

**REPORT OF THE STOCKTAKE**

**OF ALCOHOL AND DRUG ACTION TEAMS**

June 2007

## CONTENTS

<b>CHAIRMAN’S FOREWORD .....</b>	<b>3</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>4</b>
<b>SUMMARY OF RECOMMENDATIONS BY THEME .....</b>	<b>7</b>
<b>1 INTRODUCTION .....</b>	<b>11</b>
1.1 Setting the Scene .....	11
1.2 The Challenge for ADATs .....	11
1.3 Methodology .....	13
<b>2 BACKGROUND .....</b>	<b>14</b>
2.1 General .....	14
2.2 Alcohol Action Teams .....	14
2.3 Drug Action Teams .....	15
2.4 Alcohol and Drug Action Teams .....	16
2.5 Scottish Association of Alcohol and Drug Action Teams .....	17
2.6 Scottish Drugs Forum.....	17
2.7 Alcohol Focus Scotland .....	17
<b>3 THE ESSENTIAL COMPONENTS .....</b>	<b>18</b>
3.1 Introduction .....	18
3.2 National Framework and Policies .....	18
3.3 Leadership .....	25
3.4 Partnership.....	27
3.5 Capacity Building.....	35
<b>4 MAKING IT HAPPEN .....</b>	<b>38</b>
4.1 Introduction .....	38
4.2 Needs Assessment .....	38
4.3 Strategic Priorities .....	40
4.4 Resources .....	41
4.5 Commissioning.....	44
4.6 Contracting .....	45
4.7 Performance Management.....	47
<b>5 MAKING A DIFFERENCE.....</b>	<b>51</b>
5.1 Introduction .....	51
5.2 Public Engagement.....	51
5.3 Service Delivery and Outcomes.....	57
5.4 What Difference do ADATs make?.....	61
<b>APPENDIX A: TERMS OF REFERENCE .....</b>	<b>64</b>
<b>APPENDIX B: MEMBERSHIP OF THE STOCKTAKE TEAM.....</b>	<b>65</b>
<b>APPENDIX C: ORGANISATIONS &amp; INDIVIDUALS CONSULTED ....</b>	<b>66</b>
<b>APPENDIX D: RELEVANT PUBLICATIONS .....</b>	<b>67</b>
<b>APPENDIX E: MAP OF BOUNDARIES.....</b>	<b>74</b>

## **CHAIRMAN'S FOREWORD**

I was delighted to be asked by the then Health and Justice Ministers to Chair the Stocktake of Alcohol and Drug Action Teams to review their performance and capability. Having been a Chair of the Lanarkshire ADAT for 10 years during my time as Executive Director of Social Work for South Lanarkshire Council, I have seen at first hand the importance of having an effective local structure to tackle drug and alcohol misuse. I have had for many years a keen interest in the problems associated with substance misuse and have been a member of both the Scottish Advisory Committee on Drugs Misuse and the Advisory Council on the Misuse of Drugs. I am also a past Chair of the Association of Drug Action Teams

Alcohol and Drug Action Teams have been in existence in a number of forms dating back to the creation of Alcohol Misuse Co-ordinating Committees in 1989 and subsequently the formation of Drug Action teams in 1995. The time was therefore right to review how effective the ADAT approach has been in achieving local action which benefits communities and which contributes to improvements at a national level. Looking forward, we need to determine whether the ADAT approach of local partnership is the best one to tackle the continuing challenges of greater availability and lower price of both drugs and alcohol and the cost, both human and economic, which misuse brings

This Report aims to guide Ministers in reaching those decisions about the future. It is the culmination of seven months intensive work by the small multi-agency Stocktake Team, with whom I have had the considerable benefit of working. The Team has visited every ADAT in Scotland, conducting interviews with Chairs, members, staff, service users and other stakeholders. It has also consulted a wide range of national organisations and individuals with knowledge and expertise of substance misuse and the role of ADATs. In all, well over 300 meetings have taken place and the Team has drawn on a wide range of publications, data and analysis. This can therefore be fairly described as an extremely comprehensive overview and evaluation of the state of play of ADATs at the present time. The report analyses the evidence gathered, draws conclusions and makes recommendations about the way forward. The conclusions have been drawn together on the basis of what was found and as a result of very considerable discussion by the Team throughout the process and while the report is a reflection of the collective experience of the Team, the ultimate responsibility for what is put forward lies with me.

I commend and thank the Team for their professionalism and dedication and the production of a carefully considered report which I hope will provide a sound basis for future Ministerial decisions on the delivery of policy and action on alcohol and drug misuse.

Sandy Cameron, CBE

# EXECUTIVE SUMMARY

## Remit

1. Our remit was to consider the current performance of ADATs and their capability to deliver future Ministerial priorities on drugs and alcohol. The fundamental questions posed were: is the partnership approach the best way to deliver real improvements in combating substance misuse in Scotland; and, if so, are ADATs the best model for this? If the partnership approach is not the best way to deliver improvements, what is the alternative?

## Is the Partnership Approach the Right One?

2. Following extensive consultation and examination of the evidence available, our overwhelming conclusion was that a partnership approach was essential to an effective approach to tackling substance misuse in Scotland.
3. We considered whether more progress could be made if each organisation were simply charged with responsibility for taking forward its own individual activities independently, but with no co-ordination of the local delivery of these components. However it was clear, from the evidence considered and our observation of what worked well, that a joined up approach, bringing together the resources and commitment of organisations in a shared strategy was more likely to address need effectively.
4. We also considered whether one organisation should be tasked with lead responsibility and, in effect, have to drive the actions of the other organisations. In a very few ADATs where there was a very dominant lead partner, that was in practice the approach. But although it meant that the lead partner achieved good provision in its own area of responsibility, other partners appeared marginalised, disengaged and, sometimes, resentful and this undermined effective co-operation.
5. We concluded therefore that neither of these approaches offered advantages over a partnership. We also concluded very firmly that there was a need for a partnership dedicated to tackling substance misuse. Experience outside Scotland suggests that the focus on substance misuse could be lost if ADATs were to be subsumed into another existing and broader based local partnership.

## Are ADATs the best model?

6. We found ADATs that do excellent work tackling some of the most challenging and complex societal problems that we experience in Scotland today. We saw many examples of action which demonstrated that ADATs had made a positive difference to local circumstances. That is not to say that we found all ADATs to be fully effective. In a number, we found some serious shortcomings.
7. The shortcomings included poor leadership, lack of commitment and an insufficient understanding of the strategic aims of the ADAT. Some of these shortcomings were attributable to the absence of up to date national policies and priorities for drug and

alcohol misuse which reflect current understanding of patterns of substance misuse. Some were due to the need for a comprehensive review of the role of ADATs, not substantially changed since their predecessor organisations were first established in 1989 and 1995. However, the need for more national leadership and direction was by no means the sole reason for lack of effectiveness at local level. Some ADATs had significant gaps in membership and poor attendance did not seem to be acted upon. There was a tendency in some areas to allow historic relationships to impede the achievement of objectives and improvements in local services. In a number of ADATs the members had no shared vision of strategic aims. Some ADATs operated with overstretched support teams even when financial resources were available.

8. However, many ADATs had made a positive difference by identifying and meeting local needs. The key characteristics we identified in the more successful ADATs included some or all of:
  - Strong leadership
  - A commitment to effective partnership working at senior level
  - The right partners represented at the right level
  - Clear lines of accountability
  - A relationship with other local partnerships
  - A clear understanding of the strategic role of the ADAT.
  - An effective sub-structure which supported local service delivery
  - Good analysis and information about local need
  - Effective engagement with client groups.
  - Effective performance management
  - Good communication with the partnership and with the wider community

### **What could work better?**

9. Throughout the Stocktake, we sought to identify what worked well and to find ways in which clear shortcomings could be remedied. Both are addressed in our recommendations.
10. We found that for ADATs to be more effective, there must be greater clarity about what is expected of them and by whom. There should also be greater clarity and openness about the full extent of local expenditure on measures to prevent and reduce substance misuse so that ADATs can channel these resources more effectively.
11. The composition and size of ADATs should be reviewed to take account of structural changes in the wider public sector environment and partnerships which have developed in recent years. We believe this may mean fewer ADATs but with a more strategic purpose and more direct accountability to Ministers. This would bring greater clarity and focus to the strategic partnership which would oversee a more local implementation partnership with strong links to other local partnerships, especially Community Planning Partnerships.
12. Support for ADATs should be strengthened and at the same time more should be expected of them. Performance management should be more robust at national and local levels so that all ADATs level up to the best. There should be greater consistency in the availability and delivery of local services across Scotland.

13. Finally, we believe that ADATs have a valuable role to play in contributing their knowledge and experience to the development of national policies. For this reason we have recommended the establishment of a committee of ADAT Chairs, chaired by the relevant Ministers to steer policy development and implementation.
14. Our recommendations appear throughout this report but, for convenience, the summary which follows groups them in accordance with the key themes of -Remit, Composition and Structure; Performance and Accountability; Integrated and Consistent Approaches; Resources; and Capacity Building.

## SUMMARY OF RECOMMENDATIONS BY THEME

No	Recommendation	Scottish Executive	ADAT	Other
	<i>Remit, Composition and Structure</i>			
2	The Scottish Executive should review the responsibilities of ADATs in consultation with them and set this out in a single guidance framework which should identify the respective national and local responsibilities and those which will benefit most from the strength of a local partnership approach. The framework should be kept under review and take into account changes in policies, strategies and partnerships.	✓	✓	
8	The choice of Chair should be made by members of the ADAT partnership. The ADAT Chair must have the relevant skills to be able to lead the partnership.		✓	
10	The ADAT Team Leader roles and responsibilities should be consistent nationally, should reflect the high level of complexity and autonomy inherent in the role, and should be graded and paid commensurately. The ADAT Team Leader should have clear accountability to the Chair of the ADAT who will be responsible for the line management function of the Team Leader.	✓	✓	
11	There should be a review of the range of representation on ADATs bearing in mind the importance of limiting the size of the strategic team to maintain effectiveness. Membership of the wider ADAT structure should be enlarged to include, for example, CJAs and GPs.		✓	
12	Partnership representation should be at a very senior level and be representative of the strategic agencies that are involved in substance misuse issues. Partners should be given guidance about what membership of the ADAT will require of them.	✓	✓	
13	The Scottish Executive should review with ADATs (1) the number and size of strategic partnerships to enhance strategic capability and; (2) the best structure for implementation at local level to ensure a good fit in particular with Community Planning Partnerships.	✓	✓	
14	We recommend the Scottish Executive should establish clear linkages and responsibilities between the following tiers: <ul style="list-style-type: none"> <li>○ The Ministerial Steering Group (national)</li> <li>○ Substance Misuse Strategic Partnership (regional)</li> <li>○ Substance Misuse Implementation Partnership (local).</li> </ul>	✓		

No	Recommendation	Scottish Executive	ADAT	Other
	<b><i>Performance and Accountability</i></b>			
4	The Scottish Executive, in consultation with ADATs, should replace the Corporate Action Plan (CAP) with an Annual Delivery Plan which meets local and national requirements.	✓	✓	
9	ADATs should be directly accountable to the Minister(s) through an annual accountability meeting between the Minister(s) and the ADAT Chair.	✓	✓	
18	All ADATs should develop a 3-year Strategic Plan which sets the direction of travel and is regularly reviewed and updated.		✓	
21	ADATs should be prepared to consider all providers – statutory, voluntary and private – when commissioning and be prepared to move inefficient and/or poor quality services away from existing providers. There should be a level playing field among providers – statutory, voluntary and private.		✓	
22	ADATs should make use of commissioning and contracting expertise available within partner agencies.		✓	
24	The Annual Delivery Plan should meet the performance management needs of the ADAT and the Scottish Executive and should form the basis of the annual accountability meeting with the Minister.	✓	✓	
25	ADATs should promote the adoption of the National Quality Standards. The guidance framework to be developed for ADATs (Recommendation 2 refers) should include an explicit statement about the role of ADATs in relation to implementation of the Standards.		✓	
26	ADATs should give greater emphasis to meeting the needs of families and carers and the potential for their participation in shared care arrangements and in informing service development.		✓	
27	ADATs should improve the involvement of service users and put in place mechanisms to capture and act on their views.		✓	
29	ADATs should develop a public engagement strategy within their 3 year Strategic Plan. It should encompass plans in relation to communities, families and carers, and service users. Implementation should be through the ADAT Annual Delivery Plan.		✓	
30	The Scottish Executive should: ensure that compliance with the National Quality Standards is monitored; consider the use of HEAT targets to deliver improvements in drug and alcohol treatment services; and explore the need to work with the clinical community to secure consistent and equitable compliance with Clinical practice.	✓		

No	Recommendation	Scottish Executive	ADAT	Other
31	The Scottish Executive should work with ADATs to develop national outcome measures, including the identification of robust proxy measures for less tangible outcomes. This could be informed by the experience of developing outcome measures elsewhere in the UK.	✓	✓	
	<b><i>Integrated and Consistent Approaches</i></b>			
1	There should be a regular meeting between ADAT Chairs and the relevant Minister(s) to discuss and develop national policies on drug and alcohol misuse. This might take the form of a National Steering Group chaired by the Ministers.	✓	✓	
3	The Scottish Executive should have an integrated team to lead on drug and alcohol misuse issues.	✓		
7	The membership of both national expert committees, SMACAP and SACDM, should be reviewed and extended to include the same range of representation expected at local level. These Committees should be responsible for offering expert advice to the National Steering Group, chaired by the Minister(s). Consideration should also be given to merging the two expert committees to provide an integrated approach in a single substance misuse advisory committee.	✓		
17	There should be a systematic national approach to needs assessment involving service users and their families, and with better use of analytical expertise at local and national levels.	✓	✓	
23	Commissioners should contract for services with the voluntary sector on a level playing field basis; and should pay the full costs of service delivery.		✓	✓
28	The development of relevant national campaigns about drugs and alcohol should be undertaken in partnership with ADATs. This would include decisions about the focus and content through to planning and organisation. Steps should be taken to raise awareness of the National Communications Group and encourage participation by ADATs.	✓	✓	
	<b><i>Resources</i></b>			
16	ADAT partners should use existing resources to develop joint working in the sharing and analysis of local information, data collection, and trend analysis and forecasting.		✓	
19	Partner organisations in ADATs should be required to identify all dedicated expenditure on substance misuse activity and make it available for discussion and joint decision in the ADAT.		✓	✓

No	Recommendation	Scottish Executive	ADAT	Other
20	ADAT partners should be prepared to demonstrate their support where applications for charitable funding or funding from other external sources for the provision of projects and services in relation to substance misuse have been agreed with the ADAT, ADATs and partner organisations should aim to provide funding to voluntary sector organisations which is of at least 3 years duration, subject to satisfactory performance reports.		✓	✓
	<b>Capacity Building</b>			
5	There should be at national level a support unit providing guidance, statistics and analysis, research findings and information. This National Support Unit would bring together and build on the existing resource provided by ISD and Analytical Services in the relevant Justice and Health Directorates of the Scottish Executive.	✓		
6	SAADAT should review and refocus its role to ensure it meets the needs of ADATs and it should explore ways to work co-operatively with and complement the work of the National Support Unit.			✓
15	A Training Needs Analysis should be undertaken for all members and staff of ADATs and a timetable set for addressing those needs.		✓	
	<b>Conclusion</b>			
32	On the evidence gathered in the preparation of this report we believe that ADATs are, in the main, adding value to the substance misuse agenda. ADATs should continue as discrete partnership bodies, albeit in a form modified by the recommendations in this report.	✓	✓	✓

# **1 INTRODUCTION**

## **1.1 Setting the Scene**

- 1.1.1 There are an estimated 52,000 heroin and benzodiazepine misusers in Scotland, with the highest prevalence in inner cities, particularly Glasgow and Dundee. This represents around 1 % of the population in Scotland. The numbers of drug misusers coming into treatment are increasing year on year, about two thirds of them reporting heroin use. A growth in the use of cocaine and crack cocaine is also being detected across Scotland, although this remains low compared to some other parts of the UK. Thirteen percent of people entering treatment with an illicit drug use problem also report an alcohol misuse problem.
- 1.1.2 Excessive alcohol consumption is a more widespread problem. The Scottish Health Survey 2003 recorded that 27% of men and 14% of women are estimated to be drinking more than the safe weekly limits. Recommended Daily Limits are also being exceeded. The Survey recorded that of those who had drunk alcohol in the past week, 63% of men and 57% of women had drunk more than the recommended limit on their heaviest drinking day.
- 1.1.3 Among young people, 57% of 13 year olds and 84% of 15 year olds reported that they had drunk alcohol. Of these, around 15% of 13 year olds and 34% of 15 year olds reported that they had been drunk more than 4 times. Discharges from general hospitals of patients with alcohol related conditions increased by 16% over 8 years to 39,061 in 2005-6.
- 1.1.4 The misuse of drugs and alcohol in Scotland has serious implications, not just for the health and life chances of the individuals directly involved, but also for their families and wider communities. It brings additional costs for the health service and local authorities as well as for police and the criminal justice system.
- 1.1.5 To address these problems, the Scottish Executive has developed national policies on education and prevention treatment, rehabilitation and supply. The role of ADATs is to bring together the right partners at a local level to help deliver the national targets and meet identified local needs and priorities.

