Drug and alcohol services in Scotland

AUDIT SCOTLAND

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Contents

Summary

Drug and alcohol misuse are major problems in Scotland but resources to address them are not always used effectively.

Background

1. The impact of drug and alcohol misuse in Scotland is widespread. Both individuals and society more widely are affected in terms of health, child protection, crime, community safety, housing, employment and social exclusion. Drug and alcohol misuse are problems across the whole of Scotland but particularly affect people living in deprived areas.[1, 2]

2. The links between drug and alcohol misuse and efforts to address them are complex and inter-related, and many services are aimed at both drug and alcohol misuse. Numerous public sector organisations are involved in providing services, including the NHS, councils, the police and the prison service. The voluntary sector is a key partner in delivering services for drug and alcohol misuse.

3. The Scottish Government has launched new strategies for drugs and alcohol in the last 12 months: *The Road to Recovery: A new approach for tackling Scotland's drug problem* in May 2008 and *Changing Scotland's Relationship with Alcohol: A framework for action* in March 2009. The main drug and alcohol policy documents issued by the Scottish Executive and the Scottish Government over the last decade are summarised in Appendix 3.[3]

4. Multi-agency partnership working for drug and alcohol problems has been in place for around 20 years. Partnership working is a core element in the recent Scottish Government strategies for drugs and alcohol.[4, 5]

5. The Scottish Government and other key public bodies involved in providing services do not hold comparable data on the costs, activity or impact of drug and alcohol services in Scotland. In this report we have used available national data supplemented with local information where necessary.

About the study

6. The aim of our study was to identify how much the public sector spends on 'labelled' drug and alcohol services.[6] We also assessed whether evidence of need or what works determines how this money is used and what impact the money has had.

7. In this study, we:

- analysed published information on services and reviewed national documents
- collected and analysed expenditure data from all NHS boards and councils. In the absence of cost information from police services, we collected activity data from all police forces in Scotland to give an indication of expenditure
- carried out focus groups with people who have problems with drugs and alcohol, families directly affected by drug and alcohol misuse, local drug and alcohol partnership support staff and voluntary and private sector service providers
- interviewed staff and reviewed documents from agencies commissioning or providing drug and alcohol services.

8. We did not collect information on the wider costs associated with drug and alcohol misuse as existing research is available and referred to in Part 2. This research covers costs relating to generic services such as accident and emergency (A&E) departments, and wider economic and human costs such as the estimated cost of lost earnings and deaths due to drug and alcohol misuse.

9. This report is in four main parts:

- The scale of drug and alcohol misuse (Part 1).
- Direct expenditure on drug and alcohol services (Part 2).
- Effectiveness of drug and alcohol services (Part 3).
- Drug and alcohol partnerships (Part 4).

Key messages

- Scotland has high levels of drug and alcohol misuse compared to the rest of the UK. Drug and alcohol-related death rates are among the highest in Europe and have doubled in the last 15 years. Drug and alcohol misuse are found across society but people who are likely to be excluded from society and those living in deprived areas are most affected.
- In 2007/08, the public sector spent £173 million on drug and alcohol services in Scotland, £84 million specifically on drug services and £30 million on alcohol services. The remainder was spent on joint drug and alcohol services. Funding arrangements are complex and projects can have a number of separate funding streams, each with different timescales and reporting criteria. This is an added difficulty for those planning and providing services.
- There is variation across Scotland in the range and accessibility of drug and alcohol services. The Scottish Government has not set out minimum standards in terms of range, choice and accessibility that service users and their families can expect to receive. Spending decisions are not always based on evidence of what works or on a full assessment of local need.
- Given the scale of drug and alcohol problems in Scotland and the range of agencies involved, clarity of roles and accountability is essential. It is important for the Scottish Government to set out the direction and the roles and responsibilities of partner agencies and how performance will be assessed.

Key recommendations

The Scottish Government should:

- set clear national minimum standards for drug and alcohol services including their range, quality and accessibility; receive assurance that these standards are implemented in line with set timescales; and ensure performance is regularly monitored and publicly reported
- clarify accountability and governance arrangements for the delivery of drug and alcohol services in Scotland and set out clearly the responsibilities of all organisations and partnerships involved in planning or delivering these services.

Public sector bodies should:

- ensure that all drug and alcohol services are based on an assessment of local need and that they are regularly evaluated to ensure value for money. This information should then be used to inform decision-making in the local area
- ensure that service specifications are in place for all drug and alcohol services and set out requirements relating to service activity and quality. Where services are contracted, this specification should be part of the formal contract
- set clear criteria of effectiveness and expected outcomes for the different services that they provide and undertake regular audits to ensure services adhere to expected standards
- use the Audit Scotland checklist detailed in Appendix 4 to help improve the delivery and impact of drug and alcohol services through a joined-up, consistent approach.

Part 1. The scale of drug and alcohol misuse

Scotland has a greater problem with drugs and alcohol than the rest of the UK and most of Europe, with deprived communities most affected.

Key messages

- Scotland has high levels of drug and alcohol misuse compared to the rest of the UK. The levels of problematic drug misuse in Scotland are double that of England and the levels of alcohol dependency are a third higher. Alcohol misuse is a bigger problem than drug misuse.
- Drug and alcohol-related death rates are among the highest in Europe and have doubled in the last 15 years. This is at a time when indicators of drug and alcohol-related harm are reducing in other countries in Europe.
- Drug and alcohol misuse are found across society but people who are likely to be excluded from society and those living in deprived areas are most affected. People living in deprived areas are more likely to suffer serious health problems as a result of their drug or alcohol misuse.

Scotland has a significant problem with drugs and alcohol compared to the rest of the UK and Europe

10. In 1982, the Ministerial Advisory Council on the Misuse of Drugs defined someone with problematic drug use as *"any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her own use of drugs or chemical substances."* [7]

11. The World Health Organisation defines alcohol dependency as "*a cluster of psychological, behavioural and cognitive phenomena. A central characteristic is the desire (often strong, sometimes perceived as overpowering) to drink alcohol.*" [8] Our report refers to alcohol misuse and includes alcohol dependency, hazardous, harmful and binge drinking, all of which have harmful consequences in terms of health, violence and community safety.

12. The links between drug and alcohol misuse and efforts to address them are complex and inter-related. Many problematic drug users will use more than one drug and may also misuse alcohol.

There are high and increasing levels of drug-related harm in Scotland

13. There is a higher prevalence of drug misuse in Scotland than elsewhere in the UK. The estimated number of people aged 15 to 54 misusing opiates, such as heroin, decreased from 55,800 in 2000 to 51,582 in 2003. This equates to 1.8 per cent of the population.[9] This is double the level in England, where approximately 0.9 per cent of the population aged 15 to 64 misuse opiates.[10]

14. The use of cocaine is increasing in Scotland. The number of new people contacting services and listing cocaine as their main drug problem doubled from 284 in 2003/04 to 625 in 2007/08.[11] The number of drug-related deaths involving cocaine has also doubled over the past five years.[12]

15. Scotland also has the highest rate of injecting drug users in the UK with a rate of 5.6 per 1,000 population compared to 4.2 for the UK as a whole.[13] Scotland has high levels of drug users sharing injecting equipment. There are an estimated 50,000 people in Scotland with hepatitis C and drug users who inject and share injecting equipment are the largest group of people affected.[14,15]

16. There is a lack of national data on the levels of drug misuse relating to ethnicity. In 2007/08, just over 99 per cent of new people contacting services for drug problems described their ethnicity as white and almost 96 per cent as white Scottish.[16]

17. Drugs are used by people of all ages but in 2007/08 the median age of new people contacting services for drug problems was 30 years.[17] Sixteen per cent of new contacts were over 40 years of age and eight per cent were 19 years or younger.[18]

18. There are limited data on the number of children affected by parental substance misuse but there is information on pregnant women collected in hospitals. In 2006/07, 566 pregnant women in hospital were recorded as having drug problems in Scotland, a rate of 10.4 per 1,000 maternities. This rate has increased from 6.7 per 1,000 in 2002/03.[19]

Young people and drugs

19. The level of drug misuse among 13 and 15-year-olds has reduced across the UK, primarily as a result of a decline in the use of cannabis:[20]

- Nearly a quarter (23 per cent) of 15-year-olds in Scotland reported using drugs in 2006, compared to 31 per cent in 2004.
- Seven per cent of 13-year-olds in Scotland reported using drugs in 2006, compared to 11 per cent in 2004.[21]

However, reported use of illegal drugs among schoolchildren in Scotland is still high.

Drug-related health harm and deaths

20. In 2007/08, there were 5,363 discharges from acute general hospitals with a drug-related diagnosis, a rate of 108 per 100,000 population. Over the last six years, there has been little change in the rate of drug-related discharges.[22] Ninety-five per cent of people discharged with a drug-related diagnosis were initially admitted as an emergency.[23] In 2006/07, it is estimated that 148,050 consultations with GPs related to drug misuse.[24]

21. Drug-related deaths in Scotland are the highest recorded in the UK and among the highest in Europe. In England and Wales, the rate of drug-related deaths was 2.7 per 100,000 population in 2005 compared to 7.3 per 100,000 in Scotland.[25]

22. Drug-related deaths in Scotland are at their highest ever level and are increasing. In 2007, there were 455 drug-related deaths, a 103 per cent increase over ten years.[26, 27] In some local areas, there has been a reduction in the number of drug-related deaths in recent years and significant variation year-on-year. For example, in Glasgow there were 106 drug-related deaths in 2004, this fell to 75 in 2005 and then increased to 113 in 2006. In 2007, there were 90 drug-related deaths in Glasgow. Most drug-related deaths in Scotland involve more than one drug and alcohol.[28]

Drugs and crime

23. Seizures of illegal drugs by Scottish police forces increased by 27 per cent, from 16,425 in 1999/2000 to 20,938 in 2006/07.[29] Seizures of cocaine have increased at a time when figures suggest greater cocaine use in society. Between 2002/03 and 2006/07, cocaine seizures by Scottish police forces increased from 17 per cent of all seizures of Class A drugs to 30 per cent. Heroin accounted for the majority of Class A seizures.[30, 31]

24. Drug misuse and drug dealing in local communities leads to increases in both the fear of crime and actual crime. Seventy-six per cent of people surveyed by the Scottish Executive in 2006 believed that drug misuse was a 'big problem' in their community.[32]

25. In 2007/08, the average spend on a heroin addiction was £245 a week and £624 a week on a cocaine addiction.[33] Drug users report that a mixture of social security benefits and crime are most commonly used to fund their habits.[34] This has obvious implications for crime rates and the wider costs of drug misuse.

There are high and increasing levels of alcohol-related harm in Scotland

26. Alcohol misuse is a bigger problem than drug misuse in terms of the number of people misusing and the harm caused to health. Estimating the size of Scotland's alcohol problem is not easy due to a lack of national data and under-reporting of consumption.

27. In England, the first national alcohol needs assessment was carried out in 2004. It estimated that 3.6 per cent of the population aged between 16 and 64 was dependent on alcohol.[35] In Scotland, it is estimated that 4.9 per cent of the population aged 16 and over are dependent on alcohol. The higher prevalence of alcohol dependency in Scotland was found to be largely due to the higher rates of alcohol dependency in Scottish women.[36]

28. Over the last 45 years, alcohol sales in the UK have doubled, rising from 5.7 litres of pure alcohol per person aged 16 and over in 1960 to 11.3 litres in 2005.[37]

29. There have also been changes in the types of alcohol purchased over time. Sales of beer have remained steady since 1980, but there have been increases in the sale of wine, cider and drinks such as alcopops.[38]

30. More alcohol is sold in Scotland than in England and Wales per head of population. In 2007, an average of 12.2 litres of pure alcohol was sold per person aged 18 and over in Scotland, compared to 10.3 litres in England and Wales. This difference is partly due to people in Scotland buying more spirits compared to the rest of the UK, an average of 3.6 litres per person aged 18 and over in Scotland, compared to 1.8 litres in England in 2007.[39]

31. The number of females reporting drinking above the recommended weekly limit (14 units of alcohol) is increasing.[40] In 1995, 13 per cent of women aged 16 to 64 years drank more than 14 units per week, rising to 17 per cent in 2003. This is likely to be an under-estimate.[40]

Young people and alcohol

32. Levels of under-age drinking are high. In 2006, over a third (36 per cent) of 15-year-olds reported that they had consumed alcohol in the previous week. There has been a reduction in reported drinking among boys. Reported drinking among 15-year-old girls increased from ten per cent in 1990 to 23 per cent in 2002. This has since fallen to 15 per cent of 15-year-old girls reporting they drink alcohol in 2006, this is 50 per cent higher than in 1990.[41]

33. Figures for hospital A&E departments highlight the consequences of young people drinking. Over a five-week period in 2006, nearly 650 children ranging from eight to 15-years-old were treated for alcohol-related problems in Scottish A&E departments.[42]

Alcohol-related health harm and deaths

34. In 2007/08, there were 42,430 discharges from acute general hospitals with an alcohol-related diagnosis. Over the last five years, the discharge rate has increased by nine per cent, from 710 per 100,000 population in 2002/03 to 777 per 100,000 population.[43]

