

Alcohol & Drug Partnership Strategy

2015-2020

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FOREWORD

The overall vision for the Borders Alcohol and Drug Partnership is that individuals, families and communities live in an area where fewer people are using alcohol and drugs and, for those that do, recovery is a realistic option.

This strategy provides context and a high level overview to work which will take place over the next five years to make that vision a reality.

I am conscious that this strategy is able to build on previous contributions from services and colleagues. In addition during the life of the ADP Strategy 2012-2015 the ADP undertook two major pieces of strategic work. Firstly, the ADP Investment Review, supported by Scottish Government and STRADA, used evidence of need based on national and local data, service uptake and feedback from service users and colleagues to identify a 'Future Model' which supported a Recovery Oriented System of Care (ROSC). New services were commissioned and commenced delivery in May 2014 including, for the first time, a Service User Involvement Service and provision for children affected by parental substance use (CAPSM).

Towards the end of the Investment Review period the ADP was supported by STRADA to research workforce development needs locally to support a ROSC. The resulting Workforce Development Action Plan is currently being implemented.

In setting forward our strategy for the ADP we have included, for the first time, a dedicated section on how we aim to reduce drug related deaths. In Borders the number of individuals who lose their lives in this way is small but every one leaves behind children, family members and friends who are affected by their loss.

The provision of high quality, accessible services helps prevent deaths by ensuring people have the help when they need it while provision of Take Home Naloxone to individuals can allow for a potentially life-saving intervention in the event of an overdose. Colleagues have been very successful at ensuring rapid access to alcohol and drug services and in ensuring as many people as possible at risk of overdose receive a Naloxone kit. However, we believe there is more we can do to reduce these preventable deaths and that the actions set out in this document will contribute to reducing deaths in the future.

This strategy was developed in consultation with colleagues in local agencies and at Scottish Government, service users and people in recovery and carers and I extend my thanks to them for their commitment and vision.

Elaine Torrance
Chief Social Work Officer
ADP Chair

INTRODUCTION

The Scottish Borders Alcohol & Drugs Partnership (ADP) is tasked with delivering a reduction in the level of drug and alcohol problems amongst young people and adults in the Borders, and reducing the harmful impact on families and communities. We are committed to working with the Scottish Government, colleagues, people in recovery and local communities to tackle the problems arising from substance misuse.

The ADP Strategy 2015-2020 outlines high level actions which will help deliver on that task through our four key strategic aims of:

1. Reducing prevalence of alcohol and drug use by 5% by 2020 through prevention and early intervention
2. Reducing alcohol and drugs related harm to children and young people
3. Improving recovery outcomes for service users and reduce number of deaths from accidental drug use to fewer than four per year by 2020
4. Strengthening partnerships and governance structures

Governance

Our Annual Report is submitted and approved by the Community Planning Partnership. It is anticipated that regular reporting will be submitted to the Integrated Joint Board (IJB) of the Health and Social Care Partnership. These processes are still to be confirmed locally.

The ADP is made up of representatives from the following organisations:

NHS Borders (Public Health, Mental Health, NHS Borders Addiction Services, Borders General Hospital)
Scottish Borders Council (Elected Members, People Department, Safer Communities Team)
Police Scotland
Drug & Alcohol Third Sector organisations

1.1 ADP Core Outcomes

All ADP's in Scotland must deliver the Outcomes listed below, however, local priorities and outcomes can also be developed.

1. **Health:** people are healthier and experience fewer risks as a result of alcohol and drug use
2. **Prevalence:** fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others
3. **Recovery:** individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use
4. **Families:** children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances
5. **Community safety:** communities and individuals are safe from alcohol and drug related offending and anti social behaviour
6. **Local environment:** people live in positive, health-promoting local environments where alcohol and drugs are less readily available
7. **Services:** alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery

2 CONTEXT

The Road to Recovery¹, Essential Care², Changing Scotland's Relationship with Alcohol³ and the Quality Alcohol Treatment and Support Report⁴, underpinned the aims of our 2012-15 strategy. Since then the Review of Opioid Replacement Therapy⁵ and production of Quality Principles⁶ for alcohol and drugs services have given a further critique and guidance respectively on how ADP's should ensure high quality effective services and interventions should be delivered.

