ADP Strategy 2017-2020

Consultation Feedback Stages 1-3

1. Introduction

This document contains

- The collated feedback from the ADP sub group sessions, themed following the structure of the strategy.
- The detail of the sub group sessions
- Partner feedback from stages 2 and 3.

Feedback has now been integrated into the final draft for review by the ADP Strategic on 30th March 2017.

2. Consultation Process

The first stage of the consultation process, a series of small events driven by the ADP sub groups, is now complete. The City wide ADP structure comprises 10 sub-groups, 2 with over-arching strategic remit, 5 with topic focussed remit and 3 locality sub groups.

Community/lived experience participants are members of most groups and the events were open to interested stakeholders. The audience were informed and invested in the current activity, aware of gaps and keen to identify future priorities.

3. First stage consultations

All ADP sub groups were approached to organise a consultation with their members and any wider stakeholders.

- Drug Death Prevention — 19th Sept.
- CALD — 28th Sept
- Alcohol Death Prevention — 11th Oct
- Recovery — 7th Oct
    - North West Recovery — 11th Oct
    - North East Recovery — 25th Oct
    - South Recovery — 31st Oct
- Prevention and Education — 26th Oct
- Children and Young People — 21st Nov

4. <u>Second stage consultations</u>

Locality ADP structures and wider partners will be approached to consider the collated feedback from the sub groups. These include

- Voluntary Sector Drug and Alcohol Agencies
- Contract and Commissioning Team
- Alcohol and Drug Board-wide Planning Group
- Children's Executive Group
- Child Protection Committee
- Community Planning
- Homelessness
- Criminal Justice
- HSCP Strategic Planning Groups and other relevant groups

5. <u>Third Stage Consultation</u>

The ADP Exec and Strategic Groups held a joint session (26th Jan 2017) to consider the collated feedback and most recent draft and further comments, corrections, additions noted.

6. First stage Feedback

The sessions focussed on reviewing the priorities identified in the ADP Strategy 2014-2017 and new areas for development. The feedback from each session has been collated into the agreed continuing themes of the 2017-2020 strategy-

- Prevention
- Recovery
- Vulnerable Adults
- Vulnerable Children

As anticipated, much of the feedback content extends across themes. Priorities and developments raised in a particular consultation session may be included in another theme, based on review of all feedback.

The following is the collated feedback from the first stage of the consultations. There is some duplication across themes; this has been left to allow recognition of priority issues raised by a number of different groups.

7. Prevention - Continuing priorities and suggested developments

7.1 Maintaining a resilience programme for early years.

7.1.1 Develop nursery programs

7.2 Delivery of a sustainable education programme for young people focused on the potential dangers of alcohol and drugs delivered in the Education and Youth Work

7.2.1 Ensure messages include drugs harms as well as alcohol

7.2.2 Develop programme within youth work settings using the breadth of ADP partnerships

7.3 Review diversionary activities for young people as an alternative to alcohol and drug use and integrate plan for Community Alcohol Campaigns

7.3.1 Review access arrangements, map existing activity and consider best use of provision

7.3.2 Develop plan for Community Alcohol Campaign activity across the City

7.4 Continuing to work to reduce the number of new blood borne viruses. Develop and deliver on a workplan to:

7.4.1 Reduce the number of BBV infections acquired by people who inject drugs (PWID),

7.4.2 Reduce the number of undiagnosed BBV infections among PWID by promoting and providing diagnostic testing in locations accessible and acceptable to this population.

7.4.3 Increase the number of BBV-infected PWID engaged in specialist care by integrating care with existing services accessed by PWID and providing care closer to home.

7.4.4 Review of BBV harm reduction information and advice provision to PWID and make evidence-based recommendations for service developments.

7.5 Increase opportunities for parents and carers to engage meaningfully in prevention initiatives with young people with a focus on parent-child communication, delaying early onset of use and parental monitoring.

7.6 Respond to guidance / recommendations with regards to addressing New and Emerging Drug Trends

7.6.1 Focus on developing structure to quickly communicate identified risks, assess training needs, develop training package

7.7 Address the issue of over provision in the City by developing a joined-up approach to licensing.

7.7.1 Link to training and good practice guidance for licensed premises

7.7.2 Minimise harm by assessing training needs in licensed premises and encouraging good practice

7.8 Challenge cultural norms around alcohol consumption and drug use in the city.

7.8.1 Recognise the negative impact that alcohol and drugs can have and work with communities across the City to address these issues.

7.8.2 Develop Ripple effect recommendations and work of Community Aces

7.9 Single Outcome Agreement- galvanise contributions from all relevant partners in the city in order to bring about significant gains in health and social outcomes related to consumption of alcohol. The high-level outcome is as follows: **“Working with the people of Glasgow to create a healthier relationship to alcohol”**

This will be supported by underpinning outcomes that focus on two major dimensions:

reducing the accessibility of alcohol in communities; and reducing the acceptability of misusing alcohol

Partners have agreed to pursue a range of activities that will impact upon these outcomes.

7.9.1 Review sector action plans to meet SOA requirement to reduce alcohol related harm in the most vulnerable communities

8. <u>**Prevention - New priorities**</u>

8.1 Continue to challenge the drinking culture in the city, with targeted initiatives for specific audiences, e.g. younger women

8.2 Move to delivery of age appropriate multiple risk educational for children and young people

8.3 Targeted prevention interventions with groups at higher risk of alcohol and drug misuse

8.3.1 Children in contact with the social care system

8.3.2 LGBT community

8.3.3 Specific BME groups with identified risk factors

8.3.4 Older people, including resilience.

8.4 Refreshed drug prevention and education interventions to respond to emerging drug trends

8.5 Early Intervention responses to young people with emerging addictions issues

8.6 Work to strengthen attachment and reduce adverse childhood experiences

8.7 Address ADP partner responsibilities as a corporate parent to CAPSM and vulnerable young people

8.8 Suicide prevention agenda.

8.9 Link Universities and Student groups to Best Bar None.

8.10 Monitor the impact of Community sentencing for alcohol and drug related offending within the city.

8.11 Address the issue of persistent offenders within the city centre.

8.12 Address the issue of pre-loading prior to going out within the city.

8.13 Consider the safety of those under the influence who are refused admission to premises.

8.14 Consider the issue of bottles and cans being removed from premises to continue drinking outside- investigate frequency of these being used as weapons

8.15 Training required for all the relevant partners involved within the Safe Zone in the City centre

8.15.1 Currently Safe Zone gap in the west end.

8.15.2 Develop protocols for temporary Safe Zones for Street festivals.

9. **Recovery - Continuing Priorities and suggested developments**

9.1 The development and expansion of the role of the Recovery coordinator posts.

9.1.1 Develop a structure around the posts, allowing progression into and beyond the role

9.1.2 Investigate the need for a women's recovery coordinator post, recognising the specific barriers to women entering and remaining in recovery

9.1.3 Further develop and embed ethos of recovery orientation of services through new recovery hubs model, ensuring the alignment of relevant posts and services

9.2 Recognition of the work and commitment of the Recovery Volunteers across the City and the need for identified support for this commitment.

9.2.1 Develop a single induction training programme for all Recovery Volunteers

9.2.2 Develop an incentivised pathway for Recovery Volunteers, that is clear and transparent and based on level of commitment

9.2.3 Consistent ongoing training opportunities across the City- consistency of opportunity allowing individual volunteers to focus on their interests

9.2.4 Further enhance the ethos and role of volunteering as part of a programme of self-development for people in recovery.