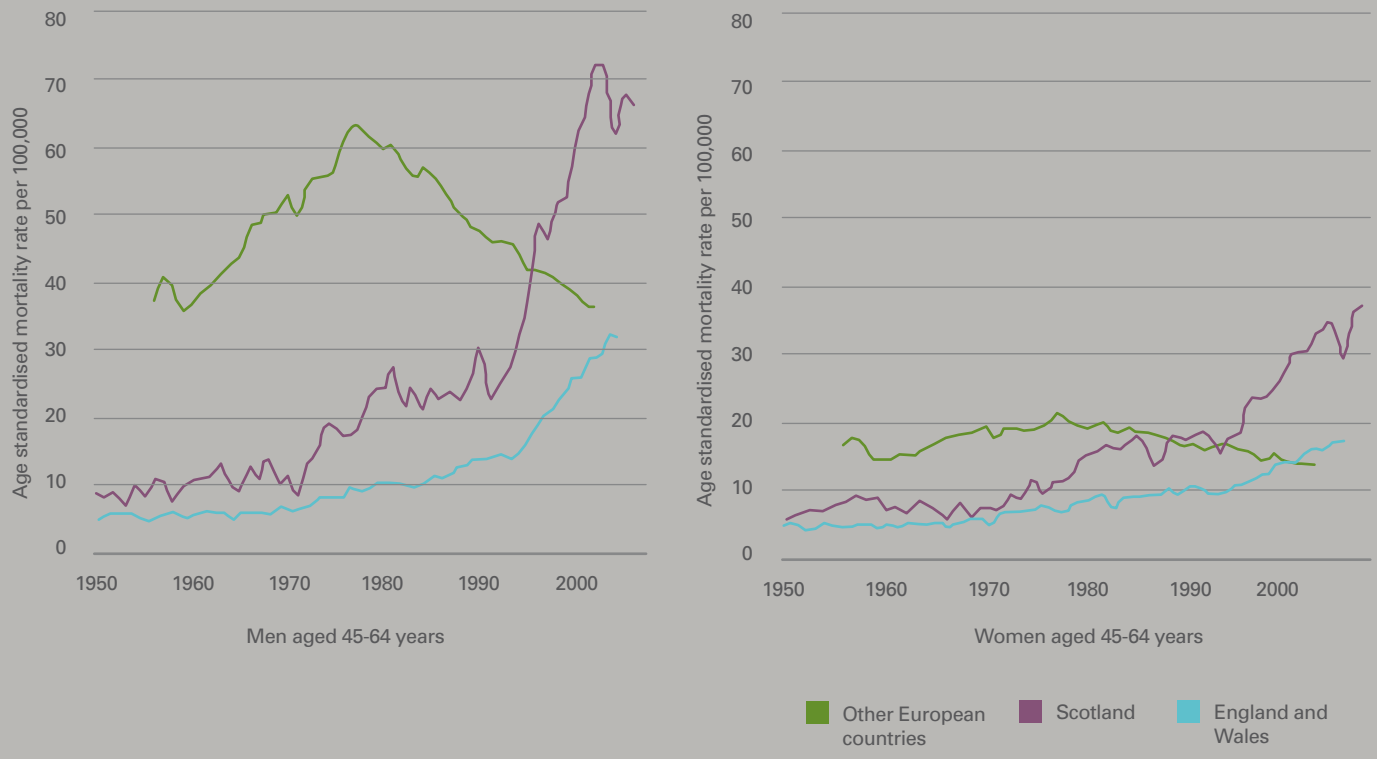
35. Alcohol is considered to be a contributory factor in 11 per cent of all attendances at A&E. The busiest time for alcohol-related attendances is Friday night/Saturday morning, between midnight and four in the morning.[44]

36. In 2006/07, it is estimated that around 111,200 consultations for alcohol misuse took place with GPs and practice nurses.[45] The role of GPs and practice staff in relation to alcohol misuse is likely to grow, with specific funding from the Scottish Government to support screening and brief interventions in primary care.[46]

Exhibit 1

Deaths from chronic liver disease and liver cirrhosis, 1950 to 2006

Deaths in Scotland are increasing at a greater rate than in England and Wales.



Source: *Changing Scotland's relationship with alcohol: a discussion paper on our strategic approach,* Scottish Government, 2008

37. Scotland has the highest alcohol-related death rate in the UK and the number of deaths in Scotland is increasing. In 2007, there were 1,399 alcohol-related deaths, a 75 per cent increase over ten years, and over 100 per cent increase over 15 years.[47] The increase in alcohol-related deaths in the last 15 years has varied across the country.[48] Alcohol-related death rates in Scottish men are double that of the rest of the UK.[49]

38. Scotland has one of the highest rates of liver cirrhosis in Western Europe and one of the fastest growing rates of deaths due to liver disease in the world. Rates of alcoholic liver disease in Scotland increased by 52 per cent between 1998 and 2002.[50, 51] The increase in chronic liver disease and liver cirrhosis in Scotland is at a time when rates are decreasing across Europe (Exhibit 1).[52]

Alcohol and crime

39. Alcohol misuse is linked to violent crime:

- A survey of three police stations in Glasgow showed that between April 2006 and March 2007, two-thirds of those in custody for a violent offence were under the influence of alcohol.[53]
- In 2003, 62 per cent of domestic abuse cases involved alcohol.[54]
- Forty-five per cent of people accused in homicide cases are reported to have been under the influence of alcohol and/or drugs.[55]

Drug and alcohol misuse affects all communities in Scotland but has a bigger impact in deprived areas

40. Drug and alcohol problems are more acute in deprived communities.[56] While there is no relationship between poverty and whether people have tried illegal drugs, there is a clear link between poverty and problematic drug use, particularly heroin and crack cocaine.[57]

41. The relationship between alcohol and deprivation is more complex. People in professional households are more likely to exceed the recommended weekly limits, but those living in the most deprived communities experience more health problems because of their drinking.[58] People living in the 20 per cent most deprived communities in Scotland are around six times more likely to be admitted to hospital and to die due to

alcohol misuse than those from the most affluent areas.[59]

People who are likely to be excluded from society have particular problems with drugs and alcohol

42. Drug and alcohol misuse are greater problems for people who are socially excluded, compared to the rest of society. Up to three in four people using drugs have mental health problems, and up to one in two people with alcohol problems may have a mental health problem.[60] Audit Scotland is publishing an overview report of mental health services in Scotland in May 2009.

43. There is also evidence of high levels of drug misuse among homeless people. A sample of 225 homeless people in Glasgow showed that 56 per cent of those under 35 years old were addicted to drugs, with heroin being the most common. The same sample showed that 54 per cent of homeless people reported hazardous drinking behaviour.[61]

44. Over 40 per cent of prisoners are likely to have an alcohol problem, four times higher than the general population.[62] Two-thirds of prisoners test positive for illegal drug use on admission to prison.[63]

45. Drug and alcohol misuse does not just affect the users themselves. Children of parents who misuse drugs and alcohol are often at increased risk of emotional and physical abuse. In the long term, they may experience poor educational attainment and limited life choices and are therefore at risk of developing substance problems themselves.[64]

46. National information on children affected by parental substance misuse in Scotland is poor, but it is estimated that a quarter of children on the Child Protection Register are there due to parental alcohol or drug misuse.[65] There are an estimated 60,000 children affected by parental drug misuse and approximately 65,000 children affected by parental alcohol misuse in Scotland.[66, 67]

Many public sector bodies commission or provide drug and alcohol services

47. Drug and alcohol services are generally classed as:

- prevention services, such as education in formal or informal settings
- treatment and care services, such as counselling, needle exchange, detoxification, relapse prevention, prescribing of chemical substitutes such as methadone, residential rehabilitation, training or employment services
- enforcement and regulation activities, such as test purchasing operations to restrict the sale of alcohol to under-age people, arrests for drug dealing or international police efforts to tackle drug trafficking and seize illegal drugs.

48. Prevention, treatment and care services to address drug and alcohol misuse are often joint and many staff address both drug and alcohol problems. More details about wider partnership working are set out in Part 4.

49. A range of drug and alcohol services are provided either directly by councils, the NHS, police and prisons or commissioned from the voluntary and private sectors (Exhibit 2, overleaf). The voluntary and private sectors also provide a variety of prevention, treatment and rehabilitation services that are not funded directly by the public sector.

50. There are many generic services that target people who are socially excluded in society that also help people who misuse drugs and alcohol such as services for homeless people. The Scottish Government's new initiative to increase the role of GPs, practice nurses and hospital A&E departments in screening and brief interventions for alcohol problems is another example of a general service providing some specialist support.

Exhibit 2

Examples of drug and alcohol services provided by the public sector

Public sector bodies provide a range of drug and alcohol services.

	Prevention	Treatment and care	Enforcement
Councils	Education in schools and communities, life skills and leisure activities for at risk groups, parenting skills	Back to work support, social worker support, education, counselling, residential rehabilitation, supported accommodation and housing	Drug Treatment and Testing Orders (DTTOs), arrest referral programmes, Drug Courts[1]
NHS	Health promotion, brief interventions, such as consultations with a GP	Detoxification in hospital, treating effects of alcohol or drug misuse, relapse prevention, GP and practice nurse contact, methadone and other substitute prescribing, harm reduction such as needle exchanges	Control misuse of prescribed drugs and prescriptions
Police and the SCDEA[2]	Choices for Life[3], school education and prevention visits, community police officer engagement	Arrest referral, services provided by police doctors and nurses, chaplains	Intelligence-led operations, drugs seizures, arrests for drug and alcohol-related offences, test purchasing[4], enforcement of licensing laws
Prisons	Awareness raising programmes on addictions	Counselling, one-to-one support and group work programmes, detoxification, methadone and other substitute prescribing, addiction nurse support, chaplains and wider 'community integration planning' with essential services[5]	Testing for illegal drug use, detection activities, eg sniffer dogs and surveillance at visits

Notes:
1. DTTO – Community sentence alternative for serious drug misusing offenders. Arrest referral – aim to divert less serious offenders into treatment at point of arrest. Drug court – specialised courts where convicted offenders agree to take part in treatment and report regularly to the sheriff.
2. The Scottish Drug Enforcement Agency (SDEA) was formally established in 2001. In 2006, the agency adopted the Scottish Crime and Drug Enforcement Agency (SCDEA) title to reflect a commitment to prevent and detect serious and organised crime and target those criminals who have the capacity and resources to cause the most damage to Scotland's communities.
3. Choices for Life is a multi-media concert delivered to all primary seven children in Scotland to raise knowledge about drugs, alcohol and smoking and to encourage positive lifestyles. It is organised by the SCDEA in partnership with the Scottish Government, NHS Health Scotland and others.
4. Test purchasing – police operation where under-18s attempt to buy alcohol to test enforcement of licensing laws.
5. Essential services – services to address financial, housing, employment and other barriers to people recovering from problematic drug and/or alcohol use.

Source: Audit Scotland, 2008

Part 2. Direct expenditure on drug and alcohol services

Spending patterns do not reflect national priorities and do not always reflect indicators of need. Funding arrangements are often complex and fragmented.

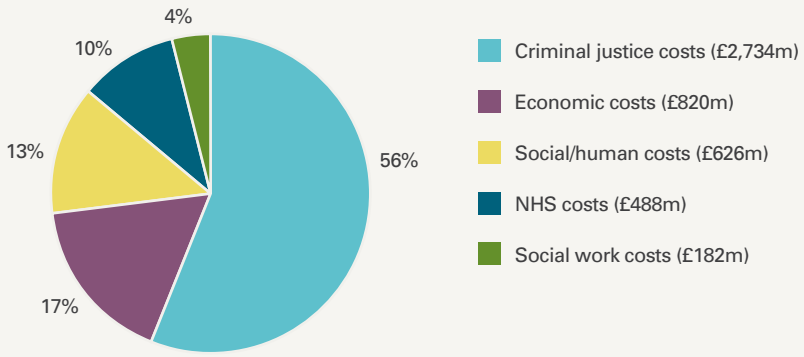
Key messages

- In 2007/08, the public sector spent £173 million on drug and alcohol services in Scotland, £84 million specifically on drugs services and £30 million on alcohol services. The remainder was spent on joint drug and alcohol services.
- Sixty-eight per cent of drug and alcohol money is spent on treatment and care services. The Scottish Government's recent strategies for drugs and alcohol have a focus on prevention but currently only around six per cent of direct spend is on preventative activities, including services for children affected by parental substance misuse.
- The amount that NHS boards and councils spend on drug and alcohol services varies across the country, from almost £14 per head of population in the Borders to just over £53 in Greater Glasgow and Clyde. While some variation would be expected, current patterns of spend do not match national indicators of need such as levels of misuse.
- Funding arrangements are complex and services can have a number of separate funding streams, each with different timescales and reporting criteria. This is an added difficulty for those planning and providing services.

Exhibit 3

The estimated wider economic and social costs of drug and alcohol misuse

The wider economic and social costs of drug and alcohol misuse are estimated at almost £5 billion per year.



Note: In the absence of alternative data we have calculated the economic and social costs of drug misuse by using the Home Office methodology and applying Scottish prevalence figures of problematic drug misusers in 2003.
Source: *Costs of alcohol use and misuse in Scotland*, Scottish Government, May 2008. *Social and economic costs of Class A drugs in England and Wales 2003/04*, Home Office, 2006

The wider costs of drug and alcohol misuse are an estimated £5 billion per year

51. It is estimated that the wider economic and social costs of drug and alcohol misuse in Scotland are almost £5 billion per year, £2.6 billion for drug misuse and £2.25 billion for alcohol misuse.[68, 69] We have estimated the wider economic and social costs of drug misuse based on a Home Office estimate for England and Wales in 2004. Scottish figures were expected in May 2008 but have not yet been published.

52. The current estimates of the wider economic and social costs of both drug and alcohol misuse are believed to be under-estimates. These estimates include wider health economic costs and the cost to the Scottish economy. For example, criminal justice costs of £2.7 billion include estimates of police time dealing with alcohol misuse (£288 million) and the costs of dealing with drug-related crime (£684 million). Health costs include A&E attendances (£46 million) and hospital inpatient care (£273 million). The health costs due to alcohol misuse are greater than those for drug misuse. Costs to the economy include people being absent from work (£286 million) (Exhibit 3).

53. In addition to services specifically for drugs and alcohol, there are many wider services that help people with drug and alcohol problems or that deal with the impact of drug and alcohol misuse (Case study 1).

The public sector spent £173 million on drug and alcohol services in 2007/08

54. Information on how much the public sector spends each year on drug and alcohol services is not readily available. There are national data on prevalence and some data on activity but there is no national information on the spend on drug and alcohol services at a local level.