¹ The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, May 2008: <http://www.scotland.gov.uk/Publications/2008/05/22161610/0>

² Essential Care: A Report on the Approach Required to Maximise Opportunity for Recovery from Problem Substance Use in Scotland, Scottish Government, 2009, <http://www.scotland.gov.uk/Publications/2008/03/20144059/11>

³ Changing Scotland's Relationship with Alcohol: A Framework for Action, March 2009: <http://scotland.gov.uk/Publications/2009/03/04144703/0>

⁴ Quality Alcohol Treatment and Support (QATS) Report, 2011, <http://www.gov.scot/Publications/2011/03/21111515/0>

⁵ Scottish Drug Strategy Delivery Commission: Independent Expert Review of Opioid Replacement Therapies in Scotland: Delivering Recovery, 2013, <http://www.scotland.gov.uk/Publications/2013/08/9760/downloads>

⁶ The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services, 2014, <http://www.scotland.gov.uk/Publications/2014/08/1726/downloads>

The Children's and Young People (Scotland) Act 2014 set out the requirement for the establishment of the Getting it Right for Every Child (GIRFEC) named person role. The local implementation of this role is in development and the ADP will require to understand any implications for its work. A multi-agency partnership group has reviewed and adapted Children Affected by Parental Substance Use in anticipation of the resulting changes.

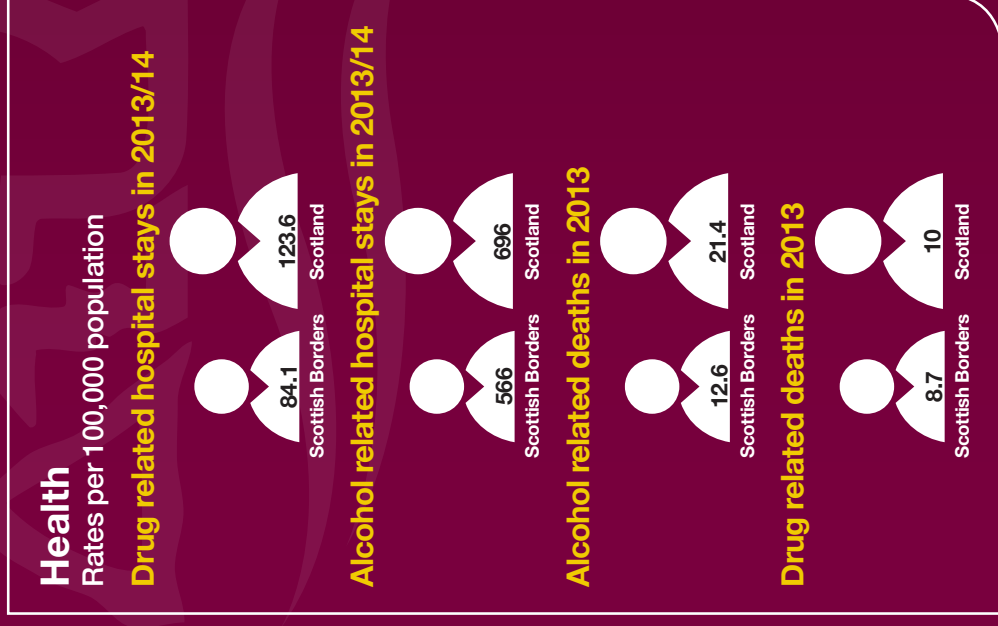
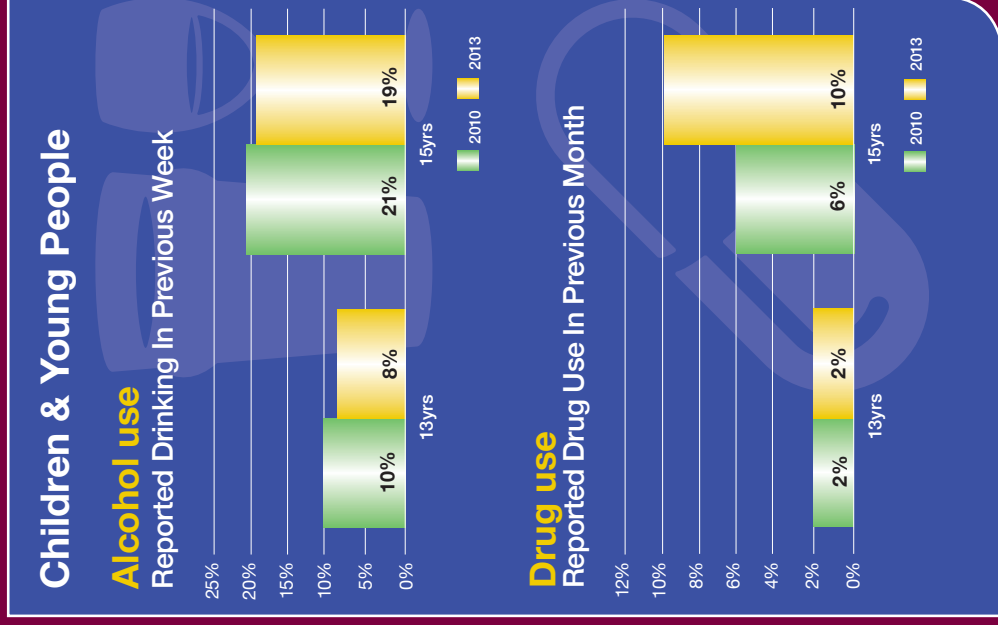
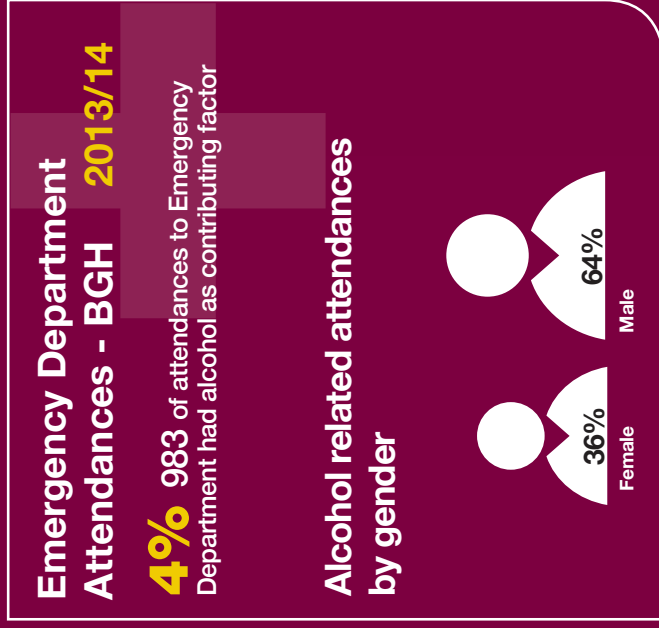
The process of Health and Social Care Integration will mean significant changes to the landscape of how services are planned. A key principle within integration is that of 'locality'. Alcohol and drugs services are already implementing a locality focussed model with the adult service holding regular integrated team meetings to ensure appropriate responses to needs.

