Scottish Alcohol and Drug Partnerships (ADP) 2021/22 Annual Returns: Summary Report

November 2022

Scottish Government
Riaghaltas na h-Alba

Executive summary

- **Responses were received from 29 of the 30 ADPs in Scotland[1].**
- **All ADPs reported that drug-related death review boards were held in 2021/22.**
- **A majority of ADPs (69%) reported having established early warning systems for drugs.**
- **The vast majority of ADPs (97%) reported offering specific volunteering and employment opportunities for people with lived and living experience.**
- **All ADPs reported involvement of people with lived experience and family members affected by substance use within their services.** ADPs tended to prioritise the involvement of people with lived experience with family members being involved to a lesser extent.
- **The majority of ADPs (93%) reported having arrangements in place to involve people with lived experience in different areas of delivery.** All ADPs reported taking steps to respond to the feedback received from people with lived and living experience and family members affected by substance use. However, some ADPs outlined a number of challenges associated with including people with lived and living experience.
- **All ADPs reported having provided information on local treatment and support services to the general public.** However, fewer than half of ADPs reported communicating this information in accessible formats.
- **All ADPs reported carrying out some form of education and prevention campaign or activity.** The most common type of campaign overall related to overdose awareness.
- **ADPs reported carrying out a number of activities with regards to education and prevention.** The majority of ADPs reported carrying out naloxone promotion activities (90%), peer-led interventions (79%), stigma reduction (69%) and providing teaching materials (69%). These activities were most commonly delivered via third sector or community partners (83%).
- **Naloxone was reported as being available to the public across a range of settings.** All ADPs reported that NHS drug services supplied naloxone. It was also reported as being most commonly offered through third sector drug services (93%) and mobile or outreach services (86%).

[1] Due to resourcing difficulties, Orkney ADP was unable to provide a response and will publish their annual return on their local webpage.

- **ADPs reported a range of available pathways and protocols to address the treatment needs of people with problem substance use at various stages of their involvement with the criminal justice system.**

- **Of the 13 ADPs that reported having a prison in their area, the majority (85%) reported that people in prison had access to non-fatal overdose pathways upon release.** Of the 13 ADPs with a prison in their area, the majority (85%) reported having arrangements in place with community justice partners to ensure people in prison identified as at risk are issued naloxone upon on release.

- **Every ADP reported development of recovery communities in their area.**

- **The majority of the ADPs (83%) reported that they had specific treatment and support services for children and young people.** These were most often aimed at children and young people aged between 16 and 25 across a range of settings. Over half of ADPs (57%) reported that their services for children and young people with substance use improved in 2021/22.

- **The vast majority of ADPs (92%) reported that mental health support was routinely available for people who use drugs or alcohol but do not have diagnosed co-occurring mental health problems**. The majority of ADPs reported that they did not have protocols in place to refer people with co-occurring problem drug use and mental health problems, or did not answer the question. Of those that didn't have protocols in place, the majority reported that they were in the process of developing these.

- **All ADPs reported having at least some services where a trauma informed approach to substance use has been adopted.** Fewer than a third of ADPs (31%) said that a trauma-informed approach to substance use had been adopted across "all services".

- **The vast majority of ADPs (90%) reported having specific treatment and support services for children and young people affected by a parent or carer's substance use.**

- **Every ADP reported contributing toward the integrated children's service plan.** A majority of ADPs (57%) reported that services for children and young people affected by a parent or carer's substance use improved in 2021/22.

- **The vast majority of ADPs (96%) also reported having specific support services in place for adult family members.** ADPs offered a variety of services to adults with the aim of supporting family-inclusive practice. This involved people with family members both in and not in treatment.

- **Over half of ADPs (52%) reported that they had not completed an audit of their service provision for families within the 2020/2021 reporting period.** However, most of these ADPs reported that audit work was in progress.

Contents

1. Background

The level of harms from alcohol and drugs in Scotland are high in comparison to the rest of the UK and Europe, and cause avoidable damage to people's lives, families and communities. Tackling the high level of drug related deaths in Scotland is a priority for the Scottish Government.

On 20th January 2021, the First Minister made a statement to parliament which set out a National Mission to reduce drug deaths and improve lives through improvements to treatment, recovery and other support services.

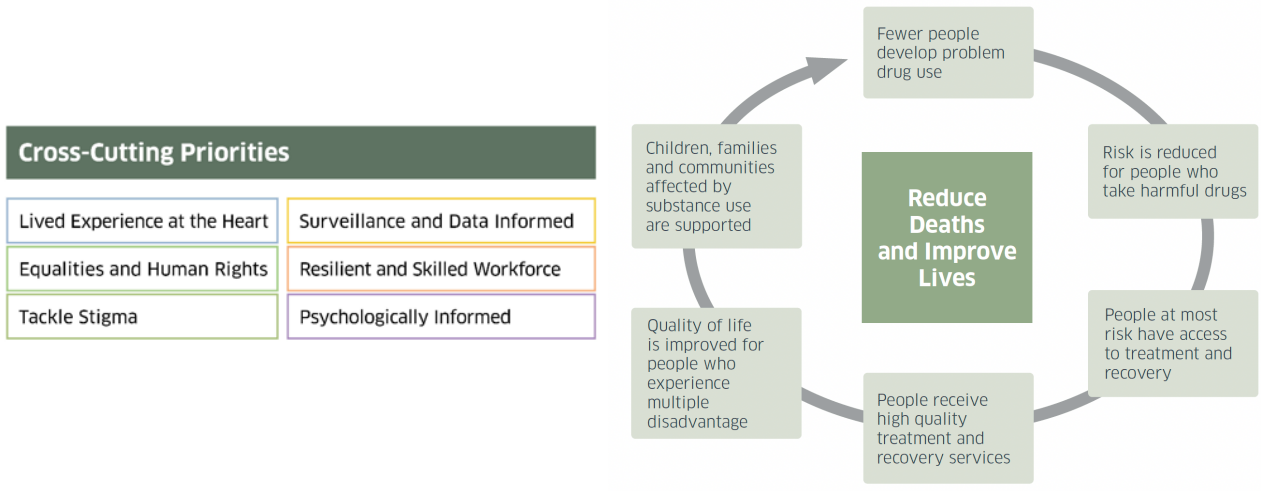
The National Mission annual report sets out the progress made from then to March 2022 by national government, local government, and partners in Health and Social Care and the third sector against the National Mission Plan. This report focuses on the progress and work of Alcohol and Drug Partnerships (ADPs) against that plan.

Scotland's 30 ADPs bring together local partners including health boards, local authorities, police and voluntary agencies to co-ordinate the response to substance use issues. They are responsible for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery, based on an assessment of local needs.

As part of the 2019 Partnership delivery framework ADPs are required to report to the Scottish Government on specific alcohol and drug funding allocations and progress made against national outcomes. This report summarises the results and findings of the 2021/22 Scottish Alcohol and Drug Partnership (ADP) Annual Report survey returns completed as part of this commitment.

The report presents the data according to the six outcomes of the National Mission Plan. It also includes data related to drug deaths, and some the six cross-cutting themes overarching the work of the National mission as summarised in Figure 1.

Figure 1: National Mission Overview



2. Aims and Methodology

A survey was sent by email to all 30 Alcohol and Drug Partnerships (ADPs) in Scotland to better understand service delivery and the local challenges faced by ADPs. ADPs are responsible for developing local strategies to deliver national outcomes and commissioning services for problem drug and alcohol use in Scotland.

The survey was designed to provide an overview of how ADPs responded to the needs of individuals in their area. Questions related to the 2021/22 financial year in order to capture progress against the Rights, Respect and Recovery strategy including the Drug Deaths Task Force emergency response paper during this timeframe. This survey was designed to reflect areas of ADP activity that are not reported on elsewhere (e.g. Medication Assisted Treatment standards), and so will not reflect the totality of ADP work. Questions were developed in consultation with policy officials and adapted from previous ADP annual reporting mechanisms.

The survey comprised of 50 questions[2], including questions on 'Education and Prevention'; 'Treatment and Recovery'; 'Getting it Right for Children, Young People and Families'; and 'a Public Health Approach to Justice'. While these questions were mainly multiple choice, the survey also included a number of open text questions in order to gather more detail on responses and gain a deeper understanding of the specific context within each ADP area. Respondents to the survey were reminded that multiple choice options available were provided for ease of completion and do not reflect expectations of what should be in place. The full survey is available in Appendix A.

ADP lead officers were asked to email back their response within 33 working days. ADPs who had not completed the survey within this time were contacted by policy officials and/or a member of the analytical team to ensure they had opportunity to be included in this research.

In submitting their return, ADPs were instructed to obtain ADP level sign off as confirmed by the ADP chair. Where this was not clear, follow-up emails were sent to individual ADPs to determine the level of sign-off received.

ADPs were encouraged to publish their own returns as part of their individual annual reporting.

Data was collected between the 21st June and 5th August 2022[3].

[2] A further 4 questions were asked on ADP activities around problem alcohol use and 3 questions on financial spend. These data are not reported on in this publication.
[3] For a number of ADPs this timeframe was extended to 28th August 2022.

3. Main findings

3.1 Demographics and response rates

Responses were received from 29 of the 30 ADPs in Scotland[4]. It is important to note that ADP areas vary considerably by size, population and demographics. A breakdown of these areas by deprivation profile is provided in Appendix B, and an urban/rural breakdown is provided in Appendix C.

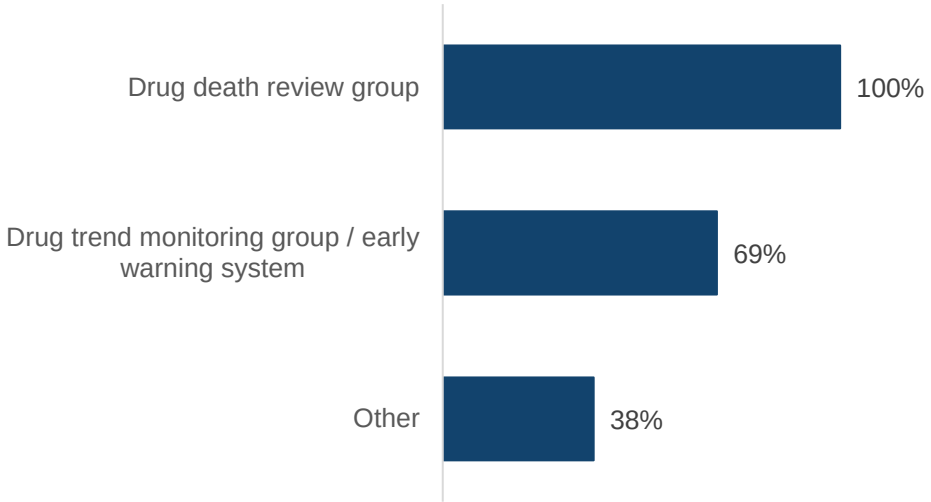
All but one ADP responses were signed off at ADP level[5]. One ADP did not respond to the follow-up email sent to clarify the level of sign off received for the submitted survey responses.