55. As part of this review, we collected information from all NHS boards and councils on how much they spent directly on drug and alcohol services in 2007/08. We also collected information from the eight police forces on the number and size of dedicated drug squads and licensing departments and on the number of dedicated campus and school liaison officers.[70, 71] We used this information to estimate the cost of drug and alcohol labelled police work.

56. Using these locally provided data, plus national labelled spend, we estimate that the public sector in Scotland spent £173 million on drug and alcohol services in 2007/08 (Exhibit 4).

Case study 1

Examples of wider services for drugs and alcohol

Housing support – Fab Pad supports recently homeless people and those at risk of losing their tenancies in Glasgow. It supports people to design and decorate their homes to give them a sense of achievement, commitment to their tenancy and ultimately commitment to move on in their lives. Many of the clients have problems with drugs and alcohol and the service offers additional support to these people. In 2007/08, approximately 60 per cent of people at the service had addiction problems. The annual cost of the project in 2007/08 in Glasgow was £379,333. The Fab Pad project is also being delivered in Edinburgh, Borders, North Ayrshire, East Ayrshire, East Dunbartonshire, West Dunbartonshire, Stirling and South Lanarkshire.

Antisocial policing – The Community Prevention Trial in Glasgow City Centre has been running since 2003 and aims to reduce violence and disorder in the city centre. As it is estimated that approximately 70 per cent of violent assaults in the city are alcohol-related, the focus of the initiative is after 10pm. The project costs approximately £80,000 per year and involves Strathclyde Police, Glasgow City Council and NHS Greater Glasgow and Clyde.

Source: Audit Scotland, 2008

Exhibit 4

Public sector spend on drug and alcohol services

The public sector spent £173 million on direct drug and alcohol services in 2007/08.

	£ million
NHS boards	90
Councils	66
Police forces	10
Scottish Prison Service	3
Scottish Government direct spend (eg, research)	4
Total	173

Source: Audit Scotland, 2008

57. There are, however, differences in the way budgets are recorded in each local area and the way that services are provided. Many services for people misusing drugs and alcohol are delivered as part of general services and so funding will not be labelled as specifically for drug or alcohol services. This makes it difficult to give comprehensive figures for what is spent on drugs and alcohol.

NHS boards

58. In 2007/08, the Scottish Government allocated £34 million to NHS boards for drug and alcohol treatment services. These allocations have increased in recent years:

- Drug funding increased from almost £9 million in 1998/99 to around £24 million in 2007/08.
- Alcohol funding increased from £3 million in 2004/05 to just over £10 million in 2007/08.[72]

59. NHS boards generally add to this money to provide services, and in 2007/08 they spent an additional £56 million (62 per cent of their total direct spend on drug and alcohol services).

60. The amount spent on alcohol and drug services should increase as the Scottish Government has allocated an additional £85.3 million for alcohol misuse over the three years from 2008/09 to 2010/11; most of this money will go to NHS boards (£24.8 million in 2008/09). The Scottish Government also plans to increase allocations to NHS boards for drug services from £24.7 million in 2008/09 to £28 million in 2009/10.

Councils

61. The Scottish Government, in agreement with COSLA, allocates funds to councils using an agreed formula known as the Grant Aided Expenditure (GAE).[73] The GAE is not an allocation but a method for calculating each council's indicative spend on each of its services based on its population's needs.[74] In 2006/07, £42 million of the GAE was identified for services for 'adults with addiction and substance misuse', although it is a council's decision how to spend its GAE.[75, 76]

62. In 2007/08, councils spent £66 million on drug and alcohol services. This includes £7.5 million transferred to them from NHS boards.

NHS and council spend

63. NHS boards and councils spent just under one per cent of their total combined revenue budgets on labelled drug and alcohol services in 2007/08.

Comparisons with England

64. In 2005/06, government labelled drug-related expenditure was estimated at £2,695 per problematic drug user in England, compared to £1,293 per problematic drug user in Scotland.[77] In England, there is no

ring-fenced funding for alcohol services, compared to just over £10 million to NHS boards in Scotland in 2007/08.

65. In England, significant resources have been allocated to drug services over the last ten years by both the Department of Health and the Home Office. Some of this money was used to establish the National Treatment Agency, a special health authority created to increase the availability, capacity and effectiveness of drug treatment services, and several intensive criminal justice interventions.

Voluntary and private sectors

66. The voluntary and private sectors provide many drug and alcohol services. Three of the main independent funders of the voluntary sector are the Big Lottery, Lloyds TSB Foundation for Scotland, Partnership Drugs Initiative and the Robertson Trust. The Big Lottery's Better Off Fund provided £10 million over five years between 2003 and 2007 to fund community rehabilitation projects for people who misuse drugs. Lloyds TSB Foundation for Scotland, in partnership with the Scottish Government, provided approximately £1.2 million for drug and alcohol services in 2007/08 and the Robertson Trust contributed an additional £730,000.

Most direct spend on drug and alcohol services is for treatment and care

67. Sixty-eight per cent of direct expenditure on drug and alcohol services is spent on treatment and care, including residential treatment and community treatment such as methadone (Exhibit 5).[78] Different treatment types are discussed in more detail in Part 3.

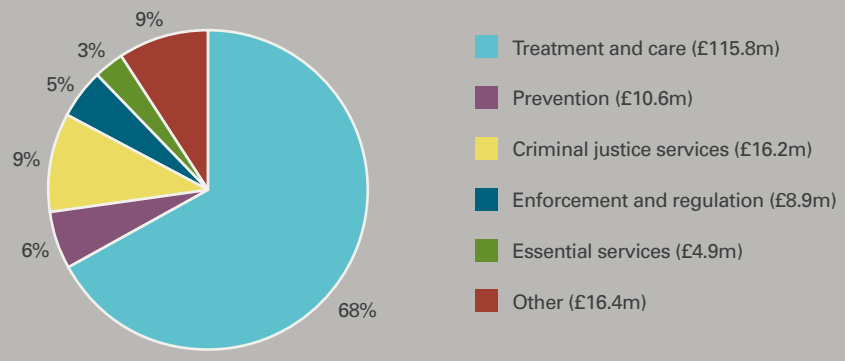
Prevention

68. The recent Scottish Government strategies for drugs and alcohol emphasise the importance of prevention.[79] However, in 2007/08, only six per cent of direct spend was on preventative activities. This includes interventions for children affected by parental substance misuse.[79]

Exhibit 5

Breakdown of direct spend on drug and alcohol services, 2007/08

Most direct expenditure on drug and alcohol services in Scotland is spent on treatment and care services.



Notes:
1. Essential services are services to address financial, housing, employment and other barriers to people recovering from problematic drug and alcohol use.
2. Criminal justice services are services aimed at diverting drug and alcohol misusing offenders from crime and into treatment.
Source: Audit Scotland, 2008

69. Scottish police forces spent almost £3 million on dedicated campus and liaison officers in 2007/08. These officers work in some schools, colleges and universities and aim to prevent the misuse of drugs and alcohol.

70. Other general prevention work that helps vulnerable young people and those considered to be at risk is not labelled as drug or alcohol-related but will help people affected by drug and alcohol misuse. *The Road to Recovery*, the Scottish Government's new drugs strategy, details wider work being undertaken to address the underlying factors associated with drug misuse such as an economic strategy and early years framework.

71. There is research on how to improve the effectiveness of different treatment services but there is not this level of evidence for prevention services. If, in line with good practice, agencies use the evidence to influence spend then this may affect how much they spend on prevention activities.

Enforcement and regulation

72. Enforcement and regulation activities account for five per cent of the direct spend on drugs and alcohol.[80]

73. Based on data collected on the number and size of dedicated drug squads and licensing departments from all forces, we estimate that expenditure on drug and alcohol labelled police work was £7.1 million in 2007/08.[81] The eight police forces in Scotland record information about drug and alcohol operations differently, therefore it is not possible to compare activity or cost between police force areas.

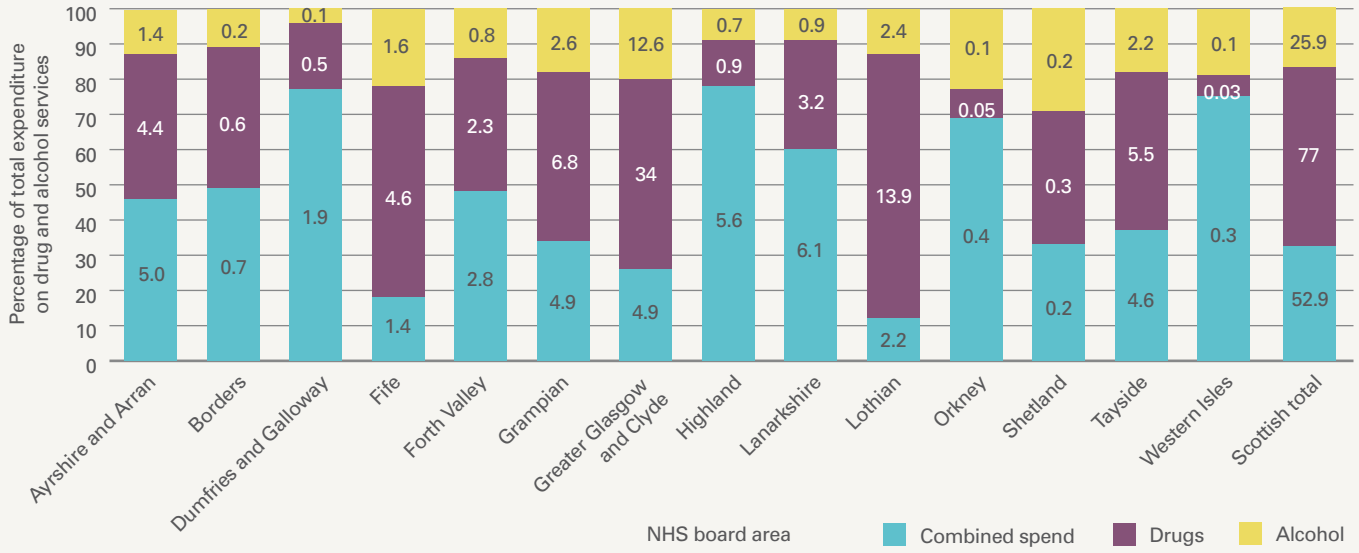
74. This estimate does not include the cost of the Scottish Crime and Drug Enforcement Agency (SCDEA). The SCDEA costs £23.3 million a year and aims to prevent and disrupt serious and organised crime. A significant amount of its work is drug-related.

75. There is also a significant amount of general police, prison and court time spent on drug and alcohol issues but this is not costed. The wider costs of drug and alcohol-related crime in

Exhibit 6

NHS board and council spend on drug and alcohol services, 2007/08

NHS boards and councils spend more on drug services than on alcohol services.



Notes:
1. Figures in the bars show how much is spent in each NHS board area, by councils and NHS boards (£ million).
2. Combined spend is spend on joint services for drug and alcohol that cannot be differentiated.
Source: Audit Scotland, 2008

Scotland, including police, prison and court time, are estimated at £2.7 billion a year.[82, 83]

Spending on drug and alcohol services does not reflect levels of need

Public bodies spend significantly more on drug services than alcohol services

76. In this section, we focus on NHS boards and councils as they spend the majority of money on drug and alcohol services. We show data based on NHS board areas although figures shown include NHS and council spend for that area.

77. In 2007/08, almost half of the money spent by NHS boards and councils was on dedicated drug services (£77 million) and a sixth on dedicated alcohol services (£26 million).[84] This does not reflect the scale of the respective problems, for example the number of alcohol-related deaths in Scotland in 2007 (1,399) was three times higher than the number of drug-related deaths (455).

78. We asked NHS boards and councils how much they spent in 2007/08 on either drug or alcohol services or combined services where it was not possible to differentiate the spend (Exhibit 6). The amount spent on drug and alcohol services by NHS boards and councils varies across the country. The combined spend in each area makes it difficult to give definite figures for the total amount spent on drug or alcohol services.

79. The percentage of total NHS and council drug and alcohol spend that is drugs specific varies from 75 per cent (£13.9 million) in Lothian to six per cent (£0.03 million) in the Western Isles. The percentage of total NHS and council drug and alcohol spend that is alcohol specific varies from 29 per cent (£0.2 million) in Shetland to four per cent (£0.1 million) in Dumfries and Galloway.

80. However, some areas, particularly rural areas, have high levels of combined spend. This is used to fund joint services rather than services specifically for drug or alcohol problems. High levels of combined spend in rural areas are possibly a reflection of the need to be more flexible in delivering services in more sparsely populated areas.