In addition, public funding is subject to ongoing constraints. It is not possible to confirm ADP funding for the length of this strategy, however, we anticipate alcohol and drugs remaining firmly on the Public Health and Safer Communities agendas. Each of our local alcohol and drug services are jointly funded either from NHS Borders or Scottish Borders Council. It is likely that our partners will continue to require to make efficiency savings targets over the next five years. Appendix 1 shows 2014-15 budget arrangements.

3 LOCAL OVERVIEW

Page 7 shows some key local data relating to alcohol and drugs in Borders and how this compares to Scotland as a whole. The data presented will form part of a suite of indicators to allow the ADP to monitor performance and progress over the next five years. The local Delivery Plan 2015-18 outlines the full set of local and national indicators.

BORDERS ALCOHOL & DRUGS PARTNERSHIP STRATEGY 2015-2020 OVERVIEW



4 STRATEGIC AIMS

Our strategic aims will be delivered through partnerships across sectors, services and with service users and people in recovery. This section outlines our commitments to delivering our aims.

In our 2013-14 Annual Report we 'benchmarked' our data against a 'family' of seven similar local authority areas. These areas are: Moray, Stirling, East Lothian, Angus, Highland, Argyll and Bute and Midlothian. Our overall aim is to be the best performing ADP within our benchmarking family on all national ADP performance indicators.

Strategic Aim: 1

Reducing prevalence of alcohol and drug use in adults by 5% by 2020 through prevention and early intervention

We will do this by:

Promoting healthier attitudes towards alcohol by creating positive, health-promoting cultures, for example within organisations for staff and service users while increasing understanding of the risks of drug use.

Reducing the availability of alcohol and illicit drugs.

Through regular communication with local communities through the media remembering that there are different messages relating to alcohol and drugs.

Specific activities:

Review NHS Borders and Scottish Borders Council alcohol and drugs policies.

Produce a local Alcohol Profile.

Production and delivery of a Communication Plan.

Key performance indicators:

% of problem drug users (15yrs-64yrs)

Individuals exceeding daily/weekly drinking limits

Individuals binge drinking

Individuals problem drinking

Number of Alcohol Brief Interventions delivered

Personal Licenses in force (on/off trade)

Serious assault, Common Assault, Vandalism, Breach of Peace, Drug use funded by crime

Perception of rowdy behaviour and drug misuse in neighbourhood

Strategic Aim: 2

Reducing alcohol and drugs related harm to children and young people

We will do this by:

Supporting the development of healthy environments which reduce initiation of alcohol and drugs use by children and young people.

Ensuring children and young people affected by their own or parental substance use are identified and supported.

Specific activities:

Providing learning opportunities for childrens social work services and adult alcohol and drugs services to increase understanding of the impact of recovery on families and children.