9.3 Support the city-wide recovery network to link its activity into the wider community
9.3.1 Promote the idea of Community Recovery, rather than recovery community
9.3.2 Work with partners to embed 'Community recovery' activities within their core work

9.4 Tackle stigma associated with drug and alcohol use.
9.4.1 Consider the creation of an anti- stigma charter for elected politicians to sign up to
9.4.2 Identify a politician/ business leader/community leader as a champion to challenge media and public perceptions
9.4.3 ADP must challenge inaccurate media coverage that creates stigma
9.4.4 Build the promotion of the role of people in recovery into wider HSCP communications

9.5 Development and expansion of recovery groups for specific groups
9.5.1 Develop focussed Equalities and Recovery strategy and action plan
9.5.2 Consider the needs of different BME communities,
9.5.3 Develop the existing women's recovery groups
9.5.4 Consider the needs of the LGBT communities
9.5.5 Consider the needs of Parents and Carers in recovery

9.6 More employment opportunities for those in recovery.
9.6.1 Develop formal links with 'Jobs and Business' and the Recovery communities
9.6.2 Develop PSP opportunities, involving Recovery hubs, beyond the traditional employment opportunities

9.7 Further financial investment in recovery support and services.
9.7.1 Demonstrate Recovery's 'value for money' by reporting employment and training through ADP
9.7.2 Ensure recovery communities are appropriately consulted on budgetary decisions

9.8 The creation of recovery hubs in each sector and possibly city-wide.
9.8.1 Develop a model for peer led recovery centres, that will complement the new Recovery Hubs as they develop

9.9 Address barriers in relation to benefits and welfare reform.
9.9.1 Develop working relationship with Dept for Work and Pensions regarding volunteer programmes, training commitments etc and recognise that Recovery Volunteers are currently punished by the system for contributing

9.9.2 Establish interface protocol with the recovery communities, recovery hubs and the DWP.

9.10 Increase the commitment to families in recovery.

9.10.1 Develop relationships with existing family support services

9.10.2 Ensure Kinship care groups and Family support groups are included in Recovery planning

9.11 Address ongoing challenges faced by those in recovery identifying appropriate accommodation/ housing options.

9.11.1 Address the accommodation needs for families in recovery

9.11.2 Consider partnership with Glasgow Homelessness Network and collaborate on work with accommodation providers

10. Recovery - New priorities

10.1 Older drug users- population of isolated, vulnerable people that could benefit from the social support offered by recovery communities

10.2 Increased investment in health and fitness agenda within recovery communities- addressing mental and physical health needs, attractive to both men and women, and to those just beginning to consider recovery as a possibility.

10.3 Develop links with the Prevention agenda regarding work with education and young people at risk- recovery volunteers

11. Vulnerable Adults

Continuing priorities and suggested developments

11.1 Monitor trends in drug use in relation to fatalities and further compliment this by monitoring alcohol use in relation to fatalities.

11.1.1 All - cause mortality within GADR Service deaths

11.1.2 Need to strengthen access to information between Acute/BBV/ Specialist Secondary Services and Primary care services.

11.1.3 Interrogate data on deaths through smoking heroin

11.1.4 Analysis of mortality to identify gender specific trends

11.2 Further expansion of the peer training Naloxone model and further promotion of Naloxone provision to those most vulnerable to overdose.

11.2.1 Encourage wider ownership of Naloxone training and provision across care services- not the domain of GADRS

11.2.2 Clarify funding implications in all services

11.2.3 Ambulance Information Sharing Protocol for use of Naloxone

11.2.4 Investigation of barriers to carrying THN by PWID and how to overcome these

11.3 Address the issue of public injecting in the City centre.

11.3.1 Review of current provision of services and flexibility within existing City Centre services e.g. Hunter Street Health Services

11.3.2 Investigate perceived increasing population in City centre with complex needs

11.3.3 Investigate incidences of public injecting beyond city centre

11.4 Remain vigilant and informed on the emerging issue of New and Emerging Drug Trends and the associated dangers.

11.4.1 Address delay between a death occurring and the subsequent identification of the new substance

11.4.2 Address concerns regarding perceived increasing Benzodiazepine use

11.4.3 Establish partnerships with Public health re communication of the risks and harm reduction messages

11.4.4 Consider problematic use of prescription drugs, antidepressants etc.

11.5 Need to engage with those not accessing treatment and address barriers to services.

11.5.1 Focus on group of individuals who don't want to access conventional treatment or access treatment in the conventional way

11.5.2 Investigate why, when most DRD's have accessed treatment services at one point, people disengage.

11.5.3 Consider best practice examples of models where engagement has improved with a vulnerable group such as those at risk of DRD

11.5.4 Establish pathway for people who are not ready for treatment (i.e. ORT) to other services or treatments (i.e. Hep C) and address barriers

11.5.5 Audit and monitor unplanned discharges and those referred on by CAT Access Team within context of transformation of GADRS

11.6 Improve links between mental health and GADR services re co-morbidity issues.

11.6.1 Improve the links between mental health and addiction services, implementing an agreed and clear pathway between the two services

11.6.2 Establish working protocols between disciplines within new HSCP structure

12. **<u>Vulnerable adults - New priorities</u>**

12.1 Develop specific relapse support within GADR services for Recovery Volunteers- recognising particular strengths and difficulties

12.2 Information sharing/ communication-

12.2.1 agreements required to share relevant information across HSCP services to the benefit of vulnerable drug users,

12.2.2 improved communication between partners and within structures, ensuring necessary information reaches front line staff

12.2.3 Improve communication with GPs re service users and those involved in risky behaviour- invite representation on ADP structure

12.3 Develop and enhance out of hours' services/ supports e.g. A&E referral to Addiction Acute Liaison

12.4 Investigate opportunities in partnerships with Public Health, and or other wider Universities to increase research capacity

12.5 Older drug users – we need to look at end of life care for older drug users, particularly those who would benefit from Older people's services in spite of being too young. Review care pathways, staff training, research and joint working opportunities

13. **<u>Vulnerable children</u>**

<u>Continuing priorities and suggested developments</u>

13.1 Address the stigma and fear that prevents parents with drug and alcohol problems from asking for help

13.2 Children's needs to be considered within the recovery movement

13.2.1 Focussed support for children and young people in recovery with their families

13.2.2 Childcare requirements for parents/ carers accessing recovery groups

13.3 Kinship carers needs to be considered across ADP structures

13.3.1 Support and training for kinship carers in dealing with challenging behaviour, emotional and educational needs

14. **Vulnerable Children – New priorities**

Plan to adopt the 4 strategic aims outlined in the draft Scottish Government 'Children and Young People's Services 2017-2020' guidance:

Priority 1. Children's services are provided in a way which best safeguards, supports and promotes the wellbeing of children in Glasgow

1.1. Develop locality ADP Children and Young People groups, linking with the locality Children's Services groups

1.1.1 Review existing CAPSM and Vulnerable Young people's services, identify gaps in safeguarding children and develop plans to fill these gaps in partnership with 3rd sector

1.1.2 Ensure learning from Significant Case Reviews regarding alcohol/ drug use is shared across all ADP partners

1.1.3 Develop a GADRS sub team in each sector, focussed on parents/carers who have alcohol/ drug problems and the necessary training, care pathways and partnerships

2.1 Children's services are provided in a way which ensures that any action to meet needs is taken at the earliest appropriate time and that, where appropriate, action is taken to prevent the needs arising

2.2 Improve the identification of unborn children at high risk of neglect -review Ante-natal information gathering on alcohol and drug use

2.3 Broaden responsibility for the identification of neglect in CAPSM across all ADP partners, using all available training

2.4 Develop responsive and flexible services for young people at risk because of their own drug/alcohol use at an early stage

3 Children's services are provided in a way that is most integrated from the point of view of the recipients

3.1 Locality Children and Young Peoples groups should be linked to CSP and CSG meetings

3.2 Membership must include recovery reps, kinship care reps and equalities reps

3.3 All plans to be made within the context of the Named Person legislation

4 Children's services are provided in a way that constitutes the best use of available resources

Stage 1- ADP Sub groups

15. **Drug Death Prevention**

19th Sept 2016

Attendees: Saket Priyadarshi, Gillian Ferguson, Lorraine Cribbin, Joe Schofield, Carole Hunter, Amanda Laird, Sam Perry, George Benson, Janice Gough, Grant Scott, Alex King, Jo McManus, Steph Dargan, Kate Browne, Laura Sills, Trina Ritchie, Jason Wallace, Ian Gair, Ann-Marie Newman, Tony Martin

Apologies: Robert Kerr, Kenny Simpson

16. **<u>Continuing priorities and suggested developments</u>**

17. **Monitor trends in drug use in relation to fatalities and further compliment this by monitoring alcohol use in relation to fatalities.**
    a. All –cause mortality within Service deaths
    b. Need to strengthen access to information between Acute/BBV/ Specialist Secondary Services and Primary care services.
    c. Interrogate data on deaths through smoking heroin

18. **Further expansion of the peer training Naloxone model and further promotion of Naloxone provision to those most vulnerable to overdose.**
    a. Encourage wider ownership of Naloxone training and provision across care services- not the domain of GADRS
    b. Clarify funding implications in all services
    c. Ambulance Information Sharing Protocol for use of Naloxone
    d. Investigation of barriers to carrying THN by PWID and how to overcome these

19. **Address the issue of public injecting in the City centre.**
    a. Review of current provision of services and flexibility within existing City Centre services eg Hunter Street Health Services
    b. Perceived increasing population in City centre with complex needs eg increase in rough sleepers and homelessness
    c. Multi-agency approach essential
    d. Investigate incidences of public injecting beyond city centre