## **1.2 The Challenge for ADATs**

- 1.2.1 ADATs were amongst the earliest partnership initiatives formed to drive forward a programme of action which transcended several statutory agencies responsibilities and required statutory, voluntary and private sector providers to collaborate in order to make a difference.
- 1.2.2 ADATs are charged with seeking solutions to some of the most challenging and complex problems that affect communities, families and individuals. Substance misuse is a societal problem with real life complexities and uncertainties that do not respect the service boundaries of statutory bodies. The challenge for ADATs is to provide a multi-faceted collective response, involving complex inter-relationships

which are joined up at strategic and operational levels. We have addressed the challenge for ADATs under three key headings:

- **The Essential Components**

These are the factors that need to be present to ensure that a complex interweaving of responsibilities can be integrated into an action centred and outcome focused programme of work. These essential components form the environment in which the ADAT operates.

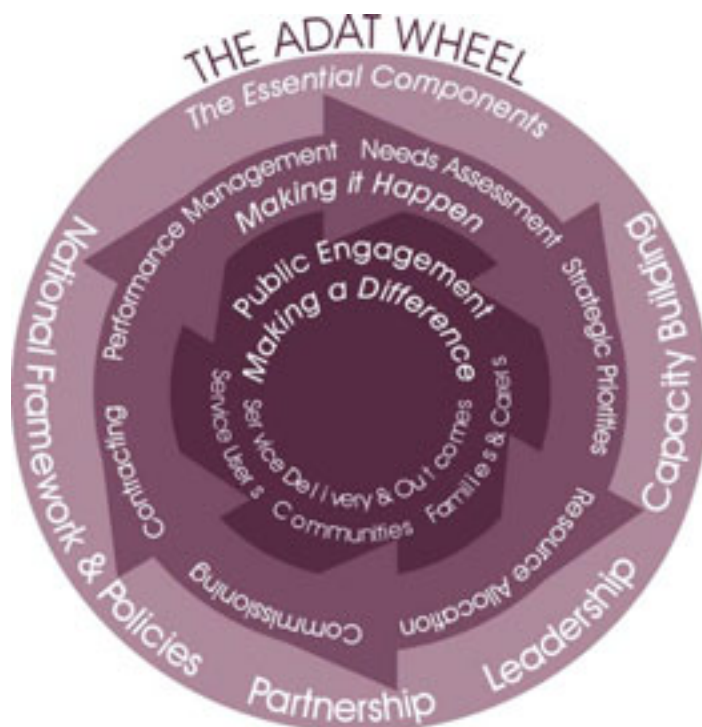
- **Making it Happen**

For ADATs to ensure that they focus their attention appropriately and effectively, they must have a clear and shared understanding of local needs and the strategic and operational measures that are required to meet those needs. This requires a planning and implementation process which both successfully delivers the ADAT's activity and continuously reviews its impact.

- **Making a Difference**

The difference that an ADAT makes is the impact of the collective endeavour of all the partners. In other words, have the actions of the ADAT resulted in services tailored to local need and which are responsive to the views of service users and carers as well as the wider community. This can be measured by the extent to which there is local awareness of the ADAT itself as well as the services available to tackle substance misuse.

1.2.3 These three key headings provide the structure for our report and we have devised a diagram to illustrate this. We have called this the ADAT Wheel, which is illustrated below.



## **1.3 Methodology**

- 1.3.1 The Stocktake of Alcohol and Drug Action Teams commenced in October 2006 and the full multi-agency ADAT Stocktake Team (AST) was in place from the beginning of November. The Stocktake was a crosscutting exercise carried out jointly for the Health and Justice Departments of the Scottish Executive to assess the performance of ADATs and examine their capability to deliver Ministerial priorities on drugs and alcohol. The full Terms of Reference are at Annex A.
- 1.3.2 The Stocktake was chaired by Sandy Cameron, also Chair of the Parole Board, and the Stocktake Team comprised an official from the Scottish Executive, a Community Planning Manager, a Police Inspector and two business consultants with collective Health Board experience as Chief Executive, Chair and Member. The Team's experience also includes executive and non-executive experience within the voluntary sector. A list of the membership is at Annex B. Analytical and research input was provided by the Analytical Services Divisions in the Health and Justice Departments of the Scottish Executive and the Information Services Division of the NHS.
- 1.3.3 The fieldwork was intensive and involved visiting every one of the 22 ADAT areas (23 ADATs) in Scotland and interviewing Chairs, staff, ADAT partners and, where possible, service users and carers. In preparation for this, the Team drew up a standard framework of questions to steer the interviews. The framework of questions was closely linked to the remit for the Stocktake and was agreed with Scottish Executive officials.
- 1.3.4 In preparation for each visit, Team Members reviewed an information pack for each ADAT. Included in this pack was the Corporate Action Plan (CAP), feedback given to the ADAT on the CAP by Scottish Executive, local statistical information, the local drug and alcohol strategy where available, local publicity material and any other available material that would be helpful to the Stocktake Team. Generally, two members of the Team undertook each visit.
- 1.3.5 In addition, the Team met a number of key national organisations and individuals as well as officials in Scotland, England and Wales. These are listed in Annex C. Altogether over 300 interviews were conducted between November and the end of April. The Team also read or consulted numerous relevant publications, many of which are listed in Annex D. The Team commissioned a survey conducted by Alcohol Focus Scotland of the views of alcohol service users and it drew on the views of service users commissioned as part of the review of methadone treatment. A survey was also undertaken of other local partnerships to identify the level of contact they report they have with ADATs.
- 1.3.6 This report is the conclusion of the work described above and the recommendations contained therein are based firmly on the evidence gathered.

## **2 BACKGROUND**

### **2.1 General**

2.1.1 Alcohol and Drug Action Teams have been in existence in various forms for over 15 years and their development is described below. In addition, there are a few other organisations that have a particularly close interface with ADATs and receive funding from the Scottish Executive to support this. Their role is also described below. There are of course many other organisations that work with ADATs in various ways but the relationship they have with ADATs is not of the same order and they are not referred to here, although they may be elsewhere in the Report.

### **2.2 Alcohol Action Teams**

2.2.1 Alcohol Misuse Co-ordinating Committees (AMCCs) were established as a consequence of a Scottish Office circular in 1989. Their boundaries were to reflect the then local government boundaries at regional and island level. Membership of AMCCs was to include representatives from the Health Board, a number of local authority departments including Social Work, Education and Housing, Licensing Boards, Police, Prisons, the drinks industry and the voluntary sector. Their remit was:

- to assess and keep under review the nature and extent of alcohol misuse and alcohol-related problems in their area;
- to develop local strategies for the prevention of alcohol misuse and to promote their implementation, including the provision of the necessary resources by the relevant authorities or agencies;
- to assess the provision of services in their area for people with alcohol-related problems and to develop and promote the implementation of proposals for improvements in services where needed;
- to promote co-ordination between local statutory and voluntary agencies and the private sector and industry in both prevention and treatment of alcohol misuse;
- to assess the education and training needs of professionals and voluntary workers concerned with the prevention and treatment of alcohol misuse, and to develop and promote the implementation of proposals for meeting these needs;
- to work, and to share information and experience, with other Co-ordinating Committees and national agencies as appropriate;
- to co-ordinate strategic plans for alcohol misuse with those for other areas of substance misuse.

2.2.2 In 1992 the Scottish Office established a fund to support the employment of AMCC Development officers and to undertake projects or campaigns, especially those aimed at the development of minimal intervention schemes. The role of the AMCC Development Officer was to include: supporting the Committee, compiling information, monitoring and liaison.

2.2.3 *The Plan for Action on Alcohol Problems* published in January 2002 recommended a wider remit for AMCCs and better co-ordination with other substance misuse issues. AMCCs were required to have at least one forum or group to ensure that community, voluntary sector and individual views were heard.

2.2.4 A Scottish Executive circular in March 2002 announced the setting up of Alcohol Action Teams (AATs) to replace Alcohol Misuse Co-ordinating Committees. The membership was to be similar to that of AMCCs and the importance of having representation at a senior level was emphasised. AATs were charged with local implementation of the Alcohol Action Plan. They were to do this by drawing up and publishing by April 2003, a local 3 year strategy. AATs were to ensure links with community planning structures.

## **2.3 Drug Action Teams**

2.3.1 Drug Action Teams (DATs) were established in 1995 on implementation of the report of the Ministerial Drugs Task Force. DATs were originally intended to be based on health board boundaries and were given responsibility for drawing up a strategic plan for tackling drug misuse locally and thereafter for driving and monitoring its delivery.

2.3.2 As a consequence of local government re-organisation at the same time, some of the new unitary authorities saw a need to have a DAT modelled on the local authority boundary. As a consequence, the number of DATs increased from the 15 originally envisaged to 22.

2.3.3 The Scottish Office circular of 1995 recommended that core membership would include representatives from health, social work, education, police and the voluntary sector. In addition, the prison service and Scottish Drugs Forum (SDF) might also be members. The circular envisaged DATs as small teams of senior people at or just below chief officer level who were knowledgeable about the issues and could develop a strategic plan to tackle all elements of drug misuse – including health, social work, education and criminal justice. The responsibilities placed on the DAT were:

- to ensure that information is collected and shared to enable an assessment to be made of the extent of, and trends in, the illicit use of drugs in its area;
- to ensure that effective drug prevention measures are developed with a view to reducing both demand (through information, education and other approaches) and supply (through a rigorous enforcement policy); and that these measures are co-ordinated across the relevant agencies represented;
- to assess whether the quality and range of services for drug misusers and their families meet identified needs (including physical, psychological and social welfare needs); and to plan and initiate improvements where they do not;
- to ensure that mechanisms are in place to take account of the advice provided by the community Drugs Forum; and
- to ensure that regular evaluation and reviews are undertaken of the services and activities of all agencies working in the field with a view to improving efficiency and effectiveness.

2.3.4 All DATs were required to draw up a strategic plan to which all members of the DAT must be committed. It was to cover education and prevention, enforcement and policing, needs assessment and service provision by the Social Work Department (including criminal justice social work services) and the Health Board, the contribution which could be made by the voluntary sector and, where

appropriate, any prisons dimension. Local objectives were to be set in relation to the key principles of:

- reducing the acceptability of drugs to young people by prevention and education methods which influence behaviour;
- policing activity to disrupt and arrest those dealing in illicit drugs thereby protecting the community from drug-related crime;
- developing responsive services for drug misusers (including arrangements for developing constructive alternatives to custody); and
- assisting misusers to become and remain drug-free.

2.3.5 Having established the strategic plan, the DAT was then responsible for ensuring, through its members, that the required resources were provided. DATs were also required to publish Annual Reports.

2.3.6 Funding for Drug Development Officers (DDOs) in each DAT was made available by the then Scottish Office through Health Boards. The principal duty of the DDO was to ensure implementation of the local strategic plan, as well as to act as secretary to the DAT, liaise with local agencies to gather information and develop prevention activities and draft the Annual Report.

2.3.7 Each DAT was to be supported by a local Drugs Forum, covering the same catchment area. The role of the forum was to represent the interests of drug misusers together with their families and carers, and representatives of communities affected by drug misuse. The Chair of the Drugs Forum would, ideally, also be a member of DAT. The practice has varied. In some areas a representative from Scottish Drugs Forum (SDF) fulfils this function.

2.3.8 The Scottish Office strategy *Tackling Drugs in Scotland: Action in Partnership* was published in 1999 and DATs were charged with a key role in delivering the strategy at local level. The strategy introduced Annual Corporate Action Plans which DATs were required to draw up to help drive local action and provide a link to the national strategy.

## **2.4 Alcohol and Drug Action Teams**

2.4.1 Because of the links between alcohol and drug misuse and because often the same people were members of the AAT and DAT, they have merged over time to become ADATs except in Greater Glasgow and Clyde. These were entirely local decisions, albeit supported by the Scottish Executive. A few areas have also added smoking to the remit. (Throughout this report we have used the acronym ADAT as a generic title for the existing teams although we recognise that they describe themselves in a variety of ways: DAT, AAT, SADAT, JADAT, DASAT, DAAT or ADAT).

2.4.2 There are 22 ADAT areas within Scotland with many different structural and operational arrangements. Of those 22 areas, 12 are based on local authority boundaries, 6 are co-terminous with both health board and local authority and 4 are based on health board boundaries. Across Scotland, the infrastructure for alcohol issues tends to be smaller than for drugs, partly as a reflection of the disparity in funding.

- 2.4.3 The membership of individual ADATs has grown beyond the dozen or so people and 7 or 8 partner organisations originally envisaged. Some ADATs have over 20 people as members and there are many different structural models including separate strategy and implementation groups.
- 2.4.4 Funding to support the operation of ADATs, including the salaries of drug and alcohol development officers and a senior co-ordinator is provided by the Scottish Executive. Some ring fenced funding for service provision is also provided. Funding is routed through the local NHS Health Board. In 2006-7, for drug services £23.7m was provided for treatment services and £1.5m for ADAT support staff. For alcohol services, £10 million was provided for treatment and prevention services and £1 million for ADAT support staff.

## **2.5 Scottish Association of Alcohol and Drug Action Teams**

- 2.5.1 The Scottish Association of Alcohol and Drug Action Team (SAADAT) is a voluntary network which aims to support ADATs by providing co-ordination between ADATs, exchanging good practice and representing ADATs at a national level. SAADAT was formed in May 2006 from the merger of the two separate co-ordinating bodies for drugs and alcohol respectively. The Association receives funding from the Scottish Executive. In 2006-07 this was £ 205,000 to cover the respective costs of the National Drug Liaison Officer and the National Alcohol Liaison Officer as well as their assistants and other associated costs. The National Liaison Officers are line managed by the respective SAADAT Vice Chairs for drugs and alcohol and their work programmes are set by the SAADAT Executive. For convenience, both National Liaison Officers are hosted in Alcohol Focus Scotland.

## **2.6 Scottish Drugs Forum**

- 2.6.1 The Scottish Drugs Forum is the national non-government drugs policy and information agency working in partnership with others to co-ordinate effective responses to drug use in Scotland. SDF aims to support and represent, at both local and national levels, a wide range of interests, promoting collaborative, evidence-based responses to drug use. Various Scottish Executive departments provide core and project funding. SDF activities, which relate only to the drugs element of ADATs, include supporting drug forums, improving the interface between ADATs and service users, sitting on ADATs or ADAT sub-groups, encouraging service users to become more engaged in the issues being discussed by ADATs and representing local voluntary sector organisations. SDF is represented at SAADAT meetings.

## **2.7 Alcohol Focus Scotland**

- 2.7.1 Alcohol Focus Scotland (AFS) is Scotland's main voluntary sector body dealing with alcohol misuse. It receives core grant funding and project specific funding (for example for the ServeWise programme for responsible retailing of alcohol) from the Scottish Executive, but is wholly independent of it. AFS is represented at SAADAT meetings.

## 3 THE ESSENTIAL COMPONENTS

### 3.1 Introduction

3.1.1 The essential components are the factors that need to be present to enable the ADAT to operate effectively. We have identified these as:

- National Framework and Policies
- Leadership
- Partnership
- Capacity Building



### 3.2 National Framework and Policies

3.2.1 *Tackling Drugs in Scotland: Action in Partnership* (1999) and *The Plan for Action on Alcohol Problems* (2002) are the key national policy documents which have guided the activities of ADATs. The more recent *Plan for Action on Alcohol*

*Problems: Update* (2007) was published towards the end of the Stocktake exercise, so the policy context in which ADATs were operating for the purposes of this report was within the original 2002 Plan.