Reviewing ADP links with Looked After and Accommodated Children.

Develop information sharing protocols between the Children and Families Service and Social Work.

Key performance indicators;

Drug use in last month (pupils aged 15)

Drug use in last year (pupils aged 15)

Weekly drinking (pupils aged 15)

Maternities with drug use

Child Protection cases with parental alcohol /drug use

Percentage of children attending Children and Families Service who report reductions in alcohol and drugs use

Percentage of parents attending Children and Families Service who report positive parenting outcomes measures

Strategic Aim: 3

Improve recovery outcomes for service users and reduce number of deaths from accidental drug use to fewer than four per year by 2020

We will do this by:

Continuing to develop our Recovery Oriented System of Care (ROSC) through ensuring local services and interventions align with policy recommendations and incorporate the Quality Principles.

Ensuring evidenced based recovery interventions aimed at reducing drug and alcohol-related illness and deaths, improving health and ensuring testing, advice, immunisation and treatment support for those at risk from blood-borne viruses.

Increasing post treatment opportunities for people in recovery.

Ensuring equality of access to alcohol and drugs services and appropriate, inclusive and non-stigmatising responses for vulnerable groups such as those fleeing violence and older drug users and those groups with known higher prevalence, or whose needs are not being met i.e. drug and alcohol-related offenders, LGBT community.

Improving support and involvement of those affected by another's substance misuse.

Increasing knowledge amongst colleagues, service users and family members of the risk factors for drug related deaths, recognising the signs of overdose, increasing availability of Naloxone and adopting learning from national and local data.

Reducing stigma through regular communications to the general public and advising media colleagues on non-stigmatising ways of presenting information.

Specific activities:

Work with the Borders Carers Centre to deliver a Family/Carers engagement event to help shape our response to Carers and Families.

Implement model for reducing drug related deaths (page 15).

Provide joint learning opportunities for gender based violence services and alcohol and drugs services to support joint working.

Key performance indicators:

Alcohol related hospital stays

Alcohol related mortality

Drug related discharges

Drug related mortality

% of problem drug users with Take Home Naloxone

Alcohol and Drug Treatment Waiting Times

Prevalence of Hepatitis C in people who inject drugs

Referral and DNA rates for adult services

Numbers of individuals attending post treatment support/recovery groups

Strategic Aim: 4

Strengthening partnerships and governance structures

We will do this by:

Continuing to develop service user and family involvement and influence within the ADP and services.

Continuing to strengthen strategic links and partnerships between the ADP, Child Protection and Adult Protection Committees, Criminal Justice Group, Health and Social Care Partnership, Community Planning Partnership, NHS Borders, Scottish Borders Council and other key stakeholders to strengthen local arrangements for screening, identification, communication and early intervention across adult and children's services.

Implementing a Workforce Development Plan to improve alcohol and drugs knowledge across our specialist, allied and universal workforce.

Ensuring interventions and services locally are informed by need and evidence; are outcome focussed and that robust monitoring and evaluation is in place.

Specific activities:

Delivery of communication plan.

Embed the Quality Principles by using the findings of a service user survey to identify and address areas for improvement.

Quarterly performance reporting to ADP Executive Group.

Delivery of Workforce Development Plan.

Key performance indicators:

Compliance with Scottish Drugs Misuse Database (SDMD)

Quarterly reports submitted to ADP Executive Group

Service user feedback reviewed monthly

Increase in numbers of alcohol and drug clients accessing independent advocacy support

4.1 Strategy development and areas for improvement

The ADP has used a co-production approach to development of this strategy. The strategic aims and activities going forward are based on feedback obtained from stakeholders via Focus Groups. Themed Focus Groups were held with colleagues from early years, children and young people, adults and criminal justice settings; service users; and young people. Participants discussed commitments from our previous strategy and identified areas for improvement going forward which were included in our initial draft strategy.

An electronic consultation was carried out on the initial draft strategy which informed this final document.

This section provides a brief overview of the key areas for improvement identified in the Focus Groups.

4.2 Recurrent themes

Communications and Workforce Development were recurrent themes within the focus groups.

Participants discussed communication problems both for people wishing to access services and for staff. It was felt that both groups were not always clear what services were available and what they offered. In addition, reference was made to barriers to information sharing and communication between services, for example, lack of an integrated IT system across health and local authority.

All groups felt there was potential for workforce development across universal and allied services.

4.3 Recommendations for action: Priorities for 2015/16

There were specific gaps or areas of work which were identified as underdeveloped. These areas are recommended to be prioritised in year one of the strategy.