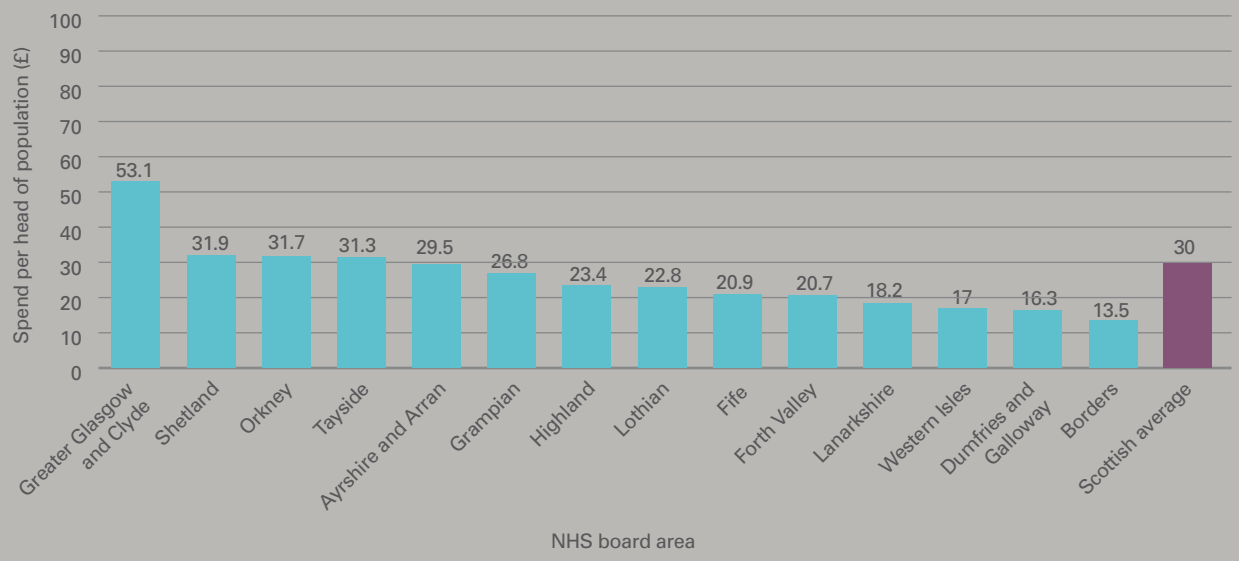
Variation in spend across the country does not reflect indicators of need

81. The amount spent on drug and alcohol services varies across the country, from almost £14 per head of population in the Borders to just over £53 in Greater Glasgow and Clyde (Exhibit 7, overleaf).

Exhibit 7

NHS and council spend on drug and alcohol services per head of population, 2007/08

Spend per head of population varies across Scotland.



Source: Audit Scotland, 2008

82. The scale of this variation in spend is not explained by differences in the levels of drug and alcohol misuse in a local area or by the levels of harm caused as a result of the misuse (Exhibits 8 and 9).

Funding arrangements for drug and alcohol services are complex and make strategic planning difficult

83. Funding for drug and alcohol services comes from a range of sources including NHS ring-fenced allocations, NHS unified budgets, council general allocations, specific grant funding, the voluntary sector, the police and the Scottish Prison Service. Funding for a project may be directed through several different agencies before it reaches the actual service (Exhibit 10, overleaf). This can make transparency of funding, planning and long-term stability for services difficult and creates a significant administrative burden on service managers.

84. The voluntary sector provides many drug and alcohol services. In 2007/08, around a third of direct expenditure on treatment and care was spent on services provided by the voluntary sector. In our focus group, voluntary sector representatives reported that the funding arrangements are particularly challenging for them, as projects are often supported by numerous funding streams with different timescales and reporting mechanisms. The funding arrangements of the voluntary sector Greater Easterhouse Alcohol Awareness Project (GEAAP) in Glasgow highlight the complexity of these arrangements. This is despite the Addictions Partnership in Glasgow coordinating funding on behalf of a range of statutory agencies in an attempt to streamline arrangements (Exhibit 11, overleaf).

85. Short-term and temporary funding of projects does not always allow for sufficient time to evaluate the effectiveness of these services. It can also have a negative effect on people using the service as the relationship and trust developed with a worker over time is vulnerable if funding is short term.

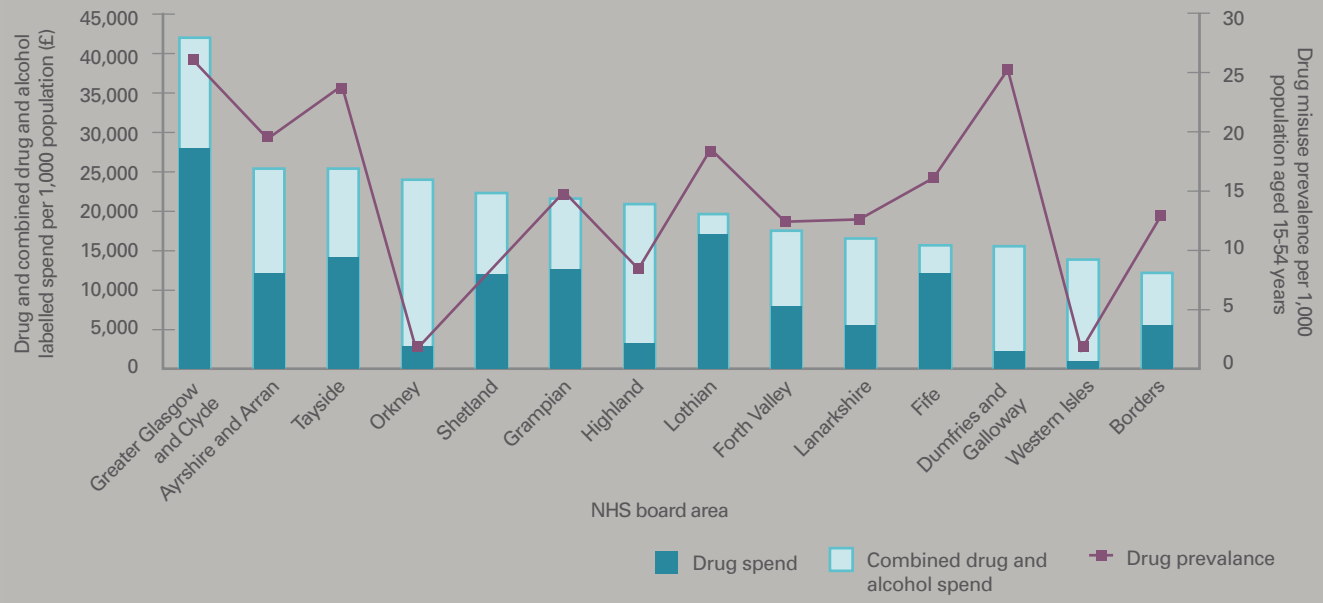
86. Multiple funding streams with different criteria and short-term funding make it very difficult to plan and deliver services and can put projects at risk. Providing services this way does not offer value for money and is likely to have an impact on vulnerable clients (Case study 2, page 20).

87. Allocations from the Scottish Government can be announced at short notice, which gives local areas a short lead-in time to plan and deliver drug and alcohol services. For example, details of a 150 per cent increase in NHS board allocations for alcohol services for 2008/09 were issued on 20 March 2008.

Exhibit 8

NHS and council spend on drug and combined drug and alcohol services per 1,000 population, 2007/08

Spend on drug specific and combined drug and alcohol services does not reflect drug misuse prevalence rates.

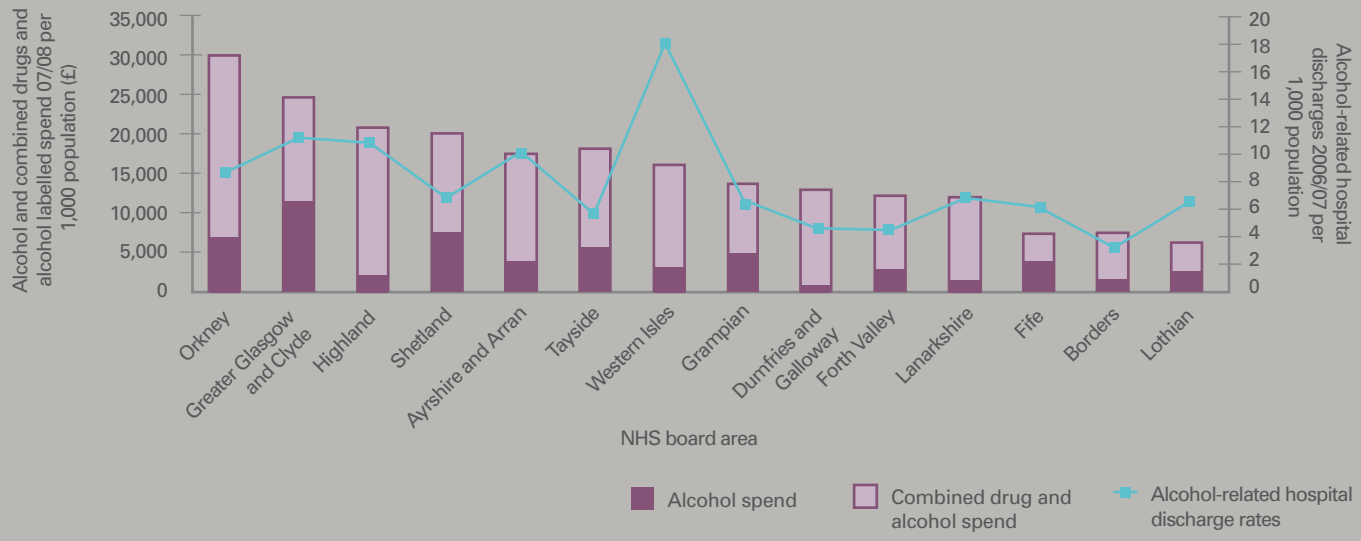


Note: Combined drug and alcohol spend is spend on joint services that cannot be differentiated.
Source: Audit Scotland, 2008

Exhibit 9

NHS and council spend on alcohol and combined drug and alcohol services per 1,000 population, 2007/08

Spend on alcohol specific and combined drug and alcohol services does not reflect alcohol-related discharge rates.

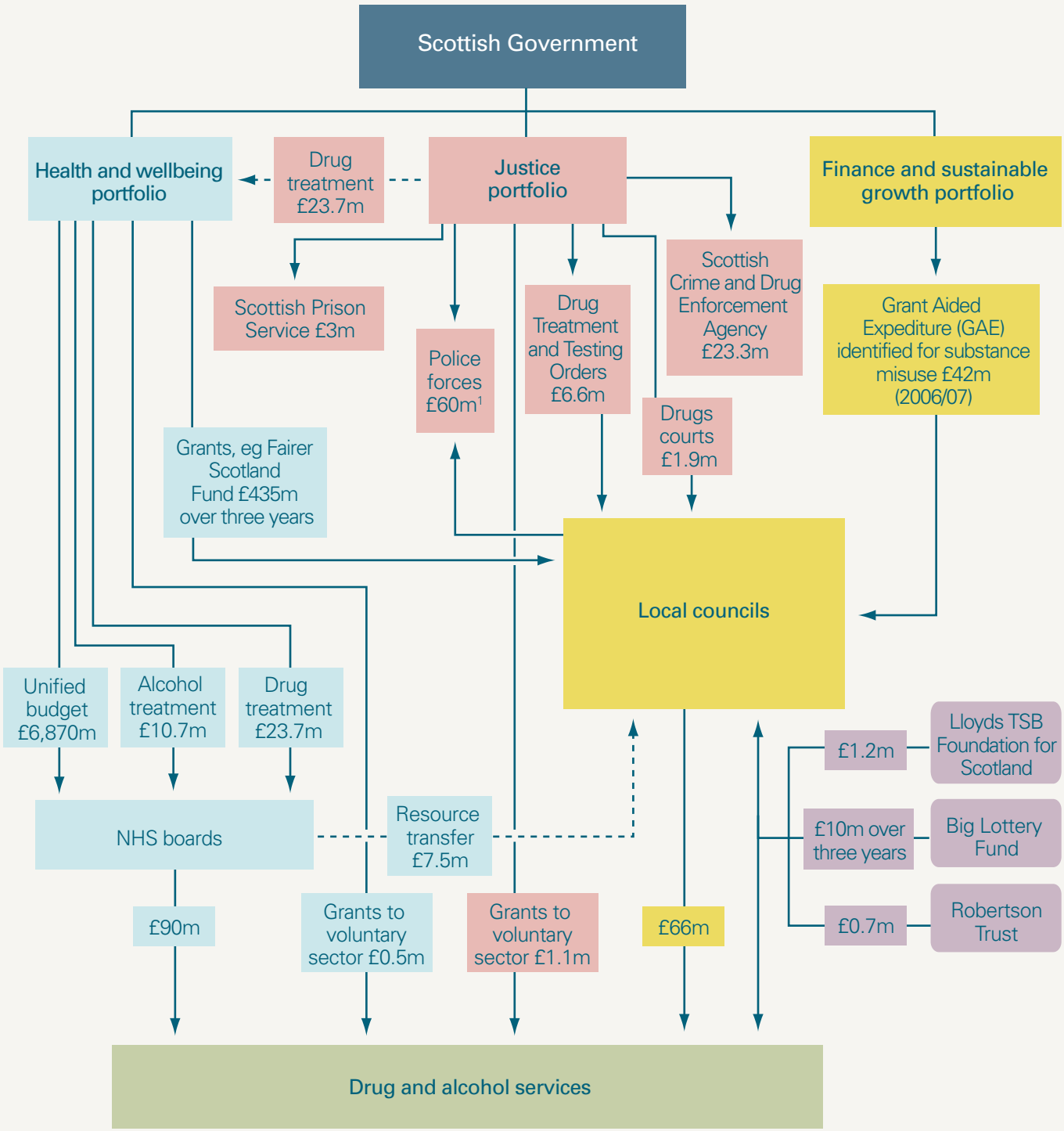


Note 1. Combined drug and alcohol spend is spend on joint services that cannot be differentiated.
Note 2. We have used alcohol-related hospital discharge rates as the prevalence of alcohol dependency is not available at NHS board level.
Source: Audit Scotland, 2008

