcohol Problems Support and Treatment Services Framework (2002).
2. All Alcohol and Drug Partnerships and services should embed the Healthcare Quality Ambitions, incorporating a person-centred, safe and effective approach to treatment and support.
3. Alcohol and Drug Partnerships must ensure service users and people in recovery are represented within the partnership and that services have meaningful service user involvement both in service design and delivery. Services should be underpinned by a recovery ethos which supports and builds on the strengths and assets within individuals, and they should consider adopting the principles contained in the Bill of Rights.
4. All alcohol services delivered locally and supported by public funding must be commissioned on the basis of delivering evidence based interventions according to identified need and subject to adequate and appropriate outcome measurements.
5. All Alcohol and Drug Partnerships and commissioned services must have, and review on an ongoing basis, robust needs assessments and Equality Impact Assessments (EqIAs) to ensure the needs of all groups within their community are identified and met, paying particular attention to those most at risk of harm.
6. We recommend that the Scottish Government continues to reinforce that Alcohol and Drug Partnerships are responsible for strategic decisions on spend to deliver priority outcomes. We further recommend that ADPs are proactive in taking responsibility for this decision making process. NHS Boards are held accountable to Scottish Government on funding for alcohol services.
7. The Scottish Government should seek to develop clearer lines of accountability and reporting mechanisms for local Community Planning Partnership outcomes in Alcohol and Drug Partnerships, ensuring alignment to national priorities, Single Outcome Agreements (SOAs) and whole population approach outcomes.
8. Alcohol & Drug Partnerships and all (statutory, third and private sector) services need to demonstrate effective, published service (outcome) specifications and explicit contract monitoring processes.
9. In line with feedback received from service users, services should develop links with peer support, mutual aid and self-help organisations.
10. The Scottish Government and Alcohol and Drug Partnerships must jointly develop core outcomes.
11. The Scottish Government should fund the development of a national outcomes-focused alcohol treatment database. Alcohol and Drug Partnerships should effectively support local services in the delivery of this.
12. Services should be adequately staffed and all staff working in alcohol services should be adequately qualified, trained, supported and enabled to deliver their agreed roles.

13. To build on the current HEAT H4 target, the Scottish Government, in collaboration with Alcohol and Drug Partnerships, should support the continued delivery of alcohol brief interventions (ABIs) in evidence based settings. As the evidence develops a wider range of settings may become appropriate.

14. All specialist alcohol services must undertake routine screening for harm against women and children as part of a thorough, ongoing assessment process to ensure provision of a package of support. Staff should be trained to deliver such screening and to provide effective support.

7.1 A Tiered Model of Service Delivery

Local alcohol and drug related services and supports have and will continue to be provided using a "stepped, tier approach" to service delivery and support i.e.



Tier 4 – Specialist inpatient/residential care
Tier 3 – Community based specialist drug and alcohol assessments and care planned treatment and care
Tier 2 – Brief psychosocial interventions, harm reduction
Tier 1 – Information and advice, screening and onward referral.

8 Lines of Accountability, National and Local Priorities and Outcome Measures

8.1 National Outcome Measures

National Objectives and National Performance Framework

Scotland's five national objectives are:

- A Wealthier and Fairer Scotland
- A Smarter Scotland
- A Healthier Scotland
- A Safer and Stronger Scotland
- A Greener Scotland.

Underpinning these is a set of National Performance Indicators, which have contributed to the local SOA.

8.2 National Outcome Measures for ADPs

In March 2011 a set of Core Outcomes specifically relating to ADPs were ratified by ADP Chairs; subsequent information regarding ADP funding indicated that these should be reflected in the ongoing development, review and monitoring of Alcohol and Drug Strategies and ADP performance overall. These Outcomes are:

- **Health:** people are healthier and experience fewer risks as a result of alcohol and drug use
- **Prevalence:** Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others
- **Recovery:** individuals are improving their health, well-being and life chances by recovering from problematic drug and alcohol use
- **CAPSM:** Children and family members of people misusing alcohol and drugs are safe, well supported and have improved life chances
- **Community Safety:** Communities and individuals are safe from alcohol and drug related offending and antisocial behaviour
- **Local Environment:** People live in positive, health promoting local environments where alcohol and drugs are less readily available
- **Services:** alcohol and drugs services are high quality, continually improving, efficient, evidence based and responsive, ensuring people move through treatment into sustained recovery.

Work on the development of Performance indicators which sit beneath the ADP Core Outcomes is on-going; again as these develop they will be integrated into future review and on-going development of the West Dunbartonshire Alcohol and Drug Strategy.

8.3 NHS HEAT Targets

Currently there are 2 active NHS HEAT targets of direct relevance to the Alcohol and Drug Partnership, these are:

- H4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines for 2011/12, and,
- A11: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

One further HEAT Target which ADP's will need to consider whilst planning their services is:

- Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.

8.4 Single Outcome Agreement

SOAs have been developed using the principles of mutual respect and partnership set out in the Concordat agreed between Scottish and local government in November 2007. This relationship provides local autonomy and defines local outcomes as part of a national performance framework.

The delivery of the local outcomes is the responsibility of local government, its partner agencies and local communities. In return the Scottish Government has allowed local partners greater autonomy in directing resources towards local priorities.

The West Dunbartonshire SOA is driven by 23 high level outcomes which are delivered and measured through a total of 52

Whilst there is a potential contribution from the Alcohol and Drug Strategy across the 23 outcomes, more direct association can be seen through the links with the Safe, Strong and Involved Communities Thematic Group; the detail of the outcomes and associated indicators of that particular group are noted below in Appendix 4.

8.5 Key Performance Indicators

KPIs are those metrics most critical to gauging progress toward core objectives. Best practice suggests that effective organisational performance management and reporting requires a balance between indicators that are indicative of the breadth of a given organisation's mainstream operations; and as tight and defined a number of high-level indicators as possible (to ensure that effective scrutiny is not hampered by data overload; and that service performance is not distracted by undue data collation/reporting).

Through the monitoring and delivery of KPI's, and in conjunction with the CHCP Strategic Plan, it is envisaged that a robust and transparent framework for organisational performance will be developed. It is essential, therefore that the ADP aligns its strategic development, where appropriate, with this method of managing performance.
Those KPI's of particular relevance to the ADP are the:

- percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug and alcohol treatment that supports their recovery (NHS HEAT)
- number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention (in line with SIGN 74 guidelines) during 2011/12 (NHS HEAT).

8.6 NHS GGC: Prevention and Education Model

The Greater Glasgow and Clyde Alcohol and Drug Prevention and Education Model; published in 2008 was developed to provide a common approach to delivering Prevention and Education and to enhance good working practice within the Alcohol and Drug Prevention and Education field. It provides a working definition for Prevention and Education, i.e. "*Prevention and Education is defined as largely concerned with encouraging and developing ways to support and empower individuals, families and communities in the acquisition of knowledge, attitudes and skills with which to avoid or reduce the development of alcohol problems, drug misuse and alcohol and drug related harm".*

This working definition is helpful in ensuring that all practitioners have a clear agreed focus on the direction of travel of the work within the Prevention and Education field. It also removes the misconception that Prevention and Education is only about work with young people by clearly setting out the wider boundaries of Prevention and Education.

The aim of prevention is to avoid initiation into alcohol and/or drug use and/or the reduction of harm to a minimum acceptable level. The aim of education is to create individuals and a society who have an informed choice and developed life-skills that can be used to reduce the harm of alcohol and drugs and enhance their overall wellbeing.

There are three main types of Prevention and Education**:**

- **Primary prevention** - aims to avoid any initial initiation to risky behaviour
- **Secondary prevention** – aims to reduce the potential for alcohol and drug-related risky behaviour to become problematic by reducing the amount of harm that is being caused (harm reduction).
- **Tertiary prevention** - aims to reduce the potential for more harm to be caused when an individual or society decide to continue with a risky behaviour even when they have potentially been informed and are fully aware of the dangers (harm minimisation).

There are 12 core elements within the P&E Model, these are noted in (Appendix 6 on page 82); the priority actions noted within the Prevention section of the West Dunbartonshire Alcohol and Drug Strategy: Implementation Plan are linked to the appropriate elements.

8.7 Local Improvement Targets

Local indicators (generally captured as Local Improvement Targets (LITs)) have been long established across partners. LITs are supported by actions within the Alcohol and Drug Strategy, the LITs currently reflected within the Strategy are:

L1 Improve access to service by ensuing 90% of clients referred for alcohol or drug treatment will receive a date for assessment that falls within 14 days of referral received.

L2 Improve access to service by ensuring that *"90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery"* by March 2013.

L3 Improve quality of service by undertaking, and reporting on, annual client satisfaction surveys.

L4 Improve quality of service through the use of peer led focus groups, which will use the findings of annual surveys to form the basis of the groups; a maximum, of 3 focus groups to be held per annum.

L5 Improve quality of service through annual audit of SSA's.

L6 Reduce Alcohol Deaths (reduce rolling 5 year average by 3 in 5 years).

L7 Reduce Drug Deaths (reduce rolling 3 year average by 3 in 3 years).

L8 Reduce Alcohol Related Hospital Admissions.

L9 Reduce Alcohol Consumption by Young People.

L10 Reduce Drug Consumption by Young People.

L11 Increase number of those in recovery from drug or alcohol misuse into education, training or employment.

L12 Measure and improve outcomes for those who access local alcohol and drug services by December 2013.

L13 Improve quality of local alcohol and drug related data relevant to assessment of need by December 2013.

L14 Achieve agreed number of screening using the setting appropriate screening tool and appropriate alcohol brief intervention in line with SIGN 74 Guidelines for 2011/12.

These 14 local indicators were developed in line with the *National Outcomes for Community Care* and, more directly, to align with the national drug and alcohol strategies i.e. the *Road to Recovery* and *Changing Scotland's Relationship with Alcohol: A Framework for Action*.

Neither document identified specific local targets, but subsequent guidance on establishing local Alcohol and Drug Partnership's (ADP's), made it clear that the expectation is that local strategies would fit with:

- National Objectives;
- HEAT (Health Improvement, Efficiency, Access and Treatment) Targets; and
- Local SOA targets.

Subsequent development of Core Outcomes for ADP's, as indicated in 7.2 above, and the indicators that sit beneath them, will be considered in the ongoing development and monitoring of Alcohol and Drug Strategies.

8.8 Local Partnerships on Alcohol and Drugs

Local partnerships on alcohol and drugs have existed in a number of forms since 1989, latterly as 'Alcohol and Drug Action Teams' (ADATs). As a result of the Scottish Advisory Committee on Drugs Misuse (SACDM) review of methadone reducing harm and promoting recovery and the Report of the Stock-take of Alcohol and Drug Action Teams, published in 2007, it became clear that changes in these structures were required.

Subsequently members of SACDM and the Scottish Ministerial Advisory committee on Alcohol Problems (SMACAP) established a joint Delivery Reform Group. The remit of this Group was to look at the future of alcohol and drug delivery arrangements. The deliberations of this Group, along with the findings and recommendations contained in Audit Scotland's study on Drug and Alcohol Services in Scotland informed the development of The Scottish Government Framework for Local Alcohol and Drug Partnerships (ADPs). These partnerships were to be established, at local authority levels, to enable effective development and delivery of strategic plans aimed at reducing the adverse affects that alcohol and drug misuse is having on the population of Scotland.

These dedicated partnerships are firmly embedded within wider arrangements for community planning and are expected to develop and implement a comprehensive, evidence-based local alcohol and drugs strategy based on the identification, pursuit and achievement of agreed local outcomes.

8.9 Delivery Reform

A framework for delivery of action on alcohol and drugs set out the Scottish Government's vision for the establishment of local partnerships on alcohol and drugs (as noted above). The Framework was used to ensure that all bodies involved in tackling alcohol and drugs problems were clear about their responsibilities and their relationships with each other; in the identification and delivery of locally agreed outcomes.

The Framework was built on the Scottish Government's national performance framework, the Concordat between the Scottish Government and CoSLA, local arrangements for community planning and single outcome agreements, performance management arrangements between the Scottish Government and NHS Boards, ***"The Road to Recovery, A New Approach to Tackling Scotland's Drug Problems"*** and ***"Changing Scotland's Relationship with Alcohol: A Framework for Action".***

The deliberations of this Group, along with the findings and recommendations contained in Audit Scotland's study on Drug and Alcohol Services in Scotland informed the development of The Scottish Government Framework for Local Alcohol and Drug Partnerships (ADP's). These partnerships were to be established, at local authority levels, to enable effective development and delivery of strategic plans aimed at reducing the adverse affects that alcohol and drug misuse is having on the population of Scotland.

These dedicated partnerships are firmly embedded within wider arrangements for community planning and are expected to develop and implement a comprehensive, evidence-based local alcohol and drugs strategy based on the identification, pursuit and achievement of agreed local outcomes.

8.9.1 Developing Recovery Capital

Through regular consultation with those who use alcohol or drug services locally, and in particular, the use of the service user satisfaction survey mentioned in points 3.7 and 3.8 above the people that we work with and support have been able to tell us that they would like to see more emphasis on functional approaches to recovery support such as education, vocational training, employment support, debt management, housing mediation etc.

There are many barriers experienced by clients leaving prison and moving into homeless accommodation.

A proposal for the future provision of supported accommodation for up to 40 individuals (in a year) who are considered as statutory homeless and who wish to attain abstinent recovery from drug addiction has been developed. The establishment of this support service along-side an addition proposal to establish 4 homeless satellite flats, will allow individuals to move from fully supported accommodation to a more independent means of living i.e. a move from addiction to recovery. This core and cluster development will be key in breaking down one of the many barriers those dependent on drugs experience as they move from a life of addiction to one of recovery.

It is envisaged that the ongoing development of recovery capital should form the basis on which other, similar, barriers are overcome and how clients will be supported *"towards a drug free life as an active and contributing member of society"*. Becoming active contributors to

their local community. ***"The Road to Recovery, a New Approach to Tackling Scotland's Drug Problems".***

8.10 Establishment of the West Dunbartonshire Alcohol and Drug Partnership (ADP)

The West Dunbartonshire ADP held its inaugural meeting on 29th September 2009, just ahead of the Scottish Government's timeline for ADPs to be established by October 2009.

Chaired by the Director of West Dunbartonshire Community Health and Care Partnership, the ADP has agreed its membership, remit, and substructures. A copy of the Aim, Remit and membership of the ADP are attached, for information, as Appendix 6.

As indicated earlier the first West Dunbartonshire Alcohol and Drug Strategy was ratified at the meeting of the ADP held in January 2010; it was subsequently reviewed in October 2010. The context of the initial strategy document and the aforementioned review were used to develop this second West Dunbartonshire Alcohol and Drug Strategy.

9. West Dunbartonshire Alcohol and Drugs Commissioning Strategy

Local authorities are expected to develop robust commissioning strategies. These should be developed in line with Single Outcome Agreements.

The West Dunbartonshire Community Health and Care Partnership Commissioning Strategy for Alcohol and Drug Services is attached as Appendix I0 of this document. This describes local strategic commissioning intentions for the period 2011– 2021. It includes areas which require further assessment and development.

It provides a vision of service configuration in the coming years and describes how that will be attained. Through analysis of need, demand, existing service provision and gaps in that provision, the Commissioning Strategy aims to assist the development of a planned response to that identified need.

Along with the West Dunbartonshire Alcohol and Drug Strategy this document will be used to build on current planning mechanisms and inform future investment and service configuration across voluntary and statutory service provision areas.

10. Financial Framework

The financial framework for the West Dunbartonshire Alcohol and Drug Partnership has been prepared on the basis of an aligned budget process (across all of the partners – both internal and external providers – on an open and transparent basis) notwithstanding that services are jointly provided and managed across West Dunbartonshire Council and NHS Greater Glasgow & Clyde.

This framework has been in place for a number of years and has operated successfully across all of the partners and in the wider context of the overall partnership.

The framework includes the following service providers and partners who contribute to the overall framework:

West Dunbartonshire Council, NHS Greater Glasgow & Clyde, External providers including both Alternatives and DACA (as examples although other providers are used), and Mixture /

Combination of funding from all of the above particularly when short-term funding becomes available and is subject to an appropriate bidding process and to be used within the partnership

It should be noted that in the main funding is recurrent although there are occasions where this is not the case and (if this was not) an appropriate comment would be made. Generally this would note a material value in the context of the overall financial framework.

The proposed financial framework is rigorously reviewed on an on-going basis by all of the partners and in particular at least once annually as an integral component of the Review and Planning of the service.

A breakdown of the financial framework; actual spend in 2010 – 2011 and forecast spend 2011 – 2012 is noted below.