Recommendation	Strategic Aim
1. Develop a communication plan for stakeholders and the wider public with appropriate messages re: alcohol and drugs and services available	1
2. Providing learning opportunities for childrens social work services and adult alcohol and drugs services to increase understanding of the impact of recovery on families and children	2
3. Implement a model to support young people to build skills and knowledge relating to alcohol and drugs	2
4. Explore potential increased links with staff engaging with Looked After and Accommodated Children	2
5. Increase post treatment recovery opportunities	3
6. Ensure involvement of alcohol and drugs services with community justice	3

5 FOCUS ON DRUG RELATED DEATHS

5.1 Introduction

Drug related deaths (DRD) in Scotland have been 'unacceptably' high. These deaths are preventable and ADP's have been tasked with developing a strategy to reduce deaths in local areas.

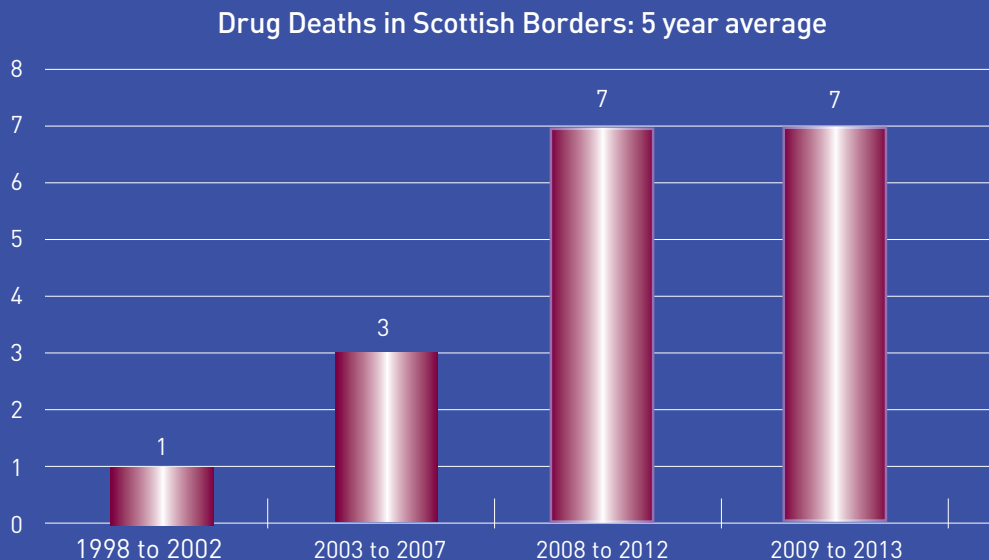
A local Drug Related Death Review group, chaired by the Independent Adult Protection Chair meets on a regular basis to review circumstances of individual deaths in Borders. Any implications for policy or practice are then taken back through members to their organisations for progression. There is also a national minimum data set which is collected to enable analysis and identification of trends with the aim of identifying potential preventative interventions. The group produces an action plan each year.

Nationally, risk factors for DRD have been identified as follows. Borders experience reflects the national picture:

- On release from prison
- On leaving residential rehabilitation or hospital
- When recently undertaken detox
- Recently relapsed
- When in poor physical or mental health
- After a recent life event, such as bereavement, relationship breakdown or loss of custody of children
- Being a longer-term user
- During festive periods, weekends or holidays

5.2 Local data

Due to the small numbers involved in the Scottish Borders, caution should be taken when assessing any apparent trends. Therefore using five year averages is a better indication. Data from 1998-2013 is presented below.



The National Records of Scotland's Drug Related Deaths 2013 Report⁶ was published in August 2014. Data from this report shows rates per 1,000 population and also per 1,000 problem drug users

	Borders	Scotland
Average deaths per 1,000 population 2009-13	0.06	0.1
Average deaths per 1,000 relative to the estimated number of problem drug users 2009-13	12.8	9.1

The low rate per 1,000 population reflects a relatively low rate of problematic drug use in Borders compared to Scotland.