20. **Analysis and research on both drug and alcohol related fatalities in Glasgow, as directed by the expansion of the Glasgow Drug Death Prevention Group to include alcohol analysis and research, becoming the Glasgow Alcohol and Drug Death Prevention Group.**

    a. More research capacity required
    b. Investigate opportunities in partnerships with Public Health , and or other wider Universities

21. **Remain vigilant and informed on the emerging issue of Novel Psychoactive Substances and the associated dangers.**

    a. Police Scotland representatives on the ground, within local communities need the information and training.
    b. Address delay between a death occurring and the subsequent identification of the new substance
    c. Address concerns re new Benzo-like drugs - very high risk
    d. Establish partnerships with Public health re communication of the risks and harm reduction messages

22. **Further education on the overdose risks of poly drug use, including alcohol.**
    a. Need a targeted approach, e.g. programmes for communities, programmes for staff, homelessness and prisons
    b. Merit in having a forum which the specific remit of poly drug use and alcohol use.
    c. Establish follow up programme/support after delivery

23. **Need to engage with those not accessing treatment and address barriers to services.**

    a. Focus on group of individuals who don’t want to access conventional treatment or access treatment in the conventional way
    b. Investigate why, when most DRD’s have accessed treatment services at one point, people disengage.
    c. Consider best practice examples of models where engagement has improved with a vulnerable group such as those at risk of DRD
    d. Establish pathway for people who are not ready for treatment (ie ORT) to other services or treatments (ie Hep C) and address barriers

24. **Improve links between mental health and addiction services re co-morbidity issues.**

    a. Identify and invite mental health representation within the ADP structure

    b. Improve the links between mental health and addiction services, implementing an agreed and clear pathway between the two services

25. **Embed alcohol and drug death prevention practices in all health, council and third sector bodies that work with vulnerable people.**

    a. Continue to use naloxone to make headway into disseminating overdose awareness into other, non-treatment services

    b. Influence the policies of other services

26. **Address the issue of drug related suicide**

    a. Increase awareness that intentional non-fatal overdoses are often not recognised as a suicide attempt in acute settings

    b. Invite Choose Life to join ADP structure

<u>New priorities</u>

27. Consider interventions for those whose behaviour is causing them harm, but who do not consider themselves at risk, e.g. students, young people

28. Develop specific relapse support within t & c services for Recovery Volunteers- recognising particular strengths and difficulties

29. Information sharing/ communication-

    a. agreements required to share relevant information across HSCP services to the benefit of vulnerable drug users,
    b. improved communication between partners and within structures, ensuring necessary information reaches front line staff

30. Improve communication with GPs re service users and those involved in risky behaviour- invite representation on ADP structure

31. Analysis of mortality to identify gender specific trends. Female drug death rate rising, need to capture this in a strategic way, considering prison, childcare, antidepressant use, prx use and polydrug use.

32. Develop and enhance out of hours services/ supports eg A&E referral to Addiction Acute Liaison

33. Join up care and treatment delivery across services- BBV, acute gastroenterology, respiratory medicine, addressing long term effects of chronic drug and alcohol misuse.

34. Audit and monitor unplanned discharges and those referred on by CAT Access Team within context of transformation of GADRS

35. Consider problematic use of prescription drugs, antidepressants etc

36. Older drug users – we need to look at end of life care for older drug users, particularly those who would benefit from Older peoples services in spite of being too young. Review care pathways, staff training, research and joint working opportunities

    a. Discussed the Bristol model. Treatment experience and needs of older drug users in Bristol, UK: Journal of Substance Use: Vol 17, No 1, http://www.drugwise.org.uk/wp-content/uploads/its-about-time-report.pdf

37. Role of recovery communities within the DRD prevention agenda and involvement in peer mentorship . eg Swedish model https://www.unodc.org/pdf/youthnet/handbook_peer_english.pdf,

38. Consider how we gather information around new drug trends. The Australian model (contingency model?) ensures that information supplied is current, realistic and would help services to design around the services users

39. Young people (u18) Pathway for accessing treatment. Interface between children and families and decisions around appropriate treatment. (example a 14yo with and opiate overdose – difficult to treat on a childrens ward but not suitable for and adult ward. Issues around children psychiatry beds

40. Ensuring research based interventions are implemented

41. Consider outreach services outwith City Centre. Mobile units/bus – Edinburgh?

42. **Prevention and Education and City Alcohol, Licensing and Drugs Group (CALD)**

P& E Sub group-26th Oct 2016

Attendees : Fiona Moss (chair), Suzanne Glennie, Linda Malcolm, Linda McInally, Laura Kemp, Lara Calder, Trevor Lakey, Julie McCarthy, Eleanor Lee, Michael Robinson, Linda Morris

CALD-28th Sept 2016

Attendees: Nikki Boyle, Gavin McGriesh, David Cowley, Stevie Lydon, Jim McBride, JO McManus, Michael Robinson, Dougie McPherson

43. **Continuing priorities and suggested developments- Prevention and education**

44. Maintaining a resilience programme for early years.
    a. Develop nursery programs
45. Delivery of a sustainable education programme for young people focused on the potential dangers of alcohol and drugs delivered in the Education and Youth Work setting.
    a. Ensure messages include drugs harms as well as alcohol
    b. Develop programme within youth work settings using the breadth of ADP partnerships
46. Review diversionary activities for young people as an alternative to alcohol and drug use and integrate plan for Community Alcohol Campaigns
    a. Review access arrangements, map existing activity and consider best use of provision
    b. Develop plan for Community Alcohol Campaign activity across the City
47. Continuing to work to reduce the number of new blood borne viruses.
    Develop and deliver on a workplan to:

    (1) reduce the number of BBV infections acquired by people who inject drugs (PWID),

    (2) reduce the number of undiagnosed BBV infections among PWID by promoting and providing diagnostic testing in locations accessible and acceptable to this population.

(3) increase the number of BBV-infected PWID engaged in specialist care by integrating care with existing services accessed by PWID and providing care closer to home.

(4) review of BBV harm reduction information and advice provision to PWID and make evidence-based recommendations for service developments.

48. Increase opportunities for parents and carers to engage meaningfully in prevention initiatives with young people with a focus on parent-child communication, delaying early onset of use and parental monitoring.

49. Respond to guidance / recommendations with regards to addressing New Psychoactive Substances.

    a. Change terminology to New and Emerging Drug Trends
    b. Focus on developing structure to quickly communicate identified risks, assess training needs, develop training package

50. Address the issue of over provision in the City by developing a joined up approach to licensing.

    a. Link to training and good practice guidance for licensed premises
    b. Minimise harm by assessing training needs and encouraging good practice

51. Challenge cultural norms around alcohol consumption and drug use in the city.

    a. Recognise the negative impact that alcohol and drugs can have and work with communities across the City to address these issues.
    b. Develop Ripple effect recommendations and work of Community Aces

52. Single Outcome Agreement- galvanise contributions from all relevant partners in the city in order to bring about significant gains in health and social outcomes related to consumption of alcohol. The high level outcome is as follows:

“Working with the people of Glasgow to create a healthier relationship to alcohol”

This will be supported by underpinning outcomes that focus on two major dimensions:

- ***reducing the accessibility of alcohol in communities; and***

- ***reducing the acceptability of misusing alcohol***

Partners have agreed to pursue a range of activities that will impact upon these outcomes.

a. Review sector action plans to meet SOA requirement to reduce alcohol related harm in the most vulnerable communities

New priorities for Prevention

53. Continue to challenge the drinking culture in the city, with targeted initiatives for specific audiences e.g. younger women
54. Move to delivery of age appropriate multiple risk educational for children and young people
55. Targeted prevention interventions with groups at higher risk of alcohol and drug misuse
    a. Children in contact with the social care system
    b. LGBT community
    c. Specific BME groups with identified risk factors
    d. Older people, including resilience.
56. Refreshed drug prevention and education interventions to respond to emerging drug trends (NPS)
57. Early Intervention responses to young people with emerging addictions issues
58. Work to strengthen attachment and reduce adverse childhood experiences
59. The C+YP legislation, responsibilities as a cooperate parent to CAPSM and vulnerable young people
60. Equalities dimension; priority groups , EQIA on the strategy.
61. Suicide prevention agenda.