Service Provision and Lead Partner / Service Provider	**Actual 2010 / 2011 £'000**	**Budget 2011 / 2012 £'000**
Alcohol Services		
West Dunbartonshire Council	£557.0	£1,202.0
NHS Greater Glasgow & Clyde	£1,094.0	£1,028.0
External Services:		
WDC Licensing	£78.0	£78.0
DACA (non NHS/non WDC funds)	£27.0	£27.0
Employability (addictions part of SSVG programme)	£45.0	£18.0
Provider 4		
Others:		
Others 1		
Others 2		
Others 3		
Total Financial Framework for Alcohol Services	**£1,801.0**	**£2,353.0**
Drug Services		
West Dunbartonshire Council	£662.0	£641.0
NHS Greater Glasgow & Clyde	£1,001.0	£935.0
External Services:		
Alternatives (non NHS/non WDC funds)	£283.0	£180.0
Employability (addictions part of SSVG programme)	£45.0	£18.0
Criminal Justice - DTTO, Prison Through care	£328.0	£328.0
Provider 4		
Others:		
Others 1		
Others 2		
Others 3		
Total Financial Framework for Drug Services	**£2,319.0**	**£2,102.0**
Total Financial Framework for Alcohol & Drug Services	**£4,120.0**	**£4,455.0**

West Dunbartonshire Alcohol & Drug Partnership

A Strategy to reduce the harmful effects of alcohol and drugs and promote recovery

2011 - 2014

West Dunbartonshire Alcohol and Drug Partnership

Implementation Plan: (Draft 4) 2011 – 2014

Prevention								
Output **(What do we need to do/change?)**	**Action** **(How will we do/change it?)**	**NCO**	**LIT No**	**P&EM**	**Input** **(What resources do we need able delivery of the action/s?)**	**Outcome** **What will be produced or will change as a result of our action/s?)**	**Review** **(Monitor/ evaluate success/ analysis/ identification of need)**	**Lead** **(Who/which group is responsible for this action?)**
APEG remit to be amended in light of changes to CHCP structures.	1. APEG remit and Membership to be reviewed by June 2011. Changes reported to and ratified by the ADP in July 2011.	2	L6 L7 L8 L9 L10		Member participation and contribution.	Amended remit ratified by the ADP and adopted by the APEG.		APEG/A King
APEG implementation plan to be established and reviewed on a six monthly basis. Content of the plan to reflect agreed priorities.	2. An implementation plan linked to agreed priority areas to be developed by June 2011.	2	L6 L7 L8 L9 L10		Member participation and contribution.	Implementation plan produced.		APEG/ A King/ H Weir
	3. Monitor, review and update the implementation plan on an annual basis (6 months after development of plan).				Member participation and contribution.	Progress on agreed actions reviewed/ forward planning of future actions undertaken.		
	4. Report to be submitted to the ADP as part of the monitoring of the Alcohol and Drug Strategy i.e. mid 2011 and early 2012.	2	L6 L7 L8 L9 L10		In kind support from APEG Chair/ADP Lead.			H Weir/ A King
Link with NHS GG&C structures for delivery of ABI HEAT and Non HEAT Targets,	5. APEG links to NGS GG&C ABI Structures to continue.	1	L6 L8 L9 L14	5, 7	APEG Chair participation in ABI Leads Structure.	APEG Chair participating in meetings.		A King

Prevention								
Output **(What do we need to do/change?)**	**Action** **(How will we do/change it?)**	**NCO**	**LIT No**	**P&EM**	**Input** **(What resources do we need able delivery of the action/s?)**	**Outcome** **What will be produced or will change as a result of our action/s?)**	**Review** **(Monitor/ evaluate success/ analysis/ identification of need)**	**Lead** **(Who/which group is responsible for this action?)**
Target develop plan for future delivery of "Wrecked/Wasted" Campaigns.	6. "Wrecked/Wasted" campaigns, to move to a focus on behaviour change, by August 2011. 7. Action Plan to be developed and agreed by Steering Group, by July 2011.	2 6	L6 L7 L8 L9 L10	4, 9, 11	Financial Resource secured via SLA with Addiction Services, in kind resources from members of the Steering Group Match funding being sought from Lloyds TSB PDI Fund.	"Wrecked/Wasted" campaign delivered via a year-long campaign with a focus on behaviour change.		G Kirkwood/ Wrecked/Wasted Steering Group
Ensure APEG Implementation Plan links to GG&C P&E Model.	8. Review link to P&E Model and ongoing access to funding to support prevention and education work. 9. Identify current P&E activity and resources and areas where resources could be enhanced/ targeted.	1 2 6	L6 L7 L7 L9 L10		In kind commitment from APEG Chair and ADP Lead.	APEG Implementation Plan to indicated links to the 12 core elements contained within the GG&C P&C Model.		APEG/ A King/ H Weir
Communicating and consulting with local groups and organisations to ensure involvement in delivery of addiction initiatives.	10. Link with local groups, organizations, and committee/s to ensure that partners and the wider community are aware of, and can contribute to, local developments regarding alcohol and drug services by March 2012. .	5	L6 L7 L8 L9 L10 L14	3	In kind commitment from APEG Chair/ADP Lead.	Input to 3 groups/ organization delivered by the end of March 2012.		APEG/ A King/ H Weir

Prevention								
Output **(What do we need to do/change?)**	**Action** **(How will we do/change it?)**	**NCO**	**LIT No**	**P&EM**	**Input** **(What resources do we need able delivery of the action/s?)**	**Outcome** **What will be produced or will change as a result of our action/s?)**	**Review** **(Monitor/ evaluate success/ analysis/ identification of need)**	**Lead** **(Who/which group is responsible for this action?)**
Develop strategic approaches to substance misuse education in line with health and wellbeing framework.	11. Provide support and training to staff from schools and other learning settings as appropriate. 12. To develop a consistent approach to Substance Misuse Education Programmes across school with youth service providers in line with Curriculum for Excellence. 13. To develop simple briefing document on prevention and education addition work in West Dunbartonshire which can be distributed by partner agencies.	1 2 5 6	L6 L7 L8 L9 L10 L14	6 6 3	Members participation and contribution. Staff time.	Clear plan for delivery of substance misuse education in line with health and wellbeing framework developed and submitted to ADP by end of 2011. Booklet/briefing developed covering prevention and education work.		APEG/ A King/ WDC Educational Services A King/ H Weir/ A Dyer/ A Eleftheriades
Support the Licensing Forum/Board to deliver its public health responsibilities as detailed within the Licensing (Scotland) Act 2005.	14. ADP Lead to act as a linked between APEG and the Licensing Forum. 15. Complete a Health Impact Assessment of the West Dunbartonshire Statement of Licensing Policy by end of March 2012.	1 2 5 6	L6 L7 L8 L9 L10	2 2	Commitment from ADP Lead. Commitment from ADP Lead, Chair of the ADP and other key stakeholders.	Continued representation on the Licensing Forum. HIA Complete and recommendations delivered to the Joint Meeting of the Licensing Forum and Board taking place in early 2012.		APEG/ H Weir H Weir

Prevention								
Output **(What do we need to do/change?)**	**Action** **(How will we do/change it?)**	**NCO**	**LIT No**	**P&EM**	**Input** **(What resources do we need able delivery of the action/s?)**	**Outcome** **What will be produced or will change as a result of our action/s?)**	**Review** **(Monitor/ evaluate success/ analysis/ identification of need)**	**Lead** **(Who/which group is responsible for this action?)**
Reducing the impact of alcohol and drug misuse on communities.	16. Address underage drinking utilise Problem Solving approach.	1 2 6	L9	1, 2, 3, 4	Partnership staff resources; some resource development costs associated with "18 for a Reason" campaign; further resource requirements to be identified within Problem Solving Group.	Action Plan agreed within West Dunbartonshire Antisocial Behaviour Task Group.		J Winder
	17. Support alcohol and drug initiatives within Public Reassurance Areas across West Dunbartonshire.	1 2 6	L9 L10	3 & 4	Partnership staff resources; some resource development costs associated with "18 for a Reason" campaign; further resource requirements to be identified within Problem Solving Group.	Alcohol and Drug Initiative embedded within Public Reassurance Plans.		I Wallace
	18. ID 25 Scheme running across West Dunbartonshire.	1 2 6	L9 L10	2	Partnership staff resources and some publicity materials.	ID 25 Schemes running in all licensed premises end December 2011.		L Knighton/ P Clyde
	19. Pub Watch to continue running in 2 locations and development of 3rd	1 2 6	L6 L8 L9	1,2	Staff time.	2 groups continue to meet and operate; 3rd Group meeting established.		G Stewart

Prevention								
Output **(What do we need to do/change?)**	**Action** **(How will we do/change it?)**	**NCO**	**LIT No**	**P&EM**	**Input** **(What resources do we need able delivery of the action/s?)**	**Outcome** **What will be produced or will change as a result of our action/s?)**	**Review** **(Monitor/ evaluate success/ analysis/ identification of need)**	**Lead** **(Who/which group is responsible for this action?)**
Reducing the impact of alcohol and drug misuse on communities	20. Tackle safety concerns within the Nigh-time Economy in line with Community Safety Strategic Assessment.	5	L6 L7 L8 L9 L10 L12 L13	1, 2	Partnership staff resources; possible development costs associated with programme to address “Drunk and Incapable”, further resource requirements to be identified within Problem Solving Group.	Action Plan agreed within West Dunbartonshire Antisocial Behaviour Task Group.		G Stewart

Recovery							
Output **(What do we need to do/change?)**	**Action** **(How will we do/change it?)**	**NCO**	**LIT No**	**Input** **(What resources do we need able delivery of the action/s?)**	**Outcome** **What will be produced or will change as a result of our action/s?)**	**Review** **(Monitor/ evaluate success/ analysis/ identification of need)**	**Lead** **(Who/which group is responsible for this action?)**
Evaluate effectiveness of Therapeutic Groups within Community Addiction Teams.	21. Run 5 therapeutic groups within Community Addiction Teams by December 2012.	7	L6 L7 L8 L9 L10 L12 L13	In kind staffing resource.	Report on number and types of groups; including number of client involved in each group.		J Carroll
Ensure that the development of the local workforce is planned and developed in line with the requirements of the Scottish Government.	22. Audit skill mix and training needs o f front line staff involved in providing local alcohol and drug services. 23. Complete Workforce Development Plan by December 2012.	1-7	L1 L2 L3 L4 L5 L6 L7 L8 L9 L10 L11 L12 L13 L14	Yet to be identified.	Workforce Development Plan implemented. Report to T&SG and ADP.		T Jackson
Support ongoing development of client involvement structures across West Dunbartonshire and linked to national developments.	24. Continue to develop the Future of Addiction Services Team (FAST). On-going.	3	L4	Service/Client Involvement Budget (WDC Addiction Services) 2011/2012.	FAST representation within ADP continues.		A Dyer/ S Halfpenny/ H Weir
	25. FAST to establish “peer led” drop in sessions by December 2011.	3, 4	L4	Service/Client Involvement Budget (WDC Addiction Services) 2011/2012.	Peer led drop in established, report to ADP/T&SG by March 2012.		A Dyer/S Halfpenny
	26. Plan and deliver year-long celebration of recovery within West Dunbartonshire.	3, 4	L4	Staffing resource from key stakeholders.	Calendar of events detailed. Report to ADP/T&SG by January 2012.		P Beharrell
	27. Plan a final stakeholder event enabling the sharing of information about the various events held throughout the year. By December 2011.	3, 4	L4	Staffing resource from key stakeholders.	Final, stakeholders, event held. Report to ADP/T&SG by January 2012.		P Beharrell

Recovery							
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Support ongoing development of client involvement structures across West Dunbartonshire and linked to national developments.	28. Develop FAST's capability to advocate and critique services.	3, 4	L4	Via Addiction Services Client Involvement Budget 2011/12.	FAST role in ADP strengthened. Report to ADP/T&SG by January 2012.		A Dyer/ S Halfpenny
	29. Move FAST towards independence. By December 2012. 30. Continue development the Client Involvement Steering Group; ensuring that this group drives forward client Involvement across the area. Ongoing. 31. Move Steering Group towards being chaired by Clients. By October 2012. 32. Carry out annual client satisfaction survey's (CSS). 33. Up to 3 focus groups using information form (SS as their basis, to be run smoothly).	3 3 3 3 3	L4 L4 L4 L4 L4	Via Addiction Services Client Involvement Budget 2011/12. In kind support from Steering Group members.	FAST confirmed as incorporated group. Report to ADP/T&SG by January 2012. Steering Group Chaired by client representative. Client Survey results used to inform the basis of focus groups. A total of 3 Focus groups delivered by December 2012. Report to ADP in October 2011/ January 2012.		
Establish one year pilot Alcohol Support Community Safety Project.	34. Meet with key partners and develop an action plan based on identified need by February 2012.	3, 5, 7	L3 L4 L11 L12 L13	£46,680	Establishment new working relationships, and new referral pathways with key stakeholders.		C Dennett
Develop a healthier relationship with food to meet identified need.	35. Develop a Breakfast/Lunch club that utilises volunteers from current client group.	3	L4, L11	£16,500	Reduce the harmful impact of alcohol consumption. Increased number of people, with alcohol problems, accessing services.		C Dennett

Recovery							
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Develop HEAR out of hours service to meet identified need.	36. Audit use of HEAR service/extend hours to meet identified trends/needs.	3	L3 L4	Staffing resources.	Quarterly audit undertaken trends identified and service developed to meet need. Operating hours modified in line with analysis.	Report submitted to ADP/T&SG.	T Jackson
	37. Develop Befriending Service; by August 2011. 38. 12 befrienders in place by August 2011.	3, 4		Funding for establishments of service received.	Befriending Service established.	Report submitted to ADP/T&SG.	A Dyer/ M McCurley
Ongoing development of equality approaches to service development and accessibility.	39. Continue ISPS links and repeat audit in Clydebank CAT & wider services. By end of November 2011.	3, 4		Local staffing resource.	Audit complete; report to T&SG/ADP by February 2011.		J Carroll
Develop robust system for recording client outcomes.	40. Develop mechanism for monitoring and improving quality outcomes. Report to ADP & T&SG by April 2012.	3, 7	L1 L2	Local staffing resource.	Mechanism developed and operational. Report to ADP/T&SG June 2012.		H Weir
	41. Launch revised Addiction Specialist SSA. By December 2011.		L12 L13	Local staffing resource.	Addiction Specialist SSA on Carefirst and being used by all staff. Report to ADP/T&SG by June 2012.		J Burrows
	42. Undertake annual audit of SSA's	7	L5	Local staffing resource.	Audit complete, report submitted to ADP/T&SG by December 2011.ADP/T&SG .		P Beharrell

Recovery							
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Reduce the number of drug and alcohol related deaths reported locally.	43. Review the number of drug and alcohol related deaths recorded locally during 2010. The Drug Related Deaths Action Plan will be reviewed by May 2012.	1 2 7 3	L6 L7	Within current resources.	Review completed. Report to ADP/T&SG by July 2012		D McGilveray/ T Jackson
	44. Six presentations, linked to the review of drug related deaths, to be delivered to key providers by December 2012.	1 2 7 3	L6 L7	Within current resources.	Presentations delivered, report to ADP/T&SG by February 2012.		D McGilveray
	45. Deliver 2 Naloxone Training events by March 2012.	1 2 7 3	L6 L7	Within current resources.	Training delivered, report to ADP/T&SG by June 2012.		J Burrows
	46. Alcohol related deaths Action Plan to be developed by July 2012.	1 2 7 3	L6 L7	Within current resources.	Report submitted to ADP/T&SG by July 2012.		T Jackson
	47. Reduce the number of drug and alcohol related deaths where suicide or attempted self harm is a factor.	1 2 3 7	L6 L7	Within current resources.	Report on the number of staff who have participated in ASIST training or received the Safe Talk, by June 2012.		R Stewart
Develop Prison Strategy across all addiction services.	48. Develop prison strategy across all addiction services, by October 2011.	3 5 7	L1 L2	Within current resources.	Strategy developed, submit to ADP/T&SG by February 2011.		T Jackson

Recovery							
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Develop Prison Strategy across all addiction services.	49. Further development of local arrest referral scheme; ensuring links to external agencies and existing prison services. Report/s to ADP and T&SG February and August 2010.	3 5 7	L1 L2	Within current resources	Report to ADP/ T&SG February/March 2012.		T Jackson/R Park
Develop Homeless/ Addiction protocol.	50. Review homeless/ addiction protocol, by October 2011.	3 5 7	L1 L2 L3 L4	Within current resources.	Protocol reviewed and reported to ADP/T&SG by August 2013.		J Kerr
	51. Carry out review of housing support services in WD.	3 5 6 7	L3 L4 L5 L11	Within current resources.	Review complete and findings reported to partners.		J Kerr
	52. Review supported accommodation in West Dunbartonshire in relation to specialist addiction need, by April 2012.	3 5 6 7	L3 L4 L5 L11	Yet to be identified.	Review complete, findings reported to ADP/T&SG by August 2012.		J Kerr
	53. Review homeless/ addiction protocol, by October 2011.	3 5 7	L1 L2 L3 L4	Within current resources.	Protocol reviewed and reported to ADP/T&SG by August 2013.		J Kerr
	54. Carry out review of housing support services in WD.	3 5 6 7	L1 L2 L3 L4	Within current resources.	Review complete and findings reported to partners.		J Kerr
	55. Review supported accommodation in West Dun in relation to specialist addiction need, by April 2012.	3 5 6 7	L1 L2 L3 L4	Yet to be identified.	Review complete, findings reported to ADP/T&SG by August 2012.		J Kerr
Continue to provide access to group work programmes.	56. Provide access to DACA's Group Work programme and review by end of 2011.	3 4	L1 L2 L3 L4	Within current resources.	DACA's Group Work programme rolled out. Report to ADP/T&SG.		J Macdonald

Recovery							
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Establish Suboxone Clinic within Clydebank CAT.	57. Glasgow Uni/ GAS study linked to establishment of Suboxone clinic to be discussed and used to enable establishment of Suboxone Clinic within Clydebank CAT.	7	L1 L2	Realignment of, existing, staff resources.	Suboxone clinic operating and assessed, report submitted to ADP/T&SG by the end of December 2011.		J Carroll
Continue to develop alternative clinical interventions to opiate use	58. Review and report to ADP/T&SG annually.	7	L1 L2				
Review/evaluate West Dunbartonshire Alcohol and Drugs Strategy.	59. Annual review and mid-year evaluation of the West Dunbartonshire Alcohol and Drug Strategy to be undertaken.	1 – 7	L1 – L14	Within current resources.	6 monthly reports to ADP/T&SG linked with annual review and mid-year evaluation.		H Weir
Update/review/evaluate Commissioning Strategy for Alcohol and Drug Services.	60. Updated Commissioning Strategy to be ready for submission to CHCP Committee by end of August 2011. 61. Annual review, and mid-year evaluation, of the Commissioning Strategy for Addictions to be undertaken (link to the review of the A&D Strategy above). 62. Carry out a review of local resources, including all key stakeholder in kind resources, used to address local alcohol or drug misuse problems, by December 2012.	1 – 7 1 – 7 1 – 7	L1 – L14 L1 – L14 L1 – L14	Within current staffing resources. Within current staffing resources Within current staffing resources	Updated version to be submitted to CHCP Committee for ratification by September 2011. 6 monthly reports to ADP/T&SG linked with annual review and mid-year evaluation. Of the A&D Strategy. Report to ADP by January/February 2013.		H Weir H Weir H Weir
Review Young Persons Service.	63. Establish a Business Plan for the sustainable delivery of the All 4 Youth Service, by January 2012.	3, 4, 5, 6, 7	L6 L7 L8 L9 L10	Staffing resource.	Business Plan produced; to be reported ADP/T&SG by February 2012.		D McGilveray

Recovery							
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Complete independent evaluation of Dawn, Rise and Calm Groups.	64. Present report to ADP/T&SG by October 2011.	3, 4, 6, 7	L1 L2	To be identified.	Evaluation completed. Results presented to ADP/T&SG by October 2011.		D McGilveray
Review opportunity to develop shared care clinics with GPs in Clydebank.	65. Review in light of changes to delivery of shared care across GP practices by September 2011.	7	L1 L2	Staffing resources.	Shared care clinics established, report via A&D Strategy Review in October 2011.		J Carroll/ P Ainsworth
Establish a community outreach service for Drug and Alcohol clients.	66. Review Bellsmyre model with a view to replication across other communities. By December 2014.	3, 7	L1 L2	Current staffing resources.	Review completed, proposals re establishment of service submitted to ADP/T&SG in February 2015.		D McGilveray
Strengthen links to prison through care.	67. Review new opportunities for TAS programme, report by October 2011.	3, 5, 7	L1 L2 L3 L4 L11 L12 L13	In kind resource, additional resources will be identified on completion of review.	Review complete, report to ADP/T&SG by December 2011.		D McGilveray/ N Firth
Improve community based secondary care services.	68. Review secondary care services within West Dunbartonshire by March 2012.	1, 2, 7	L1 L2	In kind resource in first instance.	Review complete, report to ADP/T&SG by March 2012.		T Jackson
	69. Establish new alcohol specialist home detox clinic by October 2011.	1, 2, 7	L1 L2	Current staffing resource.	Clinic established report to T&SG.		J Carroll
Build recovery capitol within West Dunbartonshire.	70. Review pilot of West Dunbartonshire's Comeback Café.	3	L3 L4	In kind staffing resource.	Review completed & report to ADP/T&SG by December 2011.		A Dyer
	71. Establish monthly comeback.	3	L3 L4	TBC	Regular café established report to ADP/T&SG by December 2012.		A Dyer

Recovery							
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Build recovery capitol within West Dunbartonshire.	72. Review family support.	4	L3 L4	In kind staffing resource.	Review complete, report to ADP/T&SG by December 2011.		A Dyer
	73. Visit recovery Service in Italy.	3	L3 L4	Staffing/ fundraising activities.	Report to ADP/T&SG by January 2012.		P Ainsworth/ D McGilveray
	74. Establish informal drop in service to increase access for wider community.	3, 4	L1 L2	Within current staffing resources	Service Implemented by December 2011. Report to ADP/T&SG by March 2012		John Macdonald
	75. Develop local supported accommodation for those coming through the Scottish Prison Services and who are in recovery from drug addiction, by April 2012.	3 5 6 7	L1 L2 L3 L4 L5 L11	Yet to be identified.	Establishment of supported accommodation achieved, report to ADP/T&SG by August 2012.		D McGilveray
	76. Develop structures and services that will support those in recovery into education, training or employment (linked to action 71 above).	3 5 6 7	L1 L2 L3 L4 L5 L11	Yet to be identified	Supports and structures developed as an integral element of the supports available to those accesses the supported accommodation (noted in Action 71 above) by August 2012.		D McGilveray

West Dunbartonshire Alcohol & Drug Partnership

A Strategy to reduce the harmful effects of alcohol and drugs and promote recovery

2011 - 2014

West Dunbartonshire Alcohol and Drug Partnership

Appendices:

2011 – 2014

Appendix 1

Alcohol and Drugs: The Scale of the Problem (In Scotland as a whole)

Alcohol -as indicated within policy documents produced by the Scottish Government such as the Alcohol Strategy ***"Changing Scotland's Relationship with Alcohol: A Framework for Action"*** - is acknowledged as an integral part of Scottish life. The relationship that Scot's have with alcohol presents both negative and positive impacts on the communities in which we live and work.