Exhibit 10

Main funding streams for drug and alcohol services, 2007/08

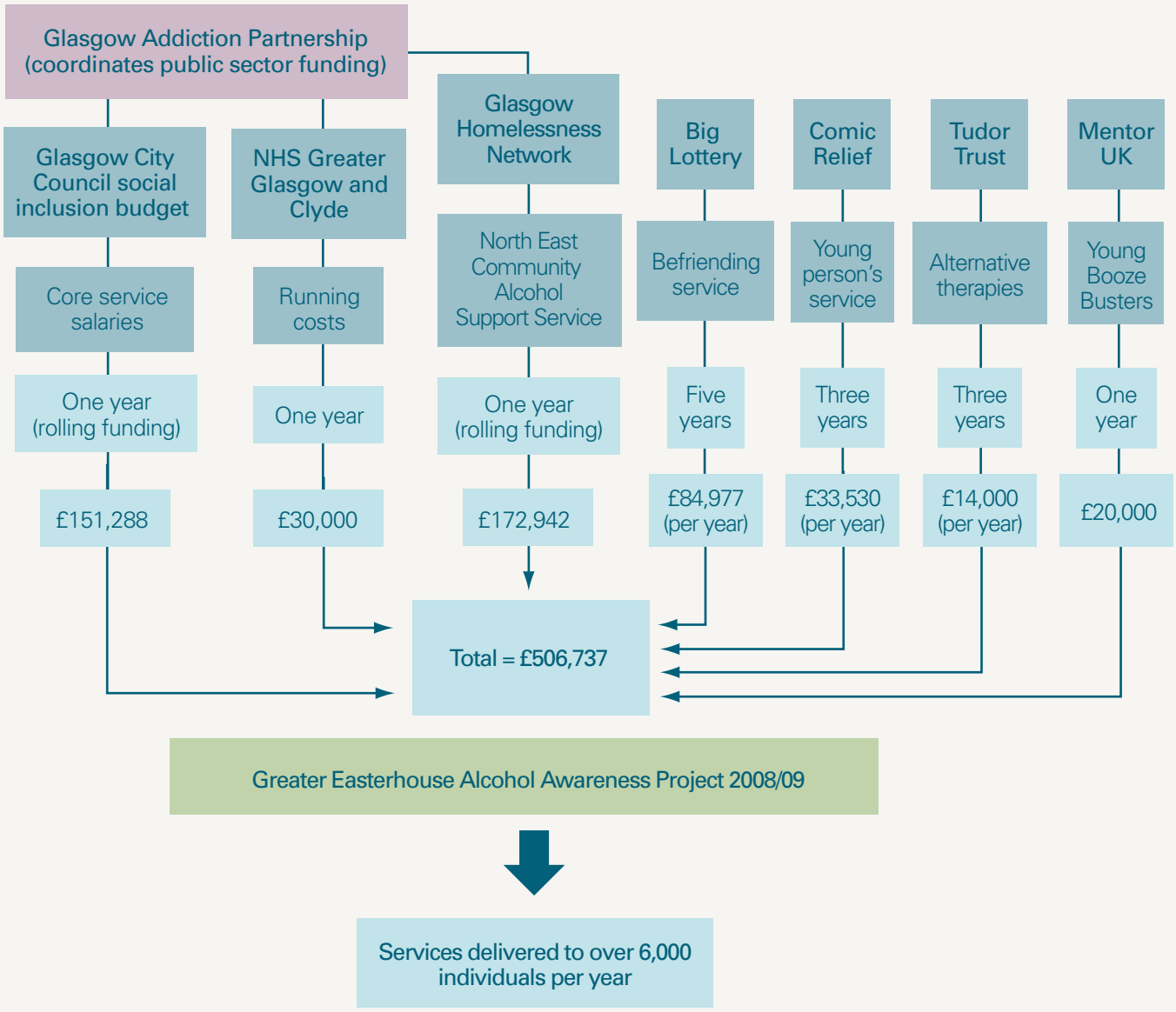
Funding streams for drug and alcohol services are complex.



Note 1. Scottish Government estimate of police spend on drug-related crime.
Source: Audit Scotland, 2008

Exhibit 11
Funding for the Greater Easterhouse Alcohol Awareness Project in Glasgow, 2008/09

Local projects often receive funding from numerous different sources, and for different time periods.



Source: Audit Scotland, 2008

The concordat and Single Outcome Agreements

88. In April 2008, following agreement of a concordat between the Scottish Government and COSLA, Single Outcome Agreements (SOAs) were introduced across Scotland. SOAs set out how each council and its partners, including their local NHS board, will address their priorities and improve services for the local population. SOAs are intended to encourage councils and their partners to focus on outcomes rather than on measuring process.

89. As part of the concordat, certain council funds are no longer ring-fenced. This means that councils can now use money previously badged for use for specific purposes as part of their general allocations. Specific grants such as the Supporting People Grant, Youth Justice monies and the Changing Children Services Fund, which helped to support people with drug and alcohol problems, are now part of a council's general allocation.

90. The reduction in ring-fencing allows greater discretion for councils, with their partners, to allocate resources according to perceived local needs and priorities. However, unless there are good information systems in place it may be difficult to know

Case study 2

Short-term funding can have an impact on services

Aberlour is a children's charity providing services and advice to vulnerable children, young people and families in Scotland.

In 1999, Scottish Enterprise grant funding (the New Futures Fund) paid Aberlour to provide an employment and training service to substance-misusing mothers with dependent children in Glasgow. The majority of these service users have not been in paid employment and have not completed basic education. In a six-month period, the service worked with around 25 clients, helping them to engage in further education, training and/or employment.

In 2006, funding for Aberlour moved to Community Planning Partnerships (CPPs). The service received a year's funding from the CPPs in 2007/08 and after this time alternative funding had to be sought. In any one year, there may not be service users from every CPP and this therefore made negotiations difficult. The project did not secure funding and had to close.

Source: Audit Scotland, 2008

whether drug and alcohol projects secure the necessary funding.

91. Drugs and alcohol are not included in the concordat as a specific commitment and although several of the 15 national outcomes could relate to drug and alcohol misuse, there is no direct link. All of the 32 first SOAs do mention drug and alcohol misuse. However, some references to drugs and alcohol are very brief and the expected impact on drug and alcohol services is often unclear.

Recommendations

The public sector should:

- regularly review funding arrangements for drug and alcohol services to ensure that they maximise value for money and reflect levels of local need
- work with provider organisations to reduce the impact of complex and short-term funding on projects.

Part 3. Effectiveness of drug and alcohol services

There is no consistency in the services available and information to assess cost-effectiveness nationally is limited.

Key messages

- There is variation across Scotland in the range and accessibility of drug and alcohol services. The Scottish Government has not set out minimum standards in terms of range, choice or accessibility that service users and their families can expect to receive.
- Spending decisions are not always based on evidence of what works or on a full assessment of local need. The majority of drug and alcohol services do not have clear aims and there is very little information on whether they are achieving specific outcomes or measures of success.
- Some local areas have information on the activity, cost and impact of drug and alcohol services but this is not available nationally. It is not possible to compare the cost-effectiveness of different services.

Case study 3

Examples of alcohol services in Tayside and Forth Valley

NHS Tayside runs the Tayside Alcohol Problem Service (TAPS). People can contact the service directly or through a GP or social worker.

The service offers assessment and treatment options in satellite clinics across the region and has a well-established residential facility in a local hospital, which people can also access.

NHS Forth Valley runs the Community Alcohol Service. People can contact the service through a GP or through Signpost Forth Valley, which is a direct access service for people with substance misuse problems across the Forth Valley area.

The service offers a range of community-based treatment including home detoxification that provides people with treatment in their home rather than in a hospital or other residential setting.

Source: Audit Scotland, 2008

Drug and alcohol services vary across Scotland

92. The drug and alcohol services that people receive vary depending on where they live (Case study 3).

93. Current Scottish Government policy highlights the need to have a range of services in place to meet individual needs but there is some evidence of a lack of choice. Drug service users who participated in our focus group highlighted that they feel they have little choice: *"one size fits all – you have to fit with the service, not it with you."* [85]

94. There is no direction from the Scottish Government on what money for drug treatment and care services should deliver. Although the Scottish Executive developed *National Quality Standards for Substance Misuse Services* in 2006 there is no national monitoring of whether they have been implemented.[86] A different approach is taken in England where the government has set out and monitors a required range of drug services which should be in place and minimum standards of access.

95. There is direction from the Scottish Government on what additional money for alcohol services should deliver. The Scottish Government's additional allocation of £24.8 million on alcohol services to the NHS in 2008/09 has come with a clear instruction to use some of the money to provide screenings and brief interventions to prevent people from developing serious problems with alcohol and the remainder on supporting additional treatment and prevention services. The Scottish Government has asked every NHS board to complete a progress report setting out how much of the additional money they have spent in 2008/09 and what services it has funded.

96. In addition, as part of the new alcohol strategy, a Monitoring and Evaluation Reference Group for Alcohol has been established to track implementation of the alcohol strategy and related outcomes. This group is chaired by NHS Health Scotland and aims to identify the impact of the additional £85.3 million over three years for alcohol misuse.

97. Despite the increased presence of cocaine in Scotland, drug services remain focused on heroin misuse and may not be set up to sufficiently meet the needs of people who misuse cocaine. The Scottish Advisory Committee on Drug Misuse estimated that only nine per cent of drug treatment services provide treatment specifically for people who misuse drugs that have anti-depressant or mood elevating properties, such as cocaine. The few specialist services for cocaine misuse are all in urban areas, such as Aberdeen and Edinburgh.[87]

Prevention

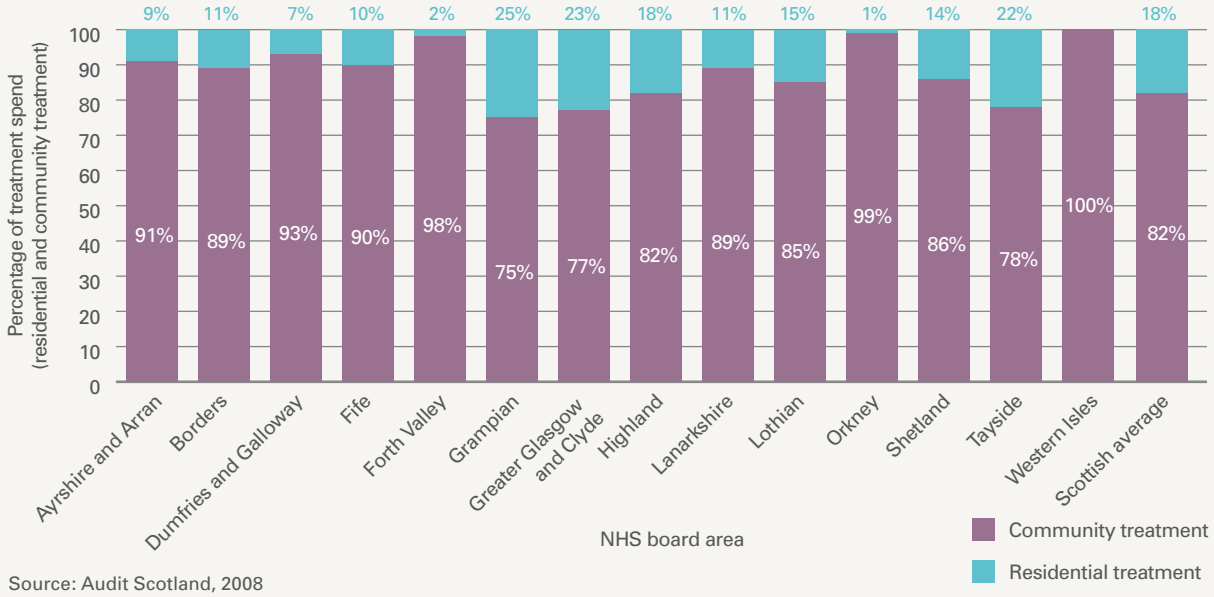
98. There are national initiatives aimed at preventing drug and alcohol misuse. For example, the Know the Score campaign aims to increase knowledge and promote avoidance of drug misuse and has a budget of £580,000 for 2008/09. There are also national prevention initiatives for alcohol, for example Alcohol Awareness Weeks, that aim to raise awareness about alcohol consumption and have a budget of £190,000 for 2008/09. There is no national information collected on prevention activity at a local level and there is no evaluation of the impact of this prevention work.

99. Often prevention forms part of the work of treatment and care

Exhibit 12

NHS board and council spend on community and residential treatment, by NHS board area, 2007/08

The spend on community treatment compared to residential treatment varies across Scotland.



Source: Audit Scotland, 2008

services and can be difficult to separate out. For example, in Greater Glasgow and Clyde it is estimated that a third of the £47 million treatment and care spend will have an impact on children affected by substance misuse through supporting parenting and treating parents.

Residential and community treatment

100. It is important that a range of services is available to meet the needs of people who misuse drugs and alcohol, as it is unlikely that a single service or type of treatment will suit everyone. Service users should be actively involved in these decisions.

101. Residential treatment, prescribing of substitutes (such as methadone) and other community treatment (for example counselling) have a place in helping to treat people who misuse drugs and alcohol.[88]

102. The use of residential drug and alcohol services varies across the country and highlights the issue of choice and accessibility. The amount spent on community treatment compared to residential treatment varies (Exhibit 12). In some areas of Scotland, people who misuse drugs and alcohol can be referred to residential treatment, while in other areas this service is rarely offered.[89] Support in the community after a residential placement is important to long-term positive outcomes for the individual.

103. There is no central monitoring of the number of people in residential treatment but there are some limited data from 2005/06 on service activity and entry criteria. A Scottish Government report estimated that in 2005/06 there were 352 beds available for residential treatment for drug and alcohol misuse, provided by 22 separate services across Scotland. The number of beds per service ranged from two to 104 and the capacity of residential services in Scotland was estimated as 1,670 people per year. In 2005/06, residential treatment occupancy rates in these 22 services varied from 36 per cent to 96 per cent.[90] Almost a third of the beds and services were located in Glasgow. The report noted that area of residence and age were the main limiting factors in accessing residential services. Only one service accepted people under 16 and a third of the beds were only available to Glasgow residents.[91]

104. Residential treatment is more expensive per service user than other forms of treatment. In 2007/08, £19.4 million was spent on residential treatment by NHS boards and local councils. In 2006 in Aberdeen City, it was estimated that the average package of care for residential rehabilitation per person cost £20,000 per year compared to £3,000 for community rehabilitation.[92] Often a person accessing residential treatment will have already tried other programmes to help them manage or recover from their use of drugs or alcohol.