3.2.2 This section focuses on the national framework and policies which provide the underpinning guidance for ADATs and identifies some of the ways in which the ADATs role could be clarified and strengthened to ensure that they have the capacity to deliver on these plans. These are considered under the following headings:

- The role and remit of ADATs
- The role of the Scottish Executive
- Corporate Action Plans
- National guidance and research
- National groups

#### *The role and remit of ADATs*

3.2.3 ADATs have a wide ranging focus – on a continuum from education and prevention to rehabilitation, taking into account enforcement issues, treatment, throughcare services, employment issues, health education and a number of interventions aimed at reducing drug and alcohol misuse. They are responsible for ensuring the provision of information and services to a diverse client group from those whose use of alcohol or other drugs does not, at least at present, affect their lives adversely to those whose lives are dominated by their addiction.

3.2.4 The overwhelming majority of ADATs felt that the partnership and its activities should reflect this wide range of issues and services. However, many ADATs felt that at a national level there was a primary focus on treatment and that the prevention and health education aspects of their services were not viewed as having

the same importance. This ranking of importance tended to be reflected at local level.

- 3.2.5 Almost all ADATs felt that there was an imbalance of focus and funding between drugs and alcohol services – with drugs having a higher national profile, priority and budget. However, in the main, outwith the major cities, while there was concern about levels of drug misuse, the majority of ADATs felt that alcohol issues were more of a concern within their areas and that the levels of centrally allocated resource for alcohol related activity were disproportionately small compared with that allocated to drugs activity.
- 3.2.6 In recent years there has been a number of policies, strategic developments and reports which have impacted on ADATs. These include issues around criminal justice, health and homelessness, community regeneration, children’s services, community safety and mental health and addictions, drug related deaths and quality standards.
- 3.2.7 Child protection in particular has become a significant additional responsibility as part of the wide ranging response to the *Hidden Harm* report on children in substance misusing households. Children in substance misusing households have been the subject of new national policies and direction over the last 4 years. This had increased the attention of all the key partners in ADATs on the vulnerability of children and the range of actions and initiatives needed to improve the way in which they can be supported and protected. This area of work had been a significant priority for ADATs and most ADATs were able to demonstrate good links with Child Protection Committees.
- 3.2.8 The development of policies and approaches in relation to Drug Treatment and Testing Orders (DTTOs) and Arrest Referral and the establishment of Community Justice Authorities appeared to have taken place without any reference to the role and potential contribution of ADATs. This had resulted in poor continuity at a local level so that people coming off a DTTO regime may have to wait to get back into mainstream treatment services. There was also some anecdotal evidence of people committing crime to get a DTTO and thereby fast track themselves into treatment.
- 3.2.9 Many ADATs expressed frustration with the lack of engagement between ADATs and Scottish Executive when national priorities and policies are determined. They felt that local needs and priorities should inform national priorities. Many ADAT members would welcome the opportunity to contribute their knowledge and experience to the development of national policies. They wanted a policy framework which set a clear lead in terms of robust national objectives but allowed the flexibility to address local needs.
- 3.2.10 It is our view that the development of national policies and priorities could be enhanced by drawing more actively on the valuable knowledge and experience that exists among ADAT members. This would enable ADATs to contribute their experience about what works at a local level and their views about where national policies could be developed. The Chairs of ADATs should be well qualified to support Ministers in this way and we propose that there should be regular dialogue, perhaps yearly or twice yearly, between Ministers and the ADAT Chairs collectively to assist Ministers in steering national policy. This might take the form of a

National Steering Group. Discussion at such meetings would be informed by the advice of experts on the national advisory committees (see paragraph 3.2.33).

**Recommendation 1: There should be a regular meeting between ADAT Chairs and the relevant Minister(s) to discuss and develop national policies on drug and alcohol misuse. This might take the form of a National Steering Group chaired by the Minister(s).**

- 3.2.11 Almost all of those interviewed had a good understanding of the main role of the ADAT (in relation to the role envisaged when DATs were first established in 1995). However few ADATs had had any partnership discussion on clarifying and updating this understanding (e.g. when new members or partners attend) which had led to partnerships not always having a shared, common understanding of their role and responsibility in relation to drugs and alcohol services. The majority of ADATs felt that it was important to revisit and clarify their role and core areas of responsibility – both at a national and local level and were keen to work with the Scottish Executive to develop this updated remit.
- 3.2.12 We have given considerable thought to whether ADATs should be responsible for the full spectrum of drug and alcohol misuse interventions from education and prevention through to treatment and rehabilitation. We have also looked at the perceived distinctions between people who are “problematic” substance misusers and those, for example, who by regularly drinking alcohol in excess of the recommended limits, are putting at risk their long term health. We concluded firmly that ADATs should retain their existing wide ranging remit because: the core education and prevention messages are broadly the same irrespective of the nature or extent of the substance misuse; for most purposes, it makes no sense to deal with alcohol separately from drug misuse, especially when there appear to be growing numbers who misuse both; and, some people will move from level of misuse to another. For example, binge drinkers or those who regularly drink in excess of recommended limits or “recreational” drug users may develop an addiction over time (or may live with someone who has an addiction). Accordingly, we take the view that ADAT partnerships should reflect the wide range of organisations that have an input into drug and alcohol related services.
- 3.2.13 That is not to assert that ADATs should give the same weight of attention to all aspects of substance misuse. For example, healthy living or lifestyle campaigns aimed at excessive alcohol consumption are most appropriately conducted at a national level, with ADAT support and reinforcement locally. And the respective partner organisations will have their own particular areas of expertise and specialism e.g. treatment services, enforcement issues, licensing, etc and these will continue to be developed by the individual organisations but inside the broad framework of the ADAT. Partnership working can not only ensure that these activities are more complementary and co-ordinated but can also add value through working together. ADATs should ensure that their activities are not simply a collection of partner services and plans ‘bolted together’ – but a complementary set of shared aims and targets which reflect local circumstances and priorities. Given the growing complexity of partnerships and the issues which impact on ADATs, an important aspect of an ADAT’s work is to focus its energies on priorities that need the added value of a partnership approach.

**Recommendation 2: The Scottish Executive should review the responsibilities of ADATs in consultation with them and set this out in a single guidance framework which should identify the respective national and local responsibilities and those which will benefit most from the strength of a local partnership approach. The framework should be kept under review and take into account changes in policies, strategies and partnerships.**

*The role of the Scottish Executive*

- 3.2.14 It is widely recognised within ADATs that the Scottish Executive has a key role to play in leading the development of effective policies, facilitating effective partnership working and providing central support and guidance to assist partners to deliver national priorities at a local level.
- 3.2.15 We heard a widely expressed view that national policies, especially in relation to drugs, placed too much emphasis on treatment and too little on education and prevention. The balance between alcohol and drugs was mentioned frequently and ADATs welcomed the increasing emphasis at a national level on tackling alcohol misuse which in most areas was seen as a far greater problem than drug misuse. They saw a role for the Scottish Executive in influencing the major producers and suppliers of alcohol to reduce availability and increase price.
- 3.2.16 Generally the majority of ADATs felt that they had a good relationship with Scottish Executive officials. Comments mostly frequently cited were good communication, information provision and contact maintained regularly. However some commonly raised concerns included: lack of communication between and within Executive departments; frequent changes of staff making it difficult to achieve consistent relationships; information requests that are often made at short notice; and asking for information that is not easily obtainable at a local level or has already been requested by another part of the Executive. There were concerns also that the expectations about what ADATs could do or influence was unrealistic. They could not, for example, force GPs to provide treatment services, although they can and do encourage GPs to do so.
- 3.2.17 Most ADATs commented on the transfer of drugs policy into the Justice Department and its separation from alcohol policy. They found this unhelpful and out of step with action at local level and the increase they perceived in dual or poly substance misuse. It was clear that ADATs thought that the separation of Departmental responsibility for drugs and alcohol signalled a significant shift in drugs policy from being a health to a criminal issue, even although the Ministerial responsibilities remained unaltered.
- 3.2.18 There is undoubtedly a high level of frustration at perceived duplication of effort which ADATs feel diverts them from other activities. While ADATs were generally very happy with the contacts they had with individual officials, they perceived the organisation was not operating in the joined up way it expected of others. This led to cynicism about the Executive's commitment to tackling substance misuse which we believe could be addressed by a visible demonstration of a commitment to a more integrated approach.

**Recommendation 3: The Scottish Executive should have an integrated team to lead on drug and alcohol misuse issues.**

- 3.2.19 Overall the majority of ADATs felt that the processes of administration they had to adhere to and the level of guidance and support received did not meet their needs or expectations. A key example of this is the development, monitoring and feedback for the Corporate Action Plans.

***Corporate Action Plans***

- 3.2.20 ADATs are required to produce an annual Corporate Action Plan (CAP) which reports on progress towards the national targets. The Plan sets out the ADAT membership and support funding, performance contract requirements, allocation of resources and provision of services, support and treatment information, ADAT progress in relation to the national targets and accounts for the ring-fenced resources expended on drug and alcohol prevention, treatment and support services. There is also a requirement to indicate in the CAP key planned actions for the forthcoming year. ADATs regard this document as the key accountability framework required by the Scottish Executive.
- 3.2.21 Despite this, few ADATs felt that the CAP was helpful and a number of ADATs had developed their own local delivery plans in parallel with the CAP. In the main, completion of the CAP was cited as a cumbersome exercise and it was not considered to be an accessible document. Few ADATs felt that the CAP helped them to take forward the business of the partnership and delivery in any robust way. Nonetheless, many ADATs seemed to rely on the CAP rather than a local strategy to direct their priorities. Six ADATs had no long term alcohol or drugs strategy and of the remainder, only eight had current specific strategies in place.
- 3.2.22 Overall ADATs are keen to progress national targets and priorities but with some degree of flexibility to take account of local circumstances, geography, social trends and issues. The process of annual action planning should provide a working framework for ADATs. The current CAP process should be reviewed and replaced with a more meaningful Annual Delivery Plan, which reflects negotiated local priorities and targets agreed between the ADAT and the Scottish Executive and will be useful as both a local planning and monitoring tool and a reporting mechanism for the Scottish Executive.

**Recommendation 4: The Scottish Executive, in consultation with ADATs, should replace the Corporate Action Plan (CAP) with an Annual Delivery Plan which meets local and national requirements.**

***National guidance and research***

- 3.2.23 Access to central research and guidance was an area that ADATs felt was important, as was information on successful interventions and areas of good practice which they could replicate. Statistics and data provided via the Information Services Division (ISD) of NHS Scotland to ADATs were regarded as being extremely useful. The dissemination and analysis of statistics and good practice on a national

and international basis was deemed to be an important central role which could be strengthened.

- 3.2.24 The majority of ADATs reported that the Scottish Executive Effective Interventions Unit (EIU) had fulfilled an important role in providing guidance and information about effective practice, evaluation and research and that its demise has left a gap in their knowledge. As a consequence, many ADATs expressed a strong desire for a central guidance and research function which would keep them informed of national and international findings, good practice and evidence of what works well.
- 3.2.25 Despite some ADATs having research and development staff, who do useful work in this area, we believe that they do need central support to ensure that research activity including national research analysis and information is co-ordinated and efficiently disseminated. It would be helpful if research information was brought together with statistical analysis, guidance and good practice advice into a National Support Unit. This Unit would bring together and build on existing resources and information currently produced by ISD and Analytical Services in Justice and Health Directorates of the Scottish Executive.

**Recommendation 5: There should be at national level a support unit providing guidance, statistics and analysis, research findings and information. This National Support Unit would bring together and build on the existing resource provided by ISD and Analytical Services in the relevant Justice and Health Directorates of the Scottish Executive.**

### *National Groups*

#### *SAADAT*

- 3.2.26 The Scottish Association of Alcohol and Drug Action Teams (SAADAT) is responsible for assisting ADATs, improving communication across ADATs and with other key organisations, sharing information and good practice and representing ADATs at a national level. SAADAT also directs the work of the National Drug Liaison Officer and the National Alcohol Liaison Officer. The Association receives almost all of its funding from the Scottish Executive.
- 3.2.27 Many of those interviewed commented on the role of SAADAT. The most frequent comments were: SAADAT meetings are too big to be useful and that it is trying to do too much being a forum for Chairs and practitioners, raising awareness of policy issues and practices and highlighting effective practices. A number of Chairs felt that attendance at SAADAT meetings was more appropriate for co-ordinators. There was a widely held view that SAADAT was trying to do too much for too many different participants and lacked focus.
- 3.2.28 Evidence and examples of good practice were identified throughout Scotland (as illustrated within this report). Sharing of good practice was an area which ADATs felt was important. There were a few examples where approaches, campaigns and activities were being shared. For example, the Pink Handbag campaign aimed at young women drinkers, and the Think Before You Drink board game were being shared across the country. Most ADATs see the need for a national ADAT

Network which will allow them to share experiences and practice. Suggestions from a few of the ADATs included a more focused role for SAADAT to ensure shared experience and alignment of activities across Scotland. In the light of this we believe SAADAT should review its role and, in consultation with the Scottish Executive, consider how it can dovetail with the National Support Unit.

**Recommendation 6: SAADAT should review and refocus its role to ensure it meets the needs of ADATs and it should explore ways to work co-operatively with and complement the work of the National Support Unit.**

*SMACAP and SACDM*

- 3.2.29 The Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) and Scottish Advisory Committee on Drug Misuse (SACDM) are the national expert groups which bring together representatives from a wide range of national organisations who have considerable knowledge and experience in their particular areas of expertise. However, a number of key interests are not represented. For example, despite the importance placed on the role of education in prevention, there is no education representative on either Committee and there is no social work representation on SMACAP although a representative has recently been added to SACDM.
- 3.2.30 These Committees have met sporadically in the last few years and direct Ministerial involvement has varied, especially in relation to SACDM. The perception this creates, however unintentional, is that substance misuse has declined in importance as a Ministerial priority.
- 3.2.31 The majority of the ADATs thought that the joining up of alcohol and drug teams at a local level was highly appropriate – the social causes and impact of these two issues having considerable overlap as well as the growing incidence of poly substance misuse. Many of the ADATs felt that this joined up approach should be reflected throughout local, national and central structures and felt that merging of the two national expert groups would be advantageous in developing national policies in relation to substance misuse. We believe this would be a sensible approach which would aid more integrated development of policy in relation to substance misuse and would be a more efficient use of resources.
- 3.2.32 With regard to the membership of the advisory committees, we take the view that all of the key interests that should be represented on ADATs should also be reflected at national level. The membership of both SMACAP and SACDM should be reviewed to include the Association of Directors of Social Work (ADSW), the Association of Directors of Education (ADES), the Association of Chief Police Officers (ACPOS) and, possibly, the Society of Local Authority Chief Executives (SOLACE).
- 3.2.33 We have also considered the role of the expert committee(s) in light of our earlier recommendation (Recommendation 1 refers) that there should be greater involvement by ADAT Chairs in advising Ministers in relation to national policy and priorities through the formation of a National Steering Group. There is undoubtedly a need for expert advice and information and we are in no doubt that

their role should continue. But rather than advising the Minister(s) alone the advisory committee(s) would advise the National Steering Group.

**Recommendation 7: The membership of both national expert committees, SMACAP and SACDM, should be reviewed and extended to include the same range of representation expected at local level. These Committees should be responsible for offering expert advice to the National Steering Group, chaired by the Minister(s). Consideration should also be given to merging the two expert committees to provide an integrated approach in a single substance misuse advisory committee.**

### **3.3 Leadership**

#### *ADAT Chairs*

- 3.3.1 The leadership of an ADAT is critical to its success and this was one of the most frequently cited characteristics in relation to identifying success criteria for ADATs. Chairs and support staff have a pivotal role to play in this success. This is clearly underlined by the evidence gathered which demonstrates that the most effective ADATs were those that benefited from strong, focused leadership.
- 3.3.2 The Chairs of ADATs across Scotland come from various organisations – but mostly health and local authority. The role of the Chair is an important one – but it is an additional role, and the time and commitment given to this varies throughout ADATs. The Chair needs to be able to take on this leadership role and champion the development and integration of drugs and alcohol services within the area. The Chair has to be well supported by the ADAT staff team to enable him/her to do this. The key issues here are that the ADAT Chair must be a very senior or chief officer; have the skills and competencies to lead, develop and give strategic direction to the ADAT; and be able to command the respect of his/her peers.
- 3.3.3 We gave consideration to how ADAT Chairs should be chosen and appointed. In this context we looked at whether it would be sensible and bring improvements if Chairs were appointed by Ministers following an open advertising and public appointments process. We concluded however that while that approach might resolve the capacity issues, it could give rise to conflicts of accountability between the appointed Chair of an ADAT and the chief officers of partner organisations. Furthermore, we concluded that partnership working would be more likely to be enhanced if the ADAT partners agreed among themselves which of them should provide the Chair of the ADAT, perhaps on a rotational basis.
- 3.3.4 We also considered the accountability of ADATs in relation to the delivery of national and local targets. This is considered in more detail in paragraphs 3.4.18-21. However, the role of the Chair and his/her direct relationship to the relevant Minister is crucial. This has eroded over recent years. We believe that there should be an annual accountability meeting between the Minister and each ADAT Chair which would provide an opportunity to discuss the national and local priorities and the achievement of targets.