The drinks industry plays a big role in supporting that relationship through the many types of alcoholic drinks currently produced in Scotland. Internationally, Scotland's "national" drink is known and enjoyed throughout the developed world. Whisky, its production, maturation, distribution, on and off sale, and the role it plays in attracting and supporting tourism, offers employment opportunities across the whole of Scotland.

However, the most up to date sales data available shows that enough alcohol is sold in Scotland to enable every man and woman over the age of 16 to exceed the sensible male weekly guideline on safe and responsible alcohol consumption during each and every week of the year. ***(****guidance from the Chief Medical Officer indicates that females should drink no more than 2 – 3 units of alcohol and males should drink no more than 3 – 4 units of alcohol per day, it is also recommended that individuals have at least 2 alcohol free days every week).*

Evidence confirms that drinking above the recommended guidelines increases the risk of lasting health damage, raised levels of consumption increases the harmful effects of alcohol on the individual. In 2007/08 there were over 40,000 hospital discharges, in Scotland, linked to alcohol-related illness and injury. There has been a fall in the number of alcohol-related discharges from general acute hospitals in Scotland between 2008/09 and 2009/10. The number of alcohol-related discharges declined from 41,977 to 39,278. Alcohol-related mortality has more than doubled in the last 15 years.

The population of Scotland was recorded as 5,118 million in 2008 and 5,144 in 2009. In 2008 there was a slight increase in the number of alcohol-related deaths which rose to 1,411, this figure reduced to 1,282 in 2009.

Recorded incidences of alcohol-related death only take into account those cases where the cause of death can be directly linked to alcohol abuse, therefore the number of actual deaths where alcohol may be a contributing factor is significantly higher.

Over two-thirds of deaths where alcohol was the 'underlying cause' were of individuals aged 50 years old or over. This was true for both males and females. More men than women died of alcohol-related conditions in 2009, with men accounting for 65% of deaths where alcohol was the 'underlying cause' (men: 837 deaths, women: 445 deaths).

The alcohol-related mortality rate for males was more than twice that for females (30.0 per 100,000 population compared to 14.4 per 100,000 population respectively).

Statistical information would also suggest that deaths recorded as "drug-related often involve those known to have an alcohol-related problem, however, if the primary cause of death is linked to drugs it is that which is recorded as cause of death and not their longer term problem with alcohol.

(Although there has been a slight reduction in the number of alcohol-related deaths and a small increase in the number of drug-related deaths the 2009 figures from the GRO confirm that on average there are 1.75 alcohol-related deaths to every drug-related death)

With one of the fastest growing rates of liver disease and cirrhosis in the world, the Chief Medical Officer for Scotland has added alcoholic liver disease to the list of 'big killers' alongside heart disease, stroke and cancer.

Life expectancy in some parts of Scotland falls far short of life expectancy elsewhere, it is suggested that alcohol plays a significant part in these inequalities.

The social and economic costs of excessive alcohol consumption are many. Evidence confirms that it can cause families to break down; it can result in crime and disorder and it causes loss of productivity through sickness. The estimated cost of alcohol-related sickness to Scottish employers is approximately £3.56 billion every year.

Drugs – historically it is recognised that Scotland has a serious problem with drugs. It is estimated that during 2006, 55,328 people were living with problems associated to use of illicit drugs; 40,000 - 60,000 children were being affected by the drug problem of one or more parent.

As indicated within a report published by Glasgow University in August 2009; ***"Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland",*** West Dunbartonshire comes second only to Glasgow City on the estimated drug misuse prevalence rates.

It is estimated that (2.61%) 1,601 people aged 15 – 64 years, living within West Dunbartonshire have problems associated with drug misuse.

Illicit drug use has negative impacts on individuals, families and society as a whole, the estimated economic and social costs are considerable with approximately £2.6bn per annum being attributed directly to problematic drug use.

As reported within ***"The Road to Recover: A New Approach to Tackling Scotland's Drug Problem"*** there has been a slight decline in the number of problematic drug users within Scotland, from the 2000 high of 56,000, to 55,000 in 2006. However, that number remains considerably higher than that reported for England during the same periods. *(It should be noted, however, that direct comparisons between statistics for England and Scotland cannot be made).*

It is clear that although the efforts of front line support services have had some success, it is also acknowledged that there is still a very significant challenge ahead of us. It has been suggested that in order to address this challenge we need to amend our approach to service delivery and ensure that the needs of the individual with problematic drug use are central to the development of their care. We need to help individuals to recover from their addiction, take ownership of their life choices and ultimately rebuild their lives and the relationships that they have with their peers, families and indeed the wider community.

As indicated within the aforementioned policy *document "Recovery is a process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society".*

It is also indicated that an essential element to achieving this goal is the need *to "reform the way that drug services are planned, commissioned and delivered to place a stronger emphasis on outcomes and on recovery".*

The 2009 Drug-Related Deaths report published by the General Register Office for Scotland indicated the figure for Scotland has risen from 455 in 2007 to 574 in 2008. In 2009 the national figure has reduced to 545 across Scotland.

For West Dunbartonshire in 2008 there were a total of 23 drug-related deaths, fortunately this figure has decreased with a total of 13 drug-related deaths being recorded within West Dunbartonshire during 2009.

Across Scotland there has been an increase in the rate of hospital discharges with a diagnosis of drug misuse over the last five years. The rate increased from 92 discharges per 100,000 population in 2004/05 to 118 per 100,000 population in 2008/09.

West Dunbartonshire a place to live and work

The Place

West Dunbartonshire lies between Loch Lomond and the Glasgow conurbation on the north bank of the River Clyde. It comprises 70 square miles of combined waterfront, urban and rural landscape and has three main town centres; Clydebank, Dumbarton and Alexandria.

It contains some of the finest lowland countryside in Scotland with part of the Council area being contained within the Loch Lomond and Trossachs National Park.

Although not a particularly agricultural area, over 40% of the area is classified as open countryside, and contains the second highest proportion of mixed leafed woodland in Scotland.

There are also important natural heritage features such as the 24 Sites of Special Scientific Interest with the Inner Clyde Estuary and the River Endrick Mouth and Islands being of international importance.

The People

In 2001 Census figures indicated a population of 93,378, however, due to a decline in the number of births and approximately 450 people per year choosing to move to neighbouring authorities, that number is projected to fall to 84,000 by 2024, a projected decrease of 9,378 (10.043%).

It is worth noting that the population of West Dunbartonshire is ageing, and the numbers of younger people migrating to other areas has been increasing. Mid-point estimates from the General Registrars Office for Scotland indicate that in 2007 the total resident population had reduced to 91,090.

The West Dunbartonshire Social and Economic Profile showed in 2009 that the local population had fallen to 90,920.

Whilst whisky distilling and maturing remains an important element of our local industry, the growing recession and decline of traditional industries presents further challenges in business growth and prosperity. West Dunbartonshire remains one of the most deprived local authority areas in Scotland.

Life (and healthy life) expectancy rates are among the lowest in Scotland. In the 2001 census, around 23% of the population reported having a chronic illness or disability and by the time people pass their mid-fifties they have a 50/50 chance of developing a chronic illness.

For men life expectancy (at birth) is estimated to be 71.7 years, 1.2 years below the Scottish average. Female life expectancy is 77.9 years, approximately 2 years less than the Scottish average. This West Dunbartonshire average hides more critical figures. Comparing different areas of the community it is clear that there is a gap in life expectancy across the neighbourhoods. Life expectancy in the least deprived areas for men rises to 72.6 and 78.6 for women, whereas in the most deprived areas life expectancy for men falls to 66.1 and for women 74.5 years.

In the period 2001 – 2005 there were 93 completed suicides. There are over 280 new in- patient admissions to psychiatric specialities annually.

The estimated number of smokers in West Dunbartonshire is 22% higher than the Scottish average. Partners in West Dunbartonshire are working together to discover new approaches that will be effective in both preventing our children and young people starting to smoke, and to help those who are already addicted.

Alcohol and smoking rates are amongst the highest in Scotland, diets are poor and physical activity levels low. Asbestos-related diseases are especially prevalent in the former shipbuilding community in Clydebank.

Child and Maternal Health

Compared to 24% nationally, 26% of women in West Dunbartonshire smoked during pregnancy; 23% of mother's breast feed at 6 – 8 weeks following birth, 13% lower than the national figure of 36%. Primary immunisation rates are slightly above the Scottish average. The rate of low birth weight babies is 27% above the Scottish average and the infant mortality rate is 80% above the average. The teenage pregnancy rate is 12% higher than the national average. On average 343 children are admitted to hospital for dental conditions annually: expressed as a rate per head of the population 78% above the national average. Child road accident casualty rate are 20% higher than the national average.

Prosperity/Poverty

Nearly 18,000 people (19.7% of the population) are defined as income deprived and 9,800 adults (7% of the working age population) are employment deprived. There are over 2,000 work places employing over 31,000 people. *(The definitions of "income deprived and "employment deprived" are those applied in the 2006 Scottish Index of Multiple Deprivation).*

Housing and Homelessness

There are 44,397 dwellings in West Dunbartonshire. Owner-occupation accounts for 25,815 (58%) of the housing stock, social rented housing from the Council accounts for 11,374 (26%) of the total stock. Social rented housing from a housing association accounts for 5,591 (13%) of the housing stock and the remaining 1,617 (3%) is taken up by the private rented sector.

West Dunbartonshire has the highest homelessness rate per head of population in Scotland; this is significantly higher than the national average. However homelessness presentations have declined in each of the last 4 years, and homeless assessment decisions have decreased in 2010/2011 for the first time in 3 years.

The total number of people presenting as homeless for 2010/11 is recorded as 2,018. Homelessness is particularly prevalent among young people in West Dunbartonshire, as those aged 25 and under account for 37% of all homeless presentations.

The Homelessness Strategy aims "*to end homelessness in West Dunbartonshire"* through a focussed approach to prevention, increasing choice, developing sustainable solutions, and; commitment.

Unemployment

As indicated earlier, the decline in traditional industries combined with the recent and ongoing, recession has contributed to the significant levels of poverty, deprivation and poor health statistics in key areas of West Dunbartonshire.

The current unemployment rate is around 5.7% compared to the Scottish average of 4.2%. Poverty levels are high, with 21% of people claiming key out of work benefits against the Scottish average of 15.1%.

The most recent figures show that 11,100 families in West Dunbartonshire were in receipt of Child and Working Tax Credits, around 20% of the working age population. This shows a 1% increase in previously reported figures. The figures also show that there are 4,900 children living in households where no-one works and 1,950 children living in households where the family are working but that are in receipt of working tax credits above the family element. This means that 42% of all children in West Dunbartonshire could be described as being poor.

Education

Education levels continue to compare well against 16 Scottish Local Authorities which have agreed to share "benchmarking" information for 5 – 14 year olds. However, in 2008/09 West Dunbartonshire saw a 1% decline in performance in reading going from 84% to 83%. Writing has decreased by 3% to 75% and mathematics has reduced by 2% to 85% these figures bring attainment levels down by 1%, 3% and 2% respectively against the other "Consortium" areas.

The number of school leavers entering full time higher or further education continues to increase having risen another 5% in the last year. The number entering training has also risen and is substantially higher than the national figure.

The number entering employment is down by 4% reflecting the national decrease. Unemployment directly from school fell slightly by 1% and is now closer to the national average.

Drug and Alcohol-Related Crime

A Strathclyde Police Public Consultation exercise conducted in 2010 identified 70% of participants identified Drug Dealing/Use, and 67.2% identified Drunk or Disorderly Behaviour as the top two priorities that Strathclyde Police should focus on. In addition, one third stated that they had been affected by anti-social behaviour in the last 12 months.

The volume of drug seizures has increased significantly in the last year, specifically in relation to cocaine, heroin and cannabis.

Pub-watch Scheme

West Dunbartonshire currently has three Pub Watch schemes running covering Dumbarton, Alexandria and the most recent addition Clydebank.

Each of these Pub Watch schemes covers relevant on-sales premises in the respective areas. Licence holders or members of their staff attend monthly meetings at which time they have the opportunity to discuss problems on the premises. At this time they can ask for persons causing problems to be banned from all premises in the relevant area. To this time Dumbarton has 50 persons banned, Alexandria 43 persons banned and the newly formed Clydebank Pub Watch 3 persons banned.

It is the long term intention that all vertical drinking establishments including clubs will come onboard with Pub Watch as this gives regular contact with both the police and LSO's.

Crime

In the year 1st January 2010 to 31st December 2010 Strathclyde Police in the West Dunbartonshire area recorded 131 serious assaults and 1,439 domestic incidents.

Test Purchasing Operations "L" Division

Strathclyde Police continue to carry out Test Purchase Operations throughout the West Dunbartonshire.
The Test Purchase Operations are based on intelligence that premises are either selling alcohol to persons under 18 years of age or that persons under 18 years of age are consuming alcohol in an area and this alcohol was purchased locally.

In the year 2010 Strathclyde Police carried out 26 Test Purchase Operations in the West Dunbartonshire area. From these operations only one premises failed an initial Test Purchase but these premises passed a second Test Purchase Operation. These premises were reported to WDC Licensing Board regarding this failure and received a warning letter in respect of this.

Alcohol and Drugs: Affects on the Health of Our Local Population

In 2006 1,181 people, 542 in local regeneration areas and 639 across the rest of West Dunbartonshire, participated in a Health and Wellbeing Survey.

As part of that exercise participants were asked about their levels of alcohol consumption, the results indicated that just under 1 in 5 of participants (19%) said they do not drink alcohol, a proportion that is consistent within the regeneration areas as well as across the rest of West Dunbartonshire.

The proportion of participants from the regeneration areas drinking alcohol on more than 2 days per week is higher than for the rest of West Dunbartonshire.

For example, 23% of those from the regeneration areas say they drink alcohol on 3 to 5 days per week compared to only 15% in the rest of West Dunbartonshire. In addition, 16% drink alcohol on 6 to 7 days per week in comparison to only 6% in the rest of West Dunbartonshire. Participants who drink alcohol were asked to estimate how many units they drank in the week prior to their completion of the survey *(they were advised that one unit of alcohol was equal to a small glass of wine, half a pint of normal strength lager or a pub measure of any spirit).*

Across West Dunbartonshire as a whole, 13% of men and 11% of women currently drink above these, recommended safe, levels. These estimates are higher in the regeneration areas, where 22% of men and 21% of women drink above safe alcohol consumption levels.

As indicated within the ***"Alcohol Statistics Scotland 2009"*** report further clarity on the recommended safe drinking levels has been agreed i.e.:

- men should not consistently **drink more** than 2 – 4 units of alcohol per day
- women should not consistently **drink more** than 2 – 3 units of alcohol per day.
- men should drink no more than 21 units per week,
- women should drink no more than 14 units per week,
- there should be at least 2 full days where no alcohol is consumed at all.

Binge drinking is confirmed as:

- men consuming more than 8 units per day, and
- women consuming more than 6 units per day.

SALSUS (2006) [taken from the West Dunbartonshire specific information]

Alcohol

Of the pupils who reported ever having drunk alcohol, a third (36%) of 15-year-olds reported having a drink in the last week compared with 14% of 13-year-olds. This is a drop in the figures reported in 2004 where 20% of 13 and 43% of 15-year-olds reported having a drink in the previous week.

Just over half of 13-year-olds who had ever had a drink reported having been drunk at least once (52% of boys and 54% of girls). The proportion of 15 year old pupils who had drunk alcohol and who had ever been drunk was higher in comparison: 71% of boys and 75% of girls. Fifteen year old girls were more likely to have ever been drunk than boys.

A third of 13-year-olds reported at least one instance when they had drunk five or more drinks on the same occasion over the past 30 days. Fifteen year olds who had ever had a drink were more likely than 13-year-olds to have ever consumed five or more drinks on the same occasion (54%).

Those who had indicated that they had consumed alcohol were asked if, as a result of drinking alcohol, they had: had been involved in an argument; a fight; visited an A&E department; been admitted to hospital overnight; had an injury that needed to be seen by a Doctor; been taken home by the police; stayed off school; been sick (vomited); tried any drugs; or been in trouble with the police. Two-fifths (40%) of 13-year-olds and 58% of 15-year-olds reported being involved in at least one of these behaviours as a result of drinking in the past year. As was the case in 2004, the most commonly reported drinking related behaviour was 'vomiting'. This was experienced by 26% of 13-year-olds and 41% of 15-year-olds who had ever had an alcoholic drink.