62. **CALD- Continuing priorities and suggested developments**

63. Maintaining a resilience programme for early years.
64. Delivery of a sustainable education programme for young people focused on the potential dangers of alcohol and drugs delivered in the Education and Youth Work setting.
65. Increasing access for young people to diversionary activities as an alternative to alcohol and drug use.
66. Continuing to work to reduce the number of new blood borne viruses.
67. Increase opportunities for parents and carers to engage meaningfully in prevention initiatives with young people with a focus on parent-child communication, delaying early onset of use and parental monitoring.
68. Respond to guidance / recommendations with regards to addressing New Psychoactive Substances.

    a. Change terminology to New and emerging trends

69. Address the issue of over provision in the City by developing a joined up approach to licensing.
    a. Link to training and good practice guidance for licensed premises
70. Work towards addressing the existing cultural norms around alcohol consumption and drug use in the city taking.
71. Recognise the negative impact that alcohol and drugs can have on our communities and work with partners across the City to address those needs.

<u>New Priorities for CALD</u>

72. Need to look at under 25s ‘knitting next generation’.
    a. Link Universities and Student groups to Best Bar None.
73. Address the affect alcohol and drug use has on offensive and anti social behaviour.
74. Monitor the impact of Community sentencing for alcohol and drug related offending within the city.
75. Address the issue of persistent offenders within the city centre.
76. Address the issue of pre-loading prior to going out for a drink within the city.
77. Consider the safety of those under the influence who are refused admission to premises, who are vulnerable.
78. Issue of bottles and cans being removed from premises to continue drinking outside. Investigate frequency of these being used as weapons; consider possible bin security etc.
79. Training required for all the relevant partners involved within the Safe Zone in the City centre
    a. Currently Safe Zone gap in the west end.
    b. Develop protocols for temporary Safe Zones for Street festivals.

80. **Alcohol Death Prevention**

11th Oct 2016

Attendees: Michael Robinson, George Benson, Linda Malcolm, Stephanie Dargan, Sarah Graham, Nikki Boyle, Graeme Callander, Louise Stewart, Jenny Torrens, Trina Ritchie, Saket Priyadarshi, Catherine Chiang, Linda Bowie, Andrea Williamson, Gary Meek, Patricia Tracey, Lorraine Cribben

81. Engagement in care
    a. Accessibility of care- improve links between primary care and specialist services
    b. Involve GPs in creation and review of care pathways
    c. Link to mental health services
    d. Link to Recovery communities/ services
82. Continuity of care
    a. Prioritise the therapeutic alliance
    b. Robust care pathways required
    c. Physical health agenda
83. Recognition of Population with complex needs
    a. Suicide
    b. Violent behaviour
    c. Prison population- preparation for release
    d. Homelessness

84. **Recovery**

City wide Recovery Group- 7th Oct 2016

Members- Eamon Doherty, John Milligan, John McCann, Thomas Tennant, Stephen Kerr, Mark Healy, Jacqueline Baker, James McDaid, Dianne@secondchanceproject.co.uk, Carole Meakin, Thomas Cunningham, Lorraine Cribbin, Amanda Laird, 'GARS - Jean Foul', 'gsburd@hotmail.com', Allan Houston, 'billy@secondchanceproject.co.uk', Stephen Kennedy, Lara Calder, Julie McCarthy, Laura Kemp, Linda Malcolm, Michael Robinson, Michael, Wendy Spencer, Amanda Miller, Anne-marie Quigg, Eric Duncan, Maureen Sullivan, Louise Stewart, t.mcarthur@addaction.org.uk; Volunteer Coordinator; Marlene Taylor

Recovery NW- 11th Oct- Michael Robinson, Bobby Kimmet, Sharon Graham, Johnny Durham, Connie Reid, Elaine Millar, Derek Watt, Allan Houston, John Lindsay, Ronnie Hart, Mark Healy

Recovery NE- 25th Oct- Michael Robinson, Paul Miller, Alice Gillespie, Steff Kerr, Catherine Wallace, Thomas Tenant, Anne marie Newman, Michelle King, GBU Development worker (illegible)

Recovery South- 31st Oct- Claire M (Chair), Linzi, Pat, Jamie, Rab, Scott, John Paul, John McC, John D (Vice Chair CREW), Johnny, Thomas (Treasurer), Wullie(Vice Chair RAFT), Brian, Danny, Murray, Martin (Vice Chair), Claire (Secretary)

Strategic Recovery Group- 9th Nov- Christine Laverty, Jackie Smith, Kelda Gaffney, Thomas Patterson, Vic Walker, David Pettigrew, John Goldie, Stevie Lydon

85. **Continuing Priorities and suggested developments**

86. The development and expansion of the role of the Recovery coordinator posts.

   a. Develop a structure around the posts, allowing progression into and beyond the role

   b. Investigate the need for a women's recovery coordinator post, recognising the specific barriers to women entering and remaining in recovery

   c. Further develop and embed ethos of recovery orientation of services through new recovery hubs model, ensuring the alignment of relevant posts and services

87. Recognition of the work and commitment of the Recovery Volunteers across the City and the need for identified support for this commitment.

   a. Develop a single induction training programme for all Recovery Volunteers

b. Develop an incentivised pathway for Recovery Volunteers, that is clear and transparent and based on level of commitment

c. Consistent ongoing training opportunities across the City- consistency of opportunity allowing individual volunteers to focus on their interests

d. Further enhance the ethos and role of volunteering as part of a programme of self-development for people in recovery.

88. Support the city wide recovery network to link its activity into the wider community

a. Promote the idea of Community Recovery, rather than recovery community

b. Work with partners to embed 'Community recovery' activities within their core work

89. Tackle stigma associated with drug and alcohol use.

a. Consider the creation of an anti- stigma charter for elected politicians to sign up to

b. Identify a politician/ business leader/community leader as a champion to challenge media and public perceptions

c. ADP must challenge inaccurate media coverage that creates stigma

d. Build the promotion of the role of people in recovery into wider HSCP communications

90. Development and expansion of recovery groups for specific groups

a. Develop focussed Equalities and Recovery strategy and action plan

b. Consider the needs of different BME communities,

c. Develop the existing women's recovery groups

d. Consider the needs of the LGBT communities

e. Consider the needs of Parents and Carers in recovery

91. More employment opportunities for those in recovery.

a. Develop formal links with 'Jobs and Business' and the Recovery communities

b. Develop PSP opportunities, involving Recovery hubs, beyond the traditional employment opportunities

92. Further financial investment in recovery support and services.

   a. Demonstrate Recovery's 'value for money' by reporting employment and training through ADP

   b. Ensure recovery communities are appropriately consulted on budgetary decisions

93. The creation of recovery hubs in each sector and possibly city-wide.

   a. Develop a model for peer led recovery centres, that will complement the new Recovery Hubs as they develop

94. Address barriers in relation to benefits and welfare reform.

   a. Develop working relationship with Dept for Work and Pensions regarding volunteer programmes, training commitments etc and recognise that Recovery Volunteers are currently punished by the system for contributing

   b. Establish interface protocol with the recovery communities, recovery hubs and the DWP.

95. Increase the commitment to families in recovery.

   a. Develop relationships with existing family support services

   b. Ensure Kinship care groups and Family support groups are included in Recovery planning

96. Address ongoing challenges faced by those in recovery identifying appropriate accommodation/ housing options.

   a. Address the accommodation needs for families in recovery

   b. Consider partnership with Glasgow Homelessness Network and collaborate on work with accommodation providers

New priorities for recovery

97. Older drug users- need to engage with this population of isolated, vulnerable people that could benefit greatly from the social support offered by recovery communities
98. Increased investment in health and fitness agenda within recovery communities- addressing mental and physical health needs, attractive to both men and women, and to those just beginning to consider recovery as a possibility.
99. Develop links with the Prevention agenda regarding work with education and young people at risk- recovery volunteers

100. **Protecting Children**

21st Nov 2016

Attendees: Gillian Ferguson, Michael Robinson, Kelda Gaffney, Claire Muirhead, Marlene Taylor, Linda Malcolm, Liz Fourna

<u>Continuing priorities and suggested developments</u>

101. Address the stigma and fear that prevents parents with drug and alcohol problems from asking for help
102. Children's needs to be considered within the recovery movement
    a. Childcare requirements for parents/ carers accessing recovery groups
    b. Focussed support for children and young people in recovery with their families
103. Kinship carers needs to be considered across ADP structures
    a. Support and training for kinship carers in dealing with challenging behaviour, emotional and educational needs

All agreed to adopt the 4 strategic aims outlined in the draft Scottish Government 'Children and Young people's Services 2017-2020' guidance