**Recommendation 8: The choice of Chair should be made by members of the ADAT partnership. The ADAT Chair must have the relevant skills to be able to lead the partnership.**

**Recommendation 9: ADATs should be directly accountable to the Minister(s) through an annual accountability meeting between the Minister(s) and the ADAT Chair.**

### *ADAT Support Staff*

- 3.3.5** Support staff across the ADATs are employed by a number of host organisations – but the majority are employed by the NHS or local authority. The roles, remit, conditions of service, salaries and levels of expertise vary enormously. Most support teams are led by a co-ordinator. While most of the co-ordinators work closely with the Chairs, few are line managed by the Chair. The majority are managed by their respective host organisations or have dual accountability arrangements. This could, on occasions, lead to difficulties with line management and appraisal responsibilities which could be resolved if the role of the employing authority was confined to “pay and rations”.
- 3.3.6** A few ADAT staff had dual responsibilities – both for ADAT development and for other duties determined by the employing or sponsoring organisation. The majority of staff interviewed regarded themselves as being ADAT staff – responsible to the partnership rather than the organisation which employed them. This was confirmed by the majority of staff having work plans which reflected the aims and objectives of the ADAT and the Corporate Action Plans.
- 3.3.7** There was a great deal of expertise and skills within the support staff team – and some extremely capable co-ordinators who were fulfilling leadership roles. However there was wide variation in skill levels and areas of responsibility from management to administrative grades and salaries.
- 3.3.8** The staff team needs to have the right capacity and capability to provide effective support to the Chair who will almost always be a senior manager with other significant demands on his or her time. In particular the role of the Co-ordinator is crucial and that individual has to have the skills to act on behalf of the Chair to drive forward the work of the ADAT. There is a need to review the roles and responsibilities of ADAT support staff, ensuring that they are consistent and that there is a national competency framework in place, which ensures that the right people with the right skills are in post.
- 3.3.9** It is our view that the role of Co-ordinator (or senior support team officer) should be enhanced to require someone of sufficient seniority and ability to drive forward the work of the ADAT on behalf of the Chair and other partners. Such a post, perhaps entitled Team Leader, would be accountable to and managed by the Chair and have responsibility for the performance of the ADAT support staff. The roles and responsibilities of the Team Leader should be consistent nationally. The complexity and autonomy of the Team Leader role will require a high level of skills and experience and the grade and salary of the post should reflect these responsibilities.

**Recommendation 10: The ADAT Team Leader roles and responsibilities should be consistent nationally, should reflect the high level of complexity and autonomy inherent in the role, and should be graded and paid commensurately. The ADAT Team Leader should have clear accountability to the Chair of the ADAT who will be responsible for the line management function of the Team Leader.**

## **3.4 Partnership**

### *Partnership and Joint Working*

- 3.4.1 This section focuses on those aspects of joint working which enable some partnerships, more than others, to be more effective and have a higher, more credible profile within their area of operation.
- 3.4.2 Some of the difficulties encountered by ADAT members included the disparate cultures of partner organisations, exacerbated by different accountabilities, decision-making arrangements and timescales. In terms of trying to understand this and work together, the role of the ADAT support officers was crucial.
- 3.4.3 Most ADATs felt that they had a key role in improving the range and quality of drug and alcohol services within their area and to ensure that these are co-ordinated and complementary. While all the partnerships were at very different stages of capability, many cited positive joint working relationships at operational level within their area and there was good evidence that this had resulted in the delivery of improved services.
- 3.4.4 ADATs cited a range of characteristics which made effective partnerships. These included: willingness and commitment; trust; good leadership particularly in relation to the Chair; experienced ADAT support staff; and, optimum geographical size where knowledge and expertise is shared.
- 3.4.5 The majority of ADATs felt that the partnership relationships at an operational or implementation level (within the sub structure of the ADAT) were particularly good and that closer working relationships had been established through developing activities and services, sharing information, networking, support and training opportunities. We saw some good examples of partnership working at an operational level with the ADAT having led the development of multi agency teams and a more client centred approach. (See Case Study 1.)

### **Case Study 1: Locality Clinic**

One ADAT agreed to provide funding to establish a Locality Clinic, to provide a fast and effective local treatment service to people referred by their GPs. The ADAT was concerned that the growth in numbers of people referred to treatment services during 2002, together with increasing reluctance among some local GP practices to treat drug users, meant that people referred to treatment services faced long waits for access to the help they needed. The ADAT partners developed the Locality Clinic model as a ‘shared care’ partnership between the LHCC, the Community Drug Problem Service, and a local voluntary organisation.

The service is available to people who are primarily dependent on opiates and are referred to the service by their GP. Waiting times are only a few days and, if necessary, patients can be seen the same day. The Clinic is staffed by a local GP, a specialist nurse and a drugs worker, who work with clients, to assess, treat and stabilise their drug use and to address other issues such as mental health, homelessness and debt. Once stabilised, the GP resumes direct care of the person, with ongoing support from the Clinic.

The Clinic has been operational for 4 years, and has proved a successful model of good collaborative practice between health, specialist drug service and the voluntary sector. In 2006-7 the service worked with 130 new clients, discharging 80 to their GP’s care with ongoing support from the Clinic. The ADAT is currently evaluating the effectiveness of the service as part of an external review of all services it funds.

- 3.4.6 Some ADATs could respond rapidly to changing situations - eg the impact of drug seizures on a user community – based on the strength of the trust that had developed among the ADAT partners. Although some smaller ADATs attributed this to the size of their “patch” and the way in which everyone knew each other, there was evidence of similar responsiveness based on trust in the larger ADATs as well.
- 3.4.7 We found that where there is a maturity of partnership working within the area (which is not just confined to the issues of drugs and alcohol) ADATs function better and have stronger links and relationships with the range of strategic partnerships in that area.
- 3.4.8 We believe that the ability to work jointly within a partnership is critical to the success of the ADAT and the processes and arrangements which underpin the teams are essential elements in aiding their effectiveness and the impact they have on tackling drug and alcohol misuse within their area. (See Case Study 2).

**Case Study 2: Development of a shared protocol for working with children and families affected by parental substance misuse**

One area has developed a protocol – involving NHS, local authority, voluntary sector and police. By working together, the ADAT and the Child Protection Committee set out actions to address the issues which impact on children within substance misusing families. Impact assessment framework and checklists have been developed and are being implemented. A comprehensive exercise was undertaken to identify all those children and young people who were affected by parental substance misuse to ensure that children and young people could be better supported. Regular communication and co-operation between the agencies has resulted in appropriate and well co-ordinated care plans for clients and highlights the needs of the children.

- 3.4.9 Having an effective, proactive structure at local level, involving all the relevant stakeholders is necessary to deliver the Executive’s drug and alcohol strategies. There needs to be a collective responsibility from the partner organisations to achieve this and a clear accountability to Ministers to delivering the key national priorities and targets.

***The right partners, at the right level***

- 3.4.10 It was originally envisaged that ADATs (or their predecessors) would comprise senior officers, or those within the key partner agencies able to make decisions and commit resources. Over time this has changed and many ADATs acknowledged that the seniority of those around the partnership table had drifted – with more middle ranking officers or substitutes representing the partner body. This has resulted in two developments: i) representatives of partner organisations lack the authority or seniority to make strategic decisions and commit resources and ii) the ADAT membership includes staff with a more operational/expert role. While operational staff undoubtedly have valuable expertise, their membership has tended to change the focus of ADATs to become more concerned with operational activity, thereby weakening the strategic focus.
- 3.4.11 We are in no doubt that to achieve their objectives, ADATs require to have representation from partner organisations at senior officer level – with the authority to commit and make decisions about resources (both budgetary and staffing) and to implement agreements made in the ADAT. ADAT partners should be in no doubt about what is expected of the individual identified to represent them in the ADAT. It would be helpful if guidance on this was prepared and issued by the ADAT.
- 3.4.12 ADATs were asked about the range of partners and the level of engagement that they had within the ADAT. A general picture throughout Scotland was that there were several partners who were not well engaged with the ADAT and consistently these were identified as education and, to a lesser extent, housing. The majority of ADATs felt that there was an extremely important role for education (schools in particular) in drugs and alcohol misuse prevention. Education services are in theory

represented on 20 ADATs but in practice they often do not participate at all or are represented at a junior level. Where education is an active participant, it can have a beneficial effect on substance misuse education. (See Case Study 3.) Only 6 ADATs had a representative from housing in their membership.

- 3.4.13 Licensing Boards were also poorly represented and their decisions often undermined the work of the ADAT. But this was not true everywhere and we saw some good examples of co-operative working. In one area the Licensing Board had been very supportive of the ADAT and worked with it to persuade local licencees not to discount alcohol or to provide “happy hours”. We heard the licensed trade generally was reluctant to become involved with the ADAT.

**Case Study 3: Developing a more consistent approach to drugs and alcohol education in schools**

Within one area an audit was undertaken of the drugs and alcohol education that was being delivered in all of the area’s secondary and primary schools. The issue of consistency was initially discussed within the ADAT forum - having been brought to their attention by differences in messages being delivered by some visiting speakers. Although the need was identified through the ADAT forum, the audit was undertaken by education staff within the area. The findings revealed a range of different approaches - and the need to have a more consistent approach across all the schools in the area was agreed. A new framework for drugs and alcohol education has been developed, identifying the key messages to be delivered. Training for teachers has also been delivered to support implementation of agreed programmes of drug and alcohol education. This has helped to equip them with the necessary skills and information required to get information across to young people as part of the broader personal and social development curriculum. All schools have now adopted the new guidelines and the way in which this educational input to young people is delivered is now much more consistent across this ADAT area.

- 3.4.14 The majority of ADATs have voluntary sector partners and a number of teams fully embraced the voluntary sector as equal partners in delivering drugs and alcohol services. Many voluntary and independent groups gained strength from the partnerships involved in ADATs. ADATs offered a wide range of expertise and a co-ordinated approach to drug and alcohol services in their areas. However many voluntary sector representatives felt they were not equal participants in the process. They attributed this to a perception that *not statutory* means *not professional* and tension with some voluntary organisations providing commissioned services. It is interesting to note that while conflict of interest was cited as a reason for not involving the voluntary sector, it did not seem to be recognised that the statutory sector partners were also providers of service as well as commissioners. In some areas a review of the structure of the ADAT had reduced voluntary sector representation significantly, while creating a separate forum for voluntary agencies that some saw as less influential.

- 3.4.15 While the range of organisations originally envisaged for DATs in 1995 and AATs in 2002 remains valid today, some adjustment is needed to reflect changes in structures and organisations. ADATs are operating within a changed partnership landscape, with a number of partnerships bodies having been developed to tackle the growing complexity of social issues.
- 3.4.16 The role of GPs and pharmacists in education, prevention and treatment is more important than ever and this should be recognised in determining the membership of an ADAT. Partner representation whether at a strategic or operational level should include health (at Board and/or CHP level), local authority (including social work, education and housing), Licensing Boards, Community Justice Authorities, police, prisons, the voluntary sector, employment, training, higher education, further education, procurator fiscal, pharmacists, General Practice, the local licensed trade and service user and community interests. However, it will be important to strike a balance between limiting the number of ADAT members to ensure an effective team while recognising the importance of relevant representation. Some representation will be more important at strategic level, other representation will be more appropriate at operational level. The structure of ADATs is considered in paragraphs 3.4.22-26.

**Recommendation 11: There should be a review of the range of representation on ADATs bearing in mind the importance of limiting the size of the strategic team to maintain effectiveness. Membership of the wider ADAT structure should be enlarged to include, for example, CJAs and GPs.**

**Recommendation 12: Partnership representation should be at a very senior level and be representative of the strategic agencies that are involved in substance misuse issues. Partners should be given guidance about what membership of the ADAT will require of them.**

#### *Partnership with other Partnerships*

- 3.4.17 In the course of the Stocktake, we wrote to other local partnerships to establish their perception of links with ADATs. The results were as follows:
- **Child Protection Committees:** 23 out of 32 of CPP's (71%) replied. Good links were clearly demonstrated throughout, the strongest of all partnerships. There were lots of examples of innovative partnership, working on joint initiatives and joint funding. Links were at a stage beyond merely structural arrangements – they were turning plans into action jointly. In some areas relationships were at an earlier stage of development but there was clear commitment and recognition of the importance of joint working.
  - **Community Health Partnerships:** 12 out of 38 CHPs (32%) replied. All reported strong structural links and official representation.
  - **Community Justice Authorities:** 6 out of 8 of the CJA's (75%) replied. All CJAs indicated that the ADAT had been identified locally as a key body to make links with; although all stated that they were currently in too early a stage of development to do this.

- **Community Planning Partnerships:** 15 out of 32 of the CPP's (47%) replied. The response suggested that ADATs seem to 'float' around the structures of CPP's with no standard place in the structure and rarely formal links. Occasionally the ADAT was a subgroup of the CSP.
- **Community Safety Partnerships:** 16 out of 32 of the CSP's (50%) replied. Where links existed they were with the alcohol side of ADAT business (where there is evidence of joint working), rather than the drug element.
- **Health & Homelessness Partnerships:** 7 out of 14 of the HHP's (50%) replied. Whilst links had been identified, they seemed to be fairly undeveloped or about to be reviewed. Links all appeared rather structural with no evidence of these being turned into joint initiatives.
- **Homelessness Local Authority Strategy Officers:** At their request, a presentation was given to this group. Feedback suggested that very few of them were aware of ADATs.

### *Accountability*

- 3.4.18 ADATs are not statutory bodies and their lines of accountability are not always clear. Almost all ADATs felt that they were ultimately responsible to the Scottish Executive in relation to delivering the national targets and priorities and accounting for the monies allocated for this purpose. However, around half saw their accountability as being three fold: i) to the Scottish Executive; ii) collectively through the other ADAT partners and iii) ultimately to local citizens and service users.
- 3.4.19 At a local level, the lines of accountability and reporting were varied. Some ADATs had reporting lines within local structural arrangements – these included informing or actually reporting to Community Planning Partnerships, Community Health Partnerships and Community Safety Partnerships. Many ADATs were 'free floating' – not anchored in any local structural arrangements, and were consequently fairly autonomous bodies lacking formal links with other local priorities.
- 3.4.20 A number of ADATs indicated that they had informal links with other local partnerships – mainly through officers being represented on more than one of these partnerships. In particular, there was often cross-representation between ADATs and Child Protection Committees. In general, these personal, cross-representational relationships were based on individual knowledge and dependent on this being shared, and not necessarily formal linkages. While undoubtedly personal contacts can help to facilitate good partnership, they may also make it difficult to challenge decisions or positions. In addition, an over reliance on personal contacts means that linkages could break down when individuals move on.
- 3.4.21 Partner organisations felt that ultimately it was the budget holder that carried the accountability for funding received – and this was primarily the NHS and the local authority. Funding via local authorities could also be complicated by having to be routed via the governance arrangements of committee structures and procedures.

Often it was the organisations who are the ‘bankers’ for the ADAT funding who were seen as the ‘lead’ partners.