Thirteen year olds who had ever had an alcoholic drink were considerably less likely to buy alcohol than 15-year-olds: 61% of 13-year-olds who had ever drunk alcohol reported never buying alcohol compared with 39% of 15-year-olds. The most common way of buying alcohol in both age groups was from a friend or relative (22% of 13-year-olds who had ever drunk alcohol reported buying alcohol in this way as did 29% of 15 year olds). The second most common way to buy alcohol was from a shop, 11% of 13-year-olds and 23% of 15-year-olds who had ever had a drink reported buying alcohol in this way.

Since 2004 the most notable difference has been an increase in the proportion of pupils buying alcohol from friends and relatives. When pupils did attempt to purchase alcohol themselves from a shop, supermarket or off-license, it was more likely to result in a purchase than a refusal. Of the 10% of 13-year-olds who had drunk alcohol and had attempted to purchase from a retailer, 6% were successful and 4% were refused. Of the 19% of 15-year-olds who had drunk alcohol and had attempted to purchase from a retailer, 14% were successful and only 5% were refused.

Among 13-year-olds who had ever drunk alcohol, the most commonly reported location for drinking was 'at my home' reported by 47% of 13-year-olds. Fifteen year olds who had ever had a drink were less likely to drink at home. 38% reported this as their 'usual' drinking location. Since 2004 there has been an increase in pupils drinking at someone else's home or outdoors (street, park, etc), this was particularly the case with 15-year-olds, 45% of those who had ever had a drink reported drinking at someone else's home compared to 39% in 2004 and 45% reported drinking outdoors compared to 36% in 2004.

Drugs

Over a quarter (27%) of 15-year-olds and 9% of 13-year-olds reported that they had ever used drugs. Around a quarter (23%) of 15-year-olds and 7% of 13-year-olds reported they had used drugs in the last year and 14% of 15-year-olds and 4% of 13-year-olds reported that they had used drugs in the last month. In 2006, there were no significant differences between boys and girls in reported drug use.

Between 2004 and 2006, prevalence of drug use in the last month declined among 15-year-old boys from 21% to 14% and among 15-year-old girls, there was a decline from 20% to 12%. Similarly among 13-year-olds there was a decline in the prevalence of drug use in the last month: from 7% to 4% among 13-year-old boys and among 13-year-old girls, a fall from 6% to 3%.

Cannabis was the most frequently reported drug used in the last month, in the last year or ever. Eleven percent (11%) of 15-year-olds and 2% of 13-year-olds reported that they had used cannabis in the last month. Very few pupils reported using any other drug. Six percent (6%) of 15-year-olds and 1% of 13-year-olds reported using cannabis and no other drugs in the last month. Fewer pupils reported using cannabis and other drugs (4% of all 15-year-olds and 1% of 13-year-olds), and 2% of 13 and 15-year-olds had used other drugs but not used cannabis in the last month.

Ten percent (10%) of all 15-year-olds and 4% of 13-year-olds said they had only taken drugs once. A total of 8% of all 15-year-olds and 2% of all 13-year-olds said they used drugs once a month or more frequently.

The most commonly reported location for using drugs was outdoors: almost half (48%) of 13-year-olds and almost half (47%) of 15-year-olds who had ever used drugs reported doing so outdoors. Someone else's home was also reported by three in ten (30%) of 15-year-olds and 19% of 13-year-olds.

Among 13-year-olds, boys were more likely to report being offered drugs than girls: 25% of boys said they had been offered drugs compared with 21% of girls.

A similar difference existed for 15-year-olds: 55% of boys being offered drugs compared with 51% of girls. The drug that most pupils reported having been offered was cannabis. Forty four percent (44%) of 15-year-olds and 14% of 13-year-olds had reported that they had been offered cannabis. Overall, since 2000, there has been a reduction in the proportion of pupils reporting that they had ever been offered drugs. In 2000, 44% of 13-year-olds and 70% of 15-year-olds reported that they had been offered drugs compared with 23% of 13-year-olds and 53% of 15-year-olds in 2006.

Younger pupils were more likely than older pupils to say that they did not know how easy or difficult it would be to get drugs, reflecting both the lower prevalence of drug use among 13-year-olds and the lower proportion of 13-year-olds reporting that they had been offered drugs: 45% of 13-year-olds said they didn't know compared to 31% of 15-year-olds. Around a third (34%) of 13-year-olds and 21% of 15-year-olds reported that it would be fairly difficult, very difficult or impossible to get drugs.

Friends were the most commonly reported source of drugs. For 15-year-olds the source was more likely to be a friend of their own age: 41% said they obtained drugs from a friend their own age and 33% from an older friend.

Younger pupils were more likely to have obtained drugs from an older friend (37%) than a friend their own age (26%). Over half of pupils across both age groups said they 'gave some away': 54% of 13-year-olds and 59% of 15-year-olds, with girls (63%) being more likely to have done so than boys (55%).

Less than one in ten pupils who had ever used drugs (8%) of 13-year-olds and 3% of 15-year-olds said that they had ever felt they needed help because of drug use. However, 61% of 13-year-olds and 71% of 15-year-olds said they would know where to go for help. Pupils living with both parents were less likely to be regular smokers, to have drunk alcohol in the last week or to have ever used drugs compared with those who were living with a single parent or step parent.

Perceived maternal and paternal monitoring was found to be associated with substance use. Pupils who were regular smokers, drinkers or drug users were more likely to perceive their parents knowledge of their activities to be below that of those who had never drank alcohol or taken drugs.

The more evenings pupils spent out with friends, the more likely they were to report smoking regularly, having had an alcoholic drink in the last week or to have used drugs in the last month. There is not only an association with the number of evenings spent out with friends but the type of activities pupils reported doing in their leisure time. Non substance users were more likely to be doing constructive leisure activities such as a hobby, a sport or reading, whereas those who were regular drinkers or drug users were more likely to spend their time 'hanging around the street'.
Unsurprisingly pupils who were regular drinkers and/or drug users were more likely to have been truant or excluded from school.

They were also more negative towards school in terms of their rating of how much they liked it and, felt more pressurised by the school work they had to do.

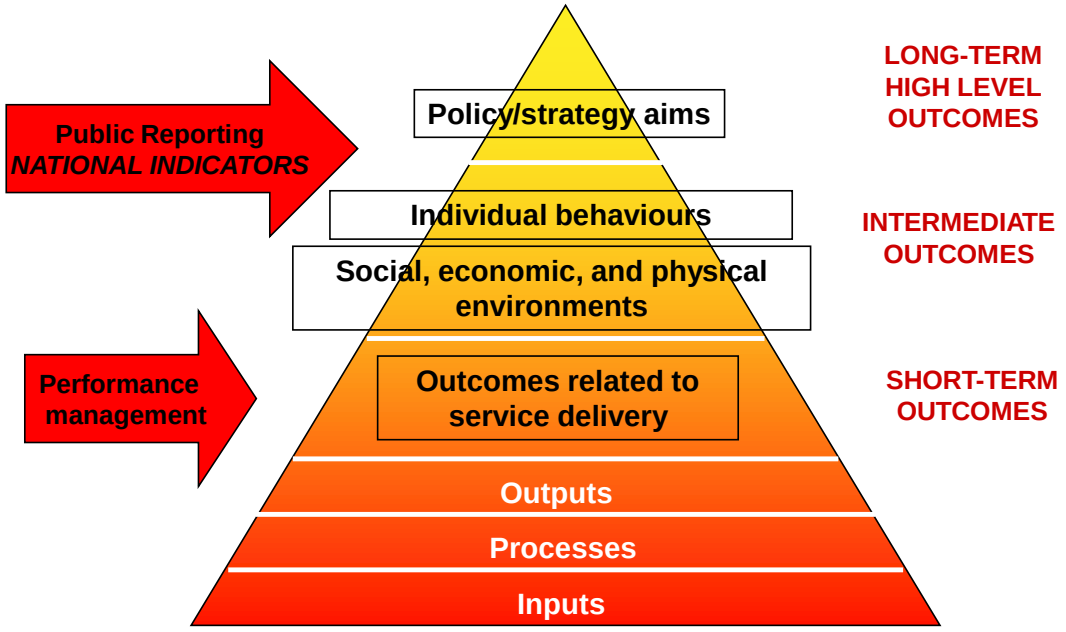
The, 2006 (SALSUS) found that 4% of 13-year-olds and 14% of 15-year-olds used drugs in the month prior to the survey. This reflects a welcome reduction from the study in 2004 (7% of 13-year-olds and 20% of 15-year-olds) and a continuing positive trend since the SALSUS study started in 1998, although the figures are not broken down to local authority area. The same study found that 47% of 13-year-olds and 63% of 15-year-olds reported being drunk within the past week.

The, 2006 ***West Dunbartonshire Pupil Health Survey*** (West Dunbartonshire Community Health Partnership), returned comparable evidence of misuse by young people. Similar to SALSUS figures, the survey demonstrated that levels of drinking increased with age and with deprivation, although it remained clear that the majority of pupils sampled reported never or rarely having been drunk.

What all the evidence shows is that young people are exposed to drugs and alcohol as part of their culture, and many will have direct experience. For some, this leads to problematic use and the potential of longer-term misuse.

Appendix 2

Outcomes Triangle



Local Priority 2: Safe, Strong and Involved Communities

Local Outcome	Performance Indicators	Frequency/ Type/ Source	Baseline (2010/11)	Local Targets & Timescales
2.1 Reduced Violent Crime	2.1.1 Number of Crimes in Group 1 (five year rolling average) per 10, 000 of adult population	Annual Rate Strathclyde Police	34	2011/12 – 33.3 2012/13 – 32.7 2013/14 – 32.3
2.2 Enhanced Safety of women and children	2.2.1 Detection rate for domestic abuse related crimes – (five year average) per 10,000 of adult population	Annual Rate Strathclyde Police	65.7	2011/12 – 67.7 2012/13 – 68.4 2013/14 – 68.7
2.3 Reduce antisocial behaviour and disorder	2.3.1 Number of crimes in Group 4 – (five year average) per 10,000 of adult population	Annual Number Strathclyde Police	288	2011/12 – 282 2012/13 – 276 2013/14 – 271
	2.3.2 Percentage of Citizens Panel respondents experiencing antisocial behaviour	Annual Percentage WD Citizen's Panel	2011/12 32%	Decrease
	2.3.3 Number of deliberate fires per 10,000 population	Annual Rate Strathclyde Fire and Rescue	104	Decrease
2.4 Home, Transport and Fire Safety	2.4.5 Number accidental house fires per 10,000 population – alcohol/smoking related	Annual Rate Strathclyde Fire & Rescue	3.85	Decrease
2.5 Reduced impact of alcohol and drug misuse on communities	2.5.1 Number of Drug related deaths	Annual Number NHS – ISD	2007-2009 WDC 17.3	Reduce rolling three year average by 3 within three years.
	2.5.2 Number of persons detected for Drug Supply Crimes.	Annual Number Strathclyde Police	184	2011/12 - >109 2012/13 - >109 2013/14 - >109
	2.5.3 Public Reported Incidents of Street Drinking (five year average)	Strathclyde Police?	864	2011/12 – 847 2012/13 – 830 2013/14 - 813

Appendix 4

NHS Scotland Performance Targets - Health Improvement

The HEAT performance management system sets out the targets and measures against which NHS Boards are publicly monitored and evaluated. Better Health, Better Case states that the system has been developed so that it:

- identifies and drives the contribution of NHS Scotland to the overall strategic objectives of the Scottish Government
- links closely with the new accountability and performance arrangements that apply for local government and enables joint roles, responsibilities and actions to be agreed at local level through Community Planning arrangements
- demonstrates clear alignment between short term operational targets and the longer term strategic direction set out within the HEAT Performance Targets

Addiction Related Health Improvement Targets: 2008/09, 2009/10 and 2010/11

- Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11

- By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

One further HEAT Target which ADP's will need to consider whilst planning their services is:

- Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014

Appendix 5

Greater Glasgow and Clyde Alcohol and Drug Prevention and Education Model: Working towards a model of good practice

The twelve Core Elements reflected within the Greater Glasgow and Clyde Alcohol and Drug Prevention and Education Model are:

1. Resilience and protective factors

2. Environmental measures

3. Community involvement

4. Diversionary approaches

5. Brief Intervention approaches

6. Education

7. Training

8. Parenting programmes

9. Social marketing

10. Workplace alcohol and drug policies

11. Harm reduction – alcohol

12. Harm reduction - drugs

Appendix 6

Aim and Remit of the Alcohol and Drug Partnership

Aim

The West Dunbartonshire Alcohol and Drug Partnership's aim is, through efficient and effective partnerships with key stakeholders, to reduce the harmful effects of alcohol and drugs and promote recovery.

Remit

- Provide a clear assessment of local needs and circumstances, including both met and unmet needs, and prioritise in line with resources
- Identify key outcomes relating to drugs and alcohol misuse, their place within the wider framework of priority outcomes contained within the Single Outcome Agreement and how their achievement will be measured
- Set out clearly and openly the totality of resources that each partner is directing to the pursuit of alcohol and drug outcomes
- Set out an outline of the services to be provided and/or commissioned reflecting the local assessment of need
- Consider issues such as workforce development and ensuring the workforce is equipped with the skills to deliver
- Set out an approach to the commissioning and delivery of services, including preventative interventions, in the pursuit of the outcomes identified
- Co-ordinate with regional (Health Board-wide) structures
- Identify and co-ordinate plans to attract external funding sources
- Prepare and collate local responses to national and other consultation exercises
- Receive, analyse and manage performance data, including regular reports on key local indicators
- Monitor performance standards and direct strategy as necessary to best achieve agreed outcomes
- Provide updates and reports as appropriate to the Safe and Strong Communities Theme group of Community Planning
- Ensure services and plans are equality sensitive and issues of bias identified and addressed

West Dunbartonshire Alcohol and Drug Partnership: Membership

Appendix 7

NAME	CONTACT DETAILS	ORGANISATION	POSITION IN ORGANISATION
ADP CHAIR:	**CHAIR'S PHONE NUMBER, EMAIL & ADDRESS**		
Keith Redpath	Community Health and Care Partnership WDC Council Headquarters Garshake Road Dumbarton G82 Tel 01389 737526 Keith.repath@ggc.scot.nhs.uk	WDC CHCP	Director
ADP VICE-CHAIR:	**VICE-CHAIR'S PHONE NUMBER & EMAIL**		
John Russell	Community Health and Care Partnership WDC Council Headquarters Garshake Road Dumbarton G82 Tel 01389 737764 John.russell@ggc.scot.nhs.uk	WDC CHCP	Head of Mental Health, Addictions and Learning Disability
MEMBERS:			
Tom Jackson	Addiction Services West Dunbartonshire Community Health & Care Partnership Dumbarton Joint Hospital Cardross Road Dumbarton G82 5JX Tel 01389 7812042 Tom.jackson@west-dunbarton.gov.uk	WDC CHCP	Joint Manager – Addiction Services
Anne Marie McDonald	Social Work and Health West Dunbartonshire Council Rosebery Place Clydebank G81 1TG Tel 0141 562 8848 AnneMarie.Mcdonald@west-dunbarton.gov.uk	WDC CHCP	Area Manager
Raymond Park	Superintendent Raymond Park Strathclyde Police, Sub Divisional Officer, West Dunbartonshire Sub-Divisional Headquarters 50 Montrose Street Clydebank Glasgow G81 2QD Tel 0141 532 3350 raymond.park@strathclyde.pnn.police.uk	Strathclyde Police	Superintendent
Norman Firth	Criminal Justice Team Municipal Buildings Station Road Dumbarton Tel 01389 738484 Norman.firth@west-dunbarton.gov.uk	CJT	Partnership Manager
Terry Lanagan	Educational Services West Dunbartonshire Council Garshake Road Dumbarton G82 3PU Tel 01389 737303 Terry.lanagan@west-dunbarton.gov.uk	WDC Education	Executive Director

NAME	CONTACT DETAILS	ORGANISATION	POSITION IN ORGANISATION
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Donnie McGiliveray	Donnie McGiliveray Alternatives Quay Street Dumbarton G82 Tel 01389 734500 Donnie@alternativeswd.org	Alternatives Community Drug Project	Manager
Janice Lockhart	Janice Lockhart Dumbarton Area Housing Office College Way Dumbarton Tel Janice.lockhart@west-dunbarton.gov.uk	Housing - Homelessness	Section Head
Cathie Dennett	Cathie Dennett DACA Westbridgend Lodge Westbridgend Dumbarton Tel 01389 731456 email@daca.org.uk	Dumbarton Area Council on Alcohol	Manager
Sheila Urquhart	Sheila Urquhart c/o West Dunbartonshire ADP Leven Valley Enterprise Centre Castlehill Road Dumbarton G82 sheilajurquhart@hotmail.com	Dumbarton Community Forum	Community Representative
Neil Etherington	Neil Etherington c/o West Dunbartonshire ADP Leven Valley Enterprise Centre Castlehill Road Dumbarton G82 neil.etherington@gmail.com	Clydebank Community Forum	Community Representative
John Smillie	c/o FAST Addiction Services Main Building Dumbarton Joint Hospital Cardross Road Dumbarton G82 Sharon@alternativeswd.org	Future of Addiction Services Team (FAST)	Client Involvement Representative
Thomas Paton	c/o FAST Addiction Services Main Building Dumbarton Joint Hospital Cardross Road, Dumbarton G82 Sharon@alternativeswd.org	Future of Addiction Services Team (FAST)	Client Involvement Representative

ADP SUPPORT TEAM

NAME	CONTACT DETAILS	ORGANISATION	POSITION IN ORGANISATION
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Amanda Eleftheriades	Dumbarton Area Council on Alcohol (DACA) West Bridgend Lodge Dumbarton, G82 4AD Tel 01389 731456 email@daca.org.uk (Mark for the attention of Amanda)	DACA	Public Relations/ Communications Officer
Hazel Slattery	Strategy, Planning and Performance Room 1.4, Levenvalley Enterprise Centre Castlehill Road Dumbarton G82 5BN Tel 01389 608106 Hazel.slattery@west-dunbarton.gov.uk	WD CHCP	Senior Clerical Assistant

Appendix 8

Glossary of Terms

ADP	-	Alcohol and Drug Partnership
T&SG	-	Treatment and Support Group
CPC	-	Child Protection Committee
APEG	-	Addiction Prevention and Education Group
CPP	-	Community Planning Partnership
WD	-	West Dunbartonshire
SACDM	-	Scottish Advisory Committee on Drug Misuse
IAF	-	Integrated Assessment Framework
ICSP	-	Integrated Children's Services Plan
LLF	-	Local Licensing Forum
ASBTG	-	Anti Social Behaviour Task Group
ILM	-	Intermediate Labour Market
SNIPS	-	Special Needs in Pregnancy Service
CAT	-	Community Addiction Team
W/WSG	-	Wrecked/Wasted Steering Group
HWL	-	Healthy Working Lives
WDC	-	West Dunbartonshire Council
CISG	-	Client Involvement Steering Group
SUS	-	Service User Survey
CSS	-	Client Satisfaction Survey
CHCP	-	Community Health Care Partnership
Ed& LLL	-	Education and Life Long Learning
CHRISTO	-	Named after Dr Christo – A tool for measuring qualitative outcomes
RR	-	Road to Recovery
SOA	-	Single Outcome Agreement
CoSLA	-	Convention of Scottish Local Authorities
CL&D	-	Community Learning & Development
C for E	-	Curriculum for Excellence
CSRA	-	Changing Scotland's Relationship with Alcohol
NOM	-	National Outcome Measures
HEAT	-	Health Efficiency and Assessment Target
HEAR	-	Help, Empathy, Advice and Reassurance (out of hours telephone support service)
EY	-	Early Years
EI	-	Early Intervention
BI	-	Brief Intervention
HI	-	Health Improvement
GRO	-	General Registrars Office
CMO	-	Chief Medical Officer
SALSUS	-	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SG	-	Scottish Government
DPU	-	Drug Policy Unit
AMT	-	Alcohol Misuse Team
SHS	-	Scottish Household Survey
H&W	-	Health & Well Being Survey
DPYK	-	Drug Proof Your Kids
CI	-	Client Involvement
SDMD	-	Scottish Drugs Misuse Database
SHeS	-	Scottish Health Survey - provides a detailed picture of the health of the Scottish population in private households. There have been three previous Scottish Health Surveys in 1995, 1998 and 2003. Currently the Scottish Health Survey is running continuously from 2008-2011
NICE	-	National Institute for Health and Clinical Excellence
HTBS	-	Health Technology Board for Scotland

Appendix 9

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Getting Our Priorities Right (GOPR)

Getting it Right for Every Child (GIRFEC)

West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Community Health & Care Partnership

Appendix 10

West Dunbartonshire Community Health & Care Partnership Commissioning Strategy For Alcohol and Drug Services

2011 – 2021

September 2011

CONTENTS

ACKNOWLEDGEMENTS

The CHCP gratefully acknowledges the comments and contributions from all those local stakeholders involved throughout the process of developing this commissioning strategy, particularly those staff planning and delivering our local services. This commissioning strategy has also benefited from considered feedback from colleagues at Social Care Social Work Improvement Scotland (SCSWIS), the Joint Improvement Team (JIT), and the Scottish Government.