105. Methadone prescribing is a common treatment in Scotland, with around 20,000 people estimated to be receiving the substitute drug in 2004.[93] Methadone on its own is a less expensive option than residential treatment and can be used to help manage addiction to opiates. In 2007/08, £24.9 million was spent on methadone treatment in Scotland.[94] There is no national estimate of the unit costs of methadone treatment but in England the average cost per person for a year has been estimated at £1,970.[95]

106. For methadone programmes to be effective, clinicians need to regularly review methadone prescriptions with the service user and ensure other services are in place to support them. However, the Scottish Advisory Committee on Drug Misuse published a review of methadone prescribing in 2007 which highlighted that although methadone was the drug treatment with the most effective track record, information on the performance of services was sparse and there were concerns about methadone prescribing in Scotland. The review noted problems relating to *"prescribing philosophy; limited availability of treatment options in some areas; inconsistency in practice and quality of service across Scotland; effectiveness of services – in particular relating to the delivery of acceptable harm reduction and recovery outcomes, crime reduction and the safety of children."* [96]

107. Drug Treatment and Testing Orders (DTTOs) are alternatives to custody and offer prescribed substitute drug treatment, such as methadone, for offenders in the community with compulsory drug testing. People who have misused drugs who attended our focus group felt that a key benefit of DTTOs is that they are able to keep the same key worker and build trust. The average cost of a DTTO is estimated at just over £18,000 per service user per year.[97]

108. It is difficult to offer a range of services for addiction in rural and remote areas. These areas often need to take a different approach to delivering services than more urban areas. For example, in Lochaber in Highland there were limited social work or support worker services for people misusing drugs and alcohol. Staff from NHS Highland and Highland Council work as one service offering integrated substance misuse services as part of the wider community mental health service. This approach has assisted communication across the service and has enabled access to a wider range of professional and support staff for service users, including those with dual diagnoses.

Services for families

109. The Scottish Government highlights the important role families affected by drug and alcohol misuse play in helping people to recover in their recent drugs and alcohol policies. The Scottish Executive established the Scottish Network for Families Affected by Drugs (SNFAD) in 2003, and the Scottish Government provided £70,000 to SNFAD in 2007/08. SNFAD is an umbrella group that supports local family groups across Scotland. However, our focus group highlighted that families in need are often not aware of the support available. There is no equivalent organisation for families affected by alcohol misuse.

Joined-up services

110. The Scottish Executive provided a series of operational guidance on integrating treatment and care services.[98] Despite this, there are still problems in the way that some services work together. This lack of joined-up working affects specific groups of people including those with a diagnosis of addiction and mental illness and recently released prisoners.[99]

111. General services, such as housing support and employment and training services, also have an important role to play but the availability of these services for drug and alcohol misusers varies across Scotland.[100]

National information on needs and the impact of services is poor

112. National drug and alcohol information exists on prevalence, indicators of harm such as hospital discharges and deaths and police information on arrests, seizures of illegal drugs and alcohol-related offences.

113. The Scottish Government funds a national database of drug treatment services that records people entering specialist drug services. This database is being developed to provide follow-up information on individuals after a set time in treatment. There is no equivalent database for alcohol services and national information on alcohol services is weak. However, the Scottish Government has funded research to estimate the capacity of alcohol services in Scotland. This is due to be published in April 2009.

114. Information on the activity, cost or impact of services designed to reduce drug and alcohol problems exists in some local areas but the type and quality of data collected vary across Scotland. National information on the cost, activity and quality of services is not available.

115. The lack of consistent, comparable and shared information makes it difficult to plan and commission prevention, treatment and care services and to influence how services develop based on evidence.

116. Service planners and providers assess local drug and alcohol service needs, but these assessments are often not done in any coordinated way across a local area. Where needs assessments are undertaken to inform the development of services, this is usually only in relation to additional resources and often done as a one-off exercise.

117. Currently, local monitoring of services generally focuses on numbers of people in a service and activity rather than on the quality of the service delivered or the outcomes achieved.

118. Public bodies do not routinely evaluate the effectiveness of drug and alcohol services. Less than one per cent of total spend by NHS boards and councils on drug and alcohol services is used for research and evaluation purposes. There are, however, some examples of good practice where there has been a comprehensive review of all drug and alcohol services in an area (Case study 4). Agencies planning and providing services in Glasgow, Edinburgh, Aberdeen and Ayrshire established a working group in 2008 to benchmark drug and alcohol services in Scotland. This work is still at an early stage.

Local cost-effectiveness

119. There are no comparable unit costs for drug and alcohol services in Scotland (with the exception of criminal justice interventions) to help local areas evaluate cost-effectiveness of services. In England, the government is consulting on guidance setting out unit costs for various treatments.

The impact of drug and alcohol services is not known at a national level

120. There is no consistent understanding of what the money spent on drug and alcohol services has bought. The Scottish Government has not defined what constitutes a 'service', an 'intervention', or any measures of success for services.

121. Funding for drug and alcohol services generally does not have clear aims or explicit outcomes attached. As part of our fieldwork, we found that many services did not have a service level agreement, contract or service specification that stated the expected activity or outcome of the funding. The use of service level agreements and contracts varied across the country.

Outcomes

122. Although demonstrating benefits from the spending on drug and alcohol services is complex, there are some examples of good practice where public sector bodies have changed the way in which they work to focus on outcomes (Case study 5).

123. The Scottish Government chairs the Delivery Reform Group, which it established in 2008 to advise ministers on how to improve delivery arrangements for drug and alcohol services and ensure better outcomes for service users. A subgroup of the Delivery Reform Group developed an outcomes toolkit for drug and alcohol services in January 2009 (Exhibit 13, overleaf). Based on the proposals of the Delivery Reform Group these outcome measures will not be mandatory but may be used by services and recorded through SOAs. It will be important for local areas to have baseline information against which to measure their performance. The proposals do not include any plans to monitor which areas implement these outcomes.

124. Given the lack of consistent high-quality performance management data and that new outcome measures are proposed as optional, comprehensive and comparable outcome information will not be available across Scotland in the near future. This contrasts with the development in England over

Case study 4

Comprehensive review of addiction services in Greater Glasgow

Before the review: In 2003, addiction services in Greater Glasgow were run across three agencies: NHS Drug Problem Service, NHS Alcohol and Drug Directorate and Social Work Addiction services. The service people received depended on where they lived.

The review: A series of strategic reviews focused on different services such as council services, homeless services and services paid for by the NHS and council but delivered by others (eg, residential services). Each strategic review included needs assessments, an analysis of levels of current use and service user views and a literature review of effectiveness. All this information was shared across agencies.

After the review: There is now a single partnership with responsibility for the planning and performance of drug and alcohol services across Greater Glasgow. There are 13 Community Addiction Teams across Greater Glasgow with a single management structure, for both NHS and council, and single accountability. The service has 580 staff and a budget of £42 million per year, which is managed through a joint financial framework.

Source: Audit Scotland, 2008

Case study 5

Outcome-based service development in West Lothian

West Lothian Alcohol and Drug Action Team (ADAT) has developed a series of stages to help to commission services based on outcome measures.

Stage 1 analysis – building the evidence base. Regular needs assessment and research into what works to provide evidence to inform funding decisions.

Stage 2 planning – specifying the outcomes. A local outcome framework is agreed based on needs assessments. The focus is on the outcomes that providers must achieve and how they will achieve these outcomes is not set out in advance. Potential service providers submit an outcome specification and an outcome delivery plan records how the provider will achieve the outcomes and what funding is needed to deliver the project. An outcome milestone chart is used to identify key client stages and capacity in the service. All tenders are evaluated against specific criteria.

Stage 3 doing – outcome contracting. Successful providers submit quarterly monitoring templates which are focused on outcomes. All successful providers are also required to complete equality impact assessments, which are reviewed on an ongoing basis.

Source: Audit Scotland, 2008

recent years of a system for national perfomance management and accountability, which combines service data with unit costs.

125. The impact of enforcement activity is complex. Arrests and drug seizures are increasing over time but the impact that this has on the availability of illegal drugs or Scotland's drug problem is not known. Recent research by the United Kingdom Drug Policy Commission highlights the lack of evidence of effectiveness of enforcement activity.[101]

126. While there are some examples of good practice in terms of reviewing services and providing integrated services, this is not routinely shared to help improve services across Scotland.

127. The public sector in Scotland should use a consistent performance framework to help them to benchmark services and performance. A self-assessment checklist is set out at Appendix 4, which aims to help partners improve the delivery and impact of drug and alcohol services in their local area in a consistent way across Scotland.

Exhibit 13

Scottish Government example outcomes for drug and alcohol services

Drug specific:

- Reduction in drug-related morbidity, mortality and deaths.
- Less drug-related crime – acquisitive, violent, organised.

Alcohol specific:

- Reduce alcohol-related injuries, physical and psychological morbidity and mortality.
- Less alcohol-related violence/abuse/offences and antisocial behaviour.

Drug and alcohol:

- Safer and happier families and communities.
- Reduced number of children looked after and accommodated/separated from parents.
- Increases in young people completing school, college or training.
- Reduction in children's exposure to substance misuse.
- Increased productivity in the workplace.
- Reduction in adults on benefits due to drug/alcohol-related incapacity.
- Less absenteeism/lost productivity caused by drug use/alcohol consumption in the workplace and educational establishments.

Source: Scottish Government, 2009

Recommendations

The Scottish Government and public sector bodies should:

- work closely together to develop a performance framework incorporating, but not limited to, existing targets. Further work is required to identify information on spend, activity and outcomes
- ensure that there is a comprehensive range of services available in each local area
- develop unit cost information for different drug and alcohol services to help public bodies measure and compare the cost-effectiveness of various services.

The Scottish Government should:

- set clear national minimum standards for drug and alcohol services including their range, quality and accessibility; receive assurance that these standards are implemented in line with set timescales; and ensure performance is regularly monitored and publicly reported.

Public sector bodies should:

- ensure that all drug and alcohol services are based on an assessment of local need and that they are regularly evaluated to ensure value for money. This information should then be used to inform decision-making in the local area
- ensure that service specifications are in place for all drug and alcohol services and set out requirements relating to service activity and quality. Where services are contracted this specification should be part of a formal contract
- set clear criteria of effectiveness and expected outcomes for the different services that they provide, and undertake regular audits to ensure services adhere to expected standards
- use the Audit Scotland checklist detailed in Appendix 4 to help improve the delivery and impact of drug and alcohol services through a joined-up, consistent approach.

Part 4. Drug and alcohol partnerships

Drug and alcohol partnerships have been in place since the late 1980s but they have not all achieved the objectives set for them.

Key messages

- Partnerships for drugs and alcohol have been in place since the late 1980s. Limited national guidance has been issued to partners, despite the creation of new partnership bodies and advances in understanding the problems of drug and alcohol misuse.
- Given the limited guidance, drug and alcohol partnerships have evolved to work in different ways across Scotland. Some partnerships have operated strategically while others have had a more detailed focus on specific services. Not all drug and alcohol partnerships have achieved the objectives set for them.
- There are many public sector bodies involved in delivering drug and alcohol services, each with different accountability and governance arrangements. A clearer structure for organising resources for drug and alcohol services in Scotland is needed, alongside clarity about the roles of services and partners and how they should link together.

A lack of central guidance has led to variation in how local partnerships operate

128. Many public sector bodies contribute to addressing drug and alcohol problems in some way. NHS boards, councils, the police and the prison service all play a part. Although these agencies address drug and alcohol problems through the routine work they do, such as city centre policing at weekends, these partners should also come together to jointly plan services and share resources to tackle drug and alcohol problems within a local area.

129. Since the late 1980s, partnership bodies have been tasked with developing cross-cutting local responses to national government strategies for drugs and alcohol. These partnership bodies have been known as Alcohol Misuse Coordinating Committees, Drug Action Teams, Alcohol Action Teams and Alcohol and Drug Action Teams (ADATs).

130. The Scottish Executive published a detailed remit for Drug Action Teams in 1995. This guidance was updated in 2002 when Alcohol Action Teams and joint Alcohol and Drug Action Teams were being formed locally. The aims for these partnerships set in 1995 were to:

- collect and share information to assess the local drug problem
- ensure effective prevention measures are developed
- assess if the range and quality of services meets needs, and plan and initiate improvements where needed
- ensure community views are taken on board
- ensure regular evaluation and reviews are undertaken of services and activities with a view to improving efficiency.

131. Each local partnership has developed a different focus: performance monitoring has been poor in some areas, involvement of local communities has been variable and partnerships were often able to influence only a small proportion of money spent in an area on drug and alcohol services. In some areas, ADATs have acted as commissioning bodies, while in others they have had a strategic planning role.

132. Despite significant changes in the way drug and alcohol services operate and advances in understanding the problems of drug and alcohol misuse (including the impact on child protection), the remit of drug and alcohol partnerships has not been revised since 2002. The Scottish Government plans to issue revised guidance on drug and alcohol partnerships in spring 2009, based on proposals made the Delivery Reform Group.

Not all drug and alcohol partnerships have achieved the objectives set for them

133. Although it is not possible to assess the performance of drug and alcohol partnerships against the revised guidance, it is possible to look at whether previous expectations have been met, and to compare the original expectations with the proposed expectations (Exhibit 14).

134. In general, ADATs have not achieved what was expected of them but there are examples of good practice. For example, in Moray, Operation Avon aims to reduce the amount of street drinking among underage youths and offers support and advice at an early stage to those who may already be suffering the adverse affects of alcohol misuse. This initiative involves Grampian Police, NHS Grampian, Moray Council, Moray Social and Health Care Partnerships, Moray Drug and Alcohol Service, Moray Youth Justice and Community Learning and Development.

The roles and responsibilities of drug and alcohol partnerships are still unclear

135. The Scottish Government plans to issue revised guidance on drug and alcohol partnerships in spring 2009. The guidance was originally planned to be published in November 2008.

136. This revised guidance will be the result of four years' work at a national level to review local Alcohol and Drug Action Teams. In 2005, the then Justice Minister asked for a review of the effectiveness and performance of ADATs in relation to drug services. This was followed in 2007 with the Scottish Executive's *Report of the Stocktake of Alcohol and Drug Action Teams*.