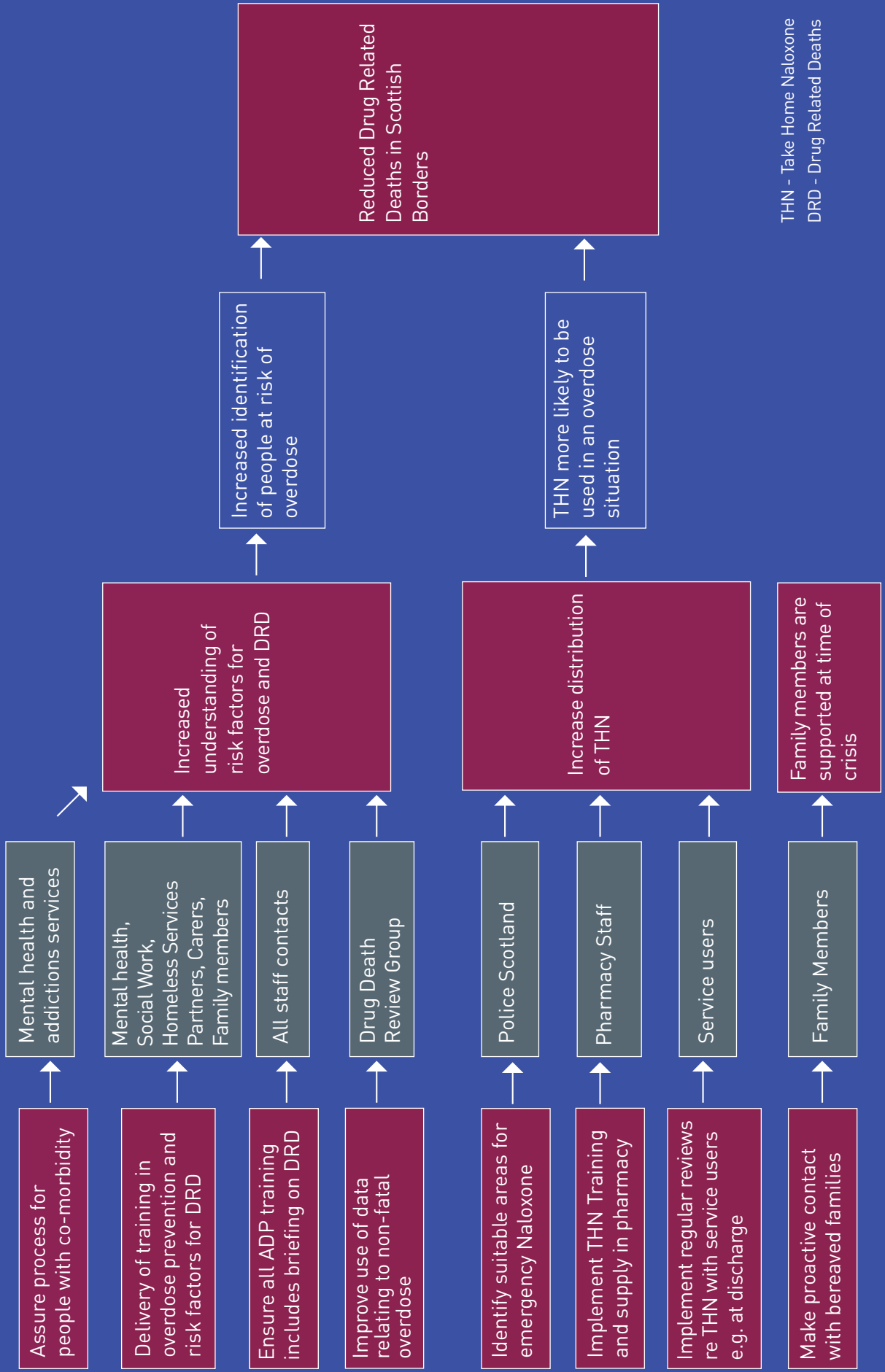
We have the highest rate of average deaths per 1,000 per problem drug user in Scotland. Our estimated population of problem drug users is 580 based on a 2009/10 national prevalence study. Given the small number of deaths and problem drug users any individual death can greatly affect the calculated rate per 1000.

The ADP has developed the model overleaf to articulate our approach to reducing DRD.

⁶ <http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/drug-related/2013/index.html>.

5.3 Model to reduce drug related deaths

To reduce number of deaths from accidental drug use to fewer than four per year by 2020.



5.4 Alcohol related deaths

While we have developed a specific strategy to reducing drug related deaths the ADP is also committed to reducing alcohol related deaths.

Most drug related deaths occur in an accidental overdose situation whereas there are very rarely alcohol related deaths associated purely with acute intoxication and these are much more likely to be as a result of experiencing end stage liver disease or cancers. Individual case management is a clinical responsibility.

Deaths from both alcohol and drugs can be prevented if we firstly reduce the number of people experiencing problematic use and secondly ensure services are equipped to respond to those who develop problems. We believe our strategy aims to ensure both these objectives are fulfilled. There are specific areas of work in which the ADP is involved which will contribute to prevalence of alcohol problems:

- Reducing access and availability: the ADP is represented on the Local Licensing Forum and takes a lead role in developing an Alcohol Profile which documents impact of alcohol in Borders and supports the Licensing Board in its decisions. The ADP has also developed a process to ensure objections to applications can be lodged based on the Board's Policy and the Licensing Objectives
- A continued commitment to delivery of Alcohol Brief Interventions (ABI's) in NHS and wider settings will ensure early identification of harmful and hazardous drinking

However, while the toxic effects of alcohol rarely cause deaths, accidents relating to intoxication, for example through fires or road traffic accidents are avoidable. We will build on existing links with Safer Communities colleagues with whom, for example, we have worked in partnership to increase alcohol awareness with Fire and Rescue colleagues and fire safety knowledge with alcohol and drugs services.