Any comments or questions about this Commissioning Strategy can be sent to:

Mr Soumen Sengupta

Head of Strategy, Planning & Health Improvement
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West Dunbartonshire CHCP HQ, West Dunbartonshire Council,
Garshake Road, Dumbarton, G82 3PU.

An electronic version of this Commissioning Strategy can be downloaded from the WD CHCP website: www.wdchcp.org.uk

1. OUR AMBITION

1.1 Vision

West *Dunbartonshire Community Health and Care Partnership's (CHCP) vision for the provision of Alcohol and Drug Services across the West Dunbartonshire Council area is to reduce the harmful effects of alcohol and drugs and promote recovery.*

1.2 Scope

The Institute of Public Care (IPC) has defined a commissioning strategy as "a formal statement of plans, for specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the NHS, the Local Authority, other public agencies or by the voluntary and private sectors".

The focus of this commissioning strategy reflects the requirements of Scottish Government as they relate to the provision of alcohol and drug services which address *prevention*, and support *recovery* from problems associated with alcohol and drug addiction. It forms part of a suite of commissioning strategies covering the breadth of operational responsibilities of West Dunbartonshire Community Health and Care Partnership (developed jointly on behalf of NHS Greater Glasgow and Clyde and West Dunbartonshire Council).

The aim of this Commissioning Strategy is to project how the local provision of community-based alcohol and drug services will need to be developed over the course of the next ten years (i.e. 2011 to 2021) so as to reflect changes in demand, development of policy, emergent best practice and available resources.

1.3 Values

There are four core values that underpin the CHCP's approach to strategic commissioning, namely:

- Quality
- Fairness
- Sustainability
- Openness

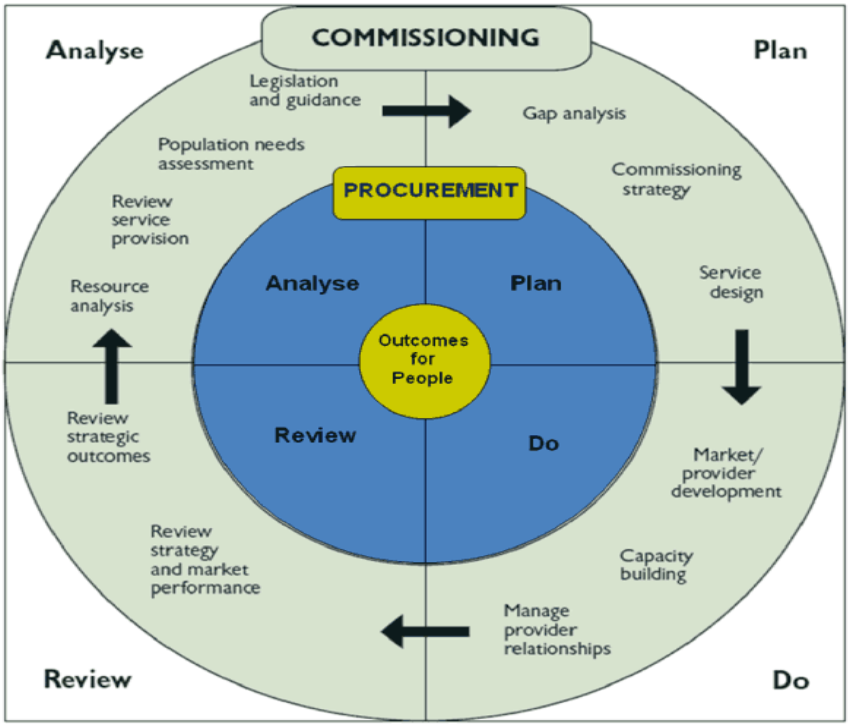
These values are manifested through a systematic concern for the following principles:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

1.4 Delivering Strategic and Outcome-based Commissioning

This commissioning strategy is a key element of an on-going process of commissioning as advocated by the IPC and illustrated below (Diagram 1) and further detailed in Appendix I.

Diagram 1: Strategic Commissioning Cycle



The Audit Commission (2003) has emphasised three particular strengths of this model:

- The cyclical nature of the activities involved, from understanding needs and analysing capacity to monitoring services.
- The importance of meeting needs at a strategic level for whole groups of service users.
- The importance of commissioning services to meet the needs of service users, no matter who provides them.

Audit Scotland has emphasised the challenging financial climate in which the public sector will be expected to deliver services over the coming years. Alongside the realities of a reduction in public sector budgets, CHCP services also have to manage the increasing complexity of demands for and capacity of services whilst being responsive to demographic changes within the population. Robust commissioning of community-based alcohol and drug services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy will drive the substance of relevant operational service plans on an annual basis, within the wider context of the Community Planning Partnership's multi-agency Alcohol and Drug Strategy 2011-2012 (that the CHCP has lead responsibility for) and the CHCP's wider set of development priorities as set within its annual CHCP Strategic Plan.

The CHCP will account for the delivery of the above approach primarily through its core governance arrangements to NHS Greater Glasgow and Clyde and West Dunbartonshire Council (as articulated within its Scheme of Establishment); and to its wider set of local partners through the auspices of the West Dunbartonshire Community Planning Partnership's Alcohol & Drug Partnership (ADP).

2. LEGISLATIVE AND POLICY CONTEXT

2.1 The Scottish Government has set a clear purpose for its policy and spending programmes, i.e. "to focus Government and public services on creating a more successful country with opportunities for all of Scotland to flourish, through increasing sustainable economic growth".

Within this overall purpose, the Scottish Government has established strategic objectives of making Scotland *wealthier and fairer, healthier, safer and stronger, smarter and greener*. At a local authority-level, the above are reflected within agreed Single Outcome Agreements (SOA) that bring together national outcomes with local priorities; and the delivery of which are overseen by Community Planning Partnerships (CPP). All health and social care services are expected to deliver outcomes in relation to:

- User satisfaction.
- Faster access to services.
- Support for carers.
- Quality of assessment and care planning.
- Identifying those most at risk.

Both the corporate priorities of NHS Greater Glasgow & Clyde and West Dunbartonshire Council in relation to alcohol and drug services reflect the above in general terms as well as the following specific policy directives:

2.1.1 Changing Scotland's Relationship with Alcohol: A Framework for Action

In March 2009, the Scottish Government published Changing Scotland's Relationship with Alcohol: A Framework for Action. This national Framework set out the strategy for tackling alcohol misuse in Scotland; adopted a population approach with specific interventions targeting particular groups; and identified the need for sustained action across four areas:

a) Reduced Alcohol Consumption
- Discount ban in off sales.
- Ensure smaller measures of wine are available in on-sales.
- Minimum retail price per unit of alcohol.

b) Supporting Families and Communities
- Increase age limit to 21 for off-sales (this may be left to the discretion of the local licensing boards to implement).
- Social Responsibility Fee (a fee that may be applied to licensed premises).
- Improve identification and assessment of children affected by parental alcohol misuse.
- Call for a reduction in the UK drink driving limit for blood alcohol concentration from 80mg to 50mg per ml of blood.

c) Positive Attitudes, Positive Choices
- Improve public awareness, e.g. information and education campaigns.
- Limit promotional material in shops, pubs and off-licenses.
- Promotion of workplace alcohol policies.

d) Improve support and treatment
- HEAT target for alcohol brief interventions.
- NHS Health Scotland Workforce Development Strategy.
- Integrated care pathways for offenders.

2.1.2 The Road to Recovery: A New Approach to Tackling Scotland's Drug Problems

In March 2008, Scotland's national drug strategy, The Road to Recovery, was published. This national strategy signalled the imperative to embrace a cultural shift focusing on the concept of recovery. The Strategy defined recovery as "a process through which an individual is enabled to

move on from their problem drug use towards a drug free life as an active and contributing member of society". It incorporated the principle that recovery is most effective when service user needs and aspirations are placed at the centre of their care and treatment. In short, an aspirational and person centred process. The strength of the recovery principle is that it can bring about a shift in thinking – a change in attitude both by service providers and by the individual with the drug problem.

The Strategy recognised that the historical polarised debate between the harm reduction and abstinence philosophies was false - they are on a 'continuum of care'; and emphasised the need to reform the manner in which drug services are planned, commissioned and delivered so as to place a stronger emphasis on outcomes and recovery. It recommended a range of appropriate treatment and rehabilitation services ought to be available at a local level. Treatment services must integrate effectively with generic services to fully address the needs of individuals with problem drug use not just their addiction. Alongside the wider effort to promote recovery from problem drug use, specific action to prevent drug related deaths was to be developed further.

2.1.3 HEAT Targets

For the period 2011/12 there are two alcohol and drug specific NHS HEAT (Health, Efficiency, Access & Treatment) targets (both of which are incorporated within the CHCP's current Key Performance Indicators):

- H4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines for 2011/12.
- A11: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

2.1.4 Health Improvement and Health Inequalities

Health improvement *is "pursued both through wide ranging health promotion effort, aimed at promoting good health and preventing ill-health, and through maximising the population benefits of treatment of ill health"* (Scottish Executive, 2005).

While the overall health of communities in Scotland is improving, it is clear that the most rapid improvements are within more affluent communities resulting in marked differences in health status, life expectancy, and premature mortality. The widening gap in health status between the most affluent communities and most deprived communities demonstrates that socio-economic factors impact on health and are determined by life circumstances and where people live. The Scottish Government has acknowledged that inequalities in health such as these are no longer acceptable, and have introduced three key social policy documents which together aim to address the ongoing cycle of poverty and inequalities which persist in deprived communities:

- Equally Well.
- The Early Years Framework.
- Achieving Our Potential.

The role of the CHCP in improving health and reducing health inequalities is set out in the WD CHCP Scheme of Establishment in terms of its corporate responsibility for health improvement; and reinforced by the 2009 CEL 26 Health Improvement and Community Health Partnerships Advice Note, i.e.:

- To take action to reduce health inequalities.
- To prioritise health improvement.
- To plan for health improvement.
- To strengthen partnership working.
- To build capacity and resources for health improvement.
- To integrate improving health activity across all functions/services.

Current policy stipulates that the delivery for improving health and health inequalities should be tackled across all Community Planning Partners with the CHCP having a key leadership role in co-ordinating the health improvement activity specifying that this should be 'outcome focused'.

2.1.5 The National Quality Standards for Substance Misuse Services

The delivery of Alcohol and Drug Services is inspected and reported using the framework of the National Quality Standards for Substance Misuse Services. A key contribution to local service standards has been the series of best practice publications issued by the Effective Interventions Unit.

2.2 The above, alongside other national guidance, have provided the core tenets for how the CHCP will increasingly discharge its responsibilities for Alcohol and Drug Services in West Dunbartonshire over the next ten years, i.e.:

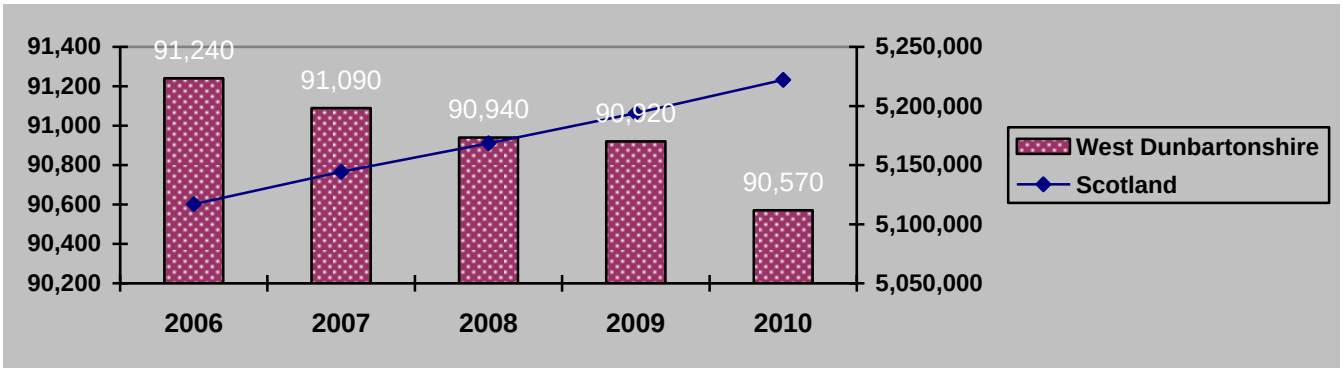
- A person-centred and outcome-based model of delivery that emphasises early intervention and recovery.
- Integrated care pathways and planning for each individual service user reinforced by co-ordinated assessment systems.
- Community alternatives to hospital admission and residential care.
- An effective contribution to a whole population prevention agenda through the local Community Planning Alcohol and Drug Partnership.

3. DEMOGRAPHIC PROFILE AND NEED

3.1 Population Size

The population of West Dunbartonshire reported in the 2001 census was 93,388. By mid-2008 the population had reduced to 90,940, and in 2009 that figure dropped to 90,920 with a further reduction by mid-2010 to 90,570 (Chart 1 - General Registrar for Scotland).

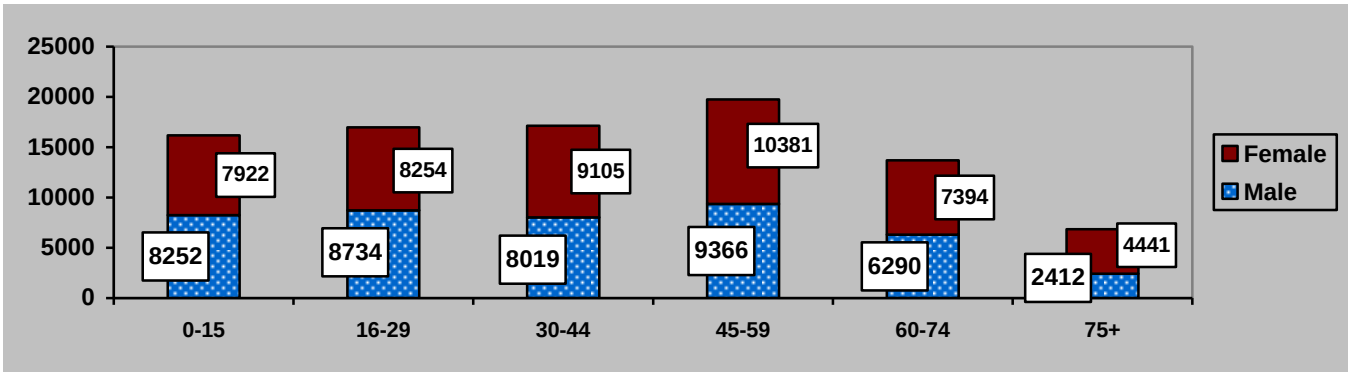
Chart 1: Population number 2006-2010



3.2 Age and Gender Profile

The population of West Dunbartonshire continues to age, and in 2011 the proportion of people over pension age (65) exceeds those of school age (under 16 years). There are more men than women in the population. Of those over 65 14% are men and 25% are women. Sixty seven percent of men and 59% of women are of working age (Chart 2).

Chart 2: West Dunbartonshire population (number) by age and gender (mid 2010)



3.3 Population Living with a Drug or Alcohol Problem

As of mid-2010, 63% of West Dunbartonshire's population was aged 15-64 years. Of these 60,554 people, 7.1% (4,668) were identified as dependent on alcohol, drugs or both; with the majority of those individuals being alcohol dependent (3,633).

In 2008/09 there were 2,686 referrals to alcohol and drug services. The level of referrals fell in 2009/10 to 2,259. It is estimated that in 2009/10, 2409 people with drug or alcohol dependencies did not seek support from alcohol or drug services.

3.4 Illicit Drug Related Deaths

The report GROS: Drug Related Deaths 2009 noted that there had been 545 drug-related deaths registered in Scotland in 2009 reflective of a continuing upward trend in drug deaths since 1999. The demographic profile of the 545 drug users who died in 2009 were as follows:

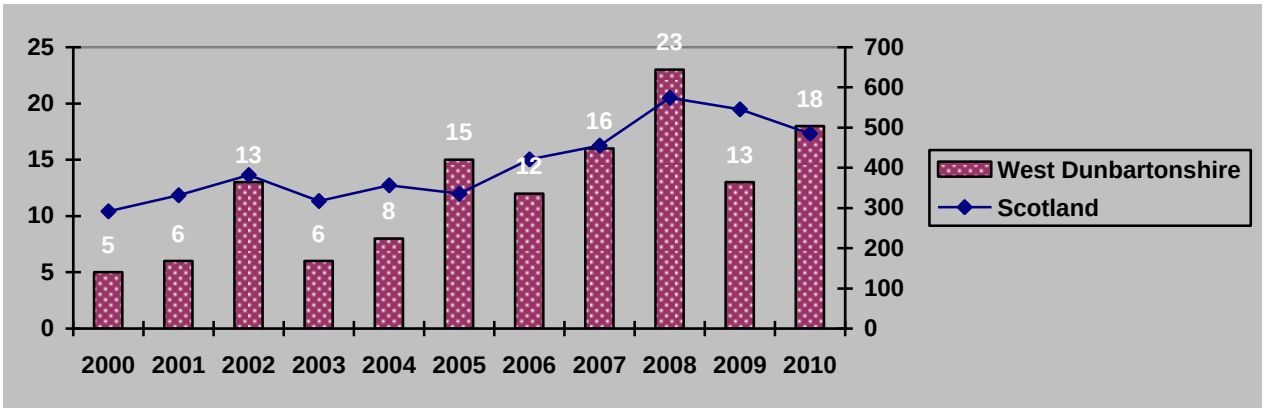
- 404 (76%) males.
- 131 (24%) females.
- 189 (35%) aged 35-44 years.
- 178 (33%) aged 25-34 years.
- 71 (13%) aged under 25 years.
- 78 (14%) aged 45-54 years.
- 29 (5%) aged 55 years and over.