3.2 Principle outcome: Reduce drug deaths

All ADPs reported that drug-related death review boards were held in 2021/22 (Figure 2). A number of ADPs reported attending their local Health and Social Care Partnership or Chief Officer meetings to review drug-related deaths. A minority of ADPs reported taking part in both groups where appropriate. Both of these groups involved the stakeholders that had been providing care to, or were aware of, the deceased individual (e.g. service providers, general practitioners (GPs), Police Scotland, Community Justice, and Scottish Ambulance Service).

A majority of ADPs (69%) reported having established early warning systems for drugs.

Figure 2: Percentage of ADPs reporting having structures in place to inform surveillance and monitoring of substance use harms and deaths, 2021/22



[4] Due to resourcing difficulties, Orkney ADP was unable to provide a response and will publish their annual return on their local webpage. One survey response contained data relating to neighbouring ADP areas.

[5] It was stated that as part of returning the survey response, ADP level sign off should be obtained. Email confirmation of ADP level sign off was sought following each return. Moray ADP did not provide confirmation of sign off.

Fewer than half of ADPs reported having other measures in place. These varied somewhat across ADPs, but generally consisted of the establishment of multi-agency protection groups where ADPs and stakeholders – such as Police Scotland and community groups – pooled resources and intelligence to rapidly respond to community needs. Some ADPs also reported internal groups and sub-groups that had specifically been set up to review drug-related deaths.

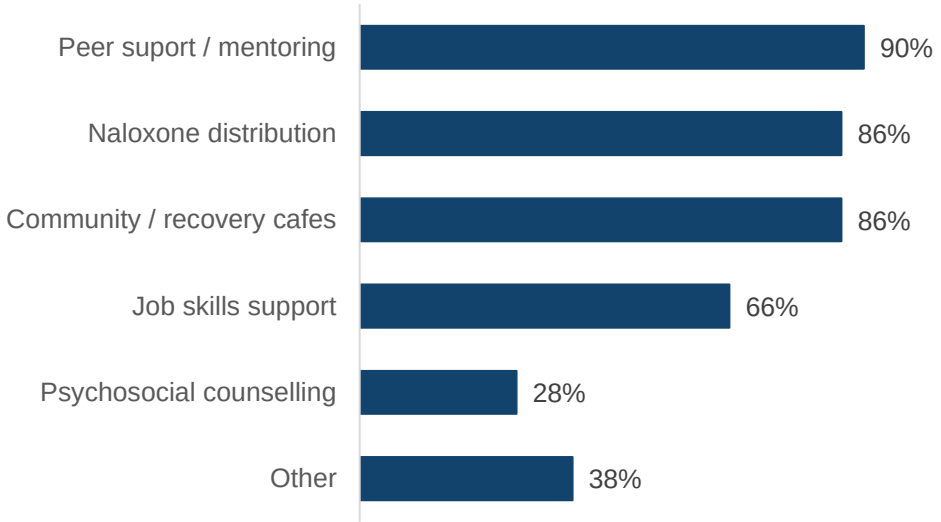
These groups and boards were used to generate a shared and informed understanding of the circumstances of an individual's death (after notification by Police Scotland or other agencies), further to which learning and good practice opportunities could be identified and shared with the relevant agencies and individuals. Where reported, meetings were often held on a quarterly or bi-monthly basis, although one ADP did report having monthly inter-agency meetings.

Some ADPs reported that they were developing or refreshing their audit processes at the time of the survey. This was typically to include lived and living experience perspectives alongside clinical reviews, to engage with all services involved in the deceased individual's care, or to invest in dedicated posts to support the drug-related deaths review process and wider drug-related death prevention agenda.

3.3 Cross cutting priorities: Lived experience

The vast majority of ADPs (97%) reported offering specific volunteering and employment opportunities for people with lived and living experience (Figure 3). Nine in ten respondents (90%) offered peer support/mentoring, and there was also high rates of naloxone distribution and community/recovery cafes (both 86%). Two in three (66%) offered job skills support, and just over one in four (28%) offered psychosocial counselling.

Figure 3: Percentage of ADPs reporting offering volunteering and employment opportunities for people with lived/living experience, 2021/22

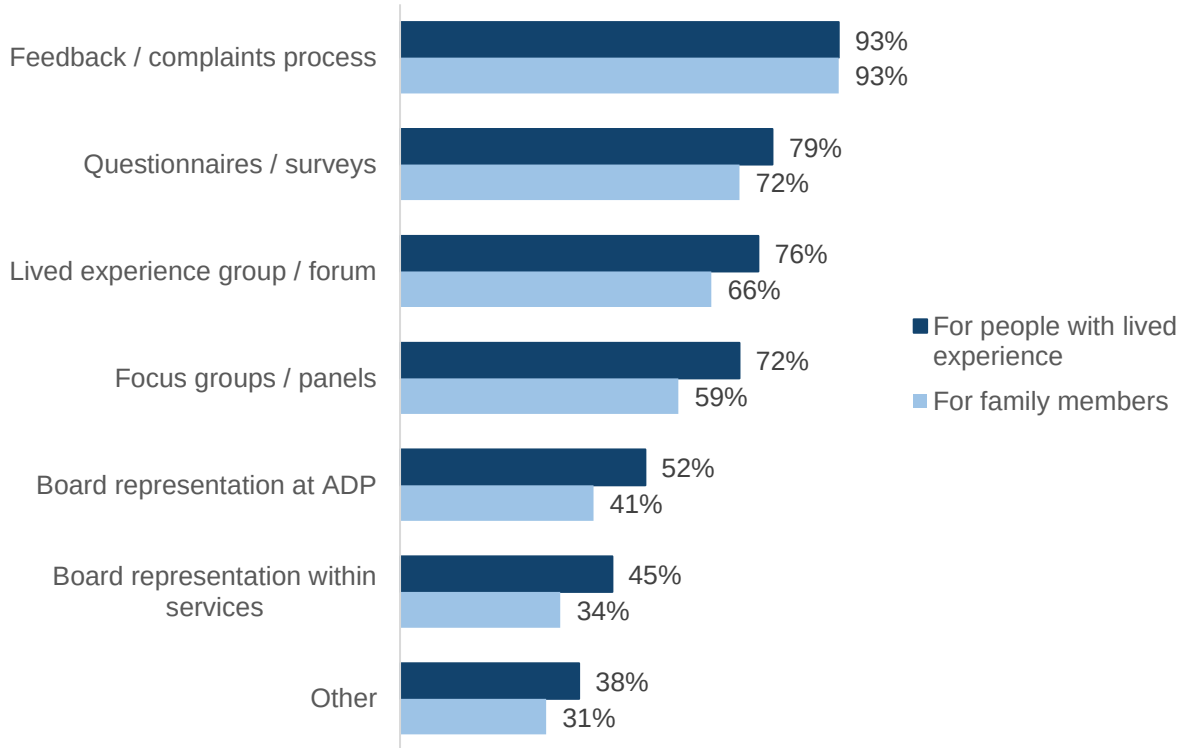


All ADPs reported involvement of people with lived experience and family members affected by substance use within their services (Figure 4). The responses indicated that **ADPs tended to prioritise the involvement of people with lived experience with family members being involved to a lesser extent**.

The most common approach reported was the use of a feedback or complaints process, with the vast majority of ADPs (93%) reporting this being in place for both groups, and one ADP specifically mentioning offering service exit interviews. For people with lived experience, this was followed by questionnaires or surveys (79%); lived experience groups or forums (76%); and focus groups or panels (72%). There were comparatively lower proportions of representation on boards at ADP level (52% and 41% for people with lived experience and their families, respectively) and representation at board level within services (45% and 34%, respectively).

In open-text responses, a few ADPs reported having their own internal lived experience panels to provide feedback and advice. Some reported having people with lived experience in advisory roles within their ADP who were involved in service evaluation and design. A substantial number of ADPs reported collaborating with local community organisations, such as recovery cafes or family groups for those affected by substance use, in order to gather feedback.

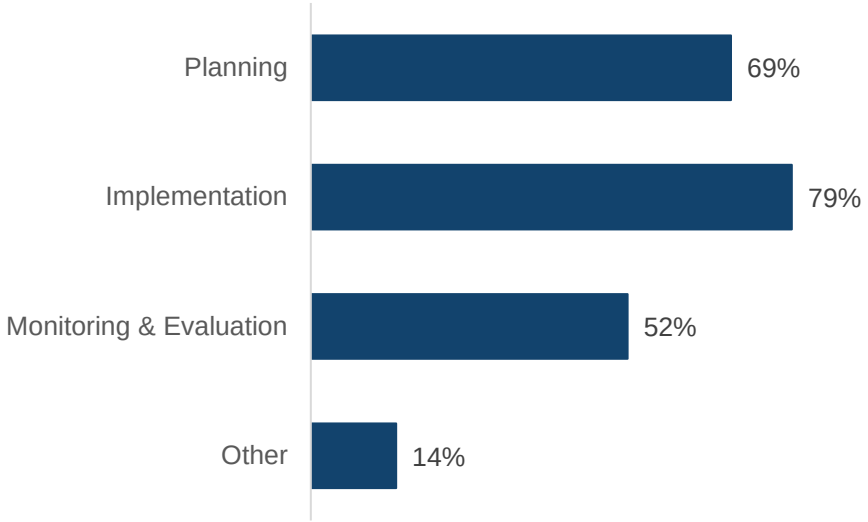
Figure 4: Percentage of ADPs reporting approaches used by services to involve people with lived experience and family members affected by substance use, 2021/22



The majority of ADPs (93%) reported having arrangements in place to involve people with lived experience in different areas of delivery (Figure 5)**.** The two ADPs that did not report doing so specified that they were in the process of developing lived experience panels or forums.

A large majority of ADPs reported involving people with lived experience in the planning and implementation of services (69% and 79%, respectively). Around half of ADPs (52%) also reported involving people with lived experience in the monitoring and evaluation of services. There were also other means of involvement reported, such as assessing demand, mapping pertinent services and organisations, and developing networks to reach more people with lived experience.