6 MONITORING PROGRESS

Supporting this strategy is an ADP Delivery Plan 2015-18 which sets out key activities, indicators and timescales against each of the Core Outcomes listed to address our strategic aims.

Progress will be monitored via the following mechanisms:

- Monthly reporting on alcohol and drugs service waiting times target
- Monthly reporting on ABI target
- Review of service user minutes at each meeting of the Executive Group
- Quarterly performance report to ADP and ADP Executive Group
- Quarterly financial report to the ADP and ADP Executive Group
- A minimum of six monthly contract monitoring meetings with commissioned services
- Annual ADP Service User Survey
- Annual Alcohol Profile updates will collate local information relating to alcohol related harm
- Annual Reports based on the Strategy and Delivery Plan will be submitted to the Community Planning Partnership and Scottish Government.

7 CONCLUSIONS

The ADP is committed to ongoing improvements and developments in our ROSC. The strategic approach outlined above informs our 2015-2018 Delivery Plan.

Appendix 1 2014-15 Budget

Scottish Government Ring Fenced ADP Allocation 2015-16	
Funding	
Alcohol Prevention, Treatment and Support	£1,039,066
Drug Services and Support	£315,141
Total 15-16 Allocation*	£1,354,207
Projected Expenditure	
TIER 1	
Responsible Drinking	£1,000
TIER 2/3	
Low- Moderate Needs & Integration Service	£269,871
Children & Families Service	£169,049
Service User Involvement	£10,000
Advocacy	£10,000
Primary Care - Locally Enhanced Service	£50,000
Primary Care - Blue Bay Licence (ABIs)	£3,960
Social Work Planning Post	£10,300
Social Work Support Worker	£30,488
NHS Borders Addictions Service	£573,207
OTHER	
NHS Borders Corporate Support	£45,104
ADP Support Team - Pays & Supplies	£124,428
Scottish Drugs Forum - Voluntary Representation	£6,800
Star Outcomes	£1,386
Service User Involvement	£1,000
Development Fund	£7,000
Naloxone Kits	£3,000
Pharmacist (0.2wte)	£13,100
CAAP (0.5wte)	£24,514
Total Projected Expenditure	£1,354,207
Variance To Budget	£0

* For planning purposes, in the absence of an allocation letter to date, Borders ADP has assumed assumed similar levels of core funding in 2015-16 to that in 2014-15 (£1,354,207)

APPENDIX 2 FOCUS GROUP PARTICIPANTS

Bridie Ashrowan, Manager, Youth Borders
 Andrea Beavon, Violence Against Women Co-ordinator, Scottish Borders Council
 Mandy Brotherstone, Head of Children's Services, NHS Borders
 Steve Cairns, Lothian and Borders Criminal Justice Authority
 Anne Chalmers, Paediatric Nurse Practitioner, NHS Borders
 Greig Coull, Consultant Psychologist, Borders Addiction Service, NHS Borders
 Heather Coupek, Alcohol and Drugs Social Worker, NHS Borders
 Amanda Erskine, Adult Survivor's Service, Children 1st
 Escape Youth Cafe, Hawick
 Tania Ferguson, Health Visitor, NHS Borders
 John Fyfe, Social Work Group Manager – Criminal Justice, Scottish Borders Council
 Paula Gaunt-Richardson, Children's Services Manager, Action for Children
 Mark Holroyd, Service Manager, Addaction
 Justin Hulford, LALO, Safer Communities, Scottish Borders Council
 Matilda Jaffray, Project Worker, Penumbra Youth Project
 Eleanor Kerr, Senior Nurse, Child Protection Unit, NHS Borders
 Beauty Kureya, Public Health Nurse Team Leader, NHS Borders
 Diana Leaver, Community Paediatrician, NHS Borders
 Gill Lunn, Midwife, NHS Borders
 Adrian Mackenzie, Pharmacist, NHS Borders
 Lynda Mays, Service Manager, Borders Addiction Service, NHS Borders
 Allyson McCollam, Joint Head of Health Improvement, NHS Borders
 Julie Murray, Public Health Principal, NHS Borders
 Isobel Nisbet, Social Work Group Manager
 Lorna Peddie, Support Worker, Action for Children
 People in Recovery
 Diana Potter, Policy, Planning and Performance Officer, Scottish Borders Council
 Gemma Roberts, Community Addictions Nurse, Borders Addiction Service, NHS Borders
 Rowland's, Selkirk
 Hilary Scott, Team Leader, ADP National Support Team, Scottish Government
 John Scott, Inspector, Police Scotland/Safer Communities
 Kerr Scott, Anti-social Behaviour Unit Officer, Safer Communities, Scottish Borders Council
 Susan Templeman, Social Work Team Leader, Scottish Borders Council
 Joanne Young, LAC Lead Clinician, NHS Borders
 Sandra Young, Specialist Community Public Health Nurse Student, NHS Borders