For the same period there were 13 drug related deaths in West Dunbartonshire. Whilst they spiked in 2008 to 23, it is important to note that the 5 year average for the period 2005-2009 was 16.

Local data indicates that the split between male and female drug related deaths mirrors that reported at a national level with the majority of drug related deaths in males aged 35 – 44 years.

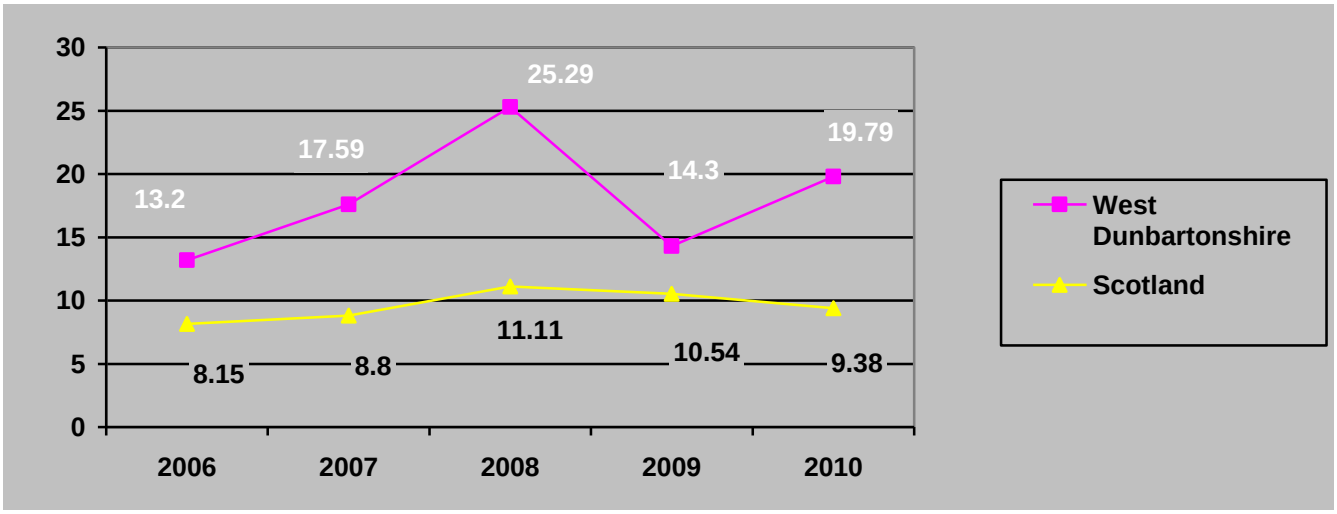
Recently published data has indicated an increase in the total number of drug related deaths to 18 in 2010 (Chart 3).

Chart 3: Number of drug related deaths



West Dunbartonshire is recorded as having the 2nd highest drug related death rates in Scotland. In 2005 the number of drug related deaths within West Dunbartonshire was recorded as 15, there has been no steady upward or downward trend over that same 5 year period, with figures falling to 12 in 2006, rising again in 2008 to 23 and dropping once again in 2009 to 13. A further rise to 18 drug related deaths was recorded in 2010 (Chart 4).

Chart 4: Drug related death rate – 5 year averages per 100,000 population



As Chart 4 demonstrates, when the figures are shown as a rate per 100,000 per head of population, West Dunbartonshire has a higher rate of drug related deaths than Scotland.

3.5 Alcohol-Related Deaths

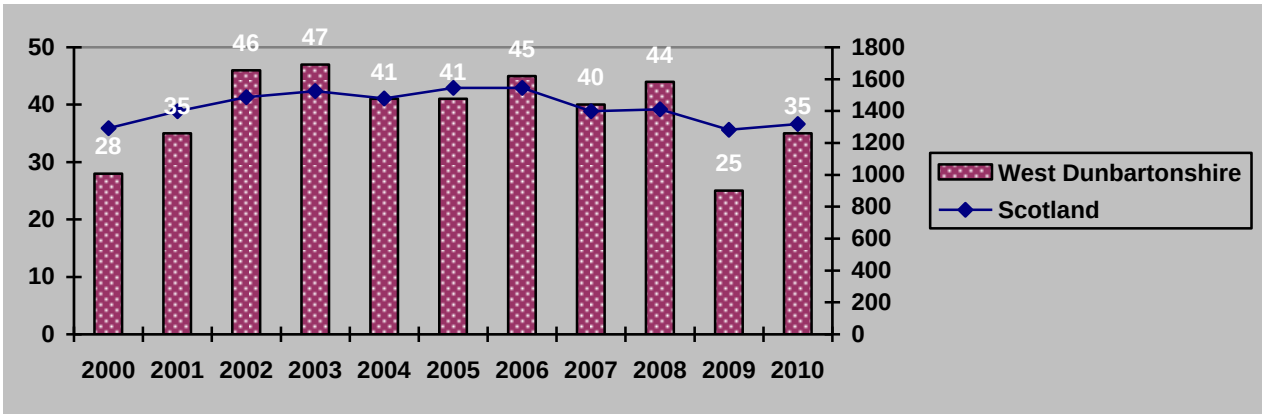
In 2009, there were 1,282 alcohol related deaths registered in Scotland. This reflects a fall from the 2008 figure of 1,411. More men than women died of alcohol-related conditions in 2009, with men accounting for 837 (65%) and women accounting for 445 (35%) of deaths where alcohol was the 'underlying cause'. Over two-thirds of deaths where alcohol was the 'underlying cause' where amongst individuals aged 50 years old or over. This was true for both men and women.

Trends over a 5 year period (2005-2009) have fluctuated. Overall, there was a 15% fall in deaths where alcohol was an 'underlying cause' from 1,513 in 2005 to 1,282 in 2009. However, the data shows that this is not a consistent trend, with deaths increasing to 1,546 in 2006 before falling to 1,399 in 2007 and then rising again to 1,411 in 2008. There was an 18% fall in alcohol-related deaths for men from 1,021 in 2005 to 837 in 2009 compared to a 10% fall for women from 492 in 2005 to 445 in 2009.

The difference in rates of alcohol-related deaths between the most and least deprived has varied over the 5 years, with rates in the most deprived areas being 6.6 times greater than those in the least in 2005, rising to 7.8 times greater in 2008, before dropping to 6.3 times greater in 2009.

In West Dunbartonshire a similar picture arises over the same 5 year period, as local figures have fluctuated from 32 in 2005 to 28 in 2006. There was a slight increase in 2007 to 29 and a further rise in 2008 to 32. A reduction of almost 50% in 2009 to 17 alcohol related deaths and a doubling of that total to 37 alcohol related deaths recorded in West Dunbartonshire during 2010 indicated against there being a clear year-on-year local pattern (Chart 5). It is fair to say though that the male/female split in terms of alcohol related deaths confirms that the majority of those deaths are of older males.

Chart 5: Number of alcohol related deaths



West Dunbartonshire has the 3rd highest recorded level of alcohol related deaths in Scotland (based upon 5 year average). Taken as an average the number of alcohol related deaths in West Dunbartonshire showed a downward trend from an average of 42.8 for the period the 2003 – 2007 to an average of 39 for the period 2005 – 2009.

Chart 6: Alcohol related death rate – 5 year averages per 100,000 population

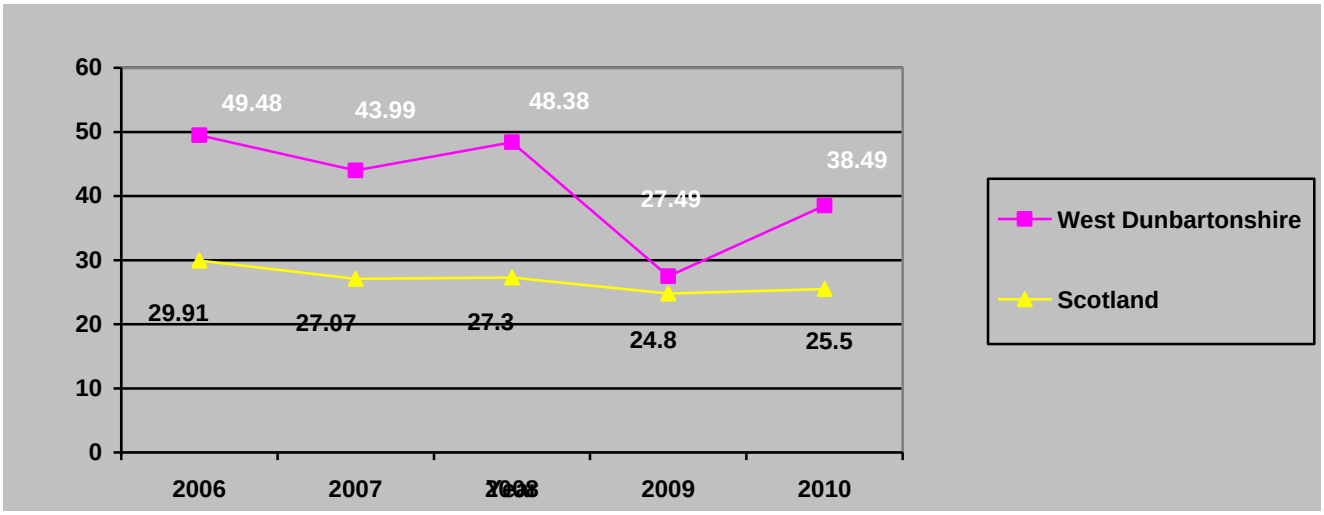


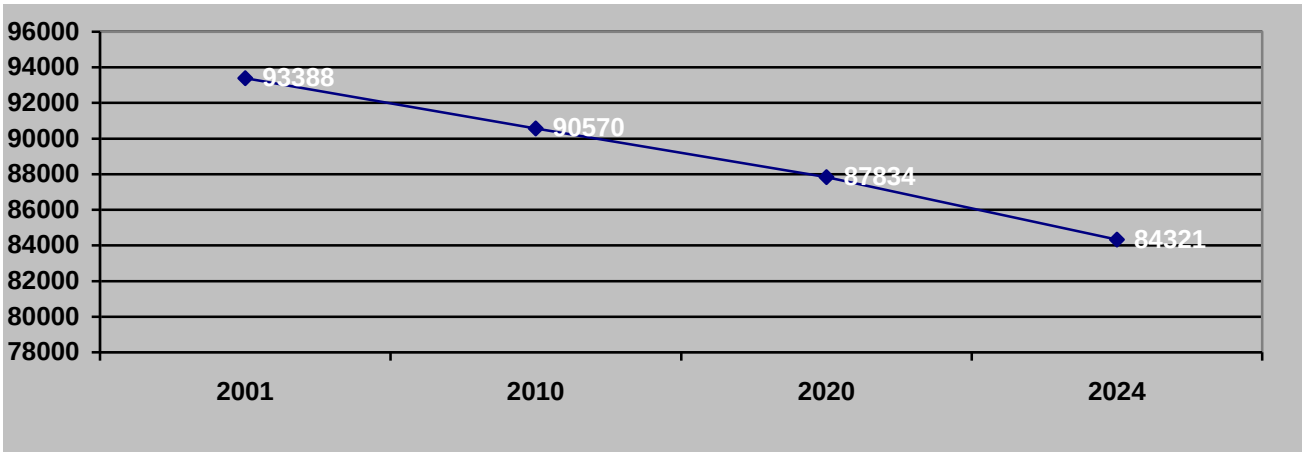
Chart 6 above indicates the rate of alcohol related deaths per 100,000 head of population. As with Chart 5, the rate for West Dunbartonshire is far greater than that recorded for Scotland as a whole. Again, similar to the rate for drug related deaths, the rate per 100,000 population has been greater in West Dunbartonshire than the rate for Scotland over the same 5 year period. Although there has been a reduction in numbers of alcohol and drug related deaths in general terms, there are approximately 1.7 alcohol related deaths to every drug related death. This is a decrease from the 2009 figures, which indicated that there were 3 alcohol related deaths to every drug related death. It is worth noting that the West Dunbartonshire Drug Related Death Group reviewed the medical records of individuals certified as drug related deaths. Whilst the majority of these had a history of chronic alcohol misuse this was not recorded as either the primary or secondary cause of death.

4. PROJECTED PROFILE OF FUTURE NEED

4.1 Population Size and Profile

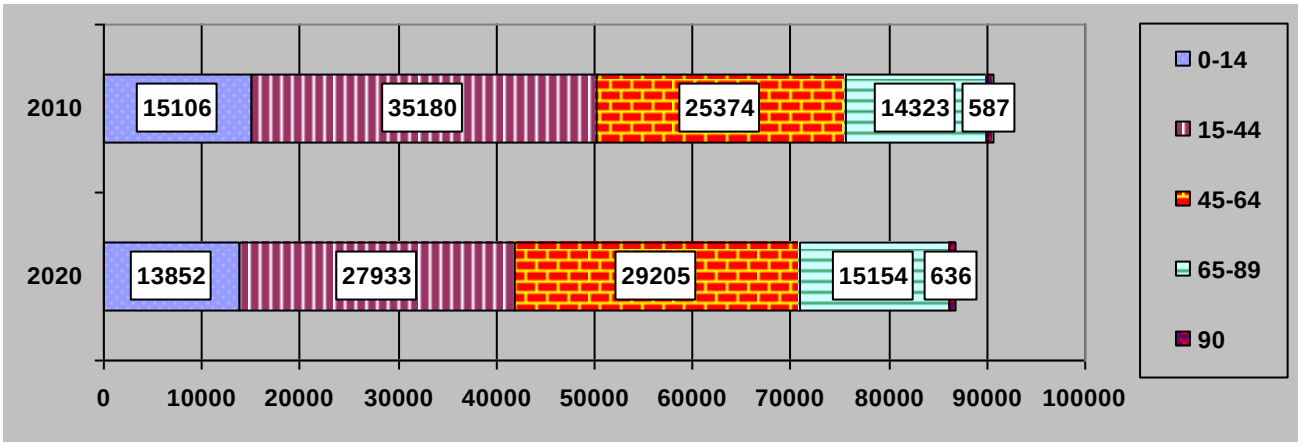
Analysis of the data taken from the General Registrar Office for Scotland and projecting likely trends in the population of West Dunbartonshire indicates a continued reduction in population size of approximately 3.2% over the next 10 years. Assuming this trend continues the population will continue to decrease at a rate of 3.2% over 10 years with a projected population of 87,834 in 2020 (Chart 7).

Chart 7: West Dunbartonshire – actual and projected population number



National and local evidence indicates that the population of West Dunbartonshire is ageing (Chart 8) due to a combination of factors: that the number of births within the area are dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling. This mirrors the situation for Scotland as a whole.

Chart 8: West Dunbartonshire - population (number) by age group at 2010 and projected for 2020



Whilst the population projections indicate a down ward trend in the total population, and that the trend is of an older rather than young population, additional information using 5 yearly projections from the General Registrars Office for Scotland demonstrate that there will be more females than males. Specifically the number of males in the 0 – 15 age range is higher than the number of females. However, as we progress through each of the age ranges that is reversed with the number of females being greater than males in each of the remaining 5 age ranged identified within Charts 9 and 10.

Chart 9: West Dunbartonshire - projected population by gender and age (2018)

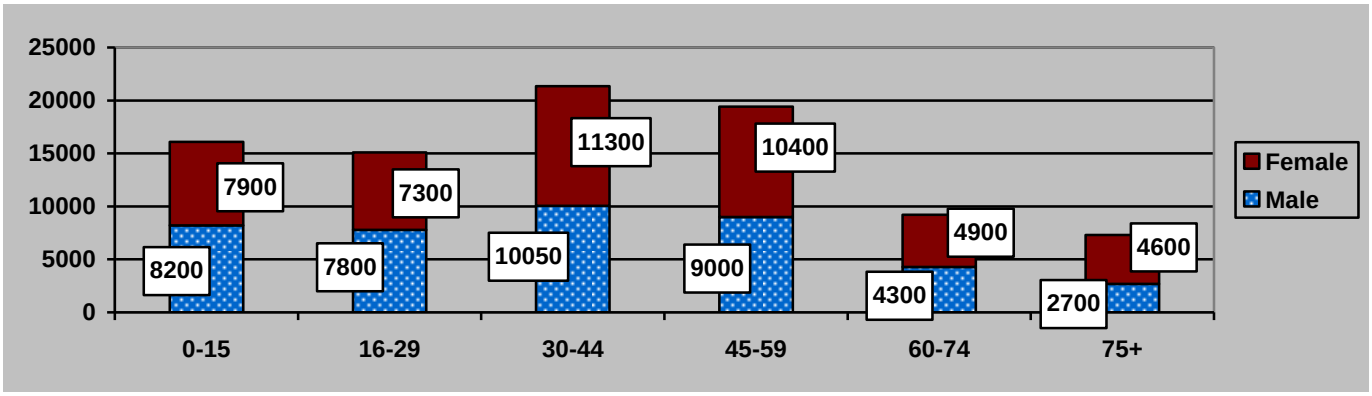
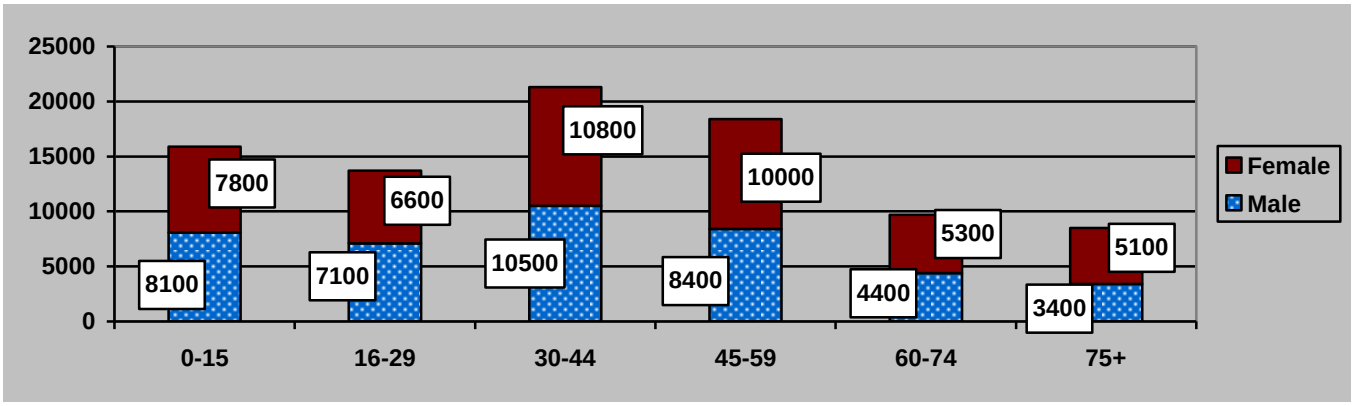


Chart 10: West Dunbartonshire - projected population (number) by gender and age (2023)



5. PROVISION AND DEMAND

5.1 Alcohol and Drug Service provision within West Dunbartonshire has been historically and predominantly shaped around harm reduction.