Figure 5: Percentage of ADPs reporting involvement of people with lived experience in areas of service delivery, 2021/22



All ADPs reported taking steps to respond to the feedback received from people with lived and living experience and family members affected by substance use. All ADPs reported that the feedback received was considered internally and shared with relevant services and individuals. Most ADPs reported that the feedback was used to inform future service improvement and design.
A substantial number of ADPs reported using a “You Said, We Did” model whereby the ways in which the feedback had been responded to was outlined and communicated back. Other approaches mentioned included conducting post-bereavement interviews with the families of people who had died while engaged with the service in order to identify areas of improvement.

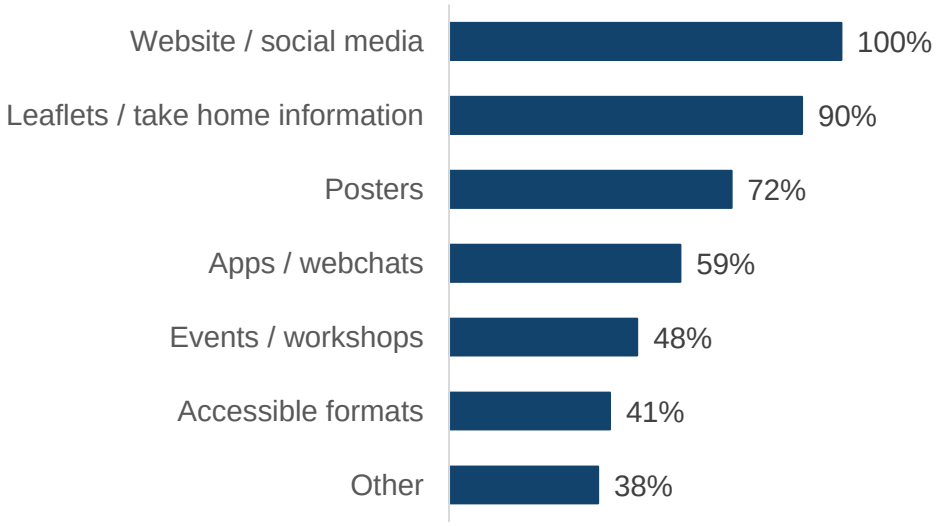
However, **some ADPs outlined a number of challenges associated with including people with lived and living experience**. Where these individuals were included as community representatives, the issues of training, role conflict, and remuneration were highlighted by a few ADPs as challenges. It was felt training was needed to help empower people with lived experience to take part and to support them in understanding their role and remit. Also mentioned was the need to address issues arising from role conflict, where an individual’s official role with an ADP could clash with their membership of the wider community of people with lived experience. In addition, engaging people who were no longer involved with services was noted as a specific challenge.

A number of ADPs were concerned with the challenge of making the inclusion of people with lived and living experience proportionate and effective. Cited barriers included practical considerations such as time constraints and both ADP and Scottish Government processes. A few ADPs noted that serving a largely remote and rural area brought its own challenges in reaching out to those with lived and living experience. They noted that declining populations spread over a large area meant that it was difficult to raise and maintain the motivation for face to face groups. Also mentioned were inequalities with regards to the use of digital technology affecting the viability of organising remote and online alternatives to face to face.

3.4 Fewer people develop problem drug use (outcome 1)

All ADPs reported having provided information on local treatment and support services to the general public (Figure 6). The most common media used were websites or social media (100%), leaflets or take home information (90%), and posters (72%). However **fewer than half of ADPs (41%) reported communicating this information in accessible formats** (e.g. in languages other than English).

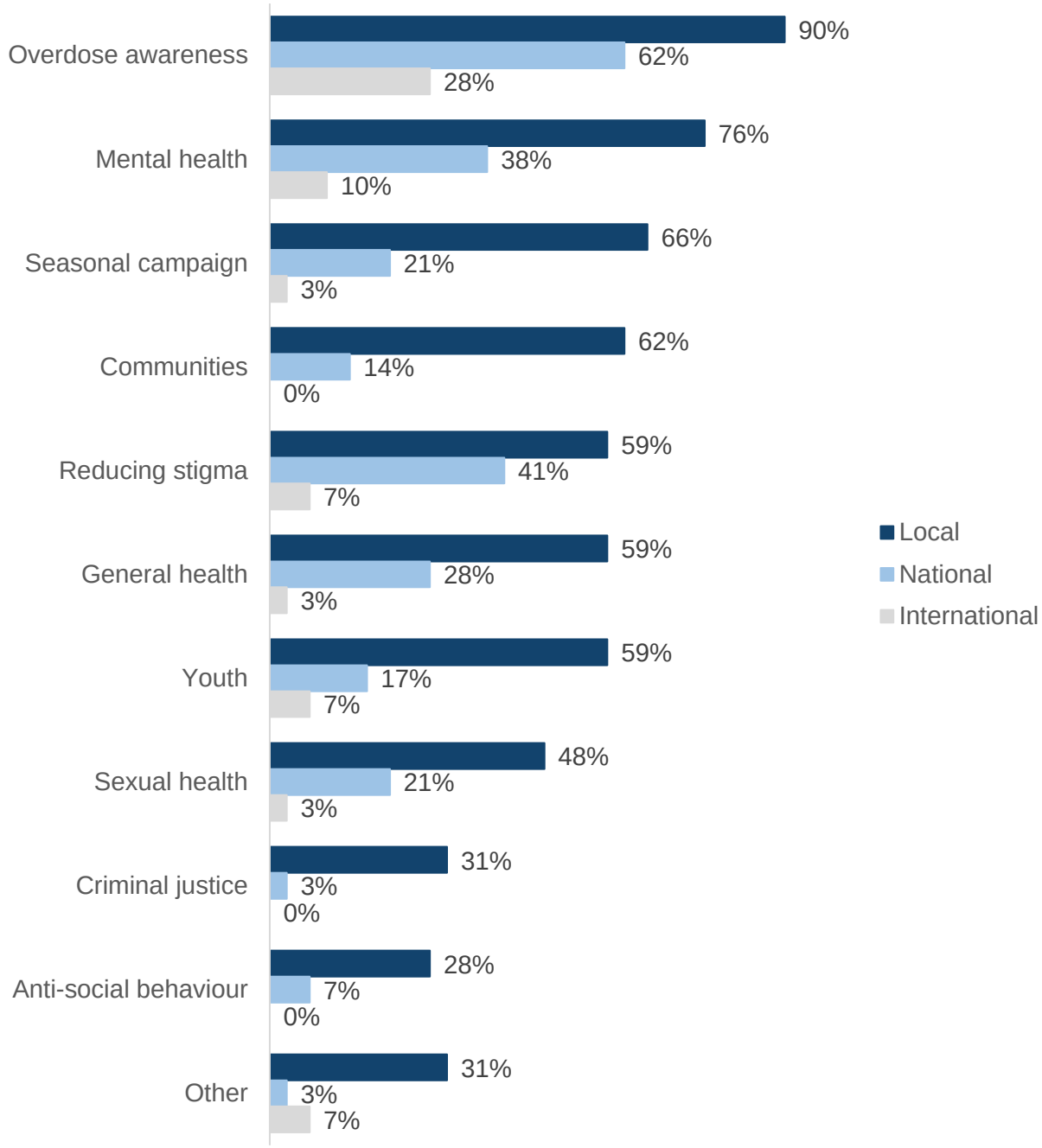
Figure 6: Percentage of ADPs reporting different media formats to communicate information on local treatment and support services to the public, 2021/22



All ADPs reported carrying out some form of education and prevention campaign or activity (Figure 7). The most common type of campaign overall related to overdose awareness, with ADPs reporting targeting this at an international level (28%), national level (62%) and local level (90%).

At a national level, the next most common campaigns reported related to reducing stigma (41%) and mental health (38%). At the local level, over three in four ADPs (76%) reported carrying out mental health campaigns, while the third most commonly reported theme was ‘seasonal campaigns’ (66%). Excluding ‘other’, the least-common type of campaign at both the national and local levels was criminal justice (3% and 31%, respectively).

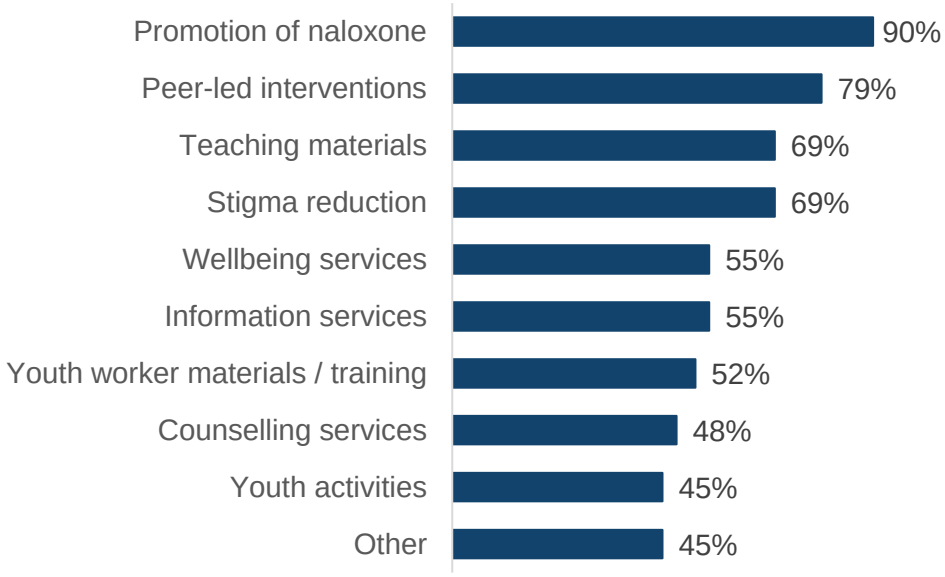
Figure 7: Percentage of ADPs reporting education and prevention campaigns carried out during 2021/22



ADPs reported carrying out a number of activities with regards to education and prevention (Figure 8). The majority of ADPs reported carrying out naloxone

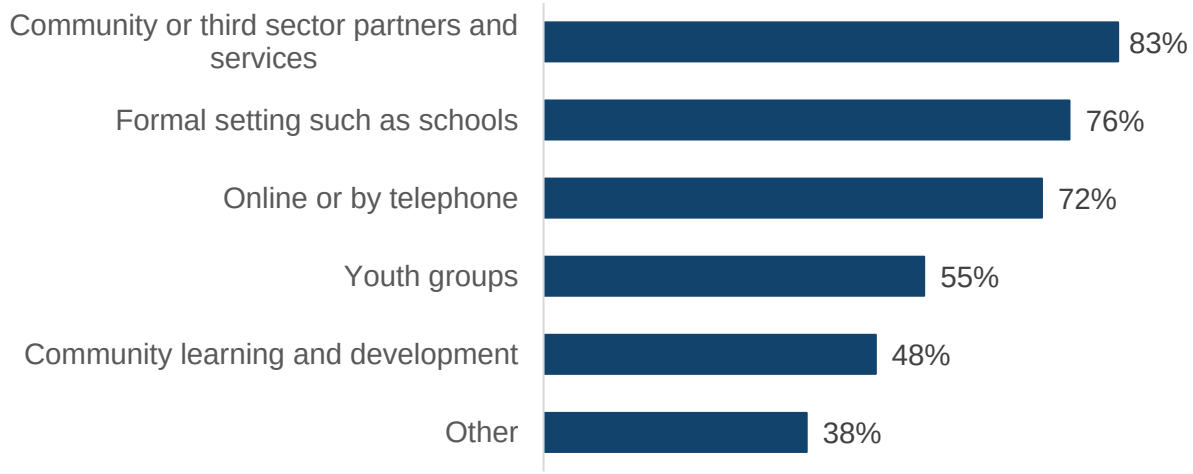
promotion activities (90%), peer-led interventions (79%), stigma reduction (69%) and providing teaching materials (69%). However, less than half of ADPs reported providing counselling services (48%) and youth activities such as sports or arts (45%).