APPENDIX 3 FEEDBACK FROM FOCUS GROUPS

Early Years

Increasing understanding between children's service and adult alcohol and drugs services of the potential impacts and risks of recovery.

Recommendation:

Colleagues in early years settings felt that those parents for whom alcohol and drugs use was identified as a problem obtained good and co-ordinated support, however, there was a concern that there may be families impacted by substance use who may go 'under the radar' as professionals were not aware. This is a workforce issue.

Workforce and practice development is required to ensure alignment of the adult timetable for recovery with the Child's Plan. It was felt that there needs to be increased understanding between children's service and adult alcohol and drugs services of the potential impacts and risks of recovery.

Children and Young People

The children and young people focus group acknowledged the importance of wider cultural and organisational attitudes to reducing prevalence in young people. In particular the potential benefit of workplace policies was noted as well as the role of the Licensing Board.

A question was raised regarding how children and young people could be equipped via substance misuse education (SME). While this is challenging given the lack of evidence in support of SME it is the case that education settings provide an opportunity to provide skills and knowledge building for young people.

Particular mention was made of the needs of Looked After Children.

Adults

The appropriate use of data and improving use of data about both who uses and does not use our services.

The need to focus both on recovery but also holistic health care needs such as oral health and smoking while also using an asset based approach.

The importance of ensuring access across all potential clients groups who might have different needs, for example, people who identify as LGBT or older adults.

Operationally it was felt that there was at times a lack of co-ordination around an individual's plan.

Criminal Justice

The use of data and understanding offender profile was felt to be key.

The importance of other 'non traditional' partners who might support early and effective intervention, e.g. youth groups.

It was suggested that there may be particular needs for children and young people in care.

Co-ordination of support for people on release from prison has been a concern but there Criminal Justice is leading an operational steering group for this.

An overall theme of partnership working was discussed.

Service Users

Service users continued the theme regarding communication as they reported they were not aware of the sort of help that might be available to people who needed it. They felt that they may have contacted a service earlier if they had known about it rather than wait until things were very difficult before going to their GP who then referred them on.

The group felt that more could be done to develop 'Recovery Cafe' activities but recognised that these would not be for everyone and the challenges locally in establishing a sufficient number of people in recovery to sustain cafes.

Young People

In the focus group young people discussed how they had seen adult members of their family be very drunk and that this made alcohol seem like fun.

They felt they had access to good information from school and the internet and did not see that there was a concern about alcohol and drugs in their area.

APPENDIX 4 AN OVERVIEW OF RECOVERY

The ADP Investment Review focussed on how to develop a ROSC locally and this work is ongoing. Recovery should be at the heart of any drug or alcohol service or whole system of care. Recovery will mean different things to different people at different times and therefore that is why recovery is most effective when the individuals needs are placed at the centre of their care and treatment, more commonly referred to as a 'person centred approach'.

Evidence tells us that recovery does not happen quickly with it typically taking four to five years for alcohol users and estimates of five to seven years for opiate users. Effective treatment (including substitute prescribing) and sustained community support has a key role to play in recovery, with the benefits not only to the individual but also their family and community.⁷ It must also be recognised that some service users have experienced significant child and adult trauma and may require sustained support and treatment for longer periods of time.

Recovery Capital, maybe described as containing four components⁸:

Social capital – supportive family members, obligations to family members (becoming a mother), part of a mutual aid group

Physical capital – employment, housing income (NB Having physical capital does not necessarily protect someone from developing dependence, particularly alcohol)

Human capital – skills, aspirations, hope and positive health

Cultural capital – lower acceptability of substance use

It is worth noting that many people will recover from drug and alcohol dependence without any formal intervention 'natural recovery', however this is more likely for individuals with low dependence and high recovery capital.

⁷ Research for Recovery: A Review of the Recovery Evidence, Best Et Al 2010 <http://www.scotland.gov.uk/Publications/2010/08/18112230/0>

⁸ Recovery From Drug and Alcohol Dependence: An Overview of the Evidence, Advisory Council on the Misuse of Drugs, 2012, <https://www.gov.uk/government/publications/acmd-recovery-from-drug-and-alcohol-dependence-an-overview-of-the-evidence-2012>

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