104. Children's services are provided in a way which best safeguards, supports and promotes the wellbeing of children in Glasgow
    a. Develop locality ADP Children and Young People groups, linking with the locality Children's Services groups
        i. Review existing CAPSM and Vulnerable Young people's services, identify gaps in safeguarding children and develop plans to fill these gaps in partnership with 3rd sector
        ii. Ensure learning from Significant Case Reviews regarding alcohol/ drug use is shared across all ADP partners
        iii. Develop a GADRS sub team in each sector, focussed on parents/carers who have alcohol/ drug problems and the necessary training, care pathways and partnerships
105. Children's services are provided in a way which ensures that any action to meet needs is taken at the earliest appropriate time and that, where appropriate, action is taken to prevent the needs arising
    a. Improve the identification of unborn children at high risk of neglect -review Ante-natal information gathering on alcohol and drug use
    b. Broaden responsibility for the identification of neglect in CAPSM across all ADP partners, using all available training
    c. Develop responsive and flexible services for young people at risk because of their own drug/alcohol use at an early stage
106. Children's services are provided in a way that is most integrated from the point of view of the recipients

   a. Locality Children and Young Peoples groups should be linked to CSP and CSG meetings
   b. Membership must include recovery reps, kinship care reps and equalities reps
   c. All plans to be made within the context of the Named Person legislation

107. Children's services are provide in a way that constitutes the best use of available resources

Stage 2- Feedback received by 13th January 2017

108. **David Walker, Head of Operations (GCHSCP South Locality) in his capacity as co-chair of the Boardwide Alcohol and Drugs Planning Group.**

  a. The strategic priorities set out within the strategy are welcomed and are consistent with the aims of the Boardwide Alcohol and Drugs Planning Group, particularly around the planning group's initiatives to promote the A&D Prevention and Education Model; better support the needs of children affected by parental substance misuse; and promoting the development of recovery focused services.

  b. Further discussion may be required on whether the ADP Strategy should be seen as the lead strategic document for GCHSCP for A&D services (beyond the high level strategic priorities set out in the IJB's Strategic Plan). If so, there would be merit in referencing significant service change programmes that the HSCP is progressing, for example around A&D day hospital services and residential rehabilitation services.

  c. Under the 'vulnerable adults' section of the strategy, no reference is made to the issue of tackling the complex needs of individuals with multiple conditions and the associated challenges of working effectively with other services such as mental health, homelessness, public health, prison health care and criminal justice to address these.

  d. For consistency, should page 8 reference the number of people supported by Glasgow Alcohol and Drug Recovery Services for alcohol problems – in the same way that this information is included on page 9 for people with a drug problem?

  e. No reference is made to the numbers and trends associated with methadone use in the City.

  f. It would also be useful to reference the number of people who are problem users of drugs and alcohol – no prevalence study for problematic drinking?

  g. The membership of the A&D Boardwide Planning Group now includes ADP Co-ordinators. This has been a welcome addition and should help to ensure a greater co-ordination of activities and mutual support to assist with the implementation of respective work programmes.

109. **Children's Exec Group- Liz Fourna**

  a. In the previous Children's services plan we put in 5,282 children affected by parental addiction. Claire Rush had been able to pull this information from an excel spreadsheet. If possible, would you be able to provide some updated figures? The figure is already included p 13.

110. **Feedback from NW ADP- Christine Laverty**

  a. Recovery Section (Priorities) Section 6: There should be a 6.4 relating to "Create greater focus on recovery outcomes for women and increase participation of women in decision making processes".

Stage 3- Feedback from ADP Joint Session 26th January 2017

111. **Recovery – Claire Muirhead**
    a. Change 7e to ‘Support the continuing development of…

112. **Homelessness- Eric steel**
    a. Welcome 9.2a- but is more detail required?

113. **Children’s Services- Mike Burns**
    a. Review with a view to feedback from inspection- meet with Mike and Christine Laverty

114. **VSDAA- Vic Walker and Gary Meek**
    a. VSDAA feedback will be forwarded asap.
    b. Broaden out 7.1a to include purchased services
    c. Mention DAISY and ROW in 10.1

115. **Associate medical Director addictions- Saket Priyadarshi**
    a. The title should acknowledge the more towards addressing the harm reduction needs of the city
    b. Increase the harm reduction profile within the document
    c. Include reference to ACMD report ‘Reducing Opiod related deaths in the UK’

116. **Contract and Commissioning- Pat Colthart**
    a. Mention the ongoing engagement of service users I the co-production process to review purchased services

117. **Addaction**

Please see our response to the ADP strategy. This response was also submitted to Scottish Government as part of the Alcohol Strategy review.

The Drink Wise, Age Well programme would like to see specific reference to older adults in any revision of the strategy. We would want the reference to include;

a. Ensuring that services do not discriminate against the needs of older drinkers via cut off ages or accessibility
b. service commissioning takes into account the needs of older adults within service design
c. data collected by Scottish Government/ ADP allows for analysis of need by age with particular reference to older adults
d. health promotion messaging considers the needs of older adults
e. workforce development and training for alcohol factors in the specific needs for older adults

118. **Voluntary Sector Drug and Alcohol Agencies**

a. The group were asked to comment on the ADP strategy and they were in agreement for the majority of the document and recognise the commitment of the ADP in the delivery of quality services and interventions regarding the provision of Alcohol and Drug services.

b. The group noted that it is a comprehensive document thought there were comments regarding the financial constraints which were only really mentioned at the end (point 12). It was noted that it would be preferred if there was more information on the impact this will have regarding service provision particularly as only an estimated 46.4% of problem drug users are in structured treatment.

c. VSDAA noted surprised by the reduction in homeless applications, VSDAA were unaware of this change in presentations and not sure if there was further research required to clarify uncounted numbers.

d. 4.0 g) In 2015/16 there were 5,426 homeless applications, a reduction on the previous year by 1,490

e. Do we know the reasons for this reduction? Was it limited access to services or have the structured prevention services been hugely successful in the reduction of homeless presentations through tenancy sustainment?

f. 1.3 Whilst Glasgow Alcohol and drug Recovery Services (GADRS) are seeing more than 10,000 people, it is estimated that only 46.4% of the City's problem drug users are in structured treatment (Source: CF6 Dec 2016, national prevalence Study 2009) and only an estimated 12% of problem drinkers are engaged with alcohol services.

g. 12 Financial Statement Glasgow city, in common with all public services, has faced significant financial challenges in recent years, with further pressures anticipated in future years. Glasgow City Council has to save £133 million within the 2016-2018 period and NHSGGC has to make a similar saving over the same period. Services for alcohol and drugs will be expected to make their contribution.

h. The current level of resource provided for alcohol and drugs is £46,292,500 (source: HSCP IJB Strategy 2016).

119. **Christine Laverty and Mike Burns**

We need to ensure that the ADSP strategy and the CSEG strategy link across the priorities for Children and Young people. The agreed priorities for the city and the outcomes we hope to achieve are;

a. ***Keep children safe*** *every child and young person has the right to be and to feel safe and protected. Free from physical, sexual or emotional harm, abuse or exploitation.*

b. **Healthy and Resilient Children –** we will continue to promote healthy lifestyle choices and the importance of play. We will focus on challenging the inequalities experienced by children in Glasgow, including child poverty and we will work with families to help children become more resilient, so they are more able to cope with life's uncertainties and problems.

c. **Family Support and Early Intervention –** We will promote the early identification of a child or family's needs: we will work with children and their families to build positive relationships and help parents to be the best they can be and ensure that the right measures are put in place to improve the wellbeing and development of the child.

d. **Raise attainment and achievement for all** - We will continue to provide support programmes for children and young people in the City to raise attainment and achievement and maximising employment outcomes and positive destinations.

e. **Looked After Children and young people** – we will continue to care for and support our care experienced children and young people to improve their life experiences and chances and we will strengthen our performance in relation to securing permanency for all children.

111 Prevention and Education- Fiona Moss

a. Glasgow context- review the stats used
b. More work required in the Prevention section, p12- speak to Drug and Alcohol team

Reviewed strategy follows:

1. Introduction

1.1 The Glasgow City Alcohol and Drug Partnership strategy is structured under the three themes of Prevention, Recovery and Protecting Vulnerable Groups.

1.2 The positive impact of the previous Strategy can be evidenced across the themes. The Prevention agenda has standardised delivery of 'Prevention and Education' input to schools across the city, embedded Community Alcohol Campaigns in each locality and identified recommendations through Ripple for engaging with the community and partners on alcohol and drug issues. The Recovery agenda has seen a marked growth in recovery communities and seen major services changes. The Protecting Vulnerable Groups agenda has seen an increase in training and subsequent awareness of children affected by parental alcohol and drug use and the roll out of Naloxone training and supply to those vulnerable to overdose.