Figure 8: Percentage of ADPs reporting different types of education and prevention activities carried out in 2021/22



Activities were most commonly delivered via third sector or community partners (83%) (Figure 9). This was followed by formal settings such as schools (76%). There was also a high proportion of services being delivered online or by telephone (72%). Other reported settings included accident and emergency departments, workplaces, recovery cafes and hostels.

Figure 9: Percentage of ADPs reporting delivery of education and prevention activities by setting, 2021/22



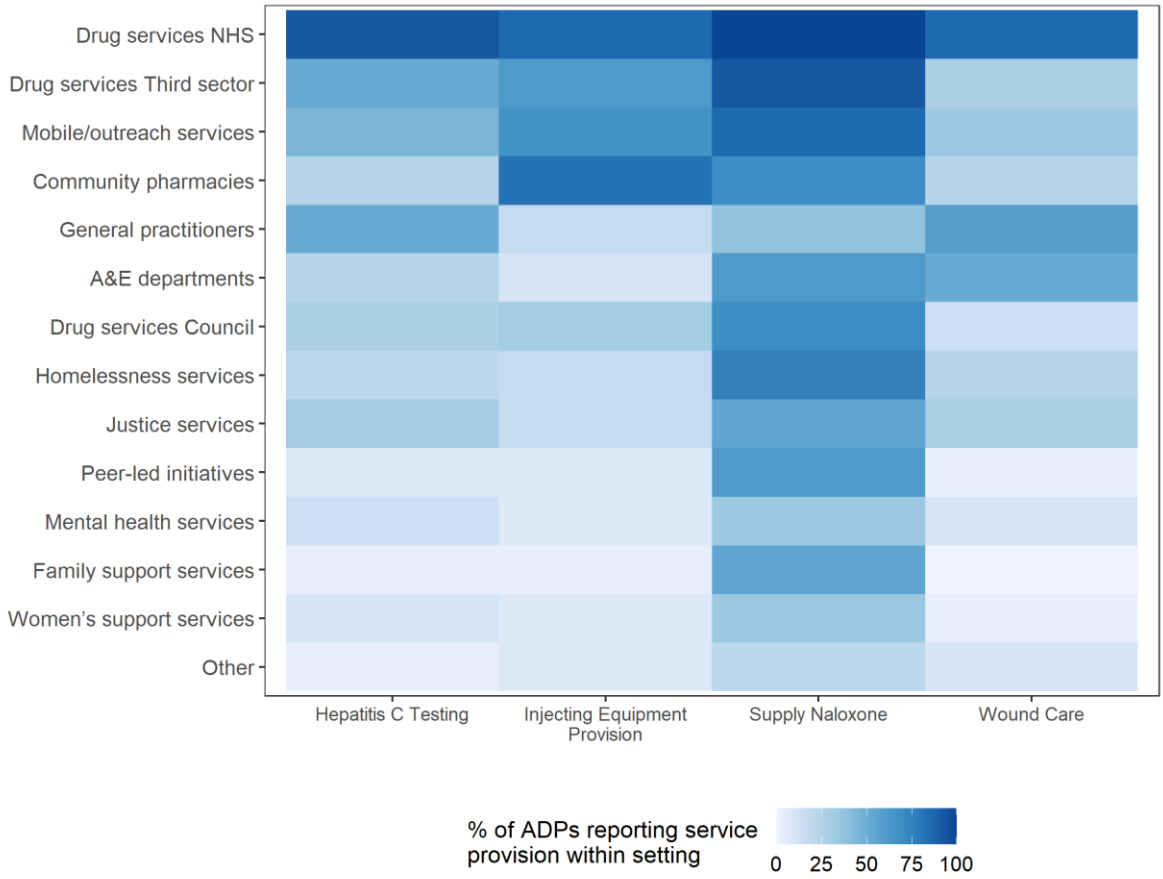
3.5 Risk is reduced for people who take harmful drugs (outcome 2)

ADPs were asked to report on the availability of four key harm reduction services: naloxone supply, Hepatitis C testing, injecting equipment provision and wound care. The heat map below (Figure 10) describes the distributions in the availability of these harm reduction services across a range of settings. This shows that most harm reduction services were reported to be available through NHS drug services.

Naloxone supply was reported as being by far the most commonly available service to the public across a range of settings. All ADPs reported that NHS drug services supplied naloxone. It was also reported as being most commonly offered through third sector drug services (93%) and mobile or outreach services (86%). Naloxone supply was also reported as being offered in women's support services and mental health services by a third of ADPs (both 34%).

The vast majority of NHS drug services also offered Hepatitis C testing (93%), the provision of injecting equipment and wound care (both 86%). Hepatitis C testing was next most commonly reported as being available through third sector drug services and general practitioners (both 52%). The provision of injecting equipment was reported by the majority of ADPs (83%) as being offered in community pharmacies. Finally, wound care was most frequently said to be available to the public through general practitioners (59%) and accident and emergency (A&E) departments (52%).

Figure 10: Substance use services offered to the public by setting, 2021/22



Of the 13 ADPs that reported having a prison in their area, the majority (85%) reported that people in prison had access to non-fatal overdose pathways upon release.

3.6 People at most risk have access to treatment and recovery services; and, People receive high quality treatment and recovery services (outcomes 3 and 4)

3.6.1 Recovery communities

Every ADP reported undertaking activities to support the development of recovery communities in their area. A number of different groups were said to have been provided with support by the ADPs, including mutual aid groups, Self-Management And Recovery Training (SMART) groups, recovery cafes, recovery support groups, family support groups, and kinship care support. In addition, some ADPs specifically reported providing support to groups focussing on people engaged with Medication Assisted Treatment (MAT) and youth or gender specific services. The groups were organised by a variety of organisations, including delivery partners, churches, community interest companies and third sector organisations.

Many ADPs highlighted the negative effect that the COVID-19 pandemic and associated restrictions had on the provision of face to face activities. The support ADPs said they had offered ranged from providing staff to facilitate meetings, to offering direct funding to various recovery-based projects within their area. The projects encompassed a broad range of activities, from health promotion to encouraging more active lifestyles. Also mentioned was the provision of support for the peer volunteers involved in assisting with running the groups. Examples given included providing access to training (including naloxone) and developing employability skills.

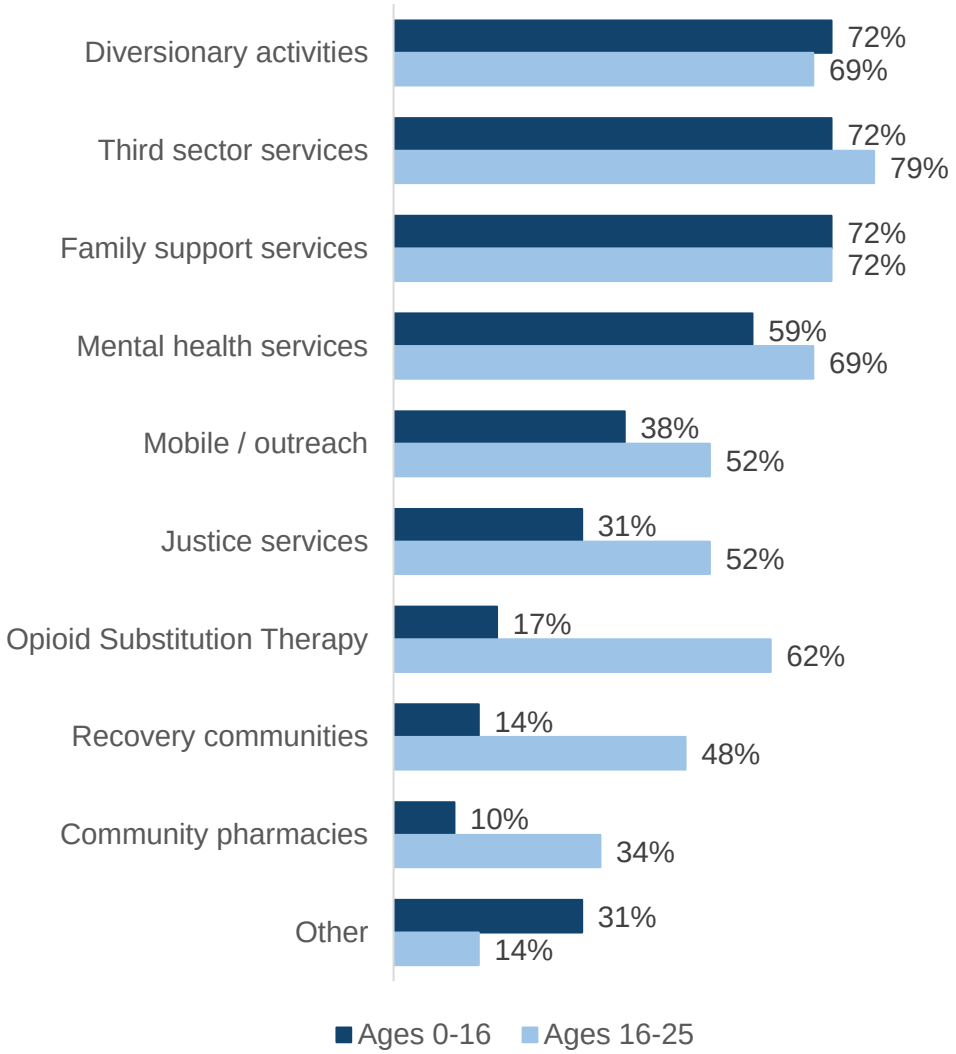
3.6.2 Children and young people

The majority of the ADPs (83%) reported that they had specific treatment and support services for children and young people (Figure 11)[6]. These were most often aimed at children and young people aged between 16 and 25 across a range of settings, the most commonly reported being third sector settings (79%), family support services and diversionary activities (both 72%), and mental health services (69%).