Exhibit 14

Drug and alcohol partnerships have not met initial objectives published in 1995

1995 guidance	Performance to date note that there is no central monitoring of these objectives	2009 proposals based on Delivery Reform Group proposals
Collect and share information to assess the local drug problem	In most areas, local data collection and analysis are undertaken by one or more partner. However, it is rare for partners to pool this information or try to build a local picture. Improvements are required to ensure that health and social work collect appropriate data, and share it. Identification and assessment of families where parents misuse substances needs to be improved.	Provide a clear assessment of local needs and circumstances, including both met and unmet needs. Set out clearly and openly the totality of resources that each partner is directing to the pursuit of alcohol and drugs outcomes.
Ensure effective prevention measures are developed	There is no national information collected on prevention activity and limited research on effective prevention measures. National focus and funding has been on treatment and this has been reflected at a local level, where only six per cent of identified direct spend in 2007/08 was on prevention services.	Set out an approach to the commissioning and delivery of services, including preventive interventions, in pursuit of the outcomes identified.
Assess if quality and range of services meets needs, and plan and initiate improvements where needed	Needs assessments are not always carried out routinely for all services or used to inform spending decisions. They tend to be ad hoc and rather than an equal partnership approach one partner may have a greater influence. The lack of information sharing between partners limits the usefulness of any needs assessment undertaken. ADATs generally only influence the funding of some of the drug and alcohol services in their area. They cannot therefore change services where needed.	Provide a clear assessment of local needs and circumstances, including both met and unmet needs. Set out a broad outline of the services to be provided and/or commissioned, reflecting the local assessment of need.
Ensure community views are taken on board	There is little evidence of routine input from service users, their families or wider communities. The involvement of service users, their carers and familes in the development of services needs to be improved. Community forums no longer exist in all ADAT areas and there is no uniformity of approach in consulting the wider community.	Provide local visibility, advocacy and leadership for alcohol and drugs issues for services, service users, families and communities.
Ensure regular evaluation and reviews are undertaken of services and activities with a view to improving efficiency	Public bodies do not routinely evaluate the effectiveness of drug and alcohol services. In some areas, services receive continuation of their funding with no evidence base. There are local examples of service evaluation but no coordinated approach or Scotland-wide information. Less than one per cent of direct spend on drugs and alcohol is spent on research and evaluation. There are some good practice examples of reviewing services in Scotland but the public sector does not routinely share this information in order to improve services.	Identify key outcomes relating to drugs and alcohol, their place within the wider framework of priority outcomes contained within Single Outcome Agreements, and how their achievement will be measured.

Source: Audit Scotland, 2009

137. The Delivery Reform Group's proposals have set out general principles for partners and partnerships, which are in line with previous guidance (Exhibit 14). These have still to be approved by ministers. If approved, further work is needed to clarify how these proposals will be implemented consistently across Scotland and what role voluntary sector partners will play.

138. Under the new proposals, drug and alcohol partnerships will sit within Community Planning Partnerships (CPPs). If there is more than one drug and alcohol partnership in a NHS board area the partnerships will be expected to coordinate activity. The local partnerships will be held accountable for Single Outcome Agreement commitments through CPPs and for health targets through NHS partners. A health target for alcohol was introduced in 2008 to provide an agreed number of brief interventions that aim to prevent people developing alcohol-related problems. A health target for drug misuse will be introduced in 2009/10 and will focus on waiting times for services. The details of this target are still unclear.

139. There are 32 councils, 14 NHS boards, eight police forces and eight Community Justice Authorities, each with different boundaries.[102] The 22 ADATs in Scotland have to work with each of these bodies. To date, they have found it difficult to ensure that drugs and alcohol are priorities in each local area, not least because of the variety of agencies they must work with (Exhibit 15). New guidance needs to help to clarify accountability and governance arrangements and priority setting.

140. In the Greater Glasgow and Clyde area, local NHS board and council partners have worked to streamline their approach to the planning, delivery and performance management of drug and alcohol services. This has focused on the creation of a single Addictions Partnership providing a single planning structure across all areas and includes CPPs and Community Health and Care Partnerships (CHCPs).

141. The new proposals for local drug and alcohol partnerships include the development of a national support function within the Scottish Government to help local partnerships achieve improvements for people who misuse drugs and alcohol. It is envisaged that support coordinators will work in local areas to support a move to an outcomes-based approach, to capture and share best practice and to facilitate discussions between partners. There would be no scrutiny role for support coordinators but they will work in areas that ask for their help. The Scottish Government hopes that the outcomes toolkit for drug and alcohol services will also help local areas move to an outcomes-based approach.

Recommendations

The Scottish Government should:

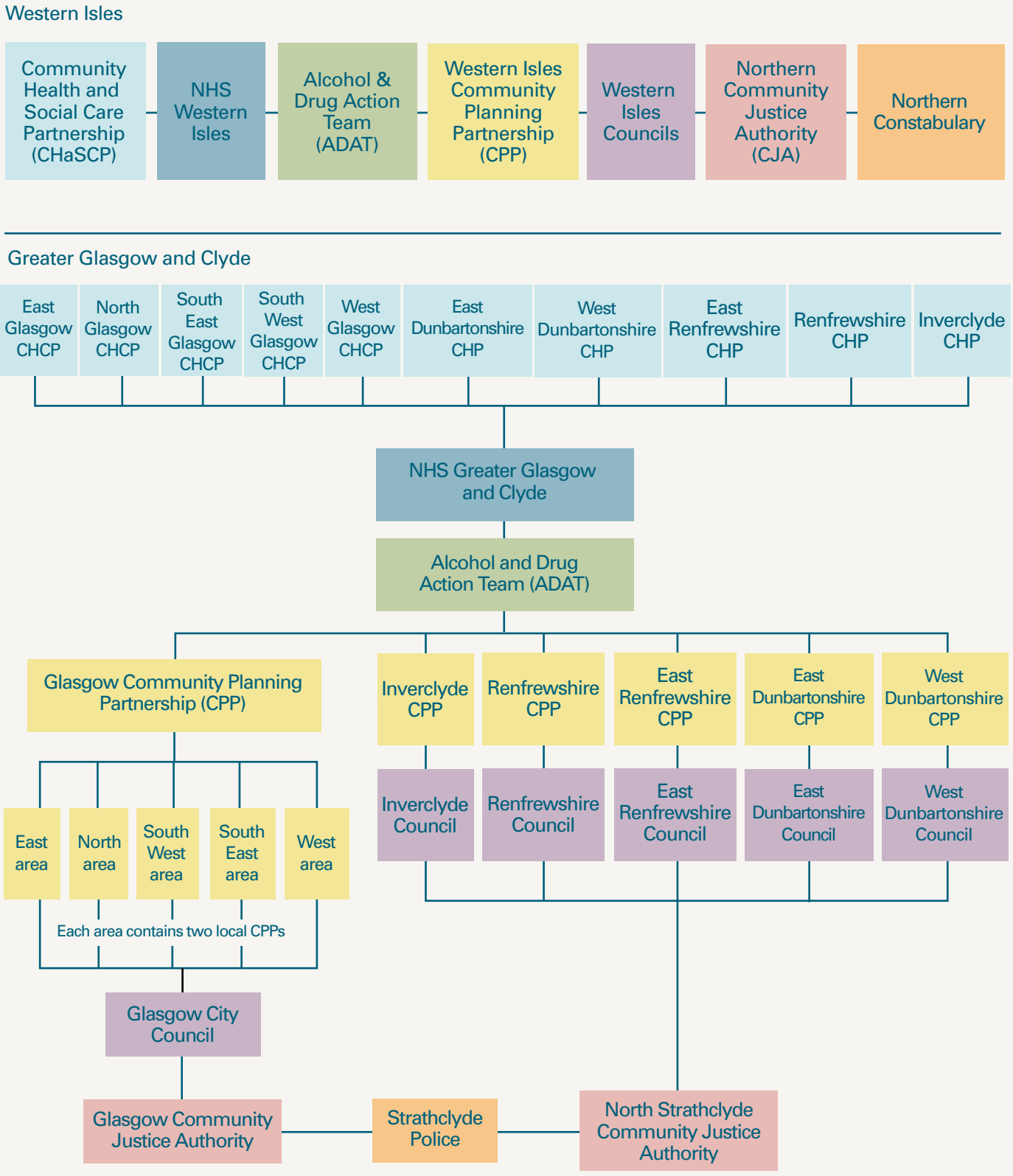
- clarify accountability and governance arrangements for the delivery of drug and alcohol services in Scotland and set out clearly the responsibilities of all organisations and partnerships involved in planning or delivering these services
- systematically identify and disseminate good practice – including the details of local drug and alcohol-related interventions and treatments.

Public sector bodies should:

- ensure that drug and alcohol partners are clear about their role in delivering effective and joined-up drug and alcohol services in Scotland
- put systems in place to routinely engage with service users and their families to ensure that their views inform the development of drug and alcohol services to address local needs.

Exhibit 15

Public sector bodies and partnerships that relate to drug and alcohol services in a rural and urban area.



Source: Audit Scotland, 2008

Appendix 1.

Notes to the text

Notes to Summary

1 *Drug misuse and the environment*, The Advisory Council for the Misuse of Drugs, 1998.

2 *Alcohol Statistics Scotland 2008*, Information Services Division (ISD) Scotland, 2009.

3 Prior to September 2007, the Scottish Administration was generally referred to as the Scottish Executive. Since the change in administration it is now called the Scottish Government. When dealing with the earlier period this document refers to the Scottish Executive.

4 *The Road to Recovery: a new approach for tackling Scotland's drug problem*, Scottish Government, 2008.

5 *Changing Scotland's Relationship with Alcohol: A framework for action*, Scottish Government, 2009.

6 We have defined labelled expenditure as direct identifiable expenditure for drug and/or alcohol specific services or specific drug and/or alcohol-related contributions for use in other services, for example, a dedicated addictions worker in a housing project.

Notes to Part 1

7 Ministerial Advisory Council on the Misuse of Drugs, 1982.

8 *International statistical classification of diseases and related health problems*, 10th revision, World Health Organisation, 2007.

9 *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland*, Gordon Hay, Maria Gannon, Neil McKeganey, Sharon Hutchinson and David Goldbery, 2004.

10 *Local and national estimates of the prevalence of opiate use and/or crack cocaine use (2004/05)*, Gordon Hay, Maria Gannon, Jane MacDougall, Tim Millar, Catherine Eastwood, Neil McKeganey, 2006.

11 Scottish Drug Misuse Database, ISD Scotland.

12 *Psychostimulant Project Group Report*, Scottish Government, 2008.

13 *2007 National Report to the EMCDDA*, UK Focal Point on Drugs, October 2007.

14 Hepatitis C is a blood-borne infection. Most cases occur in people who share needles contaminated with traces of blood to inject illegal drugs. After many years of infection some people develop cirrhosis, and a few develop liver cancer.

15 http://www.hps.scot.nhs.uk/bbvsti/Hepatitisc.aspx?subjectid=93

16 *Drug Misuse Statistics Scotland 2008*, ISD Scotland, 2008.

17 The median is the middle value of an ordered set of data.

18 *Drug Misuse Statistics Scotland 2008*, ISD Scotland, 2008.

19 *Ibid.*

20 *2007 National Report to the EMCDDA*, UK Focal Point on Drugs, October 2007.

21 *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)*, BMRB Social Research, 2006.

22 *Drug Misuse Statistics Scotland 2008*, ISD Scotland, 2008.

23 *Ibid.*

24 *Ibid.*

25 *2007 National Report to the EMCDDA*, UK Focal Point on Drugs, October 2007.

26 *Drug related deaths in Scotland in 2007*, General Register Office for Scotland, 2008.

27 Although nationally drug-related deaths are increasing there is local variation.

28 *Drug related deaths in Scotland in 2007*, General Register Office for Scotland, 2008.

29 *Drug seizures by Scottish police forces*, Scottish Executive, 2007.

30 *Drug seizures by Scottish police forces 2005/06 and 2006/07*, Scottish Government, June 2008.

31 There are three categories of illegal drugs each with different penalties for possessing or dealing. Class A, B and C drugs are detailed under the Misuse of Drugs Act 1971, with Class A considered the most harmful.

32 *Scottish Crime and Victimisation Survey*, Scottish Executive, 2006.

33 Scottish Drug Misuse Database, ISD Scotland.

34 *The Road to Recovery: a new approach for tackling Scotland's drug problem*, Scottish Government, 2008.

35 *Alcohol needs assessment research project (ANARP): the 2004 national alcohol needs assessment for England*, Department of Health, November 2005.

36 *Psychiatric morbidity among adults living in private households 2000*, Office of National Statistics, 2002.

37 *Alcohol: price, policy and public health*, Scottish Health Action on Alcohol Problems, 2008.

38 *Ibid.*

39 Neilsen Retail Tracking, 2008.

40 Scottish Health Survey, Scottish Executive, 2003.

41 *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS),* BMRB Social Research, 2006.

42 *Harmful Drinking*, NHS Quality Improvement Scotland, 2006.

43 *Alcohol Statistics Scotland 2008*, ISD Scotland, 2009.

44 Findings from randomly selected ten day period in 2005 in ten A&E departments in *Harmful drinking: The size of the problem*, NHS Quality Improvement Scotland, 2006.

45 *Alcohol Statistics Scotland 2008*, ISD Scotland, 2009.

46 A brief intervention is a discussion aimed at motivating or supporting someone to try to change their behaviour. It is often a discussion between a GP and their patient.

47 http://www.gro-scotland.gov.uk/statistics/deaths

48 *Ibid.*

49 *Health Statistics Quarterly,* Office of National Statistics, spring 2007.

50 *Health in Scotland 2007,* Annual report to the Chief Medical Officer, 2008.