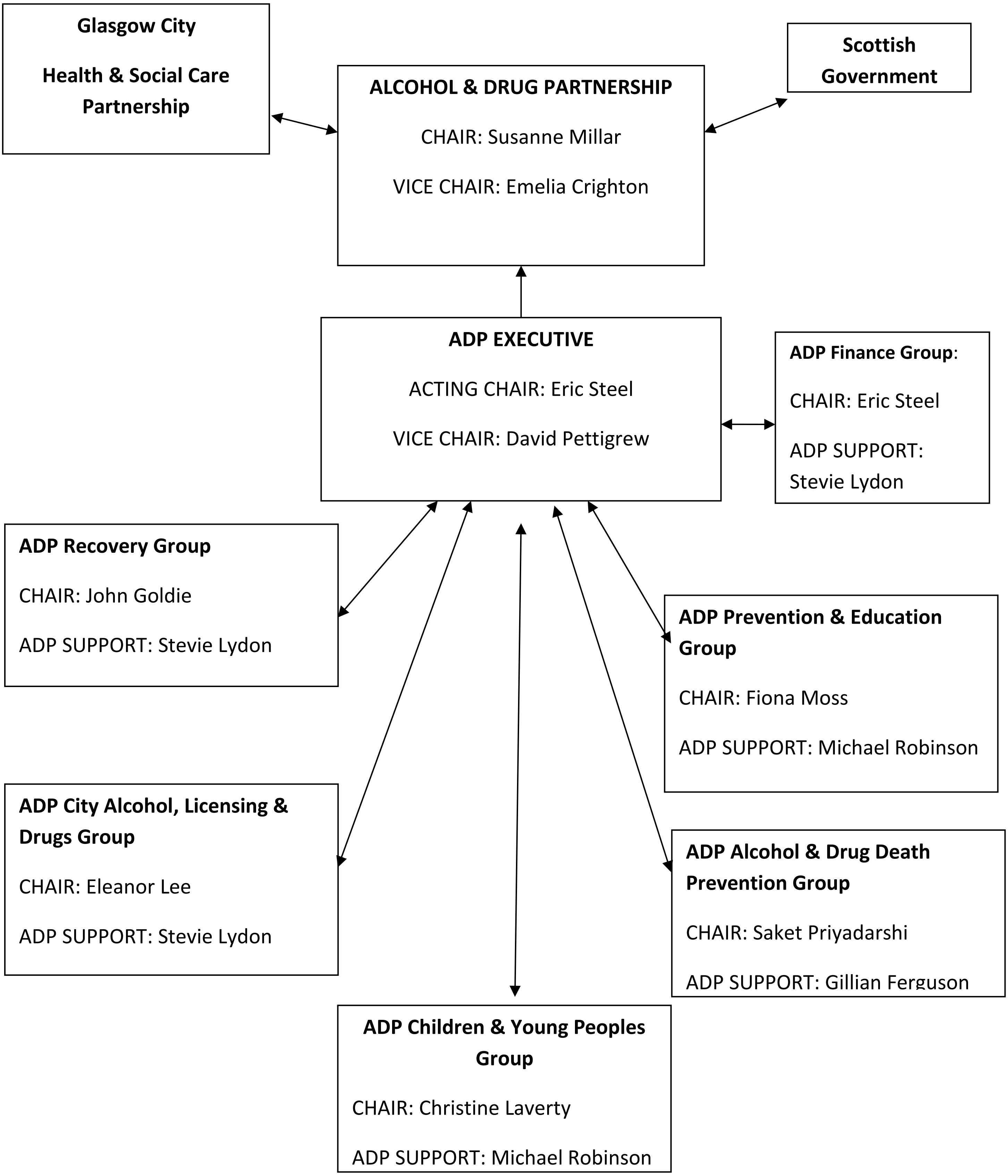
1.3 Despite improvements over the last three years the city still has some of the worst problems associated with alcohol and drugs in the whole of the UK. Whilst Glasgow Alcohol and Drug Recovery Services (GADRS) are seeing more than 10,000 people, it is estimated that only 46.4% of the City's problem drug users are in structured treatment (Source: CF6 Dec 2016, national prevalence Study 2009) and only an estimated 12% of individuals with alcohol problems are engaged with alcohol services.

1.4 The ADP became a 'Strategic Planning Group' of the Glasgow City Health and Social Care Partnership in 2016. The GCHSCP Strategic Plan is available in the link below:
https://www.glasgow.gov.uk/CHttpHandler.ashx?id=33418&p=0

2. ADP Arrangements

The Glasgow City Alcohol and Drug Partnership (ADP) was set up in 2010 to provide strategic direction on how the partners within the City should tackle alcohol and drug issues. The first two strategies launched in 2011 and 2014 were designed to ensure that ADP partners work together to provide a collective response to the problems affecting the city, making the best use of available resources.

GLASGOW CITY ADP



The ADP partners are

- Health and Social Care Partnership
- Community Planning Partnership
- Community Safety Glasgow
- Education Services
- Recovery Communities
- Glasgow Life
- Glasgow Works
- Licensing Board
- Participant volunteers, service users and carers
- Police Scotland
- Scottish Prison Service
- Sector-based community groups
- Social Work Services
- Scottish Fire and Rescue Service
- Voluntary Sector
- Scottish Ambulance Service
- NHSGG&C

These partners make up the membership of the five ADP sub-groups:

- Children and Young People
- City Alcohol, Licensing and Drugs
- Alcohol and Drug Death Prevention
- Recovery
- Prevention and Education

The ADP also operates via the three city localities, linking with community planning, local services and community groups.

3. Strategy Rationale

3.1 The strategy's purpose is to maintain our commitment to prevention and recovery across the city, to reduce the harm caused by alcohol and drug use and support more people with alcohol and drug issues to recover and enable them to reintegrate as participating citizens.

3.2 The Glasgow City Single Outcome Agreement 2013 (SOA) has identified the key outcome 'Working with the people of Glasgow to create a healthier relationship to alcohol'. The ADP strategy will continue to contribute significantly to this outcome. The SOA can be found at: https://www.glasgowcpp.org.uk/index.aspx?articleid=11056.

3.3 The strategy covers a three year period from April 2017 to March 2020.

3.4 The strategy will address the recommendations from a number of national documents:

a. The Scottish Government drugs strategy 'The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem' was published in May 2008. This set out a significant programme of reform to tackle Scotland's drug problem. Central to the strategy is the concept of recovery - a process through which individuals are enabled to move on from their problem drug use towards a drug-free life and become active and contributing members of society. The policy also outlines the importance of prevention as an effective approach in reducing the harm caused by drug use. The strategy can be found at: http://www.gov.scot/Publications/2008/05/22161610/0

b. The Scottish Government published 'Changing Scotland's Relationship with Alcohol: A Framework for Action' in March 2009. The 'Framework for Action' recognises that problems associated with alcohol use are much more prevalent across Scottish society than previously recognised. As a result, it adopts a whole population approach, with an overall focus on early years, early intervention and addressing health inequalities as well as recognising that some vulnerable groups and communities require a more targeted approach. The framework can be found at: http://www.gov.scot/Publications/2009/03/04144703/0

c. The Scottish Government published the updated, good practice guidance 'Getting Our Priorities Right' in April 2013. This policy is targeted at all agencies and practitioners working with vulnerable children, young people and families affected by problematic alcohol and/or drug use and advocates providing support for them to develop resilience and protective factors. The guidance can be found at: http://www.gov.scot/Publications/2013/04/2305

d. Scottish Drug Strategy Delivery Commission: 'Independent Expert Review of Opioid Replacement Therapies in Scotland: Delivering Recovery' was published in August 2013. The review can be found at: http://www.gov.scot/Publications/2013/08/9760

e. ‘Caring Together: The Carers Strategy for Scotland’ sits within a wider context and reform agenda. The carers strategy is available at: http://www.gov.scot/Resource/Doc/319441/0102104.pdf

3.5 The ADP has carried out a series of community-based and theme-focussed consultations over the past 5 years. In the development of this strategy, the ADP has built on the feedback from these consultations and worked with the ADP sub-groups to build the latest strategy on the foundation of previous strategies.