The most commonly reported settings for services aimed at children aged 16 and younger were diversionary activities, third sector services and family support services, with 72% of ADPs indicating availability of each of these services. For services aimed at children and young people aged between 16 and 25, the most commonly reported settings were third sector services (79%), family support services (72%) and diversionary activities and mental health services (both 69%).

[6] The survey question was asked in relation to four age groups: 0-5, 6-12, 12-16, and 16+ (under 25). For simplicity, the analysis presented here combines the three under 16 age groups.

Figure 11: Percentage of ADPs reporting treatment and support services available for children and young people by age band, 2021/22



Over half of ADPs (57%) reported that their services for children and young people with substance use improved in 2021/22, while 43% said that they stayed the same[7]. No ADP reported either scaling back or removing the services they offered for these age groups.

3.7 Quality of life is improved by addressing multiple disadvantages (outcome 5)

3.7.1 Mental health

The vast majority of ADPs (92%) reported that mental health support was routinely available for people who use drugs or alcohol but do not have diagnosed co-occurring mental health problems[8].

The majority of ADPs reported they did not have protocols in place to refer people with co-occurring problem drug use and mental health problems, or did

[7] The base number of ADPs for this question was 28.
[8] The base number of ADPs for this question was 26.

not answer the question. Of those that did not have protocols in place, the majority reported that they were in the process of developing these.

Some of the ADPs that reported not having formal protocols in place specifically detailed alternative joint working or referral procedures that operated on a formal or informal basis. These included co-locating or sharing a management structure with mental health services and utilising a case management approach across services, with regular meetings to discuss the individual's treatments and to develop and maintain good working relationships across teams and services; and establishing a team leaders' forum.

ADPs were further asked to describe their local arrangements with mental health services to enable support for people with co-occurring drug use and mental health problems. Several ADPs reported multi-disciplinary team working as the main way they supported people with co-occurring problem drug use and mental health problems. This was typically described as mental health professionals, such as community mental health nurses, being located within (or working closely with) substance use services. However, there appeared to be various arrangements in place as other ADPs also reported that mental health teams would take the lead in most cases of co-occurrence or noted that their staff were trained in in providing low intensity mental health interventions such as Cognitive Behavioural Therapy.

All ADPs reported having at least some services where a trauma informed approach to substance use has been adopted. Fewer than a third of ADPs (31%) said that a trauma-informed approach to substance use had been adopted across "all services", a slightly higher proportion (38%) reported it has been adopted in "the majority of services", and an additional 31% in "some services". Once again, ADPs listed a variety of examples illustrating the progress made towards integrating this approach across all services, such as training, recruiting new staff and engaging with third sector and community partners. Many also said that they had established working groups and sub-groups to ensure a trauma-informed approach was effectively embedded across their ADP area.

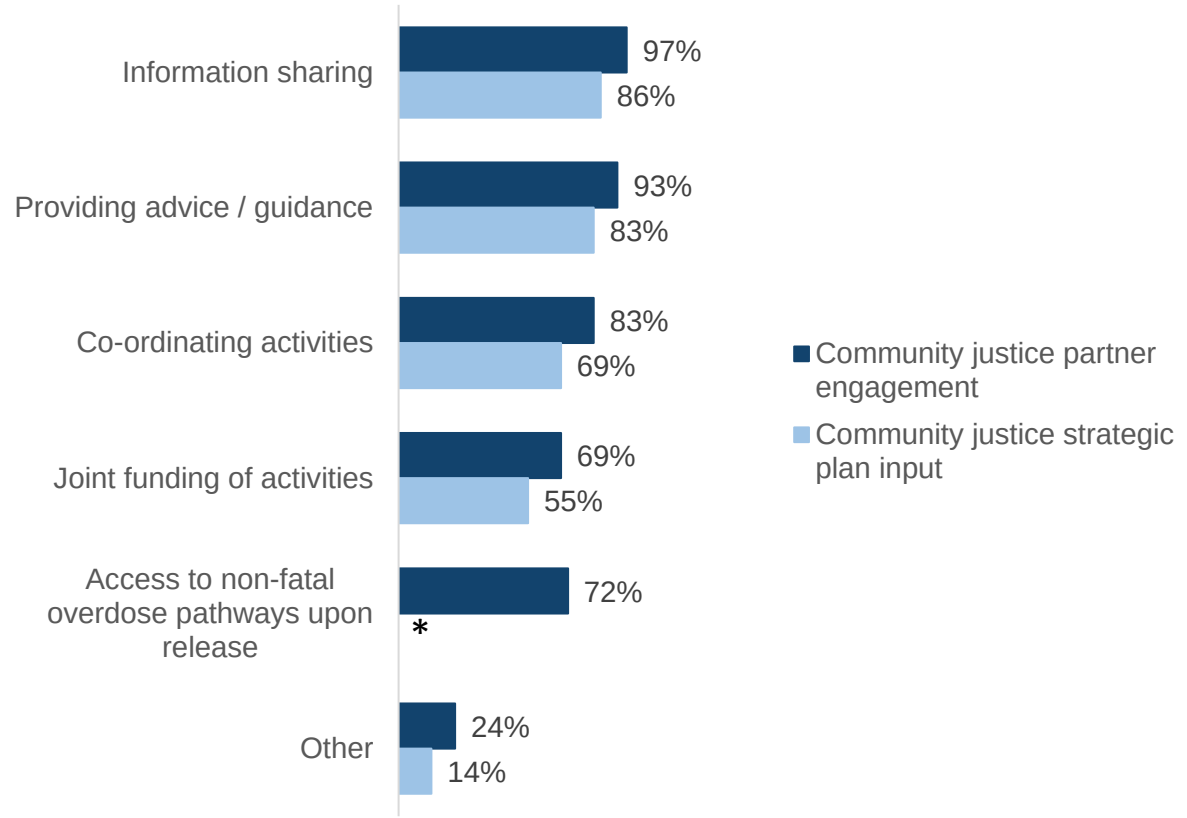
3.7.2 Justice

Of the 13 ADPs with a prison in their area, the majority (85%) reported having arrangements in place with community justice partners to ensure people in prison identified as at risk are issued naloxone upon on release. Moreover, ADPs also reported working with community justice partners at both operational and strategic levels (Figure 12).

In relation to working with community justice partners, over 9 in 10 ADPs indicated having mechanisms in place for information sharing (97%) and providing advice or guidance (93%). The lowest reported figure was for joint funding of activities, but nearly 7 of 10 ADPs (69%) had systems in place for doing this.

The percentages were similar for ADP contributions to community justice strategic plans.

Figure 12: Percentage of ADPs reporting joint working with community justice partners, 2021/22



* 'Access to not-fatal overdose pathways upon release' not applicable for 'Community justice strategic plan input'.

ADPs reported a range of available pathways and protocols to address the treatment needs of people with problem substance use at various stages of their involvement with the criminal justice system (Figure 13).

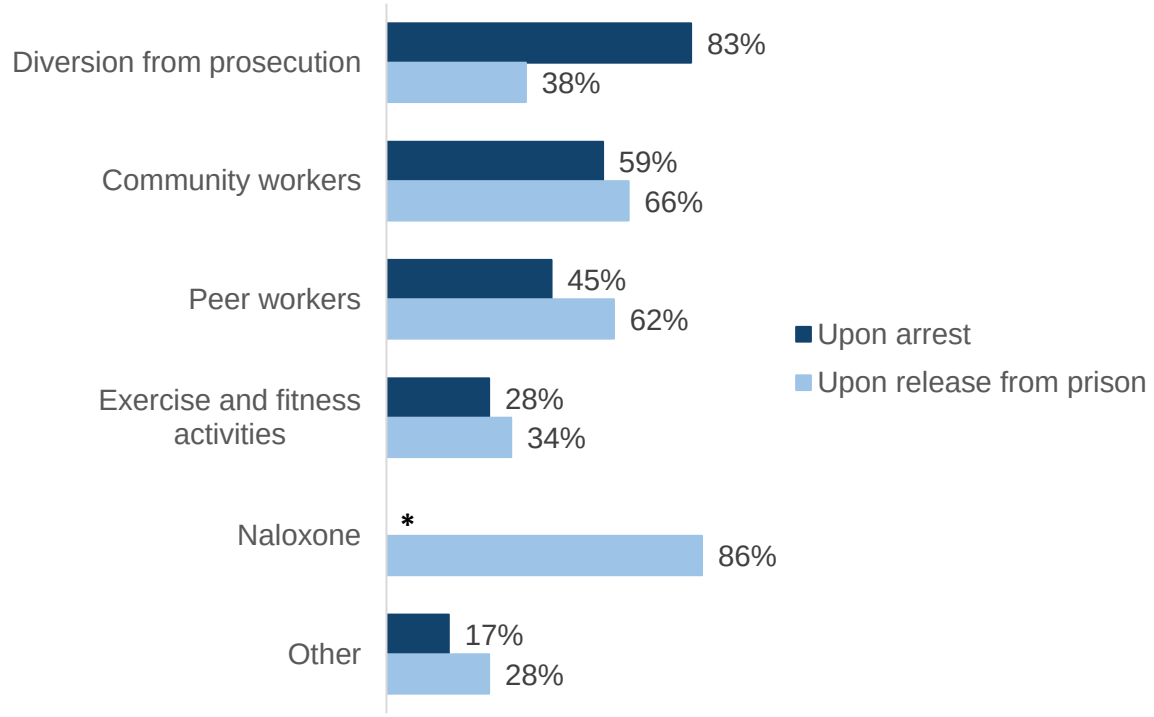
Upon arrest, well over half of ADPs (59%) said the individuals had access to community workers and 83% reported pathways being in place to divert the individual from prosecution.

Nearly 9 in 10 ADPs (86%) reported providing naloxone upon release from prison[9]. ADPs indicated that ongoing support was provided to people leaving prison, including access to community workers (66% of ADPs) and peer workers (62%).