CHCP Alcohol and Drug Services provide integrated health and social care services for individuals living with problems linked to drug/and or alcohol misuse. In delivering those services, staff consider the physical, medical and social needs of individuals. This, along with the use of Integrated Care Planning of services, reflects the aim of ensuring that our local services and indeed the care plans of individuals are focussed on their specific needs. Within the Community Health and Care Partnership (CHCP) there are two Community Addiction Teams (CATs): the Clydebank CAT and the Leven CAT. Both of these well-regarded teams are composed of health and social care staff working together.

Alcohol and drug services are also provided by other parts of the NHS system locally (e.g. general practice and community pharmacy); supported by other CHCP services (e.g. CHCP Health Improvement Team); and through funding arrangements/service level agreements with local voluntary sector providers.

There is a demonstrably strong track record for delivery within local alcohol and drug services (e.g. in relation to waiting times and delivery of alcohol brief interventions), positive user engagement and established partnership working (most evidently within the local Alcohol and Drug Partnership).

5.2 Service demand has grown by approximately 11% since 2006, in part as a consequence of additional resources and increased capacity in service provision. That increase in demand for services is starting to slow down, with local interrogation of data suggesting that a plateau has been reached. However local analysis also indicates that that there is a large cohort - probably more than 2,500 - who does not seek help (i.e. who have needs but do not express demands) alongside a significant fall-out from service interventions.

5.3 It has been problematic to precisely quantify the number of referrals who take up services across public and voluntary sectors. Whilst work is on-going to improve the accuracy of data collection systems, the local estimate of 2,409 people not seeking services is most probably a conservative one (taking into account that a significant percentage of referrals will not follow through). Given the changing context, challenges and financial realities previously highlighted, the only way such unmet need can be addressed will be through the re-modelling of services (both those directly managed and those delivered via a service level agreement/contract by other organisations) as set out within this commissioning strategy and re-apportioning of available resources accordingly.

5.4 Work is also on-going to review the provision of residential rehabilitation. This is because:

- It is, on the whole, a costly service, which is only available to a minority of individuals recovering from drug or alcohol addiction.
- Changes in resource allocation across NHS Greater Glasgow and Clyde has meant that current access to residential rehabilitation is being reduced.
- More effective use of local resources and the provision of a more needs led service will be achieved by delivery of local community rehabilitation services.

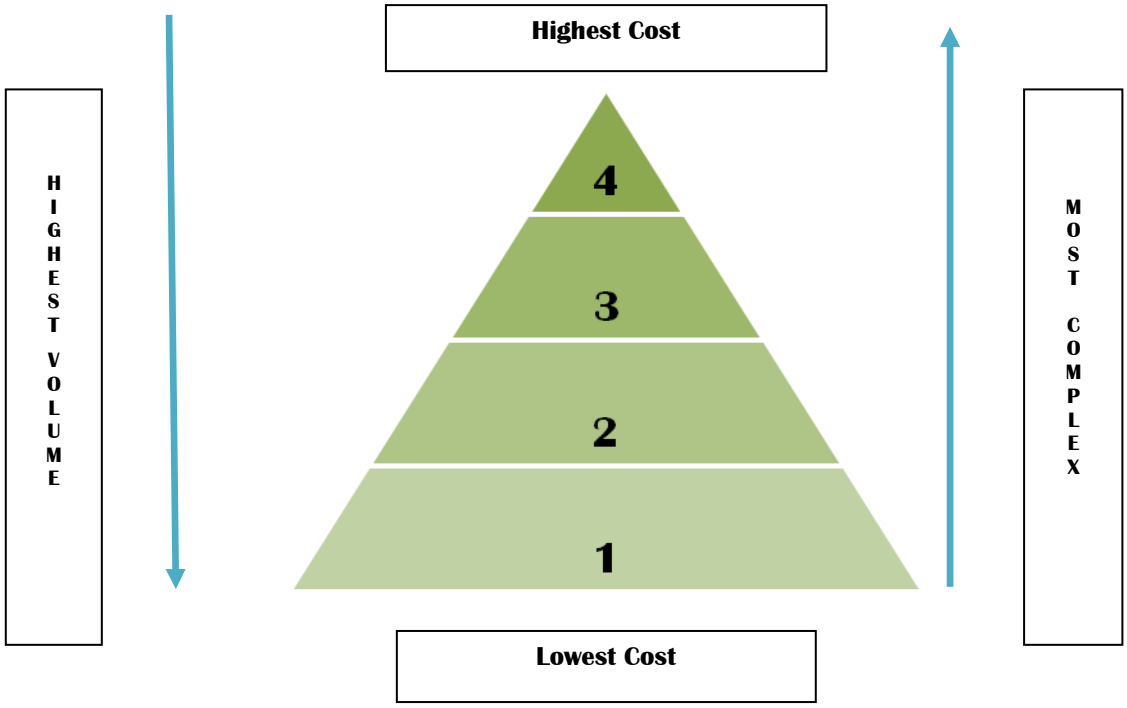
5.4 Based on prevalence data, service usage and service fallout, it is likely that the current level of demand for services is likely to continue over the next 3 – 5 years. What is anticipated to change is the nature of the needs within the population, the types of demands that are expressed, the expectations concerning how best to meet them and the reduced finances available to resource them. Fortunately all of the above provide a strong foundation for the developments necessary going forward to ensure that the CHCP continues to lead and operate a service model that is fit-for-purpose and contributes positively to the wider agenda of the Community Planning ADP.

6. MODEL OF SERVICE PROVISION – NOW & NEXT

6.1 Service-Oriented Model of Provision – 2010

The operating systems in West Dunbartonshire are based on the pathway for the individual, who may directly access any one of the first three tiers. This service-oriented tiered model of provision is illustrated in Diagram 2 below.

Diagram 2: Service-Oriented Tiered Model of Provision



6.1.1 Tier 1 services are:

- General information provision about drugs, drug use, associated harms, treatment options and related matters.
- Identification and referrals to other services.
- Prevention and education activities.
- Alcohol Brief Interventions

6.1.2 Tier 2 services are:

- Group work and recovery.
- Relapse management.
- Therapeutic interventions (non-clinical).
- Harm reduction.

6.1.3 Tier 3 services are:

- Advice/Information about alcohol and drug use, associated harm, Blood Borne Viruses (BBV), treatment options and other clinical treatment related matters.
- Post residential rehab/detox support.
- Drug/alcohol testing.
- Maintenance/Stabilisation/Substitute Prescribing and Titration.

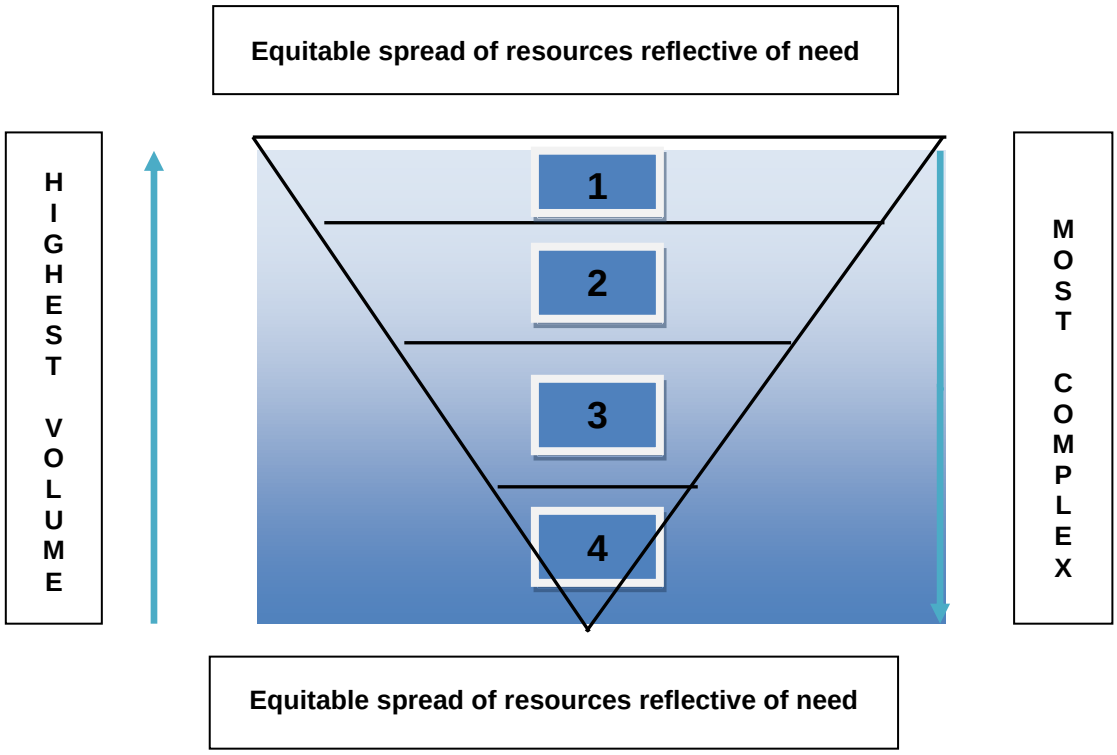
6.1.4 Tier 4 services are:

- Inpatient/residential specialist alcohol and drug detoxification and stabilisation.
- Residential Rehabilitation.

6.2 Person Centred Model of Provision – The Future

Increasingly, alcohol and drug services are driven to develop and provide interventions which ensure that the individual is explicitly central to the development, implementation and management of their own care package. This will be manifested in the implementation of a recognised tiered person-centred approach to service provision and which represents a paradigm shift in the way local services will increasingly be delivered (Diagram 3).

Diagram 3: Tiered Person-Centred Model of Provision



6.2.1 Tier 1 is available for the whole community.

6.2.2 Tier 2 is for people with alcohol or drug problems.

6.2.3 Tier 3 is for people with more complex needs.

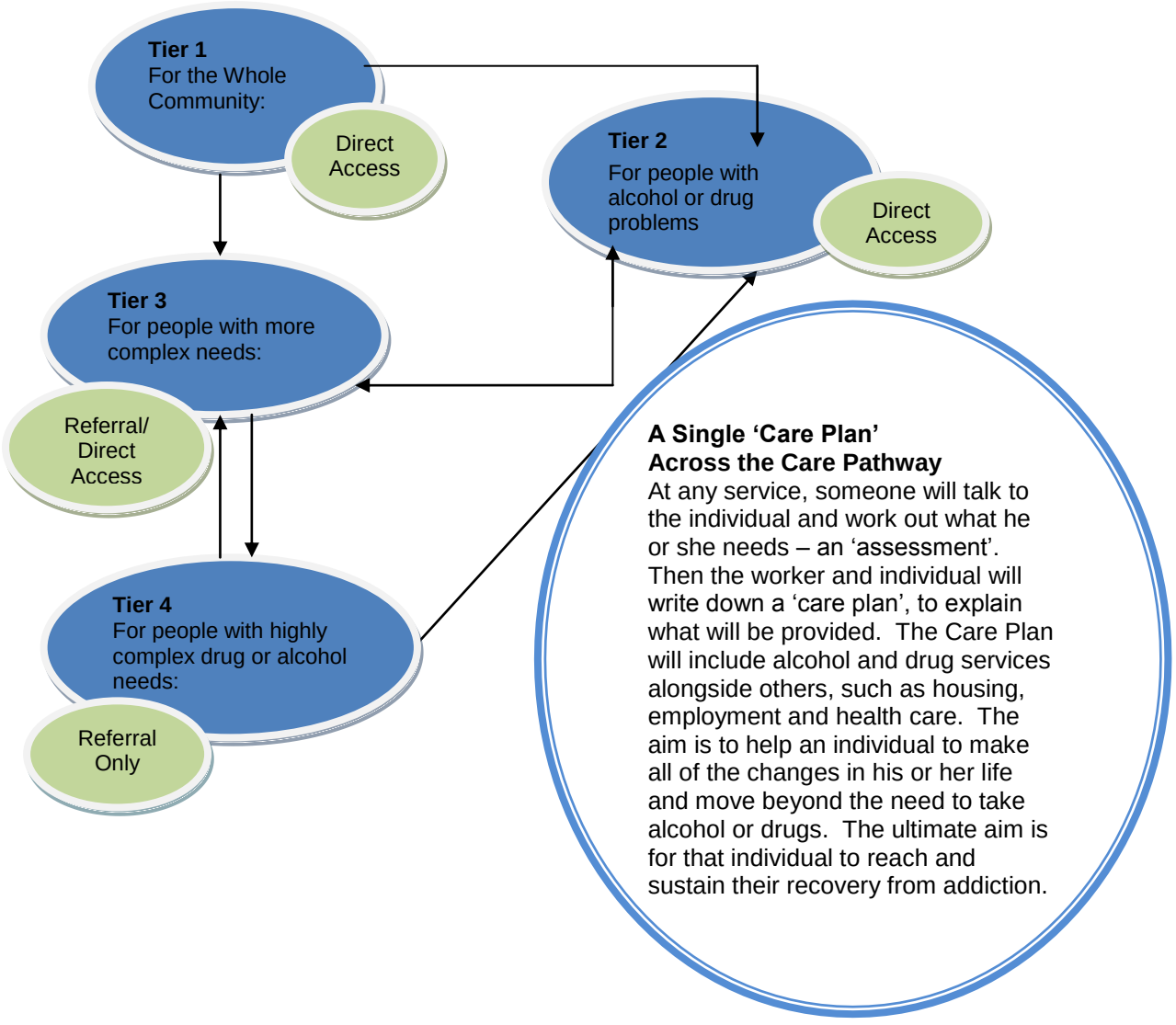
6.2.4 Tier 4 is for people with highly complex drug or alcohol needs.

6.3 Part of this approach to offering appropriate and increasingly personalised support to enable people to recover from problem drug and alcohol use is to develop an individual care plan based on a holistic assessment of their needs with agreed outcomes (goals) detailed within a recovery plan. This will be routinely carried out through the Single Shared Assessment (SSA) process and be subject to regular review to allow the support needed to be adjusted to reflect progress made towards recovery. It will cover both treatment and rehabilitation services, as well as addressing associated issues such as training or employment needs. The relevant actions in the recovery plan can then be shared with the appropriate service providers involved in that individual's care, to ensure an integrated approach to delivering the plan, as well as forming the basis for a more proactive engagement of the individual in their own recovery.

7. CARE PATHWAY

7.1 Audit Commission reports suggest that the drive to expand community services requires a well-planned "journey of care" with a package of support. This has been and is the ethos of alcohol and drug services in West Dunbartonshire. That commitment remains, albeit in an up-dated version that explicitly reflects the new model above and the principles set out earlier within this commissioning strategy (Diagram 4 below).

Diagram 4: The Person-Centred and Outcome-Focused Care Pathway



7.2 A key element of this person-centred and outcome-focused model is the provision of specialist and rehabilitation services that are locally based within a community setting. While it is acknowledged there will continue to be a need for residential care, the evidence suggests that better outcomes are achieved when individuals can access a range of care in their own communities. This will mean facilitating a change in emphasis from residential and hospital provision to community based rehabilitation, accompanied by the necessary reallocation of resources to support this shift in the balance of care to community settings.

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8. FINANCIAL FRAMEWORK

8.1 The financial framework for West Dunbartonshire CHP has been prepared on the basis of an aligned budget process that complies with and respects the integrity of the distinct financial governance and accountability arrangements of its parent organisations, i.e. West Dunbartonshire Council and NHS Greater Glasgow & Clyde. The corresponding financial framework for each and all CHCP service areas are rigorously reviewed on an annual basis, with an increasing emphasis on ensuring a clear relationship with and understanding of the service priorities that need to be met, both in-year and going forward.

8.2 The total financial framework for alcohol & drug services in the 2011 – 2012 financial year is £4,445,000.00.

8.3 All public sector services face budgetary restrictions. The rising gap between provision and potential need will be further challenged as local services manage further limitations on budgets. Increasing emphasis on efficiencies and effectiveness will become the norm, as will an increasing need to review the wider partnership demands to collaborate to reduce the impact on the individual and the community.

8.4 Local government and health boards have faced demanding budget reductions and the expectation is this will be the challenge over the next few years. Importantly any substantial dependence on such non-recurrent and time-limited funding streams poses risk in terms of sustainable service delivery, especially in the challenging financial climate that is anticipated to continue for some years ahead.

8.5 Addiction is recognised as an issue of concern across Scotland, and West Dunbartonshire services have notable successes in attracting new funding streams from the Scottish Government, including new uplifts arising for 2008-2011 (and recurring). The development of new services and/or improved access will result in higher expectations; expectations from individuals for enhanced access and broader service choice as well as expectations from central government regards performance. Operational service planning needs to recognise these expectations, particularly where these expectations are linked to performance contracts with the Government. Failure to link performance to investment in the short-term will lead to a withdrawal of funding streams.

8.6 In addition to its directly managed services, the CHCP has also funded activity and service provision from third sector organisations in relation to alcohol and drugs. It is both appropriate and fair that the CHCP's external funding arrangements are robustely and routinely tested to ensure best value against the resources available and the model of provision identified. In doing this, it is important to appreciate that local voluntary sector partners have often faced challenges of managing a range of short-term funding streams and appropriate weight should be attached to continuity of defined service provision for individuals. It is also important to understand that while matched funding arrangements between third sector organisations with the local authority and/or NHS has to-date enabled successful levering in of further external resources, the changed financial climate will likely diminish the scope for such arrangements and the capacity it supported going forward (not least because of the increased pressures on and reduced availability of such external funding).

8.7 Reviews of all service provision, in house and externally purchased in line with best value competitiveness principles is required corporately and departmentally. This may result in a shift in both service provision and the associated financial framework. This new service design or reconfiguration will be carried out in accordance with the Procurement Guiding Principles set out in Appendix II and will be detailed as part of the procurement planning within the service's Operational Plan.