### *The Size and Structure of ADATs*

- 3.4.22 The majority of ADATs felt that there was a requirement to have a structure which reflected local circumstances, needs and priorities. Accordingly, the size and boundaries of ADATs across Scotland varies significantly. Those that covered larger populations and more than one local authority area tended to have substructures intended to facilitate effective relationships at a local level whilst maintaining strategic integrity at a higher level.
- 3.4.23 Many ADATs had developed operational/implementation or themed sub-groups. However, the relationship between the ‘strategic’ and ‘operational’ levels was not always clear. Only a few of the ADATs across the country appeared to have a truly strategic overview. A ‘one size fits all’ approach to ADAT structures is unlikely to meet the needs of the diverse populations across Scotland. Nevertheless, the more effective ADATs tended to have a good strategic overview underpinned by operational sub-groups which drove activity and had a clear connection back to the main ADAT. From the evidence we collected, we believe that there would be merit in a two tier structure for most ADATs.
- 3.4.24 At a strategic level, reflecting health board or police authority boundaries, there should be a strategic partnership – perhaps called a Substance Misuse Strategic Partnership (SMSP). In some parts of Scotland it may be appropriate for health boards to join together in such a partnership. (We are aware of increasing activity across health board boundaries in relation to the planning of tertiary health services.) The SMSPs would take over the strategic roles and responsibilities of ADATs. The Chair of the SMSP would be accountable to the relevant Minister(s) as described in paragraph 3.3.4. The SMSP support team would be led by the team leader described in paragraph 3.3.9.
- 3.4.25 At an implementation or operational level, there is a need for close working with other key partnership groupings including Community Safety Partnerships, Child Protection Committees, Community Health Partnerships, Community Planning Partnerships and Community Justice Authorities. All of these partnerships are concerned with issues which connect with different aspects of drug and alcohol policy at a local level and the importance of a co-ordinated approach between them cannot be overstated. ADATs need to ensure that they recognise these interdependencies and ensure that they co-ordinate and align with these. For this reason we believe that at the level of Community Planning Partnerships, there should be implementation partnerships – perhaps called Substance Misuse Implementation Partnerships (SMIP) - which are accountable to the SMSP but are also firmly rooted within the statutory CPP, ensuring that the CPP is aware of and can support the work of the SMIP and SMSP.
- 3.4.26 The SMSP support team will provide the necessary administrative support arrangements to the SMIPs. This structure, together with the establishment of a National Steering Group (Recommendation 1 refers) would provide a clear linkage between national policy development through the Ministerial Steering Group, strategic implementation and sub national policy development through the SMSPs

and implementation through SMIPs who would be accountable to their SMSP and have a clear and explicit link to the Community Planning Partnership. A possible model, which also takes into account Recommendation 7, is illustrated below.



**Recommendation 13: The Scottish Executive should review with ADATs (1) the number and size of strategic partnerships to enhance strategic capability and; (2) the best structure for implementation at local level to ensure a good fit in particular with Community Planning Partnerships.**

**Recommendation 14: We recommend the Scottish Executive should establish clear linkages and responsibilities between the following tiers:**

- **The Ministerial Steering Group (national)**
- **Substance Misuse Strategic Partnership (regional)**
- **Substance Misuse Implementation Partnership (local)**

## 3.5 Capacity Building

*What is it?*

- 3.5.1 Capacity building is the process of developing and strengthening the skills, processes and resources that organisations need to grow and adapt. Individuals have the most important roles to play in that their personal and organisational skills, as well as development in terms of training, form a major part of this process. Good communication across structures and with individuals is essential. Capacity building within the ADAT structure should be driven by the leadership of the Chair and the organisations involved.
- 3.5.2 Capacity building is an area that needs to be constantly evaluated, monitored and supported. All ADATs require time, resources, flexibility and support to engage in training and development to sustain people, strategies and good performance monitoring to achieve their mission.

*What we found and commentary*

### ***Training and Development***

- 3.5.3 ADATs varied widely in how much priority they gave to addressing the training and development needs of ADAT members and staff as well as those of staff delivering services. A Training Needs Analysis for DATs was carried out by the DAT Association in 2002. However there appeared to be very little knowledge of it and no evidence that it had been acted upon.
- 3.5.4 STRADA (Scottish Training on Drugs and Alcohol) is a national training organisation which is funded by the Scottish Executive. STRADA is a partnership between the University of Glasgow's Centre for Drug Misuse Research and the Department of Adult and Continuing Education, and Drugscope (UK wide policy and practice organisation). STRADA provides a range of training, education and development opportunities to staff working in the drug and alcohol field.
- 3.5.5 STRADA has developed and runs a programme for primary care practitioners – "Care and treatment of drug misuse in primary care". This can lead on to the Royal College of General Practitioners (RCGP) Scotland Certificate in the Management of Drug Misuse in Primary Care, which is aimed at all practitioners with a special interest in drug misuse. The Scottish Executive has provided funding for 100 practitioners in 2007.
- 3.5.6 Since 2002 STRADA has commissioned the Scottish Leadership Foundation (SLF) to provide leadership development to ADATs across Scotland. SLF offers a customised development programme for ADAT partners in areas of leadership and partnership working. The objectives are to develop partnership working at a local/area level, and to create strategies and action plans to enable them to deliver their goals. The training also helps to develop a shared set of standards by which performance is evaluated as well as accountability arrangements for stakeholder organisations. The programme aims to develop a shared knowledge base on all areas of substance misuse and provide practical tools and techniques to support

partnership working. It has a core framework, which can be tailored to the needs of individual ADATs and comprises an initial development day, a two-day leadership programme and a follow up day after 6 months to review the action plan. To date eighteen ADAT areas have been involved in the leadership development programme to at least the first stage.

- 3.5.7 Members of the ADATs involved rated the SLF programmes very highly in terms of developing a shared understanding of the issues and a clearer understanding of the constraints of individual organisations, as well as having time to reflect with colleagues. ADAT support staff felt that these courses were excellent in terms of team building and helping them to understand their role, and that they assisted staff to know where they fit into the ADAT structure, providing some knowledge of the wider context.
- 3.5.8 For ADATs to be as effective as possible, the Chair, members and staff need to have a clear and shared understanding of its aims and objectives and of partnership working. Leadership skills are particularly important for ADAT Chairs and team leaders. Training has a key role in ensuring that the necessary skills are present. ADATs should assess their training needs, particularly in the light of any structural changes, and put in place arrangements to meet those needs.

**Recommendation 15: A Training Needs Analysis should be undertaken for all members and staff of ADATs and a timetable set for addressing those needs.**

#### *Research, Information Sharing and Communication*

- 3.5.9 Some ADATs had research and information officers. Those that did reported that they were an extremely valuable resource and some that did not have them felt the lack of such a role within the support team. These post holders provided a wide range of support including:
- Local data collection and dissemination.
  - Local research projects.
  - Information for the local provider network which assisted them to work more effectively together.
  - Linking with colleagues across Scotland and at the Scottish Executive and ISD to help develop national data bases and inform the research agenda.
- 3.5.10 The IT infrastructure available to ADATs was variable and there were issues of compatibility with other local systems. However, the underlying issues here were around information sharing and confidentiality which have been identified in other reports about joint working as requiring high level action. In several ADATs, considerable attention was being given to the issue of information sharing across agencies, mostly in the context of achieving single shared assessment.
- 3.5.11 Many ADATs were working on a Single Shared Assessment (SSA) model but none of these were fully operational. The design of the SSA varied from ADAT to ADAT. Some ADATs were developing a fully electronic system and were encountering problems with IT compatibility. Others were developing a paper based approach with the aim of moving to an electronic system in due course. Some

ADATs were including voluntary organisations in the SSA, others had decided that voluntary organisations should not participate, or at least not initially. Among both voluntary and statutory organisations there were reservations about sharing client information and concerns that there would be a breach of confidentiality.

- 3.5.12 It seemed to us that while many ADATs had a strong commitment to an SSA approach, some organisations used reasons of system compatibility or client confidentiality to slow down the development of an SSA when in reality the reluctance to share information was much more about cultural differences and about retaining ownership. It would be helpful to ADATs if the major statutory organisations such as health, local authority and police made a clear commitment to SSA and backed it up with endorsement and resources at a local level.
- 3.5.13 We looked at the extent to which ADAT partners shared non-client based information between themselves. There were some good examples of individual organisations seeing that their actions could impact on another organisation. For example, a number of police authorities had adopted the practice of informing the ADAT when they had made a significant seizure of drugs or when contaminated drugs were in circulation. The ADAT was then able to alert the other partners so that health and social work services in particular were prepared to deal with the consequences. The recent report *Common Knowledge* issued by H.M. Inspectorate of Constabulary for Scotland contains some very helpful recommendations about information sharing at all levels which, if implemented, would be helpful to ADATs.
- 3.5.14 ADATs communicated with the wider public through a variety of means including web based information, leaflets and the media. This is considered in Section 5.

## 4 MAKING IT HAPPEN

### 4.1 Introduction

4.1.1 In this section we address some of the key issues around the subject of what ADATs do in order to influence and put in place services that will make a difference to the problems of substance misuse.

4.1.2 To achieve this, ADATs need a planning and implementation process which successfully delivers and continuously reviews the impact of its activity. A number of stages are required starting with an assessment of needs and moving through other stages to the monitoring of performance which should feedback into re- assessing needs. The stages we identified in this process are:

- Undertaking Needs Assessment
- Determining Strategic Priorities
- Allocating Resources
- Commissioning
- Contracting
- Managing Performance



### 4.2 Needs Assessment

*What is needs assessment?*

4.2.1 Needs assessment is about identifying the needs of the target population and planning and delivering services to meet those needs. The aim is to ensure that the required range and capacity of services is available and accessible in a local area.

4.2.2 In the commissioning cycle, the starting point is the assessment of needs. This might be for a particular segment of the population. For example, for 12-14 year olds using alcohol/drugs, the assessment of needs would involve:

- the identification of prevalence and incidence of a condition or conditions.
- Needs as perceived by different agencies – for example intelligence from police, CSPs, schools, GPs, A&E departments.
- Needs as perceived by individual users, carers, communities – involvement of young people, families.

*What we found and commentary*

4.2.3 The predominant sources of information about needs were identified as:

- Prevalence data eg from SALSUS<sup>1</sup> & ISD<sup>2</sup>
- Trend Data eg from ISD

<sup>1</sup> SALSUS – The Scottish Schools Adolescent Lifestyles and Substance Use Survey

<sup>2</sup> ISD – Information Services Division, NHS Scotland

**ISD Substance Misuse Team:  
Alcohol and Drug Misuse**

**Information Sites**

These sites provide information, statistics and research on alcohol and drugs misuse in Scotland.

Information is provided at a national and local level. Target users are policy makers, professionals, researchers, employers and the wider community.

- Practitioners
- Providers (largely voluntary organisations)
- Partner agencies (sharing information and intelligence)
- ADAT Subgroups
- Any local surveys undertaken.

- 4.2.4 Public health involvement in ADATs was patchy, and more engagement from public health - a discipline that has expertise in formal needs assessment techniques - might ensure a more robust, evidence based approach. The police collect a large amount of relevant data and intelligence and had the expertise of analysts on their staff and we found some limited evidence of this being used in a collaborative way within ADATs. Most ADATs used a mixture of national statistics and local information to assess need. Some ADATs had commissioned surveys while others used their subgroups as conduits of locally derived information and intelligence. In rural areas there were comments about the problem of lack of anonymity when assessing the needs of a small rural community.
- 4.2.5 We found that in most areas local data collection and analysis was being undertaken by one or more of the partners. However, it was rare for partners to pool this information or to try to build a good local picture. We believe that much more effective use could be made of existing local information.
- 4.2.6 Most ADATs recognised that needs assessment was an aspect of their work that tended to be ad hoc, and over influenced by individuals and agencies making cases driven by their own interests.

**Recommendation 16: ADAT partners should use existing resources to develop joint working in the sharing and analysis of local information, data collection, and trend analysis and forecasting.**

- 4.2.7 Capturing the needs of any client group from the perspective of individual service users and their families is notoriously difficult. People have very different life experiences and expectations, and, particularly in the field of substance misuse, families are affected in widely different ways. In addition to these challenges, people abusing drugs and/or alcohol frequently experience chaotic lives that make it even more difficult to ascertain their perspective of their own needs.
- 4.2.8 Nevertheless, there are techniques that can be used, and organisations, such as SDF, have experience of assessing the needs of those affected by substance misuse. Service providers and practitioners can gather valuable information from those receiving services, although these sources inevitably focus on those already receiving services and may not only underestimate unmet needs but also leave them unidentified.
- 4.2.9 We found little evidence of systematic input from service users, their families or communities. User/stakeholder consultation and its impact on needs assessment was informal and relatively underdeveloped (see Section 5.2 - Public Engagement). In most ADATs there was a recognition that this was the case.

**Recommendation 17: There should be a systematic national approach to needs assessment involving service users and their families, and with better use of analytical expertise at local and national levels.**

### 4.3 Strategic Priorities

4.3.1 Eight ADATs had a current 3 year strategy. Of the remainder, eight had no specific strategy and six strategies were time expired. Most of the strategies, whether current or out of date, addressed both drugs and alcohol. Three ADATs had alcohol strategies only and all were out of date. Only one area had separate alcohol and drugs strategies but both were out of date. Many ADATs indicated they were in the process of revising strategies but were awaiting publication of the updated national strategies on drugs and alcohol. The approach to developing strategies varied from leaving the coordinator and other support staff to develop it, with later input from the ADAT, to the use of development days and full consultation with stakeholders. Despite its limitations (see paragraphs 3.2.20-22), some areas used the CAP as the starting point; in others, the main influencers were the sub-groups and/or local forums.

4.3.2 We take the view that all ADATs need to have a shared understanding and commitment to address local needs and national objectives. A Strategic Plan, produced as a result of dialogue between the ADAT partners is an important step in achieving that.

**Recommendation 18: All ADATs should develop a 3-year Strategic Plan which sets the direction of travel and is regularly reviewed and updated.**

4.3.3 There were some recurrent themes across ADATs in relation to determining strategic priorities:

- The importance of partner involvement at a senior level.
- Tensions among partner agencies in terms of an individual agency's priorities for resourcing.
- Cultural and political differences among partner agencies in terms of how strategic priorities should be determined.
- Getting the right balance between the strategic ADAT and its sub-groups – whether geographic or themed – in terms of agreeing strategic priorities.
- A tendency to focus on treatment services – influenced by what is relatively easily measured and the way that funding streams are directed.

4.3.4 Generally, ADATs reported a reasonable fit between national priorities and local needs and priorities. But the national preoccupation – at least until very recently – with illegal drugs rather than alcohol had not reflected the balance anywhere in Scotland, and in some areas, particularly rural Scotland, problems relating to alcohol abuse far outweighed those relating to illegal drugs. ADATs expressed consequent frustration with the perceived inflexibility of the way in which ring fenced money from SE has been focused on drug services, and the way in which the CAP demanded data that bore little relationship to local priorities. In particular, the CAP did not provide an appropriate focus for alcohol services.

## 4.4 Resources

4.4.1 ADATs have three potential sources of statutory funding:

- Scottish Executive ring-fenced money which currently goes to ADATs via local NHS Boards.
- Money already spent within individual agencies on substance misuse, for example:
  - a local authority may be funding a local voluntary organisation to provide support for people with substance misuse problems;
  - a health board may be providing a specialist health team for people with substance misuse problems.
- Additional money from agencies not ring-fenced nor currently spent on substance misuse services. This might come from the agency's efficiency savings or from additional general allocations from the Scottish Executive.

### *What we found and commentary*

4.4.2 There was variable transparency regarding the way in which resources were allocated, although some areas reported it was improving. A few ADATs had the assistance of a financial expert from one of the partners which had been helpful. Virtually all the funding that was allocated to the ADATs for decision was the ring-fenced funding which came through the Health Board. Many ADATs complained that the restrictions on the ring-fenced money made it difficult to meet locally agreed priorities, for example, where alcohol had been determined as a greater priority than drugs. Some however described their creativity in terms of ability to “bend the spend”, for example by shifting emphasis from drugs to alcohol where this was felt to be more of a local priority. But not all ADATs felt able to do this. Despite the restrictions on ring-fenced funding, some ADATs felt that the protection ring-fencing gave to drugs and alcohol money was very important as they felt that they would receive very little if it were left to the local NHS/LA to decide between other competing priorities. A few took the view that ring-fenced funding let the Health Board “off the hook” because they regarded the ADAT money as the limit of what is needed rather than as a lever to bring in more.

4.4.3 It was envisaged at the outset that the existence of the ring-fenced money would encourage the partners in an ADAT to put up for joint discussion and decision some or all of their respective, core expenditure on substance misuse. However, few ADATs had their ring-fenced money supplemented by additional resources from partners although a few did receive “in kind” support in the form of staff or accommodation.

4.4.4 In some areas, decisions tended to be governed by waiting times and other NHS priorities. In one area we were told that the Health Board had established a practice of top slicing the ring-fenced funding from its ADATs to fund alcohol treatment services. There appeared to have been no consultation with the ADATs about this. In some ADATs, there could be a conflict of interest, for example when an influential sub-group was chaired by a practitioner with a vested interest in the direction of spend.