Exercise and fitness activities were the least commonly offered forms of support reported, both upon arrest (28%) and release from prison (34%).

[9] This statistic describes ADP responses to the question "What pathways, protocols and arrangements were in place for individuals with alcohol and drug treatment needs at the following points in the criminal justice pathway? (a) Upon arrest; (b) Upon release from prison". There are prisons in 13 ADP areas. 25 of 29 ADPs reported providing naloxone to people upon release – that is, it includes ADPs where there is no prison in their area but individuals may move into the ADP area on release.

Figure 13: Percentage of ADPs reporting pathways, protocols and arrangements available to individuals engaging with the criminal justice system, 2021/22

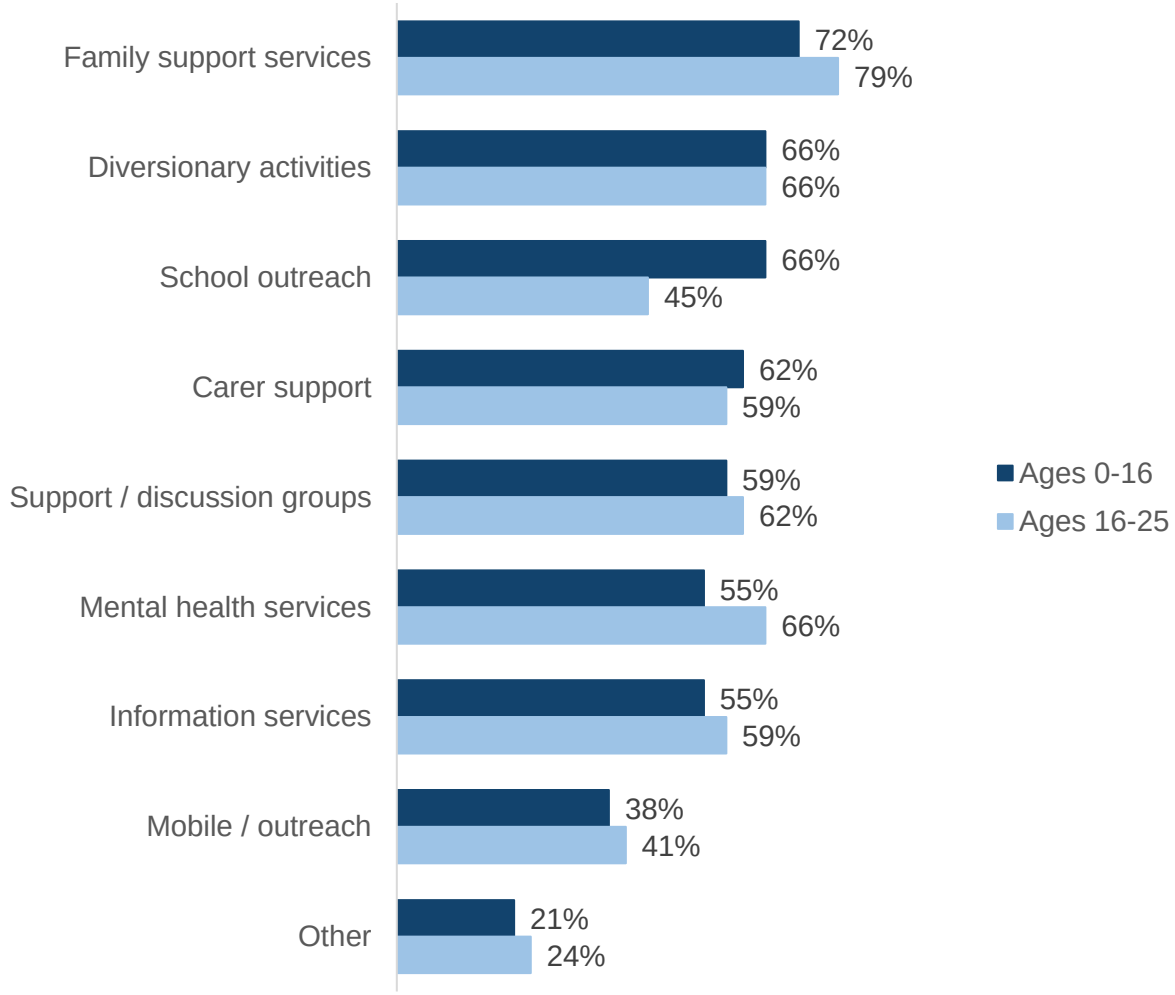


* 'Naloxone' was an option for ADP responses on pathways and protocols available upon release from prison only.

3.8 Children, families and communities affected by substance use are supported (outcome 6)

The vast majority of ADPs (90%) reported having specific treatment and support services for children and young people affected by a parent or carer's substance use (Figure 14)[10]. In general, a slightly greater proportion of services were available for those aged 16 and over, with family support being the most common service across the age groups. The next most commonly reported services by age group were diversionary activities and mental health services for 16 to 25 year olds (both 66% of ADPs), and diversionary activities (66%), school outreach (66%) and carer support (62%) for children aged 0 to 16 years.

Figure 14: Percentage of ADPs reporting availability of services for children and young people affected by the problem substance use of a parent or carer by age, 2021/22

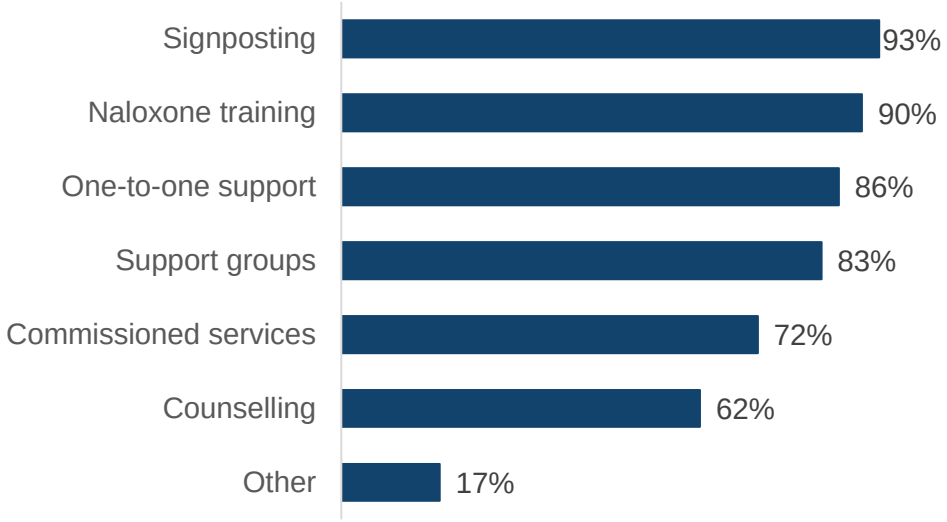


[10] The survey question was asked in relation to four age groups: 0-5, 6-12, 12-16, and 16+ (under 25). For simplicity, the analysis presented here combines the three under 16 age groups.

Every ADP reported contributing toward the integrated children's service plan. Many ADPs noted that they are represented on the relevant working and planning groups, and there is evidence of a high degree of engagement with this work. Moreover, **57% of ADPs reported that services for children and young people affected by a parent or carer's substance use improved in 2021/22[11].** An additional 43% felt that they had stayed the same. No ADP reported either scaling back or removing the services they offered for these age groups.

The vast majority of ADPs (96%) also reported having specific support services in place for adult family members (Figure 15)[12]. Over 9 in 10 ADPs said there was signposting (93%) and naloxone training (90%), and there were also high percentages of ADPs reporting one-to-one support (86%) as well as support groups (83%). Once again, many ADPs reported working with third sector and community partners to ensure these services were delivered. Just under half of ADPs (48%) said that their adult family member services improved in 2021/22, while 52% felt they stayed the same. No ADP reported either scaling back or removing the services they offered for this group.

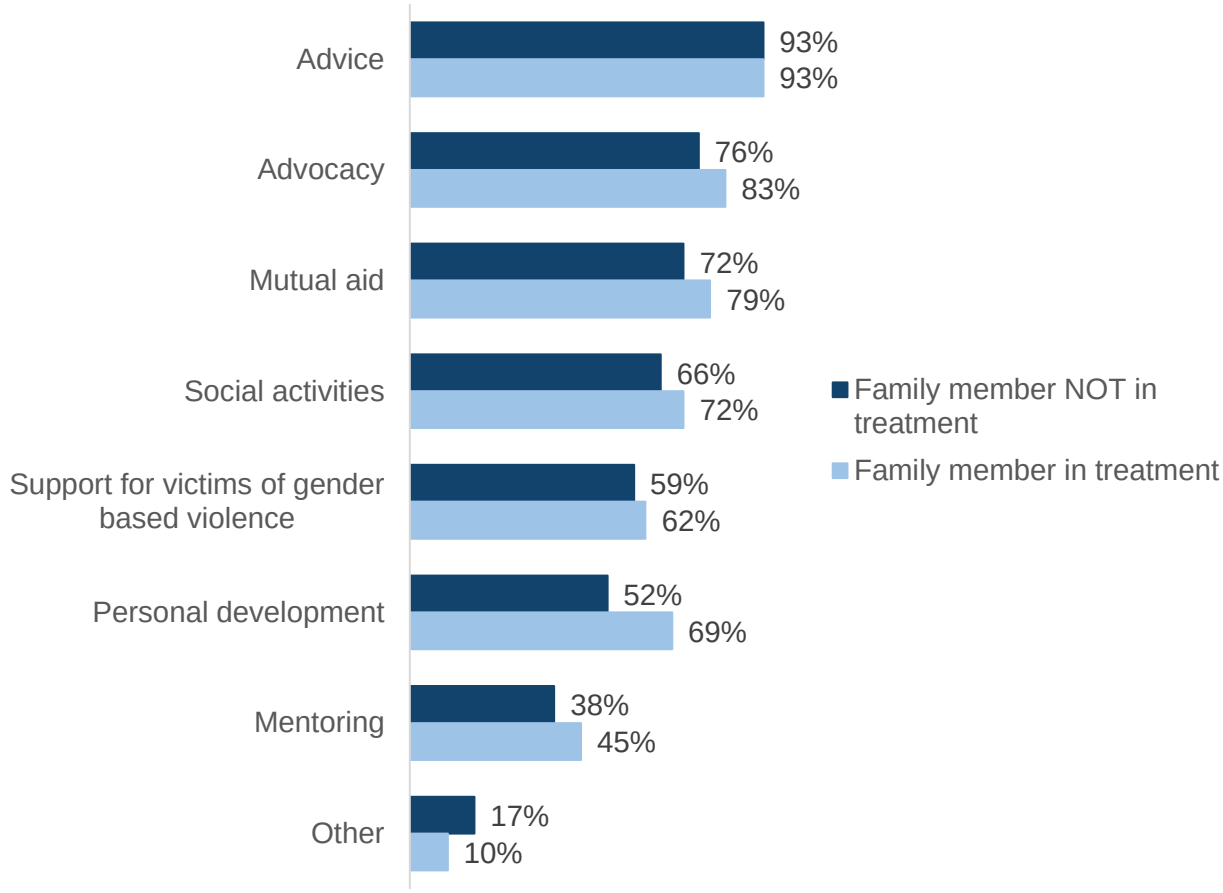
Figure 15: Percentage of ADPs reporting support services available for adult family members, 2021/22



ADPs offered a variety of services to adults with the aim of supporting family-inclusive practice (Figure 16). This involved people with family members both in and not in treatment. Across both categories, advice was the highest-reported service, with over 9 in 10 ADPs (93%) providing this. Overall, a slightly greater proportion of services were reported to be offered to people with family members in treatment compared to those who were not.