51 *Alcohol: price, policy and public health*, Scottish Health Action on Alcohol Problems, 2008.

52 *Changing Scotland's Relationship with Alcohol: a discussion paper on our strategic approach*, Scottish Government, 2008.

53 Unpublished data supplied to the Scottish Government by Strathclyde Police, 2007.

54 *Alcohol and intimate partner violence*: key findings from the research, Home Office, 2004.

55 *Homicide in Scotland 2007-2008*, Scottish Government, 2007.

56 Deprived communities are identified by looking at indicators that show disadvantage in the population, such as income, employment, education, housing, health and geographical access.

57 *Drug Misuse and the Environment*, The Advisory Council for the Misuse of Drugs, 1998.

58 http://www.drugscope.org.uk/resources/faqs

59 *Alcohol Statistics Scotland 2008*, ISD Scotland, 2009.

60 *Mind the Gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems*, Scottish Executive, 2003.

61 *Survey of the health and well-being of homeless people in Glasgow*, A Kershaw, N Singleton and H Meltzer, 2000.

62 *Prison Health in Scotland: A health care needs assessment*, Scottish Prison Service, 2007.

63 *Ibid.*

64 *Hidden Harm: Responding to the needs of children of problem drug users*, Advisory Council on the Misuse of Drugs, 2003.

65 *Ibid.*

66 *Have we got our priorities right?* Aberlour, 2007.

67 *Changing Scotland's Relationship with Alcohol: A discussion paper on our strategic approach*, Scottish Government, 2008.

Notes to Part 2

68 Due to the absence of Scottish estimates of the wider economic and social costs of drug misuse we have used the methodology from *Social and economic costs of Class A drugs in England and Wales 2003/04*, Home Office, 2006, and applied Scottish prevalence figures.

69 *Costs of alcohol use and misuse in Scotland*, Scottish Government, May 2008.

70 The Association of Chief Police Officers in Scotland (ACPOS) highlight that this is likely to be a significant under-estimate as it does not include work undertaken by operational uniformed officers or plain clothes divisional units who will deal with drug offenders or make routine licensed premises visits as part of their routine activities.

71 Campus/liaison officers and police officers who work with schools, colleges and universities to raise awareness of substance misuse and prevent problematic behaviour.

72 National NHS ring-fenced allocations for drugs existed from 1998 before dedicated money for alcohol was introduced in 2004.

73 The Convention of Scottish Local Authorities (COSLA) is the representative voice of Scottish local government and also acts as the employers' association on behalf of all Scottish councils.

74 The GAE formula is based on factors such as demographics, deprivation and health indicators. The actual funding allocation is made through a block revenue support grant. Councils have the discretion to set their local service budgets at different levels to the indicative levels in the GAE.

75 *Scottish local government financial statistics,* 2006/07 (web only publication – http://www.scotland.gov.uk/publications)

76 Published data currently only available for 2006/07.

77 *2007 National Report to the EMCDDA*, UK Focal Point on Drugs, 2007.

78 Figure includes NHS, council and Scottish Prison Service labelled expenditure.

79 Figure includes NHS and council spend, the cost of police campus and liaison officers and Scottish Government labelled expenditure (eg, Know the Score and Choices for Life).

80 Figure includes police, Scottish Prison Service and some Scottish Government labelled expenditure.

81 This is police enforcement and regulation work and does not include the prevention work of campus and liaison officers.

82 *Costs of alcohol use and misuse in Scotland*, Scottish Government, May 2008.

83 Due to delays in Scottish Government estimates of the wider economic and social costs of drug misuse we have used methodology from Social and economic costs of *Class A drugs in England and Wales 2003/04*, Home Office, 2006, and applied Scottish prevalence figures.

84 The remaining £53 million was spent on combined drug and alcohol services.

Notes to Part 3

85 Audit Scotland fieldwork, 2008.

86 *National Quality Standards for Substance Misuse Services*, Scottish Executive, 2006.

87 *Psychostimulant Project Group Report,* Scottish Advisory Committee on Drug Misuse, 2008.

88 *The Road to Recovery: a new approach for tackling Scotland's drug problem*, Scottish Government, 2008.

89 *Review of Residential Drug Detoxification and Rehabilitation Services in Scotland*, Scottish Government, 2007.

90 *Ibid.*

91 *Ibid.*

92 *Ibid.*

93 *Review of methadone in drug treatment: prescribing information and practice*, Scottish Government, 2007.

94 This includes £10.8 million on the costs of the methadone and £14.1 million on pharmacy dispensing costs.

95 *Unit Costs for Drug Misuse*, National Treatment Agency, 2006.

96 *Reducing harm and promoting recovery: a report on methadone treatment for substance misuse in Scotland*, Scottish Advisory Committee on Drug Misuse, 2007.

97 *Costs and equalities and the Scottish criminal justice system 2005/06*, Scottish Government, 2008.

98 The Effective Interventions Unit of the Scottish Executive provided a series of documents on Integrated Care.

99 *Approaches to alcohol and drugs in Scotland*, Scotland's Futures Forum, 2008.

100 *Essential Care*, Scottish Government, 2008.

101 *Reducing drug use, reducing reoffending*, United Kingdom Drug Policy Commission, 2008.

Notes to Part 4

102 Community Justice Authorities (CJAs) were established by The Management of Offenders, etc. (Scotland) Act 2005. The eight CJAs are: Fife and Forth Valley, Glasgow, Lanarkshire, Lothian and Borders, North Strathclyde, Northern, South West Scotland and Tayside.

Appendix 2.

Project advisory group membership

Member	Organisation
Alison Douglas	Head of Alcohol Misuse Team, Scottish Government
Joe Griffin	Head of Drugs Policy Unit, Scottish Government
Neil Hunter	Joint General Manager, Glasgow Addiction Services (A partnership between NHS Greater Glasgow and Clyde and Glasgow City Council)
Jack Law	Chief Executive, Alcohol Focus Scotland
Ken Lawton	Chair of Scottish Council, Royal College of General Practitioners
Dave Liddell	Chief Executive, Scottish Drugs Forum
Willie MacColl	National Drugs Coordinator, Scottish Crime and Drug Enforcement Agency
Ronnie Paul	Head of Housing and Social Work, North Lanarkshire Council
Peter Rice	Consultant Psychiatrist, NHS Tayside
Maggie Watts	Chair, Scottish Association of Alcohol and Drug Action Teams
Tom Wood	Former Chair, Scottish Association of Alcohol and Drug Action Teams

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3.

Drug and alcohol policy and guidance summary

Drugs policy 1997 to 2008

Year	Policy	Main issues
1999	*Tackling Drugs in Scotland: Action in Partnership*	Scotland's national drugs strategy produced in response to UK's White Paper *Tackling Drugs to Build a Better Britain*. It sets out national objectives to prevent use and limit harm.
2000	*Drug Action Plan: Protecting our Future*	Scottish Executive action plan to take forward the national drugs strategy.
2002	*Know the Score Drugs Strategy*	The launch of a national campaign providing information on drugs and messages about the dangers of drug use.
2002	*Integrated Care Pathways for Drug Misuse*	Information and support on the planning and delivery of integrated services for drug misusers. Details the principles and elements of effective practice.
2003	*Mind the Gaps*	Report on meeting the needs of people with co-occurring substance misuse and mental health problems.
2003	*Getting our Priorities Right*	National guidance to protect children from the damaging consequences of their parents' substance misuse.
2004	*Review of Treatment and Rehabilitation Services*	Summary and action plan to ensure effective provision of drug treatment and rehabilitation services.
2006	*Hidden Harm: Next Steps*	Scottish Executive action plan to address issues for children and young people affected by parental substance misuse.
2008	*The Road to Recovery: A new approach to tackling Scotland's drug problem*	Drugs strategy for Scotland structured around themes of prevention, enforcement, child protection and recovery.

Alcohol policy 2002 to 2009

Year	Policy	Main issues
2002	*Plan for Action on Alcohol Problems*	National strategy aiming to reduce harmful social and individual consequences of binge drinking and harmful drinking.
2003	*Mind the Gaps*	Report on meeting the needs of people with co-occurring substance misuse and mental health problems.
2003	*Getting our Priorities Right*	National guidance to protect children from the damaging consequences of their parents' substance misuse.
2004	*Anti-social Behaviour Act*	Tackling all forms of antisocial behaviour including street drinking, noisy pubs and clubs and drunken behaviour.
2005	*Licensing Act*	Aims to address Scotland's record on alcohol by: reforming outdated licensing laws; tackling underage drinking; cracking down on binge drinking; and involving local communities.
2006	*Hidden Harm: Next Steps*	Scottish Executive action plan to address issues for children and young people affected by parental substance misuse.
2007	*Plan for Action on Alcohol Problems Update*	Builds on progress of 2002 plan. Sets out a comprehensive programme of action for the next three years to change drinking cultures and reduce alcohol-related harm through government action, partnership working and encouraging individual responsibility.
2007	*Partnership Agreement: Scottish Executive and the Alcohol Industry*	The Scottish Executive and the alcohol industry agreed a number of actions in a first step of a long-term collaborative approach to alcohol consumption in Scotland.
2008	*Changing Scotland's Relationship with Alcohol: A discussion paper on our strategic approach*	Illustrates the scale of alcohol-related harm and outlines the Scottish Government's strategic approach to tackling alcohol misuse. Proposes, for consultation, a package of measures designed to reduce alcohol consumption and related harm.
2009	*Changing Scotland's Relationship with Alcohol: A framework for action*	Sets out the Scottish Government's approach to tackling alcohol misuse around four main areas: reduced alcohol consumption; supporting families and communities; positive public attitudes; and improved treatment and support.

Appendix 4.

Self-assessment checklist for partners

The checklist on the next few pages sets out some of the high-level practical issues around drug and alcohol services raised in this report. NHS boards, councils, police forces, prisons and the voluntary and private sectors should use the checklist to assess themselves against each statement as appropriate and assess the strength of all relevant partnership arrangements.

This checklist is based on statements from a variety of sources including previous Audit Scotland reports, Audit Commission reports and National Audit Office reports.

	Assessment of current position					
	No action needed	No but action in hand	Yes in place but needs improving	Yes in place and working well	Not applicable	Comments
Governance for partners and partnerships						
Agreed priorities and plans						
Are all outcomes, strategies and action plans related to drugs and alcohol in a local area compatible?						
Is there joint involvement in strategic planning, priority setting, and resource allocation by partner agency and partnerships?						
Does planning for drug and alcohol services happen across agency and partnership boundaries?						
Are service outcomes, priorities and plans included in all service development and commissioning activities?						
Risks						
Has a joint risk assessment been carried out against agreed key priorities and actions?						
Are identified risks being actively addressed and monitored?						
Accountability						
Is there an agreed scheme of delegation that clearly states what services, resources and responsibilities partner agencies have devolved to other partner agencies or partnerships?						
Does the agreed scheme of delegation set out the process for accountability of the partnership?						
Financial management						
Has a joint financial framework been agreed by all relevant parties?						

	Assessment of current position					
	No action needed	No but action in hand	Yes in place but needs improving	Yes in place and working well	Not applicable	Comments
Does the joint financial framework include: • an agreed budget? • regular update reports? • accounting systems?						
Will the joint financial framework allow the tracking of the funding?						
Commissioning						
Is the commissioning process between partners integrated, or at a minimum, complementary?						
Is there a clear protocol or established arrangements for commissioning and developing services involving NHS boards, local councils and the voluntary and private sectors?						
Do the commissioning arrangements link to each partner's mainstream activities and budget processes?						
Is there a standard contract or service level agreement used for all drug and alcohol services across the area?						
Does the contract or service level agreement include: • clearly defined roles and responsibilities? • lines of accountability? • quality standards, eg clinical guidelines or good practice that should be followed? • expected activity and/or outcomes?						
Does every service have a contract or service level agreement in place?						
Are there shared guidelines, protocols and procedures with essential services (such as in housing, children's services and employment services) detailing the criteria for referral between services, the treatment and support options available and the protocols for sharing information between services?						

	Assessment of current position					
	No action needed	No but action in hand	Yes in place but needs improving	Yes in place and working well	Not applicable	Comments
Performance management framework						
Data collection						
Do performance monitoring arrangements collect robust and proportionate information on costs and performance of drug and alcohol services?						
Is there an agreed minimum level of data to be collected by all drug and alcohol services at a local level?						
Do these data incorporate: • national data requirements? • clear definitions? • activity, outcomes and spend so that value for money can be monitored and evaluated? • set timescales for collection?						
Is there a brief reporting template for services to complete the data?						
These data will provide a financial benchmarking tool to compare services in terms of activity, outcomes and cost and to determine whether the services offer value for money.						
Service quality						
Does the performance framework include service quality such as national quality standards, application of clinical guidelines and service users' views?						
Is this performance framework monitored regularly?						
Are protocols in place to deal with failures in the application of these quality measures?						

	Assessment of current position					
	No action needed	No but action in hand	Yes in place but needs improving	Yes in place and working well	Not applicable	Comments
Evidence based services						
Basic questions						
Has all expenditure on drug and alcohol services in the area been identified?						
Have the range, activity and outcomes (or aims if outcomes are not available) of all the services provided in the area been mapped out?						
Are there evidenced reasons to justify the split of spending between different types of services?						
Make full use of existing evidence						
Is all of the information collected locally used to regularly review current provision against good practice, service activity and service outcomes (where available)?						
Is this information used to identify evidenced options for change?						
Is the latest evidence of effectiveness and identified good practice used?						
Is this information used to change existing services or commission new ones?						
Involving service users, their families, service providers and commissioners:						
Have the views of service users, their families, service providers and commissioners on the quality, accessibility and range of existing services been canvassed?						
Have the views of service users, their families, service providers, commissioners and the police on the new trends in drug and alcohol use been canvassed?						
Is the latest evidence of effectiveness and identified good practice used?						

Drug and alcohol services in Scotland

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