- 4.4.5 The evidence suggests that ring-fenced funding is needed to ensure the prioritisation of expenditure on drugs and alcohol services. However, the balance of what is and is not inside the ring-fence is generally unhelpful and inhibits more comprehensive discussion and decision making by the ADAT. One area described the ADAT ring-fenced funding as “the icing on the cake” when they felt that the ADAT should have been dealing with the whole cake.
- 4.4.6 Most ADATs had little influence on the core funding streams of partner organisations. There were examples of “behind the scenes” influence that was difficult to quantify – a sense that the ADAT – usually through its support workers – was making some difference to the priorities of individual partners. It was felt that the influence varied according to which agency the Chair came from. Thus an NHS Chair was likely to have greater influence on the NHS than on the local authority.
- 4.4.7 ADATs found it difficult to get a complete picture of local allocations and expenditure on drugs and alcohol services. In addition to the ring-fenced funding for ADATs, Health Boards, local authorities, police, court services and prisons also spend significant sums on substance misuse. Some of this is hard to quantify where it is part of a service not dedicated to substance misuse, such as Accident and Emergency provision. But there is also significant expenditure on dedicated provision for substance misuse about which the ADAT is given no information. This includes national funding for Drug Treatment and Testing Orders and Arrest Referral and local expenditure on police campaigns as well as the more obvious expenditure by Health Boards and local authorities.
- 4.4.8 We believe that the role originally envisaged for ADATs is the correct one. The partnership should be the place where joint decisions are made about the most effective use of shared and complementary resources. To achieve this, however, needs greater transparency about the resources provided to and spent by the ADAT partners. Partner organisations should be required, with assistance from the Scottish Executive if necessary, to identify the resources that they spend on dedicated substance misuse services and put them up for joint discussion in the ADAT. ADATs will need appropriate financial expertise, possibly provided by one of the partner organisations, to monitor these resources.

**Recommendation 19: Partner organisations in ADATs should be required to identify all dedicated expenditure on substance misuse activity and make it available for discussion and joint decision in the ADAT.**

- 4.4.9 A few ADATs generated additional income and funding as a result of partnership working. There were examples of the following in several ADATs:
- Joint funding of a post eg between the ADAT and a Community Safety Partnership.
  - Input of different resources to achieve a single goal.
  - Access to charitable funding – usually through trusts eg Lloyds TSB Foundation, Big Lottery.
- 4.4.10 Some areas were good at stocking a “bottom drawer” with worked up proposals that could be taken out at short notice should Scottish Executive or charitable funding become available. Others gave no thought to this.

- 4.4.11 Funding is problematic in particular for voluntary sector organisations who find it difficult to access. Concern was expressed about the emphasis by the Scottish Executive and other funders on new and innovative approaches, often at the expense of existing and effective services whose budgets were frozen or discontinued. Often there is an unrealistic expectation by funders that services will somehow become self funding. Sometimes the voluntary organisation finds an alternative source of funding in the hope that the services will eventually be mainstreamed into the statutory sector. There are few examples across Scotland of this happening. As a result some voluntary sector organisations are financially precarious because they have to constantly chase funding from numerous resources to sustain services. The constant search for funding is time consuming and a diversion from client care obligations. Additionally, funding is often insufficient and short term. (See also Section 4.6 on contracting.) This can lead to the loss of experienced and qualified staff who require a secure, stable and structured environment in which both themselves and their organisation can progress.
- 4.4.12 Rapid turnover of staff and uncertainty about future or continued funding can undermine the quality of services. ADATs can address this by committing to providing longer term funding, of at least 3 years duration, subject to regular and satisfactory performance reports. Performance reporting should be rigorous but realistic in terms of the time commitment required to complete it and appropriate to the amount of funding being provided.
- 4.4.13 Many of the voluntary sector ADAT members receive funding from charities such as Lloyds TSB Foundation Partnership Drugs Initiative. However, many ADATs reported that they did not have a clear understanding or knowledge of funding coming from charitable or other sources. Sometimes, when that funding ran out, ADATs were expected to provide continuation funding even where they had had no say in determining whether the purpose of the funding fitted with the priorities of the ADAT.
- 4.4.14 There is no doubt that voluntary organisations play a valuable role in ADATs. They are often better placed to provide particular services and may be able to access funding that would not be available to the statutory partners. ADATs should recognise this potential. However, where there is an expectation that the ADAT may be required to match fund or in due course fully fund particular projects or services, then decisions about their development and applications for funding to operate them should be taken in the context of the strategic priorities of the ADAT. Decisions should be strategy, not funding, led. It follows that voluntary organisations have to be able and willing to participate fully in ADATs.
- 4.4.15 Where the ADAT partners have agreed that an application for external funding should be supported by the ADAT, partners should be prepared to demonstrate their support by formally endorsing the application or, if necessary, providing supplementary funding.

**Recommendation 20: ADAT partners should be prepared to demonstrate their support where applications for charitable funding or funding from other external sources for the provision of projects and services in relation to**

**substance misuse have been agreed with the ADAT, ADATs and partner organisations should aim to provide funding to voluntary sector organisations which is of at least 3 years duration, subject to satisfactory performance reports.**

## **4.5 Commissioning**

*What is Commissioning?*

4.5.1 Commissioning is the mechanism that translates strategic priorities into services on the ground and levers change, driving up quality and efficiency. It takes into account evidence of effectiveness of interventions, quality of services, and quantity required regardless of whether the provider comes from the statutory, voluntary or private sector. At the commissioning stage, the ADAT should agree where it should focus its partnership energy to effect maximum impact. It may agree that a service sits largely or wholly within one agency and should continue either to be the sole responsibility of that agency or that the delivery should be led by that agency. This may be appropriate where:

- Responsibility for the service clearly rests with a single agency eg blood testing for abnormal liver function.
- The ADAT partners agree following review that a service is currently running effectively and is not in need of change at present.

Thus an important aspect of the ADAT's work is to focus its energies on priorities that demand the added value of a partnership approach.

*What we found and commentary*

4.5.2 We found a few examples of service redesign that could be described as commissioning. (See Case Study 4.). Overall, there was little evidence of ADATs taking a "level playing field" approach to providers, in as much as the voluntary and, to a much lesser extent, the private sectors were required to tender for services; while statutory providers continue to be funded for services without the challenge of external competition. The key issue here is that services should be delivered by the agency best suited to do the job, and that there should be no presumption that statutory service providers are better able to deliver. Nor should a history of being the provider be an influence on future service delivery decisions.

#### **Case Study 4: Direct Access Service**

The evidence base supporting this development was summarised within a number of local and national publications including the national guidance document *Integrated Care for Drug Users – Principles and Practice*, EIU 2002. Local need was highlighted by a variety of service providers. Evidence suggested that stimulant users would be more likely to access a “Direct Access Service”. Prevalence figures estimated that in this ADAT area there could be around 1400 “hidden” problematic drug users (ie users who were not in touch with any services.)

The Direct Access Service would offer a range of interventions including assessment, social care and onward referral from multiple access points across the ADAT for people with problems relating to drug misuse or for those affected by another’s use, such as families and carers. It would also expand the nature of service interventions available to individuals who were unable or unwilling to access the services on offer locally. The service would cater for all age groups and cover all drugs. The service would have flexible opening times and would support up to 300 new clients a year with an additional capacity to offer information, assessment and onward referral.

Key deliverables were identified as:

- Increased new clients in the system
- Reduced waiting times – maximum referral to assessment of 72 hours.
- Widened range of interventions

Following a bidding process, a voluntary organisation was commissioned to develop the service which has been in operation since March 2007.

**Recommendation 21: ADATs should be prepared to consider all providers – statutory, voluntary and private – when commissioning and be prepared to move inefficient and/or poor quality services away from existing providers. There should be a level playing field among providers – statutory, voluntary and private.**

## **4.6 Contracting**

*What is contracting?*

- 4.6.1 A contract is an agreement – usually written and legally binding – that specifies the terms of the agreement between the purchaser and the provider. It defines the parties, the value of the contract and what each party agrees to. It should clarify which risks are to be borne by the purchaser and which are the responsibility of the provider and establish reasonable risk sharing. The process of moving effectively from a service specification to a contract, or a range of contracts, is specialised work, and the relevant experience may only be available to the ADAT through one or more of the partner agencies.

4.6.2 The term ‘service level agreement’ is sometimes used interchangeably with contract but it is more correctly used to describe the obligations within a contract that set out the service, required levels of service, responsibilities and priorities. An SLA is also often used as a performance management tool especially in internal markets where one part of an organisation (the commissioning department) agrees with another part of the same organisation (a service department) a performance framework for delivering services. An SLA can be an effective tool for creating a common understanding between two parties regarding services, expectations, responsibilities and priorities.

*What we found and commentary*

4.6.3 Much of the contracting between ADATs and providers was in the form of Service Level Agreements (SLAs) usually with voluntary organisations, and rarely with statutory services. However, we found that few ADATs had the skills to tender and negotiate contracts effectively, and we would not expect this specialism within an ADAT support team. Some ADATs resolved this by using the contracts teams of partner agencies, such as the local authority or health board. This highlights the more general point that ADATs need to be supported by partner agencies for a range of specialisms including finance, contracting, needs assessment etc. In addition, as ADATs are not legal entities, they were unable to enter into contracts and where contracts were required, these were held in the name of a partner agency.

4.6.4 Across Scotland we heard that work was in progress either to introduce SLAs where there were none, or to improve the effectiveness of existing SLAs. Some ADATs were working collaboratively with their providers to develop meaningful outcome measures.

4.6.5 The role of the ADAT in monitoring SLAs was variable from no input to total responsibility for writing the agreement and monitoring it. Monitoring was not always a clear or standardised process. In one area, accountability was monitored according to the requirements of a partner, whilst in others the ADAT required quarterly update reports. Overall the accountability arrangements varied and those concerned did not necessarily fully understand them.

**Recommendation 22: ADATs should make use of commissioning and contracting expertise available within partner agencies.**

4.6.6 The relationship between ADATs and the voluntary sector is relevant here. We heard repeatedly of frustration among voluntary organisations in relation to commissioning and contracting. There were three main concerns. First, voluntary organisations felt that they were subject to much more stringent monitoring arrangements than statutory providers, and that contracts tended to have unreasonably short timeframes, with annual renewal, often not confirmed until the last moment. Second, local voluntaries that had enjoyed a close relationship as providers without SLAs found themselves competing with larger national voluntary organisations as tighter commissioning arrangements came into play. Thirdly, there was a presumption that the voluntary sector should be a cheaper option. Some voluntary organisations found themselves penalised by an expectation that they should not recover their full costs despite the recommendations of the Strategic Funding Review carried out jointly by central and local government and the

voluntary sector in Scotland. Some voluntary organisations also found that when statutory agencies were experiencing serious financial constraints voluntary sector providers were the first to have their contracts revised to their financial detriment.

**Recommendation 23: Commissioners should contract for services with the voluntary sector on a level playing field basis; and should pay the full costs of service delivery.**

## **4.7 Performance Management**

*What is Performance Management?*

- 4.7.1 Performance management is a strategic approach to managing an area of work. It aims to improve organisational effectiveness and add value by enhancing existing capabilities and building new ones. It is largely concerned with continuous improvement of the organisations broad strategic capabilities and the specific capabilities of individuals and teams. Within ADATs, it deals with the broader issues that agencies have to face in the ever changing environment of drug and alcohol misuse and gives general direction for ADATs to achieve longer term goals. Performance management provides a real opportunity for ADATs to be proactive and innovative in influencing strategy and contributing to the way in which service delivery meets local need.

*What we found and commentary*

- 4.7.2 In a few ADAT areas there had been reviews of performance and an evaluation of the service provision. This encouraged continuous improvement, ensuring that the right services are offered, delivered and reported upon. However, there were also some areas where there were no competing services and the existing ones were funded year on year. In some areas, due to a lack of performance monitoring services were unable to demonstrate clearly their success criteria.
- 4.7.3 Annual performance monitoring in all of the ADATs was carried out mainly through use of the Corporate Action Plan (CAP) (see also paragraphs 3.2.20-22). However, this document was not viewed as being a robust means of monitoring outcomes. It was perceived as being neither an effective monitoring tool nor a planning tool.
- 4.7.4 Across Scotland there was a strong desire to place more emphasis on local compared to national targets. It was perceived that the national accountability through the CAP diverted the energy of ADATs and reduced the time that they could spend on addressing the realistic local issues that were of concern to the community. A few ADATs had supplemented the CAP with local performance monitoring, whilst others had sought assistance from specialist research and evaluation agencies to assist with needs assessment and monitoring and evaluating services.
- 4.7.5 In some areas the assistance of a financial advisor had been sought which had been of benefit to the team. In some areas, local action plans reflected ongoing activity, links with other strategies and on-going progress. Many local performance measures concentrated more on activity reporting than outcomes. In a few areas, the ADAT priorities were reflected in the corporate plans of the relevant partners and monitored through them, reporting back to the ADAT.

- 4.7.6 There was some evidence of staff appraisal and development schemes but the extent to which they were linked to the planning cycle was variable. In a few ADATs there was some understanding of how staff objectives aligned with corporate objectives and performance appraisal. Most ADATs were less able to demonstrate evidence of a link between performance management and staff appraisal as a tool of staff governance.
- 4.7.7 Support is needed at a national level to enable ADATs to undertake more effective monitoring through a performance management framework. This would enable individual partners to remain accountable in respect of their contribution at a local level to the achievement of targets on substance misuse which might help to drive up performance nationally. Most ADATs recognised that they needed continuously to improve performance and outcome measurement but had found this process difficult and would have welcomed more guidance and support in this regard.
- 4.7.8 We have already recommended (see Recommendation 4) that the Scottish Executive should work with ADATs to revise and replace the CAP with an Annual Delivery Plan (ADP). This Plan should be designed so that it meets the performance management needs of ADATs and the Scottish Executive. The Annual Delivery Plan would be the means by which ADATs would implement the priorities in their 3 year strategic plan. The ADP would also form the basis of the annual accountability meeting with the Minister. (Recommendation 9 refers.)

**Recommendation 24: The Annual Delivery Plan should meet the performance management needs of the ADAT and the Scottish Executive and should form the basis of the annual accountability meeting with the Minister.**

*National Quality Standards for Substance Misuse Services*

- 4.7.9 The National Quality Standards for Substance Misuse Services and accompanying guidance were published in September 2006 with the aim of improving the consistency and quality of substance misuse service provision in Scotland.
- 4.7.10 In November 2006, a request was made to ADAT support officers to obtain information from service providers as to their readiness for the implementation of these Standards. This was viewed positively and 14 ADATs participated in the baseline exercise, which was intended to measure the ability of services to demonstrate that they meet the Standards and identified common themes and support needs.
- 4.7.11 The baseline exercise highlighted the following issues:
- Variation among ADATs in their involvement in commissioning and performance management of services and duplication of information required for monitoring and management purposes.
  - In some areas there was over-reliance on verbal understanding of service policies and procedures.
  - The absence of a strategic approach to service planning and development, including poor needs assessment, commissioning practice and performance

management was found to affect the ability of services and ADATs to demonstrate compliance with the Quality Standards.

- A lack of a shared understanding about user involvement, and little consistency in family/carer involvement.

However, it was stated that further guidance would be welcomed. The report on the baseline exercise made a number of recommendations including that the role and expectations of ADATs in relation to implementation of the Quality Standards should be stated formally as soon as possible.

- 4.7.12 As part of the key findings of the Alcohol User Involvement survey, there was evidence that in most areas clients had received a personal care plan and that those clients with alcohol problems who moved between services did so in a positive way that was planned and structured by service workers. However, the SDF User Involvement Report found that services for clients with drug problems were not joined up and there was little evidence of continuity of service provision for clients who moved to another area. Both the need for service users to have personal care plans and the need for a wide range of providers to ensure that their services work together to benefit the service user are covered in the National Quality Standards.
- 4.7.13 In the course of the Stocktake, some ADAT staff reported that it was too early to draw conclusions but they felt that the Quality Standards would be beneficial in helping them to document and support much of their work and that this would lead to consistent standards and co-ordinated services which would meet a full range of service-user needs. However, at the time of the Stocktake there was generally, a low awareness of the Quality Standards across the country.

**Recommendation 25: ADATs should promote the adoption of the National Quality Standards. The guidance framework to be developed for ADATs (Recommendation 2 refers) should include an explicit statement about the role of ADATs in relation to implementation of the Standards.**

#### *Value for Money*

- 4.7.14 The Local Government in Scotland Act 2003 places a duty on local authorities to secure Best Value which is defined as continuous improvement in the performance of the local authority's functions. The objective of Best Value is to ensure that effective management delivers better and more responsive public services. It is about local authorities:
- balancing the quality of services with cost
  - achieving sustainable development
  - being accountable and transparent, by engaging with the local community
  - ensuring equal opportunities
  - continuously improving the outcomes of the services they provide.
- 4.7.15 There is no requirement for ADATs to operate in accordance with Best Value which does not in any case apply to other ADAT partners although they may have a commitment to similar approaches. It would therefore be inappropriate to measure the performance of ADATs in strict accordance with the Best Value regime. Nevertheless, the principles of Best Value are relevant to the delivery of efficient

and effective services and they provide a good template against which to consider the performance of ADATs.