[11] The base number for this question was 28.
[12] The base number for this question was 28.

Figure 16: Percentage of ADPs reporting adult services offered to support family-inclusive practice, 2021/22



Over half of ADPs (52%) reported that they had not completed an audit of their service provision for families within the 2020/2021 reporting period. However, most of these ADPs reported that audit work was in progress. For some ADPs this was also in parallel with recruitment for new posts to assist with the development of services taking a whole family approach and further audit work. Most intended to have this audit work complete by the end of 2022 or early 2023.

A similar proportion reported that some form of audit activity had taken place and detailed how Scottish Government funding had been spent. This included the funding of new posts; either to expand or develop pre-existing services, to employ a family wellbeing worker, or to create new coordinator posts for women's and young people's services. Other ADPs said they had partnered with carer support organisations to offer support to people caring for someone with problem substance use or taking over the care of children with a parent or carer with problem substance use. Also mentioned was the using the funding to "formalise" the partnership model that existed between third sector delivery partners, creating a more joined up and integrated service for young people. One ADP outlined ways in which the audit had been used to map service provision within their area and using the funding for a small scale test of change, with the intention of gathering learning to inform the future delivery of whole family inclusive approaches.

Appendix A – Survey Distributed to ADPs

Name of ADP: Click or tap here to enter text.

Key contact: Click or tap here to enter text.
Name: Click or tap here to enter text.
Job title: Click or tap here to enter text.
Contact email: Click or tap here to enter text.

1. Education and Prevention

1.1 In what format was information provided to the general public on local treatment and support services available within the ADP?

Please select those that apply (please note that this question is in reference to the ADP and not individual services)

Leaflets/ take home information	☐
Posters	☐
Website/ social media	☐
Apps/webchats	☐
Events/workshops Please provide details…	☐
Accessible formats (e.g. in different languages) Please provide details…	☐
Other	☐

1.2 Please provide details of any specific education or prevention campaigns or activities carried out during 2021/22 *(E.g. Count 14 / specific communication with people who alcohol / drugs and/or at risk)*.

Campaign theme	International	National	Local
General Health	☐	☐	☐
Overdose Awareness	☐	☐	☐
Seasonal Campaigns	☐	☐	☐
Mental Health	☐	☐	☐
Communities	☐	☐	☐
Criminal Justice	☐	☐	☐
Youth	☐	☐	☐
Anti-social behaviour	☐	☐	☐
Reducing Stigma	☐	☐	☐
Sexual Health	☐	☐	☐
Other Please specify…	☐	☐	☐

1.3 Please provide details on education and prevention measures/ services/ projects provided during the year 2021/22, specifically around drugs and alcohol (select all that apply).

Teaching materials	☐
Youth Worker materials/training	☐
Promotion of naloxone	☐
Peer-led interventions	☐
Stigma reduction	☐
Counselling services	☐
Information services	☐
Wellbeing services	☐
Youth activities (e.g. sports, art)	☐
Other (please provide details)	☐

1.4 Please provide details of where these measures / services / projects were delivered.

Formal setting such as schools	☐
Youth Groups	☐
Community Learning and Development	☐
Via Community/third Sector partners or services	☐
Online or by telephone	☐
Other (please provide details)	☐

1.5 Was the ADP represented at the alcohol Licensing Forum?

Yes	☐
No	☐

1.6 What proportion of license applications does Public Health review and advise the Board on?

All	☐
Most	☐
Some	☐
None	☐

1.7 If you would like to add any additional details in response to the questions in this section on Education and Prevention, please provide them below (max 600 words).
Click or tap here to enter text.

2. Treatment and Recovery

2.1 What treatment or screening options were in place to address alcohol harms? (select all that apply)	
Fibro scanning	☐
Alcohol related cognitive screening (e.g. for ARBD)	☐
Community alcohol detox	☐
Inpatient alcohol detox	☐
Alcohol hospital liaison	☐
Access to alcohol medication (Antabuse, Acamprase etc.)	☐
Arrangements for the delivery of alcohol brief interventions in all priority settings	☐
Arrangements of the delivery of ABIs in non-priority settings	☐
Psychosocial counselling	☐
Other (please provide details)	☐

2.2 Please indicate which of the following approaches services used to involve lived experience / family members (select all that apply).

For people with lived experience:

Feedback / complaints process	☐
Questionnaires / surveys	☐
Focus groups / panels	☐
Lived experience group / forum	☐
Board Representation within services	☐
Board Representation at ADP	☐
Other (please provide details)	☐

For family members:

Feedback/ complaints process	☐
Questionnaires/ surveys	☐
Focus groups / panels	☐
Lived experience group/ forum	☐
Board Representation within services	☐
Board Representation at ADP	☐
Other (please provide details)	☐

2.3 How do you respond to feedback received from people with lived experience, including that of family members? (max 300 words)
Click or tap here to enter text.

2.4 Please can you set out the areas of delivery where you had effective arrangements in place to involve people with lived experience?

Planning, I.E. prioritisation and funding decisions	☐
Implementation, I.E. commissioning process, service design	☐
Scrutiny, I.E. Monitoring and Evaluation of services	☐
Other (please provide details)	☐

Please give details of any challenges (max 300 words)

2.5 Did services offer specific volunteering and employment opportunities for people with lived/ living experience in the delivery of alcohol and drug services?

a) Yes ☐
No ☐

b) If yes, please select all that apply:

Peer support / mentoring	☐
Community / Recovery cafes	☐
Naloxone distribution	☐
Psychosocial counselling	☐
Job Skills support	☐
Other (please provide details)	☐

2.6 Which of these settings offered the following to the public during 2021/22? (select all that apply)

Setting:	Supply Naloxone	Hep C Testing	IEP Provision	Wound care
Drug services Council	☐	☐	☐	☐
Drug Services NHS	☐	☐	☐	☐
Drug services 3rd Sector	☐	☐	☐	☐
Homelessness services	☐	☐	☐	☐
Peer-led initiatives	☐	☐	☐	☐
Community pharmacies	☐	☐	☐	☐
GPs	☐	☐	☐	☐
A&E Departments	☐	☐	☐	☐
Women's support services	☐	☐	☐	☐
Family support services	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐

Justice services	☐	☐	☐	☐
Mobile / outreach services	☐	☐	☐	☐
Other (please provide details)	☐	☐	☐	☐

2.7 What protocols are in place to support people with co-occurring drug use and mental health difficulties to receive mental health care? (max 300 words)
Click or tap here to enter text.

Is mental health support routinely available for people who use drugs or alcohol but do not have a dual diagnosis (e.g. mood disorders)?

Yes ☐
No ☐

Please provide details (max 300 words)

2.8 Please describe your local arrangements with mental health services to enable support for people with co-occurring drug use and mental health (max 300 words)

2.9 Did the ADP undertake any activities to support the development, growth or expansion of a recovery community in your area?

Yes ☐
No ☐

2.10 Please provide a short description of the recovery communities in your area during the year 2021/22 and how they have been supported (max 300 words)

2.11 What proportion of services have adopted a trauma-informed approach during 2021/22?

All services ☐
The majority of services ☐
Some services ☐
No services ☐

Please provide a summary of progress (max 300 words)

2.12 Which groups or structures were in place to inform surveillance and monitoring of alcohol and drug harms or deaths? (mark all that apply)

Alcohol harms group	☐
Alcohol death audits (work being supported by AFS)	☐
Drug death review group	☐
Drug trend monitoring group / Early Warning System	☐
Other (please provide details)	☐

2.13 Please provide a summary of arrangements which were in place to carry out reviews on alcohol related deaths and how lessons learned are built into practice. If none, please detail why (max 300 words)

2.14 Please provide a summary of arrangements which are in place to carry out reviews on drug related deaths, how lessons learned are built into practice, and if there is any oversight of these reviews from Chief Officers for Public Protection. (max 300 words)

2.15 If you would like to add any additional details in response to the questions in this section on Treatment and Recovery, please provide them below (max 300 words).

3. Getting it Right for Children, Young People and Families

3.1 Did you have specific treatment and support services for children and young people (under the age of 25) with alcohol and/or drugs problems?

a) Yes ☐
No ☐

b) If yes, please select all that apply below:

Setting:	0-5	6-12	12-16	16+
Community pharmacies	☐	☐	☐	☐
Diversionary Activities	☐	☐	☐	☐
Third Sector services	☐	☐	☐	☐
Family support services	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐
ORT	☐	☐	☐	☐
Recovery Communities	☐	☐	☐	☐
Justice services	☐	☐	☐	☐
Mobile / outreach	☐	☐	☐	☐
Other (please provide details)	☐	☐	☐	☐

3.2 Did you have specific treatment and support services for children and young people (under the age of 25) affected by alcohol and/or drug problems of a parent / carer or other adult?

a) Yes ☐
No ☐

b) If yes, please select all that apply below:

Setting:	0-5	6-12	12-16	16+
Support/discussion groups	☐	☐	☐	☐
Diversionary Activities	☐	☐	☐	☐
School outreach	☐	☐	☐	☐
Carer support	☐	☐	☐	☐
Family support services	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐
Information services	☐	☐	☐	☐
Mobile / outreach	☐	☐	☐	☐

Other (please provide details)	☐	☐	☐	☐

3.3 Does the ADP feed into/ contribute toward the integrated children's service plan?

Yes ☐
No ☐

Please provide details on how priorities are reflected in children's service planning e.g. collaborating with the children's partnership or the child protection committee? (max 300 words)

3.4 How did services for children and young people, with alcohol and/or drugs problems, change in the 2021/22 financial year?