8.8 The Scottish Government has initiated some scoping on the Integrated Resource Framework (IRF): this is specifically to improve the quality of financial frameworks across Local Authorities and NHS organisations, including Primary Care and Acute Services. This work will require to be undertaken by the CHCP as part of the improving and developing financial framework for the service.

9. DELIVERING OUR AMBITION – NEXT STEPS

9.1 Addiction remains a significant and growing issue within West Dunbartonshire, posing difficulties for individuals with a drink or drug problem, for family members affected by someone's problem and for the wider community. Alcohol and drug problems are themselves mirrors of social deprivation, and collaboration across the Community Planning ADP is pivotal to future well-being within the area.

9.2 Robust commissioning of community-based alcohol and drug services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy will drive the substance of relevant operational service plans on an annual basis, within the wider context of the Community Planning Partnership's multi-agency Alcohol and Drug Strategy 2011-2012 (that the CHCP has lead responsibility for) and the CHCP's wider set of development priorities as set within its annual CHCP Strategic Plan.

9.3 The following provides a synopsis of the key issues for continued prioritisation in the short-term as per the vision and values set out at the start of this commissioning strategy.

9.3.1 Quality Service Provision

National Quality Standards call for all areas across Scotland to offer a range of service routes, and for the quality of services to reflect a minimum standard. Service inspections and supported self-assessments for and by SCSWIS aim to ensure that quality standards and personalised services achieving good service user outcomes are maintained.

Local deliberations within the Alcohol and Drug Strategy process continue to identify ways of improving both choice and service quality. Using the Public Service Improvement Framework (PSIF) there will be an expectation on services, internal and externally purchased to set fresh, aspirational goals which continually drive further improvements. Regular, internal audits of the Single Shared Assessment (SSA) process and documentation will continue to provide an overview of service delivery and support a shared approach to Care Planning and Review.

Whilst CHCP services have a good track record in achieving national targets, there is no room for complacency. There is wide ownership of targets and a commitment to sustain achievements. A new national framework for collating waiting times data, and a new target (HEAT A11: 90% accessing treatment within 21 days of referral) will continue to test the CHCP.

9.3.2 Personalisation

The CHCP works with people using our services to offer more flexibility, choice and control over their support so that they can live at home more independently. It is important that our local services create arrangements which will facilitate more choice and control over service provision and promote the opportunities for co-production with service users. This will include ensuring built in flexibility by the introduction of framework agreements that enable individuals to access these services via Self-Directed Support (SDS) options.

In line with the National Standard Eligibility Criteria and Waiting Times for the Personal and Nursing Care for Older People framework, West Dunbartonshire is amending relevant policies, procedures and assessment documentation. The existing criterion used in West Dunbartonshire CHCP is compatible with the current Scottish Government Guidance of Critical, Substantial, Moderate, Low or No risk. Work is progressing to update current recording systems to be able to report in line with the Guidance. The updated Guidance from the Scottish Government suggests that eligibility for services is recorded at the end of the assessment. The recording of Eligibility Criteria is a mandatory field on all Single Shared Assessments (SSA) and Specialist Assessment templates across client groups and service areas. West Dunbartonshire will be applying the criteria to all Community Care Client groups and services and will be able to report on this in the near future following the updated Scottish Government Guidance.

Work on the development of local qualitative service user outcomes is progressing. Adopting such a framework will assist in the assessment of the impact of services on the people who use them. This will

enable monitoring and reporting of outcomes which our services are supporting individuals to achieve and will be consistent with the client centred personalised approach within our new service model. A clearer and improved focus for service delivery and the resulting improved outcomes for individuals will be evident. Developing the service user satisfaction survey (undertaken annually since 2006/07) will be an important element of this.

9.3.3 Recovery

While it is acknowledged there will continue to be a need for residential rehabilitation, the CHCP is committed to developing and enabling greater access to rehabilitation within community settings. As already described, this will mean facilitating a change in emphasis from residential and hospital provision to community based rehabilitation, accompanied by the necessary reallocation of resources to support this shift in the balance of care to community settings.

Recovery Capital refers to the capacity of communities both directly and indirectly to support recovery. Monitoring and analysis of how the wider community, and groups within the whole population, lead the recovery agenda will be important in guiding specialist services. Involvement of service users in planning and developing addiction services is part of the Scottish Government's national plans for alcohol and drug services. The drive is reflected in its published *National Quality Standards for Substance Misuse Services* (2006). The capacity to undertake regular consultations and surveys has been limited to an annual audit of single shared assessments and the annual service user satisfaction surveys. The need to gather and monitor local data, linked to need, has been highlighted as a proposed action within the Community Planning Alcohol and Drug Strategy. The West Dunbartonshire Community Planning ADP is committed to ensuring that the services provided locally are needs led; and that the people who are accessing those services are actively encouraged to participate in the planning and delivery of those services. Through a combination of CHCP and broader Community Planning engagement and consultation activities a strategic approach to the development of recovery capital will be established. This provides a sound platform for developing this important agenda, particularly across equality groups and in a manner that is appropriately representative of the wider community (and not just special interest groups).

9.3.4 Early Intervention and Prevention

The Scottish Government encourages local areas to develop a whole population approach to the prevention of alcohol or drug misuse problems. Prevention related activity and outcomes are more difficult to quantify than the delivery of services (outputs) and demonstrating the benefits of our activity will be a challenge. Traditionally focussed on the younger population, prevention now needs to develop a targeted approach to all population groups. With the apparent gap in numbers of individuals living with alcohol or drug misuse problems and those actually seeking support and services, the projected reduction in population size and the increase in the population aged 64+, it is essential that the development of a whole population approach to prevention related activity needs to be supported.

Work is on-going to review the current prevention and education delivery, resources, and range of work undertaken in West Dunbartonshire. This work aims to provide a financial figure for the current spend in prevention and education and identify areas where realignment of investment in prevention and education may pay dividends to the wider public purse. Current examples of prevention related activity include delivery of Alcohol Brief Interventions and a move from awareness raising activity to the provision of diversionary related activities aimed at changing behaviours. In recognising that the current gap between need and access to support should be reduced there is a strong argument that the current level of resource allocation linked to the delivery of Alcohol Brief Interventions (ABI) in particular is at least maintained (e.g. within general practice); and that the potential for extending ABI training and thus provision to other key staff groups is explored. West Dunbartonshire has to-date a good track-record in exceeding its contribution to the national target: thus the intention is that the number of ABIs delivered locally should be increased in order that the gap between the numbers living with alcohol problems and those accessing supports may be reduced.

9.3.5 Best Value

The financial challenges facing the public sector are well documented the scale of the reduction in finances brings immediate challenges for the CHCP to manage expenditure more efficiently and effectively but also to ensure long term sustainable services. Whilst there is scope to make further efficiency savings the funding gap currently faced is unlikely to be bridged by efficiency savings alone. The need to reduce costs provides the CHCP with an opportunity to reconfigure and streamline service delivery. However, in doing so we must focus on two things, long-term financial sustainability for services and the achievement of good outcomes for service users. This requires a clear understanding of service costs including how different activity levels affect costs, and a clear methodology for setting service specifications and budgets based on priorities and the outcomes to be achieved for the people who use those services. In keeping with the IPC's cyclical commissioning process, this necessary work stream (including the application of the Procurement Principles appended here) will be taken forward as an explicit element of annual operational service plans for the CHCP's Addiction Services.

9.3.6 Population Needs

The Equality Act 2010 imposes a general equality duty designed to integrate consideration of the advancement of equality into the day-to-day business of public authorities. Therefore the CHCP, in the exercise of its functions (e.g. as an employer, service planner and provider) must have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
2. Advance equality of opportunity between people who share a characteristic and those who don't.
3. Foster good relations between people who share a characteristic and those who don't.

All CHCP strategies, plans, performance reports and procurement activity are scrutinised to ensure that the requirements and duties laid out within Equalities legislation are being met.

Access to alcohol and drug services by certain groups remains low. Historically, women are less likely than men to access addiction services, particularly women with parenting roles. Through local reviews, however, it has become evident that there are increasing numbers of women accessing some local services i.e. the Out of Hours Telephone Support Service which, through its confidential nature, allows a degree of anonymity. Similarly the delivery of equitable access to services has enabled an increase in the number of women accessing treatment services. This increase requires the provision of more holistic support to families to reduce the likelihood of referrals to social work and to promote early intervention to assessment of need. Steps have been taken to increase the level of care planning activity for vulnerable groups; in particular women with co-morbid profiles, yet access levels have not shifted significantly.

A review of service access by older people (50 +) also suggests an area of service need which has not had specific attention previously. *"Alcohol and Ageing: Is Alcohol a Major Threat to the Baby Boomers*", a Health Scotland commissioned report states that if the baby boomers (born between 1945 – 1965) carry their current drinking patterns into old age they are likely to experience higher than anticipated levels of morbidity. Analysis of drug and alcohol related deaths, and the changing population demographics suggest that focussed interventions for older people are required. Within that cohort it is suggested, that particular attention should be paid to the alcohol and drug related support needs of older men, in particular. Targeting delivery of ABI on this particular population group may therefore be a way of ensuring that older males are able to access appropriate supports and services at a point before their alcohol misuse becomes problematic or chronic.

With constraints on budgets it is apparent that different approaches to service delivery are required to reflect the needs of different types of people and ensure equitable access to supports and services to other population groups i.e. women and older people.

9.3.7 Information Management

The commissioning task starts with improvements to data collection and analysis. Current performance management systems are provided across a number of service areas and due to the complexity of information recording and gathering it is difficult to ascertain the definitive number of people using the services compared to the number of referrals currently recorded. The ability to adequately utilise the data contained within both the Commissioning and Alcohol and Drug Strategies, and convert it to viable options to achieve an effective challenge to the rise in substance misuse and associated problems will require staff commitment and time, an additional resource burden which will need to be addressed. Whilst some national data will be used appropriately there are many data fields that are collected at levels far greater than that covered by the West Dunbartonshire CHCP and will not provide local data. Going forward there is a pressing need to refine data collection systems that provide clear, unambiguous, local data that informs commissioning the cyclical commissioning process that this document is a key part of.

Realising the potential of outcome based commissioning as described requires improving information recording and sharing between and within the NHS and the local authority and across CHCP services (including the systematic application of Single Shared Assessment and recording of the Care First information system).

9.3.8 Strengthening Links with Other Service Areas

- Out of Hours Support Services

Established as a direct result of an identified need; the HEAR Out of Hours Telephone Support Service has, through the use of internal audit, grown and developed in a way that is led by the needs of those who access local services. Whilst continued funding and extension of operating hours remains a local priority, use of the service will be reviewed and modifications implemented as required. Opportunities to link with other local authority areas to maximise efficiency need consideration. The longer term view is that this and other out of hours supports will grow to the point where support is available on a 24/7 basis.

- Blood Borne Viruses (BBV) and Sexual Health

The transmission of BBV, particularly between injecting drug users, continues to present a number of challenges to services, including reaching those at risk but not engaging with services and providing treatment, support and advice to those already living with a BBV. Services such as the needle exchange service, attempt to address issues of reaching those furthest from services, as does the new Hepatitis C treatment service available within Dumbarton Joint Hospital. Further developing the range of services and embedding new practice across West Dunbartonshire will require partnership support and resources. The promotion of good health remains a core component of services which focus on individuals holistically. This includes the promotion of positive sexual health and the need for individuals to take responsibility for their own health.

- Child Protection

The welfare of children affected by parental substance misuse is a paramount concern. Local protocols and training have supported developments, but the volume of work is concerning, with a working estimate of over 2,000 young people directly affected by parental drug misuse and a further 3,000 affected by parental alcohol misuse (as reflected by national estimates within Audit Scotland Report, March 2009 - *Drug and Alcohol Services in Scotland*). On-going training, as well as discussion with and guidance from the Child Protection Committee (CPC) will continue to be important.

- Domestic Violence

Following the introduction of the Domestic Abuse Pathfinder Project in Clydebank, there has been an increase in the number of women being referred to the Police with complex needs, including alcohol and drug addiction issues. Future services need to develop to respond to the needs of these women and their families, supporting them on their journey to recovery, and supporting the continued identification and pathway support in the absence of the Pathfinder Project. Services will need to

continue to monitor access by women and note patterns of need. Cross referencing of information and actions contained within the Integrated Children's Services Plan and its associated Commissioning Strategy will ensure an accurate picture of those patterns of need is obtained and used to shape future service provision.

- Adult Support & Protection

The CHCP and its partners are committed to the support and protection of adults at risk of harm, who by virtue of disability or illness, are more vulnerable to being harmed. The West Dunbartonshire Adult Protection Committee brings together Council, Health, Police and Third Sector members to provide cooperation, guidance and oversight of policies and services that support and protect adults at risk. There is an extensive programme of knowledge and skills based training that equips staff in the public and independent sectors to intervene, support and protect adults at risk and this priority will continue.

- Mental Health

A high level of mental ill health is experienced by addiction clients. Whilst a local protocol is in place joint training and maintenance of care pathways remain key tools to improve services for individuals with the most complex needs.

The CHCP is committed to the prevention of suicide and self harm. The Choose Life initiative in West Dunbartonshire is lead by the CHCP Health Improvement Team. Cornerstones of prevention activity include, co-ordination of work across organisations, project development (for example, the Seasons for Growth Programme in schools), public awareness campaigns, and suicide prevention and self harm awareness training to public sector and third sector staff and community interest groups.

- Homelessness

A high percentage of people with alcohol and drug problems experience homelessness. Local protocols between alcohol and drug services and homelessness are in place. The CHCP recognises that there were many barriers experienced by clients leaving prison and moving into homeless accommodation. Whilst in prison, and with support from the Prison Through-care Service and a local voluntary sector drug service, the clients drug intake is reduced. However, once they moved from prison to homeless accommodation those same clients became significantly at risk of overdose.

Discussions between West Dunbartonshire Council Homeless Services and the CHCP's Addiction Service have led to a proposal for the future provision of supported accommodation for up to 40 individuals (in a year) who are considered as statutory homeless and who wish to attain abstinent recovery from drug addiction. In addition it is the proposed to establish four homeless satellite flats, with some housing support, which will allow individuals to move from fully supported accommodation to a more independent means of living. This core and cluster development will be supported by and independent sector provider following an appropriate procurement exercise

- Criminal Justice

A local steering group has been established to look at issues of Prison Through-care, Drug Treatment and Testing Orders, Turnaround Services, Arrest Referral and all other criminal justice links with addictions. With changes in sentencing policies, in particular the roll out of Community Payback Orders (CPO), a shared pathway is essential to support the needs of this particular client group. The financial impact addiction has on the public purse, through crime, disorder and the public response to crime and disorder indicates a need to prioritise this area for continued collaboration.

- Welfare Rights and Money Advice (WRMA)

Partnership discussions with WRMA are being pursued with changes to the UK benefits system, good collaboration will be vital. Income maximisation remains central to ensuring better "recovery capital" for those experiencing drug or alcohol problems.

Appendix I

COMMISSIONING: DEFINING THE STAGES OF THE PROCESS

Analyse

- Identify the impact that you wish to have in relation to your strategic objective. This will take account of the mission and key policy drivers within your organisation and will mean focussing resources on the achievement of results for people w ho use our services. This "Outcome based' commissioning" is a strategic process of specifying, securing and monitoring outcomes to meet peoples' needs at a strategic level.

- Develop an understanding of the needs of service users and link this back to the outcomes desired for service delivery. This will involve consultation with service users and organisations that advocate on their behalf. You will be seeking to understand 'how' you will know that the outcomes and impact you are looking for have been achieved.

Plan

- Resources or a budget for the service should be agreed based on the outcomes sought and the assessed need. Initial targets will become clearer once the budget is agreed. The process is reiterative and may require that you take a step back if it is clear that your budget will not allow you to achieve the desired outcomes.

- The best service available within resources should be designed based on the outcomes sought and the assessed need. Effective outcome based commissioning minimises the attention on inputs and the micromanagement of services and focuses on the achievements made by service users at the end of any programme.

Do

- Options appraisal helps decide how the service should be delivered. Purchasing the service through a competitive process – procurement – is often the best option in terms of securing Best Value. At this point you will engage more fully with procurement professionals to follow established processes that will take account of Best Value, EU legislation and the strategic aims of the procurement strategy.

Review

- Once your service delivery organisation is in place you will have to monitor and evaluate the service delivery, involving key stakeholders (particularly service users) as appropriate. Monitoring and evaluation should be proportionate to the contract value and contract length to ensure value for money. Information gathered from the monitoring/evaluation process should help you redesign the service and make decisions regarding any future contracting processes.

PROCUREMENT GUIDING PRINCIPLES

The following guiding principles for the procurement of care and support services reflect the complexity of procuring care and support services and the complexity and the challenges associated with upholding values, delivering high standards and responding to individuals needs whilst complying with procurement rules and securing best value. Taken together, the principles govern all procurement activity and will be used as a framework for evaluating local practice.

1. **Outcomes** – achieve positive outcomes for service users and carers through the delivery of good quality, flexible and responsive services which meet individuals' needs and respect their rights.

2. **Strategic commissioning** – place the procurement of services within the wider context of strategic commissioning, reflecting strategic and service reviews.

3. **Personalisation** – secure personalised services which provide independence, choice and control for service users.

4. **Involvement** – involve service users and carers as active partners in defining their needs and the outcomes they require and in the design of their services.

5. **National Care Standards** – ensure services meet the National Care Standards and adhere to the principles underpinning the Standards (dignity, privacy, choice, safety, realising potential and equality and diversity).

6. **Codes of Practice (Scottish Social Services Council)** – ensure staff involved in procuring services promote the interests and independence of service users and carers, protect their rights and safety and gain their trust and confidence; ensure employers provide training and development opportunities which enable staff involved in procuring services to strengthen and develop their skills and knowledge.

7. **Best value**– secure best value by balancing quality and cost and having regard to efficiency, effectiveness, economy, equal opportunities and sustainable developments.

8. **Benefit and risk** – base strategic decisions concerning the procurement of services on benefit and risk analysis of the potential effects on: the safety and well-being of service users and carers; the quality and cost of services; and partnership working with service providers and workforce issues.

9. **Procurement rule** – ensure procurement exercises comply with the principles deriving from the Treaty on the Functioning of the European Union (equal treatments, non-discrimination and transparency), the requirements of the Public Contracts (Scotland) Regulations 2006, statutory guidance issued under section 52 of the Local Government in Scotland Act 2003 and Scottish public procurement policy.

10. **Leadership** – ensure senior managers give a high priority to the procurement of care and support services, setting clear strategic goals managing.

11. **Workforce** –ensure the procurement of services takes account of the importance of skilled and competent workforce in delivering positive outcomes for service users.

12. **Partnership** – promote collaboration between public bodies and partnership working across the public, private and voluntary sectors to make the best use of the mixed economy of care and bring about cultural change in all sectors.