- 4.7.16 There were few examples of ADATs having programmes of review of services in place to identify alternative action or justify retention of services. In some areas there was an over reliance on verbal and informal understanding of service policy and procedure as opposed to written documentation. However, in a few areas, stakeholders were consulted to identify issues of concern and to influence future approaches regarding overall needs assessment and these processes although informal seemed to work well. There was some evidence of providers being compared on an informal basis with others to identify and stimulate good practice.
- 4.7.17 Overall the majority of areas established local targets and standards for at least some of their services. However, many reported on performance in terms of activity rather than outcome measurement. There were few examples of the use of recognised quality management tools and benchmarking tended to take place on an informal and ad hoc basis. In some areas ADAT support staff met informally and shared information with each other. This seemed to work well and allow for some sharing of good practice

## 5 MAKING A DIFFERENCE

### 5.1 Introduction

5.1.1 The central question is: Are ADATs making a difference? This can only be answered by effective monitoring of impacts through data collection by ISD and others and by communication and consultation with the very wide range of people affected by substance misuse. We have considered this question under the following sections:

- Public Engagement
- Service Delivery and Outcomes
- What difference do ADATs make?

### 5.2 Public Engagement

*What is public engagement?*

5.2.1 We have used the term *public engagement* as a generic description of the whole field of activity including communities, families and carers, service users and wider public information. Where we are discussing one of these groups we have used the specific description.



5.2.2 At the inception of AATs and DATs it was envisaged that alcohol and drugs forums would be established. Their purpose was to bring in advice and input from communities, families and carers, and service users. They might also include voluntary sector representatives. The chair of the forum would ideally have a seat on the AAT or DAT.

5.2.3 Over time and especially in the last decade, there has been a significant shift in the relationship most professionals working in public and voluntary services expect to have with individuals for whom they provide a service, whether they are described as service users, patients, clients or customers. This change is exemplified by the following comment of a service manager working in one of the ADAT areas: “When I did my social work training I was taught that as social workers we are the change agents for clients but through my training and experience in counselling I have come to realise that the client is the change agent and we facilitate them. It is now more the client's view that defines the service, rather than the professional's.”

5.2.4 There has also been a transformation, partly due to Best Value and other similar approaches in the relationship between public services and the communities they serve involving consultation and sometimes participation in the decision making processes. The guidance by the Scottish Executive to the NHS in Scotland is a typical articulation of official policy in relation to public engagement. The approach is described in the Scottish Executive document *Patient Focus and Public Involvement* (PFPI) which was published in December 2001. Its stated aim is to

achieve culture change in the way the service interacts with the people it serves and the way services are delivered. It says that “it is no longer good enough to simply do things *to* people; a modern healthcare service must do things *with* the people it serves.”

- 5.2.5 Another example of official policy in relation to public engagement is contained in Communities Scotland’s *National Standards for Community Engagement*. Like the *PFPI* policy for the NHS it seeks to change the way public services interact with communities. The Communities Scotland document sets out principles, behaviours and practical measures that underpin effective engagement.

*What we found and commentary*

### ***Forums***

- 5.2.6 We found forums in some ADAT areas but not in all. With the passage of time since the DAT guidance of 1995 and the 2002 Plan for Action on Alcohol and the changed role from AATs and DATs to ADATs, it is not surprising that we found that the idea of forums has evolved in different ways in different parts of the country. In some areas there were geographically based sub-groups that worked in similar ways to the forums originally envisaged. The distinction between a forum for consultation and a sub-group of the ADAT was sometimes not clear. However, as a method of getting input from communities, families and carers, and service users, forums were often of little benefit and in some areas no longer existed.
- 5.2.7 What has emerged from our Stocktake is that even where there were forums there were different ideas about their purpose, their composition and the benefits they brought to the ADATs’ work. In some areas forums were seen as the practitioners’ networking meetings; in others they were criticised as having become the property of a single interest group; while in other areas they were a successful mechanism for two way communication with the strategic ADAT, providing both a forum for consultation and a fertile ground for ideas and energy to develop local initiatives.
- 5.2.8 Forums can be a useful mechanism but they cannot be the only response to the need for public engagement which is a complex area requiring a range of responses to suit different needs and purposes.

### ***Wider Community***

- 5.2.9 A comment that was typical of the responses we found in most parts of Scotland is: “more needs to be done to involve service users and the wider community in drugs and alcohol issues”. Some ADATs with geographical forums or sub-groups regarded these as having close community connections. An example of another approach was an ADAT having a community engagement officer within the support team who had a specific role to work with communities.
- 5.2.10 There was no uniformity of approach in consulting the wider community but the range of approaches included:
- Conducting special surveys (youth, street, etc) and getting results from wider quality of life surveys organised by local authorities and community planning partnerships.

- Attending local events, fairs, freshers' weeks, tenant/resident groups, community meetings, etc.
  - Parent awareness sessions at family centres and young people forums in schools.
  - Citizens' Panels established under Community Planning arrangements.
  - Councillor members of ADATs feeding in the views of the wider community.
- 5.2.11 Generally it was felt that this was a difficult area which lacks a structured and strategic approach. Rurality was often cited as a difficulty because of stigma and confidentiality but some ADATs operating in rural areas also felt that the closeness of the community was an advantage in having informal knowledge of the wider community views.

### *Families and Carers*

- 5.2.12 We found little evidence that ADATs consult families and carers about the services in their area. There is no doubt that families and carers are knowledgeable and experienced about the problems of substance misuse in a way that could inform strategic planning and commissioning and yet their potential seemed to be largely overlooked by most ADATs.
- 5.2.13 Families can offer vital support for a person who is a substance misuser and family members can become the victim or sufferer of a substance misuser's chaotic lifestyle. We met families whose lives were totally dominated by the need to care for a substance misuser. This ranged from obvious concerns about the health of the family member and the risk of early death to a fear of violent outbursts, as well as concerns about criminal behaviour.
- 5.2.14 In some ADAT areas there were family support networks, often run by local voluntary organisations, where people came together to gain mutual support. We met some who were dissatisfied with the level of support they received from the statutory services and who felt unrecognised by the ADAT. In recent years the need to support carers who care for older and disabled people has received increasing government support and recognition. By comparison, the needs of families and carers of substance misusers appears to be an area of need that is under-recognised and under-resourced by ADATs. ADATs should address this when drawing up their Strategic Plans.

**Recommendation 26: ADATs should give greater emphasis to meeting the needs of families and carers and the potential for their participation in shared care arrangements and in informing service development.**

### *Service Users*

- 5.2.15 We found few examples of service user involvement in the ADAT and its subgroups. Where it did exist, such as when a former service user was a member of a forum, it was likely to be dismissed as tokenistic or unrepresentative. We often heard that it was difficult to get beyond the "usual suspects" when engaging service users in planning and designing services and that the views they bring are not necessarily representative of the client group.

- 5.2.16 There was some evidence of public consultation being designed to engage a wider group of service users in order to inform the strategic processes. This sometimes took the form of open days and surveys of service users and evaluations of services. SDF often played a key role in survey and evaluation design and implementation. In order to overcome the challenge of substance misusers often being a hard to reach group, some surveys were carried out as peer research.
- 5.2.17 At service delivery level it was commonly reported to us that the service provider would have arrangements to capture service user feedback about the quality of their service, although this was not always in documented form. This was supported by an Alcohol Focus Scotland survey of service users which found “almost all interviewees felt that they could raise concerns freely” and concluded that services were responsive to ad hoc issues. SDF or other organisations were sometimes commissioned to provide evaluation of services which was a useful input for service providers.
- 5.2.18 In some areas it was a requirement of the Service Level Agreement for the service provider to obtain feedback from the service users and this would feed into the commissioning process but in other areas collecting this information relied on the initiative of the service provider with no link into commissioning. Where service users’ views were sought and acted upon, it could make a real difference to the service. (See Case Study 5.)
- 5.2.19 Service users undoubtedly have a useful role to play in making services more responsive to client need. While we recognise it can be difficult, for a variety of reasons, to capture the views of service users, we believe this is an area where ADATs generally could do more and they should include a commitment to this in their Strategic Plans.

**Case Study 5: Involvement of drugs service users in a peer research project**

In one ADAT area forum, concern was raised about the experience of drug users in their communities and how this experience might inform the development of services locally. The ADAT applied to the Scottish Community Action Research Fund (SCARF) and was granted funding to develop a peer led appraisal of the needs of drugs and alcohol service users in its area.

Providing service users with a voice was felt to be important and the resulting profile of drug service users has begun to inform the way services are being developed. These profiles have been considered by the ADAT forum who have identified a number of areas where key improvements in service delivery could be made to address gaps in general service provision as well as issues around methadone prescribing and needle exchange services.

**Recommendation 27: ADATs should improve the involvement of service users and put in place mechanisms to capture and act on their views.**

### ***General Public***

- 5.2.20 ADATs used a variety of means to communicate with the public including radio, articles in local newspapers, press releases, newsletters, annual reports, leaflets, advertising, directories of local services and holding ADAT meetings in public (although these did not appear to be well attended). Some ADATs used several of these approaches and appeared to be particularly conscious of their role to provide public information both by raising awareness of issues and by informing the public about services. But there were also some who did little or nothing. Even though some ADATs put a fair amount of resources into providing public information there was little evidence of them obtaining structured feedback or evaluation of this work.
- 5.2.21 In order to raise their profile and improve communication of their activities, most ADATs had developed websites to advertise their work and the services available as well as local contact numbers. Only two appear to have no presence on the internet while the others either have their own website or webpages within a section of one of the partners' websites. However, not all of the websites had been kept up-to-date and the standard of information and content is variable. Some websites mention only services and not the ADAT itself. Websites can be a useful means of communication, especially in rural areas.
- 5.2.22 ADATs also used open days, information stands in public buildings such as sports centres and libraries, community meetings and focus groups. Most ADATs recognised they could make a contribution to educating young people by linking in with programmes at local schools as well as taking information out to dances and night clubs. The need to catch people's attention had also led to novel methods of communicating messages about substance misuse such as the Pink Handbag campaign on safe alcohol use. (See Case Study 6.)
- 5.2.23 Significant effort is going into local campaigns but ADATs thought that national campaigns were not always relevant at a local level or that they replicated work already being done locally. Many ADATs felt that they needed greater communication with the Scottish Executive with regard to the focus and content of national campaigns for drugs and alcohol. They wanted to ensure that through good planning arrangements, their local campaigns would dovetail with the national agenda, ensuring consistently powerful messages across the country. Such improved communication processes would enable the partners within each ADAT to jointly plan and organise their local role within the national agenda. An example quoted by one police authority was of a national campaign on safe drinking targeted at younger people. The distribution of posters and leaflets was determined nationally and did not tap into local knowledge of venues used by young people. As a result, many of these were not included in the campaign whereas venues not usually used by younger people, such as ex-servicemen's clubs, were included.
- 5.2.24 The development of national campaigns does seem to be an area where the expertise and knowledge of ADATs could make a useful contribution. Although there is a Scottish Executive National Communications Group on drugs and alcohol which includes a representative from SAADAT, and a further two places for ADATs, the ADATs did not seem to be aware of this. It would be helpful if SAADAT and the

Scottish Executive took steps to raise awareness of the National Communications Group and encourage more ADATs to participate.

**Recommendation 28: The development of relevant national campaigns about drugs and alcohol should be undertaken in partnership with ADATs. This would include decisions about the focus and content through to planning and organisation. Steps should be taken to raise awareness of the National Communications Group and encourage participation by ADATs.**

- 5.2.25 ADATs' development of policies and practices for public engagement was patchy. Although at their best we came across ADATs making serious efforts in a difficult field with limited resources, even they admitted that they relied on fragmented coverage and immature methods. Most respondents recognised that their ADAT should be doing more and doing better in this area. Few ADATs had developed a communications strategy and while most were clear about which approaches they prioritised and preferred, there was a lack of a strategic approach to communications with the public.
- 5.2.26 There is a clear need to develop clarity about whom the ADATs should be engaging with, for what purposes and by what means. Guidance such as *Patient Focus and Public Involvement* and *National Standards for Community Engagement* are useful guidance and available to ADATs to draw upon in this area. ADATs need to develop a strategic approach and a structured plan of action and should draw on guidance that will help them to tackle these issues in a consistent way.

### **Case Study 6: Pink Handbag Women & Alcohol Communications Campaign**

One ADAT developed an alcohol health promotion resource targeting young women aged between 16 – 25 years old. The need for this campaign emerged because of an increase in the number of young women drinking harmfully.

The ADAT was successful in bidding for £10,000 from the Scottish Executive alcohol communications budget and worked with a design firm to develop an innovative, eye-catching leaflet to educate young women on the health and personal safety risks associated with binge drinking. A member of the ADAT support team liaised with the design company throughout and provided the text input for the resource. The draft leaflet design, in the shape of a pink handbag, was circulated to all ADAT members for comment and then market tested with young women. The ADAT organised a formal launch of the campaign and 20,000 copies of the pink handbag leaflet were distributed to young women via pubs, nightclubs, schools, specialist services, health centres and homeless units.

The campaign was evaluated 6 months after the formal launch, with extremely positive results. The evaluation results indicated a very high recall rate of the campaign amongst young women and specialist alcohol services in the area noted a significant increase in referrals from young women.

As a result of the resource's success, the relevant ADAT support officer was invited to make a presentation at two international health-related conferences and the leaflet was selected as a top finalist in the Association of Public Service Excellence (APSE) awards 2006. Moreover, the Pink Handbag has been rolled out to several other ADAT areas in Scotland, England and Europe. The ADAT has since developed a male equivalent resource to the Pink Handbag, which is also proving to be extremely popular within the target group.

**Recommendation 29: ADATs should develop a public engagement strategy within their 3 year Strategic Plan. It should encompass plans in relation to communities, families and carers, and service users. Implementation should be through the ADAT Annual Delivery Plan.**

## **5.3 Service Delivery and Outcomes**

*What is Effective Service Delivery? What are Relevant Outcomes?*

- 5.3.1 The core function of ADATs is to ensure the delivery of services, activities and projects which meet Ministerial targets and commitments in relation to tackling drug and alcohol misuse. It is beyond the scope of the Stocktake to assess directly the quality and effectiveness of these services – but the Stocktake did examine the processes undertaken by ADATs to ensure that the right services are delivered to the right standard and as cost effectively as possible.

5.3.2 All services – statutory, voluntary and private – are struggling to develop relevant, measurable outcomes where personal perceptions and human condition are significant factors. At present the emphasis in performance management tends to be put on the easily measurable – numbers treated, waiting times, etc. This can distort the real priorities of a partnership or single agency and where proxy measures are used these need to be linked by evidence to a sound understanding of better outcomes. An increasing focus on outcome measurement should not deflect attention away from the relevance of effective processes since the impact of a service on people largely depends on the way it is delivered.

*What we found and commentary*

5.3.3 All of the ADATs felt that the existence of the drugs and alcohol partnership had resulted in improved services within their areas – extending the range and diversity of services and service providers.

5.3.4 ADATs were asked to identify their success criteria in terms of service delivery. The most commonly cited aspects were:

- Customer focus – services which are appropriate and accessible and which address need
- Sustainable, quality services
- Consistency of standards across service provision
- Impact assessment – knowing what difference the services are having
- Value for money

5.3.5 Many of these success criteria were being met resulting in the range and diversity of services within ADATs having increased and almost all of those interviewed regarded this as a direct result of partnership working and ADAT activity. This was the single most reported benefit of partnership working by interviewees.

5.3.6 We encountered a number of examples, some highlighted within this document, of good practice and a number of examples where there is a move towards being much more customer focused and organising services around client need – rather than the more traditional model of suiting organisational need. However this appeared to be confined to pockets of good practice rather than an overall deliberate attempt to put the customer at the heart of service delivery. One door approaches, and single point of service entry were in evidence in a number of areas.

*Consistency of services*

5.3.7 There were examples of ADATs contributing to more consistent services. Shared protocols had been developed for prescribing, information sharing, drugs and alcohol policy for schools. The National Quality Standards were also beginning to be embraced which, in time, should lead to a standardised level of service which customers can expect. There were a few areas where the voluntary sector was an equal partner on the ADAT. This had resulted in less unproductive competitiveness for funding between voluntary sector organisations and more co-operation between the statutory and voluntary partners.