Improved ☐
Stayed the same ☐
Scaled back ☐
No longer in place ☐

3.5 How did services for children and young people, affected by alcohol and/or drug problems of a parent / carer or other adult, change in the 2021/22 financial year?

Improved ☐
Stayed the same ☐
Scaled back ☐
No longer in place ☐

3.6 Did the ADP have specific support services for adult family members?

a) Yes ☐
No ☐

b) If yes, please select all that apply below:

Signposting ☐
One to One support ☐
Support groups ☐
Counselling ☐
Commissioned services ☐
Naloxone Training ☐
Other (please provide details) ☐

3.7 How did services for adult family members change in the 2021/22 financial year?

Improved	☐
Stayed the same	☐
Scaled back	☐
No longer in place	☐

3.8 The Whole Family Approach/Family Inclusive Framework sets out our expectations for ADPs in relation to family support. Have you carried out a recent audit of your existing family provision?

a) If yes, please answer the following:

Last year SG provided an additional £3.5m to support the implementation of the framework. Please provide a breakdown and a narrative of how this was used in your area. (max 300 words)

Please detail any additional information on your progress in implementing the framework in 2020/21 (max 300 words)

b) If no, when do you plan to do this?

3.9 Did the ADP area provide any of the following adult services to support family-inclusive practice? (select all that apply)

Services:	Family member in treatment	Family member not in treatment
Advice	☐	☐
Mutual aid	☐	☐
Mentoring	☐	☐
Social Activities	☐	☐
Personal Development	☐	☐
Advocacy	☐	☐
Support for victims of gender based violence	☐	☐
Other (please provide details)	☐	☐

4. A Public Health Approach to Justice

4.1 If you have a prison in your area, were satisfactory arrangements in place, and executed properly, to ensure ALL prisoners who are identified as at risk were provided with naloxone on liberation?

Yes	☐
No	☐
No prison in ADP area	☐

Please provide details on how effective the arrangements were in making this happen (max 300 words)

4.2 Has the ADP worked with community justice partners in the following ways? (select all that apply)

Information sharing	☐
Providing advice/ guidance	☐
Coordinating activities	☐
Joint funding of activities	☐
Access is available to non-fatal overdose pathways upon release	☐
Other (please provide details)	☐

4.3 Has the ADP contributed toward community justice strategic plans (e.g. diversion from justice) in the following ways? (select all that apply)

Information sharing	☐
Providing advice/ guidance	☐
Coordinating activities	☐
Joint funding of activities	☐
Other (please provide details)	☐

4.4 What pathways, protocols and arrangements were in place for individuals with alcohol and drug treatment needs at the following points in the criminal justice pathway? Please also include any support for families.

a) Upon arrest (please select all that apply)
Please provide details on what was in place and how well this was executed.

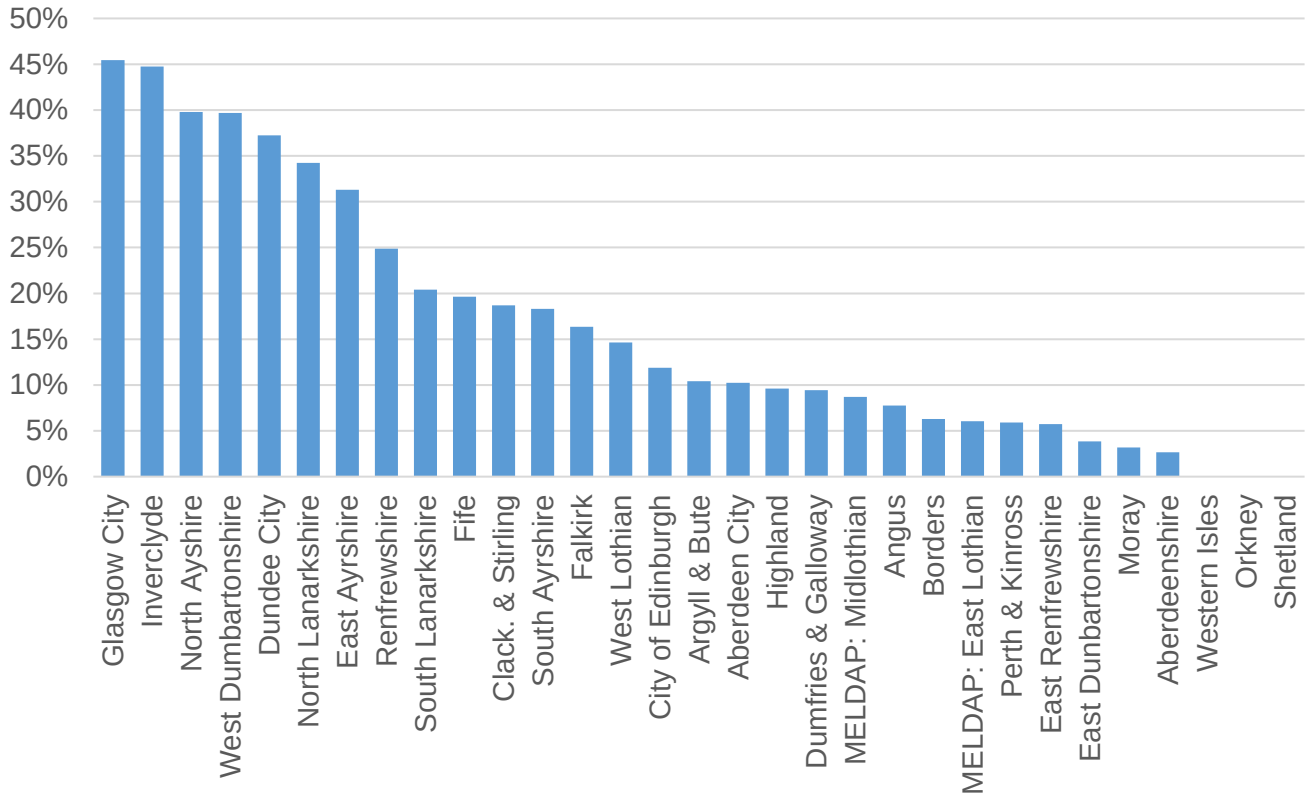
Diversion From Prosecution	☐
Exercise and fitness activities	☐
Peer workers	☐
Community workers	☐
Other (please provide details)	☐

b) Upon release from prison (please select all that apply)
Please provide details on what was in place and how well this was executed.

Diversion From Prosecution	☐
Exercise and fitness activities	☐
Peer workers	☐
Community workers	☐
Naloxone	☐
Other (please provide details)	☐

4.5 If you would like to add any additional details in response to the questions in this section on Public Health Approach to Justice, please provide them below (max 300 words).
Click or tap here to enter text.

Appendix B – ADP Local Share of 20% Most Deprived Data Zones (SIMD 2020)



Source: [Scottish Index of Multiple Deprivation 2020 - gov.scot (www.gov.scot)]

Appendix C – Demographic Characteristics of ADP Areas across Scotland

	Percentage (%) Urban/Rural Classification[1]						Mid-Year Population Estimate[2]
ADP	**Large Urban Areas**	**Other Urban Areas**	**Accessible Small Towns**	**Remote Small Towns**	**Accessible Rural**	**Remote Rural**	**Estimated Population**
Aberdeen City	93.4	0.0	5.3	0.0	1.4	0.0	229,060
Aberdeenshire	0.0	30.4	14.4	6.8	35.0	13.4	260,780
Angus	7.6	53.9	11.6	0.0	26.1	0.7	115,820
Argyll & Bute	0.0	17.9	4.2	30.6	4.2	43.0	85,430
Clacks & Stirling	0.0	45.3	29.2	0.0	20.5	3.5	145,370
Dumfries & Galloway	0.0	29.7	17.4	7.7	24.2	20.9	148,290
Dundee City	99.5	0.0	0.0	0.0	0.5	0.0	148,820
East Ayrshire	0.0	42.0	19.1	10.3	20.6	8.0	121,600
East Dunbartonshire	60.1	27.4	7.4	0.0	5.1	0.0	108,750
East Renfrewshire	68.6	18.8	9.1	0.0	3.5	0.0	96,060
Edinburgh, City of	96.2	0.0	2.8	0.0	1.0	0.0	527,620
Falkirk	0.0	90.0	2.0	0.0	8.0	0.0	160,560
Fife	0.0	67.1	15.4	0.0	17.5	0.0	374,130
Glasgow City	99.6	0.0	0.0	0.0	0.4	0.0	635,640
Highland	0.0	31.3	4.2	17.0	9.5	37.9	235,430
Inverclyde	0.0	85.5	12.5	0.0	2.0	0.0	77,060
MELDAP (Midlothian and East Lothian)	11.6	49.45	11.4	7.65	18.95	1.0	201,150
Moray	0.0	36.3	8.2	14.0	29.8	11.8	95,710
Na h-Eileanan Siar (Western Isles)	0.0	0.0	0.0	27.6	0.0	72.4	26,500
North Ayrshire	0.0	72.0	18.8	0.0	4.9	4.3	134,250
North Lanarkshire	1.9	81.6	8.5	0.0	8.1	0.0	341,140
Orkney Islands	0.0	0.0	0.0	34.0	0.0	66.0	22,400
Perth & Kinross	1.2	31.5	10.3	10.9	33.2	12.9	151,910
Renfrewshire	76.0	9.9	9.4	0.0	4.7	0.0	179,390
Scottish Borders	0.0	25.1	22.0	6.0	36.1	10.7	115,240
Shetland Islands	0.0	0.0	0.0	29.6	0.0	70.4	22,870
South Ayrshire	0.0	68.7	4.1	5.7	17.5	4.0	112,140
South Lanarkshire	19.0	59.6	10.7	0.0	9.2	1.6	320,820
West Dunbartonshire	48.2	50.6	0.0	0.0	1.3	0.0	88,340
West Lothian	0.0	82.0	9.7	0.0	8.3	0.0	183,820
Scotland	**34.6**	**36.2**	**8.5**	**3.5**	**11.2**	**5.9**	**5,466,000**

Sources: [1] - Scottish Government Urban Rural Classification 2016 - gov.scot (www.gov.scot) and [2] - Mid-2020 Population Estimates Scotland | National Records of Scotland (nrscotland.gov.uk)

How to access background or source data

The data collected for this social research publication:

☐ are available in more detail through Scottish Neighbourhood Statistics

☐ are available via an alternative route

☐ may be made available on request, subject to consideration of legal and ethical factors. Please contact **socialresearch@scotland.gsi.gov.uk** for further information.

☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
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