3.6 The ADP continues to strengthen its partnership by ensuring that its strategic planning is also linked into local partner plans:

a. The Scottish Fire and Rescue Service’s (SFRS) strategic priorities are contained in the Local Fire and Rescue Plan for Glasgow City 2014-17; this corporate planning framework reflects the Single Outcome Agreement and Community Planning objectives for the city. See link for more detail: http://www.firescotland.gov.uk/media/644936/sfrs_local_plan_glasgow_v1.0.pdf

b. The ‘Glasgow Health and Social Care Partnership Homelessness Strategy’ sets out an ambitious transformational reform programme for homelessness services in the City and details how the Health and Social Care Partnership intends to work with its partners to improve homelessness services for some of the most vulnerable people living in our City. See link for more detail: https://www.glasgow.gov.uk/CHttpHandler.ashx?id=34784&p=0

c. The ‘Glasgow Criminal Justice, Social Work (CJSW), Strategic Plan 2013-2015’ has been produced to inform the public, service users and staff of the strategic priorities of criminal justice social work services to reduce reoffending in Glasgow. It describes the planning structure, partnership working and the activity that is taking place to achieve national and local priorities. See link for more detail: http://www.glasgow.gov.uk/CHttpHandler.ashx?id=17057&p=0

d. The Interim ‘Children and Young People Services Plan’ has been developed to cover the period 2015-2017, while we await guidance on the implementation of

Parts 1 and 3 of the Children and Young people (Scotland) Act 2014. See link for more detail:

e. http://www.glasgow.gov.uk/CHttpHandler.ashx?id=15283

3.7 The ADP will aim to develop and improve good quality cost effective services focused on minimising duplication or waste and cultivating successful connections between strategic and locality planning.

3.8 The role of equalities is central to all developments and Equality Impact Assessments

(EQIAs) are paramount to all ADP service redesign.

4. Glasgow City Context

a. Glasgow City has a population of 606,340 (Source: National Records of Scotland 2015)

b. 45.7% of the population is aged between16-44 (Source: National Records of Scotland 2015)

c. The current death rate in Glasgow City (10.7 per 1000) is higher than the Scottish average (10.4 per 1000) (Source: National Records of Scotland 2015) – Not sure what this refers to?

d. The City is ethnically diverse with over 12% of citizens in an ethnic minority group (Source: National Records of Scotland 2013)

e. In 2015/16, 65.2% of working age Glaswegians were employed. Glasgow's employment rate is 8% lower than the Scottish average of 72.9% (Source: Understanding Glasgow: the Glasgow Indication Site 2016)

f. Alcohol and drug use by householders featured as a contributory factor in 113 incidents in Glasgow, 13.5% of all dwelling fires in Glasgow City. This continues the decreasing trend over the past 5 years. (Source: SFRS 2016)

g. Glasgow City Council receives the largest number of homeless applications per year in Scotland, disproportionate to the size of the population. In 2015/16 there were 5,426 homeless applications, a reduction on the previous year by 1,490 (Source: Scottish Government Prevent 1 Annual report)

h. Recorded incidents of anti-social behavior in Glasgow City have reduced from over 90,000 in 2004/05 to just over 40,000 in 2014/15 (Source: Community Safety Glasgow 2016).

i. Glasgow has consistently had a higher rate of adults claiming out-of-work benefits than other Scottish cities although that rate has declined from 29.2% in 2000 to 16.1% in 2016. (Source: http://www.understandingglasgow.com/indicators/economic_participation/overview)

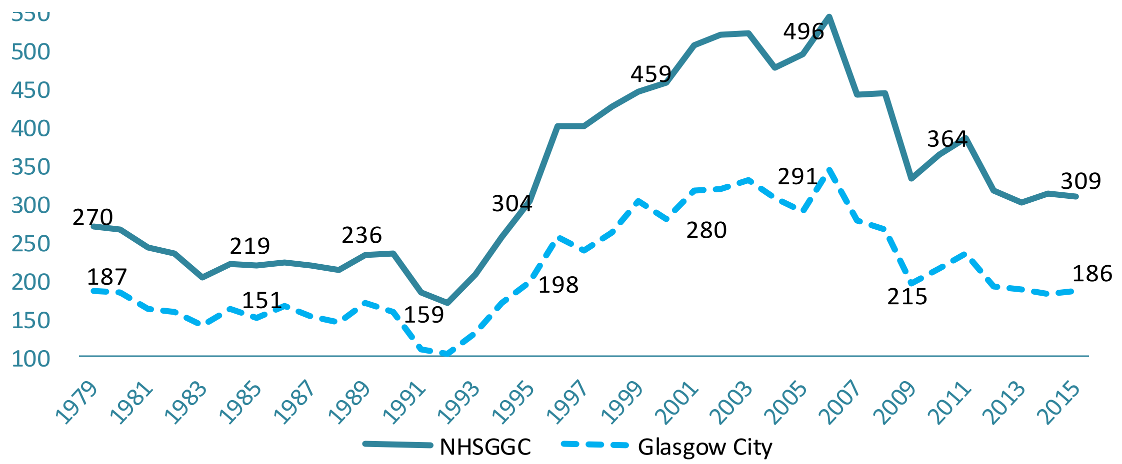
4.1 Glasgow Context: Alcohol

a. Drinking alcohol appears to be becoming significantly less prevalent among school pupils in Glasgow. Trends for S1-S4 pupils across the last three surveys show that pupils have become much more likely to say they never drink alcohol - rising from 46% in 2006/7 to 72% in 2014/15. (Source: Glasgow Schools Health and Well Being Study 2014-15)

b. Glasgow Alcohol and Drug Recovery Services support 4292 people with problematic alcohol use, 45% of the GADRS caseload (Source: CareFirst 6 2017)

c. The alcohol related death rate in Glasgow City is the highest rate of any ADP (36.6 per 100,000), in comparison to the national rate (21.8 per 100,000) (Source: ScotPHO Alcohol Profile; Glasgow ADP, 2015). See graph below: (The graph below does not show a comparison between Glasgow City and the National

Glasgow City & NHSGGC Alcohol Related Deaths 2010 - 2015



National Records Scotland; Alcohol Related Deaths 2015.

d. Glasgow has the highest rate of alcohol related hospital stays (1,240.5 per 100,000) in Scotland in comparison to the national rate (684.5 per 100,000) (Source: ScotPHO Alcohol Profile; Glasgow ADP, 2015)

e. Glasgow currently has a total of 1,828 premise licenses, on and off trade. (Source: ScotPHO Alcohol Profile)

4.2 Glasgow Context: Drugs

a. In Glasgow City schools, S1-4, 1 in 9 pupils (11%) said they had ever used drugs (Source: Glasgow Schools Health & Wellbeing Survey 2014/15)

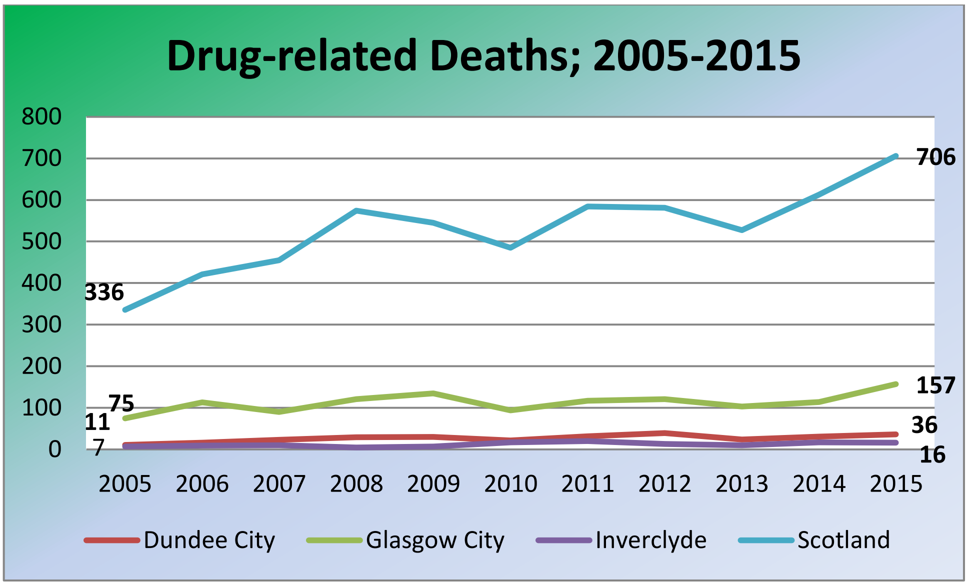
b. The trend for reported drug use in the last year by S1-4 pupils has reduced significantly, from 18.2% in 2006/7 (Glasgow Schools Health & Wellbeing Survey 2006/07) to 6.5% in 2014/15 (Glasgow Schools Health & Wellbeing Survey 2014/15)

c. Glasgow has an estimated 13,256 problem drug users, a prevalence rate of 3.27% - the highest in Scotland. (Source: National Prevalence Study 2009)

d. Glasgow Alcohol and Drug Recovery Services support 6150 people for their drug use, 46.4% of the estimated population of drug users in the City (Source: CF6 Dec 2016)

e. Glasgow has an estimated 5,458 drug injectors, a prevalence rate of 1.35%, the third highest in Scotland. (Source: National Prevalence Study 2009)

f. Whilst the rate of drug related deaths continues to rise in Glasgow (Table 1), the rise is not as significant as it is nationally. (Source: National Records of Scotland Drug-Related Death Report 2015)



g. Over the past 5 years there has been an average of 122 deaths per year in the city. (Source: National Records of Scotland Drug-Related Death Report 2015)

5. Strategy Structure

The strategy will continue to be structured under 3 themes: Prevention, Recovery and Protecting Vulnerable Groups (children and adults).