- 5.3.8 However, we also encountered examples where practice was not consistent or client centred. Most significantly there were examples of Health Boards and local authorities taking unilateral decisions, apparently for reasons of internal policy, which were inconsistent with practice elsewhere in Scotland and which acted against a client based approach.
- 5.3.9 For example, one Health Board had set the budget for methadone treatment at a level which ensured that some patients, mainly single men with no dependants, would never receive a treatment service. This increased the burden on other service providers such as social work and the police as well as neighbouring Health Boards. It also meant that offenders being released from prison in another Health Board area where they had been stabilised on methadone, could find themselves no longer able to access a treatment service. ADAT partners had tried, unsuccessfully, to change the Health Board's policy.
- 5.3.10 In another Health Board, we heard that clinicians had decided on a policy to provide methadone treatment at clinically sub optimal dosage levels. This approach, compounded with a strict approach to clients who topped up with other substances, meant that many clients complained of a "revolving door" approach to treatment and social work staff were concerned about the additional burden on them.
- 5.3.11 A third example is of a social work department which had adopted a policy of opposition to residential rehabilitation – it seemed on grounds of cost and conviction rather than evidence - even though this was not an approach shared by the other local authorities in that ADAT.
- 5.3.12 Waiting times for drug and alcohol assessment and treatment services varied widely across Scotland and this may in part be due to the absence of relevant targets in the Health Efficiency Access Treatment (HEAT) key targets set by the Scottish Executive to secure effective performance by Health Boards.
- 5.3.13 We heard from a number of ADATs that they had been unable to influence what was seen as inconsistent standards relative to the practice elsewhere in Scotland or, in a very few cases, non-compliance with clinical guidance. While, we believe that some of these inconsistencies can be addressed by compliance with the National Quality Standards, ADATs have few other means at their disposal. Their position could be strengthened by the introduction of national targets and we propose that the Scottish Executive should seek to improve waiting times for treatment services; and improve consistency between treatment services by considering the development of appropriate HEAT targets. The Scottish Executive should also consider the need to work with the clinical community such as the medical Royal Colleges to ensure compliance with guidelines and good clinical practice.

**Recommendation 30: The Scottish Executive should: ensure that compliance with the National Quality Standards is monitored; consider the use of HEAT targets to deliver improvements in drug and alcohol treatment services; and explore the need to work with the clinical community to secure consistent and equitable compliance with Clinical practice.**

### ***Primary Care and General Practitioners***

- 5.3.14 Many ADATs expressed concern that the changes in the General Medical Services (GMS) contract for GPs in 2003 had led to significant problems in the availability of treatment services. However, in some ADAT areas Health Boards had used a mix of funding and support to persuade GPs to offer shared care to patients with less complex needs and we heard that this worked effectively. In other areas, Health Boards had increased capacity of centrally provided services.
- 5.3.15 Problems of access to treatment for service users often arose where there was little choice of general practitioner and poor access to specialist services – usually but not always in rural areas. Poor public transport links compounded this. We heard from some GPs and others in the NHS that the engagement of GPs might be aided by greater clarity of national policy, with regard to, for example, the evidence underlying a harm reduction approach as compared with the evidence underpinning an abstinence programme. However, most ADATs who raised GP services as a concern, indicated that GPs were unwilling to engage with substance misusers as a client group.
- 5.3.16 Recent changes in NHS structure place responsibility for the development and management of primary care services with Community Health Partnerships (CHPs) and we consider that close links between CHPs the ADAT structure are essential to resolve this issue. While CHPs are the appropriate mechanism for engaging GPs in service planning and delivery, some ADATs might find it helpful also to build a relationship with local GPs.

### ***Moving from inputs and outputs to relevant outcomes***

- 5.3.17 There was a strong sense across all ADATs that the determination of relevant outcome measures was key to ensuring the effective delivery of services. Some ADATs had invested a significant amount of time and effort into this work, often with external facilitation. However, all ADATs had struggled with developing outcome measures and would welcome – and need – support from the Scottish Executive to achieve this.
- 5.3.18 There is no doubt that across Scotland organisations and partnerships of all kinds find it difficult to measure outcomes. For this reason there is often a heavy reliance on measuring inputs and outputs – measuring activity rather than impact. ADATs are thus far from unique in finding outcome measurement a challenge. In other parts of the UK there are helpful examples of a national approach to performance management and outcome measurement.
- 5.3.19 One such example is the Welsh Assembly Government's *Key Performance Indicators for Substance Misuse Treatment in Wales*. These were developed in consultation with commissioners and service providers and implemented from August 2006. The KPIs were intended to tackle high “do not attend” rates and long waiting lists. They are the first phase of the development of an outcome measurement framework to ensure a comprehensive and consistent approach across Wales. The aim is that eventually all clients in substance misuse services will have their experience measured against four key outcomes:

- Effect on offending behaviour
- Effect on substance misuse behaviour
- Improvement in relationships with family
- Improvement in general health

5.3.20 The National Treatment Agency for Substance Misuse has recently launched its Treatment Outcomes Profile tool (TOP) which is intended to measure improvements in the health and wellbeing of drug misusers across a range of factors including substance use, crimes committed, health, employment and education and housing.

5.3.21 It is our view that a national approach to outcome measurement should be developed in Scotland. In doing so it would be sensible for the Scottish Executive to work with ADATs and to draw on the experience of developing outcome measurement elsewhere in the UK.

**Recommendation 31: The Scottish Executive should work with ADATs to develop national outcome measures, including the identification of robust proxy measures for less tangible outcomes. This could be informed by the experience of developing outcome measures elsewhere in the UK.**

## 5.4 What Difference do ADATs make?

*Why does this matter?*

5.4.1 Any partnership has an opportunity cost. It takes time, money and effort to work collaboratively across agencies that may have different philosophies, priorities and cultures. At worst, the existence of a partnership to address issue or issues may offer an excuse to individual agencies to avoid focusing on the very topic that is considered important enough to have a partnership in the first place. Therefore it is essential that we can support our conclusion – that the ADAT approach to tackling the issues of substance misuse is appropriate with robust evidence from the Stocktake.

*What we found and commentary*

5.4.2 The majority of ADAT partners that we interviewed felt that the drug and alcohol partnership was making a difference to services, and hence to service users. They considered that the time and effort required to sustain partnership working was rewarded by successes that could not be achieved by individual agencies. There was an overwhelming view that the complexities of the issues relating to substance misuse demanded a collaborative effort from a wide range of agencies.

5.4.3 It is important to note that most of the respondents were giving time to the ADAT partnership that was over and above their “daytime job”. There was no evidence of that view being influenced by vested interests. Indeed, we might have expected ADAT partners to welcome the opportunity to reduce their workload.

5.4.4 The overwhelming message from all ADATs was that focus on substance misuse would be lost if the ADAT agenda were to be subsumed by an alternative partnership. The evidence found throughout the Stocktake supported the

continuation of a dedicated partnership for substance misuse. The benefits of a partnership approach were identified as:

- Being able to focus clearly on the issues of drugs and alcohol and their impact on the community
- Having a multi-agency response to complex issues that did not sit within the remit of a single agency
- Raising the profile of substance misuse locally
- Providing a conduit for co-ordinating service interventions – cutting down duplication and overlaps
- Identifying gaps in provision – through needs and gap analysis
- Integration of services and single point of entry for service users
- Enabling the re-design of services that focused on the needs of service users
- Providing a mechanism for joint commissioning and allocating finance to the services
- Protecting resources dedicated to tackling substance misuse problems
- Creating a mechanism for sharing information and having a shared perspective of the area
- Closer working between the voluntary and statutory sectors
- Sharing training needs analysis and training plans and opportunities.

5.4.5 Many ADATs were undergoing significant change and development – generally they recognised the need for their partnerships to be more focused, to generate more resources and to sharpen up commissioning, contracting and performance management.

#### ***Characteristics of Effective ADATs***

5.4.6 There is a number of characteristics displayed by the more successful ADATs which have had an impact on their success and effectiveness. These include:

- Strong leadership – the ability of the Chair and support team to facilitate and lead the development of the partnership.
- A commitment to effective partnership working at senior level in the partner organisations.
- Having the right partners at the right level to be able to commit and deploy resources.
- Clear lines of accountability
- An interlinked relationship with other strategic partnership bodies at a local level.
- Having a clear understanding of the strategic role of the ADAT.
- Good analysis and information about local need
- Effective engagement with service users, families and carers and the wider community.
- Effective performance management.

5.4.7 There is an important role for the Scottish Executive to provide strong leadership at Ministerial level and to ensure that its executive functions are organised and managed to support the joined up working expected of ADAT partners at Strategic and Implementation levels of the proposed structure.

## *Conclusion*

- 5.4.8 We are firmly of the view that the fundamental principles and purposes of ADATs as set out in the 1995 and 2002 circulars and the respective drug and alcohol strategies are as relevant now as they were then.

**Recommendation 32: On the evidence gathered in the preparation of this report we believe that ADATs are, in the main, adding value to the substance misuse agenda. ADATs should continue as discrete partnership bodies, albeit in a form modified by the recommendations in this report.**

## **APPENDIX A: TERMS OF REFERENCE**

### *Purpose of the Review*

The purpose of the exercise is to assess the current performance of ADATs and examine their capability to deliver Ministerial priorities on drugs and alcohol within the framework and against the principles of best value.

In doing so, the following should be established:

- the methods used by ADATs to demonstrate their strategic leadership, vision and direction and how strategic decision-making at a local level is used to inform the identification of priorities, the use of resources and the assessment of their impact at a local level and against national priorities;
- the mechanisms in place to secure a culture of continuous improvement in relation to key areas such as performance and financial management including those arrangements in place between the Scottish Executive and ADATs; commissioning and service review practices; staff development; and strategic partnership working to achieve shared outcomes for service users and communities;
- the methods by which ADATs demonstrate improvement in services and outcomes year on year whilst balancing quality and costs with service delivery;
- best practice demonstrated by ADATs; and
- the issues that prevent efficient and effective working within the current ADAT structure and recommendations on the actions that are needed to overcome these.

The exercise should provide a firm evidence base to enable the Minister for Justice and Minister for Health and Community Care to take a view on the partnership framework needed to deliver on the Executive's priorities for drugs and alcohol; and – as appropriate - to what extent ADATs should be developed to ensure that they are the most efficient and effective partnership model for taking this work programme forward and the associated resource implications.

## **APPENDIX B: MEMBERSHIP OF THE STOCKTAKE TEAM**

Robin Burley, Non Executive Director, Lothian Health Board

Lindsay Burley, Chair of NHS National Waiting Times Centre Board; Non-Executive Director of NHS Education Scotland; and a former Health Board Chief Executive

Linda Cunningham, Community Planning Manager, West Lothian Council

Joan Fraser, Head of Stocktake Team, Scottish Executive

Marcella Houston, Inspector, Strathclyde Police

### ***Chair of Stocktake***

Sandy Cameron, Chair of the Parole Board

### ***Support to the Stocktake Team***

Elsbeth Hamilton

Sally Thompson

## **APPENDIX C: ORGANISATIONS & INDIVIDUALS CONSULTED**

Aberlour  
Alcohol Focus Scotland  
Apex Scotland  
Association of Chief Police Officers in Scotland (ACPOS)  
Association of Directors of Education (ADES)  
Association of Directors of Social Work (ADSW)  
Association of Nurses in Substance Abuse, Scotland (ANSA)  
Audit Scotland  
Barnardo's Scotland  
Peter Bates, OBE  
Camden Drug Action Team  
Crew 2000  
Department of Health, England  
Fast Forward  
Home Office  
Libra Women and Alcohol Support service  
Lloyds TSB Foundation for Scotland  
National Treatment Agency  
NHS Health Scotland  
NHS National Services Scotland  
Dr Roy Robertson  
SACRO  
Scottish Association of Alcohol and Drug Action Teams (SAADAT)  
Scottish Drugs Enforcement Agency  
Scottish Drugs Forum  
Scottish Executive Education Department  
Scottish Executive Health Department  
Scottish Executive Justice Department  
Scottish Executive Office of the Permanent Secretary  
Scottish Prison Service  
Scottish Training on Drugs and Alcohol (STRADA)  
Social Work Inspection Agency  
Society of Local Authority Chief Executives (SOLACE)  
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Welsh Assembly Government

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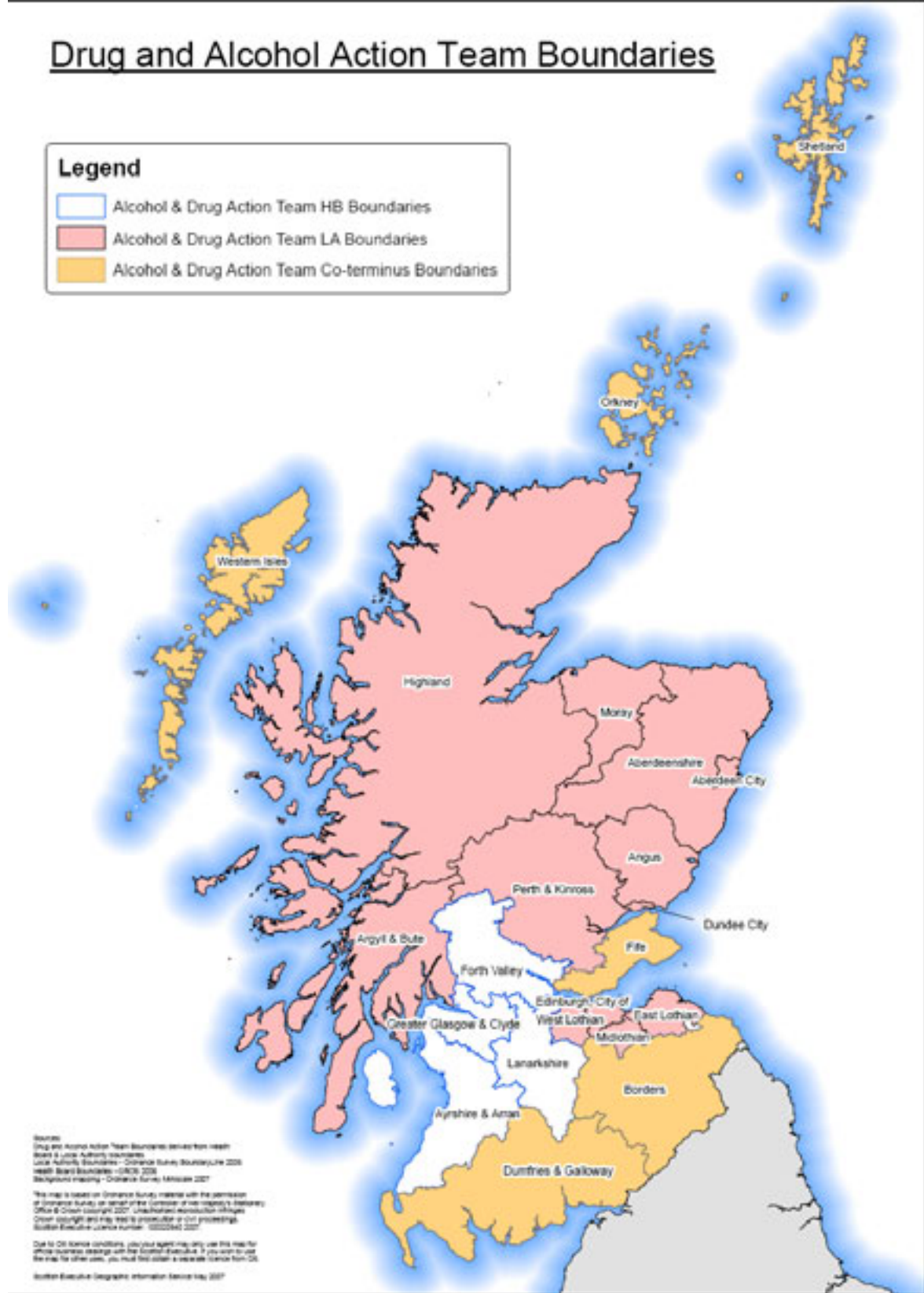
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# APPENDIX E: MAP OF BOUNDARIES

## Drug and Alcohol Action Team Boundaries

**Legend**

- Alcohol & Drug Action Team HB Boundaries
- Alcohol & Drug Action Team LA Boundaries
- Alcohol & Drug Action Team Co-terminus Boundaries



Source:  
Drug and Alcohol Action Team Boundaries derived from Health Board & Local Authority boundaries  
Local Authority Boundaries – Ordnance Survey BoundariesLine 2008  
Health Board Boundaries – OPCS 2008  
Background mapping – Ordnance Survey, Ordnance Survey 2007

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