6. Prevention and Education

Glasgow City ADP has a strong history of working to prevent alcohol and drug problems and continues to prioritise prevention as the best way of minimising alcohol and drug harm. Our plans continue to be informed by the best evidence available within the context of local insights and experience. The Scottish Government 'What Works in Drug Education and Prevention?' (2016) and the existing GGC NHS Alcohol and Drug Prevention and Education Model (http://nhspande.lifesm.co.uk (username: model / password: pande12)) have informed this next stage of our prevention work.

Our prevention strategy includes action in four key areas;

- Work to reduce the accessibility of alcohol and drugs in the community (**systems prevention**)
- For everyone in the city the delivery of information and the development of skills and values to change our 'norms' around alcohol and drug use (**population prevention**).
- Working with those more likely to develop a harmful relationship with alcohol and drugs because of other life events affecting them e.g. trauma in childhood, to reduce the chances of this happening (**targeted prevention**)
- Programmes to work with those at earlier stages of alcohol and drug use to reduce and divert from increasing harm (**early stage prevention**)

6.1 Continuing Strategic Priorities

Over the next 3 years

System Prevention

- Contribute to the control of the accessibility of alcohol and drugs in communities through licensing, enforcement, policy and regulatory mechanisms.
- Undertake co-ordinated and timely responses to local drug trends including new and emerging drugs.

1. Population Prevention.
    - Work more closely with early years establishments to support children to thrive
    - Support further delivery of age specific multiple risk learning programmes in education and youth settings
    - Continue to develop responses to reduce the acceptability of misusing alcohol and drugs within communities

2. Targeted prevention
    - Understand, engage and develop responses with groups of people at most risk of future alcohol and drug harm.
    - Build the skills of those working with people who have experienced traumatic events to promote their well-being and protect them from alcohol and drug harm
    - Work with others to reduce the impact of adverse events in childhood on future well-being
    - Support corporate parent's to minimise the alcohol and drug risks and harms for young people in the care system.

3. Early stage prevention
    - Continue to extend the workforce in Glasgow able to undertake Alcohol Brief Interventions (ABI's) and delivery to enable people to consider more often their own alcohol drinking patterns and harm.
    - Provide accessible information on the risks and testing to reduce the number of new Blood Borne Virus infections acquired by people who inject drugs (PWID's)
    - Test a new service to identify and support young people at risk from their own, or another's, alcohol and/or drug use

Glasgow City will continue to deliver prevention and education activity aligned to the evidence within the GGC Alcohol and Drug Prevention and Education Model (2017-22)

7. Recovery

Recovery is a course of action through which an individual is able to progress on from their problem alcohol or drug use, towards a life as an active and contributing member of society.

Recovery is most effective when service users' needs and aspirations become the central core of their care and treatment.

Recovery is an aspirational, person centred process.

In practice, recovery will mean different things, at different times to each individual person.

The 'road to recovery' might mean developing the knowledge and skills to prevent relapse, rebuild broken relationships, forge new ones and actively engage in meaningful activities.

7.1 Continuing Strategic Priorities

a. Further develop the idea of Community Recovery and embed ethos of recovery orientation of services through new recovery hubs model, ensuring the alignment of relevant posts and services
b. Further enhance the ethos and role of volunteering as part of a programme of self-development for people in recovery
c. Continue to address stigmas as part of the overall recovery approach, including securing a clear focus on equalities
d. Maintain employment opportunities for those in recovery and address barriers in relation to benefits and welfare reform

e. Develop a model for peer led recovery activities, to complement evolving service developments
f. Increase the commitment to provide relevant support to families and carers in recovery. See link: http://www.gov.scot/Resource/Doc/319441/0102104.pdf
g. Address ongoing challenges in identifying appropriate accommodation. See link: https://www.glasgow.gov.uk/CHttpHandler.ashx?id=34784&p=0.

7.2 Additional Strategic Priorities

a. Develop a new focus on engagement with older drug users
b. Increase awareness of health and fitness opportunities within communities in recovery
c. Enhance links between Recovery and Prevention planning work around education and young people at risk

8. Protecting Vulnerable Groups: Children and Young People

Glasgow City has an estimated 6,188 Glasgow Alcohol and Drug Recovery service users who have a relationship with a child under 16 years (Source: CF6 Dec 2016).

The 'Glasgow City HSCP Interim Children and Young People Service Plan 2015-17' builds on the previous 'Integrated Service Plan 2012-15'. The plan is framed around the 'Children and Young People's Act 2014', which brings a legislative drive to 'Getting It Right For Every Child'.

The plan supports the principles of early intervention and prevention by promoting the well-being of children, including safeguards and improving corporate parenting for our looked after children and care leavers.

8.1 Continuing Strategic Priorities

a. Continue to address the stigma and fear that prevents parents with alcohol and drug problems from asking for help
b. Continue to consider children's needs within community recovery
c. Continue to consider the needs of kinship carers, families and carers across ADP structures

8.2 Additional Strategic Priorities

The ADP will adopt the 4 strategic aims outlined in the draft Scottish Government 'Children and Young People's Services 2017-2020' guidance:

a. Children's services are provided in a way which best safeguards, supports and promotes the wellbeing of children in Glasgow
b. Children's services are provided in a way which ensures that any action to meet needs is taken at the earliest appropriate time and that, where appropriate, action is taken to prevent the needs arising
c. Children's services are provided in a way that is most integrated from the point of view of the recipients
d. Children's services are provided in a way that constitutes the best use of available resources

9. Protecting Vulnerable Groups: Adults

The ADP recognises the challenges posed by vulnerable adults at risk through their alcohol and drug use and the need for a continued focus on harm minimisation, whilst remaining committed to the recovery agenda.

9.1 Continuing Strategic Priorities

a. Monitor existing trends in alcohol and drug use
b. Promote Naloxone training and provision across all care services
c. Continue to address the complex needs of the city centre population
d. Continue to monitor New and Emerging Drug Trends and coordinate actions across services
e. Consider low threshold services for those not accessing treatment

9.2 Additional Strategic Priorities

a. Tackle the complex needs of individuals with multiple conditions and the associated challenges of working effectively with partners including mental health, homelessness, public health, prison health care and criminal justice to address these.
b. Develop specific relapse support within GADRS for Recovery Volunteers
c. Develop Information sharing protocols
d. Investigate opportunities to increase research capacity

e. Address barriers to appropriate end of life care for older drug users

10. Performance Management

10.1 Performance Monitoring

The ADP will sit within the GCHSCP performance framework as well as the annual performance management arrangements set by the Scottish Government. The ADP will continue to utilise an annual delivery plan, outlining key actions against strategic priorities and the 7 national outcomes.

10.2 National ADP Outcomes

The seven core national ADP outcomes, described in the Scottish Governments 'Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements 2013-15':

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 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 services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery.

10.3 Indicators

The ADP will deliver against core HSCP indicators in terms of service delivery and compliment these by delivering against further local and national indicators in line with Scottish Government and partner expectations.

10.4 Annual Report

Performance monitoring will form a fundamental part of the ADP's reporting to the HSCP and in the Annual Report to the Scottish Government.

11. Communication

Progress on the delivery of the strategy will be communicated to all partners and the public. This will utilise:

a. ADP sub-group and locality participation in engagement events around the strategy development and delivery

b. Regular reporting of progress via HSCP monitoring reports and ADP annual report.

c. Regular reporting/ involvement with ADP community engagement including participants including service users, lived experience, carers

d. On-going work to address the Glasgow drinking culture and stigma around drug use – utilising social media

12. Financial statement

Glasgow city, in common with all public services, has faced significant financial challenges in recent years, with further pressures anticipated in future years. Glasgow City Council has to save £133 million within the 2016-2018 period and NHSGGC has to make a similar saving over the same period. Services for alcohol and drugs will be expected to make their contribution to this cost saving process.

The current level of resource provided for alcohol and drugs is £46,292,500 (source: HSCP IJB Strategy 2016).