NEEDS ASSESSMENT OF DRUG AND ALCOHOL PROBLEMS IN THE SCOTTISH BORDERS

Report prepared for: Borders Drug and Alcohol Action Team

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EXECUTIVE SUMMARY

BACKGROUND AND AIMS

This document presents findings of the needs assessment of current alcohol and drug services in Scottish Borders and reports on the future requirements for services for people with drug and alcohol problems in the area.

The purpose of this project is to assist Borders DAAT in meeting the recommendations of the Delivery Reform Group report (2009) by providing an assessment of current specialist drug and alcohol services, as well as a health needs assessment of local needs and gaps.

Figure 8 Consultancy Services Ltd. was commissioned by Borders DAAT in April 2009 to carry out the study, and field work took place between April 2009 and June 2009.

The specific objectives of this project were to assess current provision and examine current use of specialist drug and alcohol services in the Borders,

   a. to conduct an assessment of local need for such services,
   b. to identify gaps and areas of unmet need in current provision, and
   c. to provide evidence-based recommendations for the development of local specialist services.

METHODS

The study was conducted in six stages. Each stage was tailored to the needs of the study, requiring a mix of methods of data collection including questionnaires, online surveys, one-to-one interviews and focus groups. Sample populations included service users and carers, GPs, drug and alcohol service managers and staff and a range of wider stakeholders from health, social care, police and criminal justice settings.

RECOMMENDATIONS

The recommendations set out below are drawn from the evidence of current practice with regard to the range and capacity of drug and alcohol services in Borders compared to the research and guidance referred to throughout this report. These are presented for the consideration of the Borders DAAT and its partner organisations.
**Range and capacity of services**

There is a need to ensure that a full range of evidence based interventions is available to meet the identified needs of alcohol and drug dependent people in Borders. This range of interventions would include access to counselling services. As this is a relatively low-cost, high quality service there would be merit in considering the re-provision of this intervention.

Evidence from the gap analysis, as well as the existence of waiting lists suggest that there is an under-resource in terms of drug and alcohol treatment provision. Evidence based on the national prevalence study points to a need for more services for men however no such distinction should be made on any additional resource put in place.

A multi-agency waiting times strategy should be developed and implemented. This should ensure that current resources are being utilised to maximum effect. Guidance on the development of a waiting times strategy is available at [http://www.drugmisuse.isdscotland.org/ieu/intcare/Cha3.pdf](http://www.drugmisuse.isdscotland.org/ieu/intcare/Cha3.pdf)

Further exploration as to the level of joint working between substance misuse services and employment, training and further education services should take place. This should result in clear pathways being developed for drug and alcohol users to access the range of services available.
CHAPTER 1: INTRODUCTION

1.1 Background

The importance of alcohol and drug partnerships conducting a full Needs Assessment has been made in a number of national reports, for example, by the Delivery Reform Group. More recently in the Audit Scotland report, Drug and Alcohol Services in Scotland one of the Key recommendations for public sector bodies was to:

"Ensure that all drug and alcohol services are based on an assessment of local need and that they are evaluated to ensure value for money."

The recent Scottish Government delivery framework also reinforced the need for partnerships to conduct needs assessment.

The purpose of this project is to assist Borders DAAT in meeting the recommendations of the Delivery Reform Group report (2009) by providing an assessment of current specialist drug and alcohol services, as well as a health needs assessment of local needs and gaps.

Figure 8 Consultancy Services Ltd. was commissioned by Borders DAAT in April 2009 to carry out the study, and field work took place between April 2009 and June 2009.

1.2 Scope of the Project

This document presents findings of the needs assessment of current alcohol and drug services in Scottish Borders and reports on the future requirements for services for people with drug and alcohol problems in the area. Figure 8 Consultancy were also commissioned by Borders DAAT to conduct a quality evaluation of existing drug and alcohol services in Scottish Borders. This piece of work is presented as a separate supplementary report.

1.3 Objectives

The specific objectives of this project, as indicated by the project brief, are as follows:

d. to assess current provision and examine current use of specialist drug and alcohol services in the Borders,
e. to conduct an assessment of local need for such services,
f. to identify gaps and areas of unmet need in current provision, and
g. to provide evidence-based recommendations for the development of local
specialist services.

1.4 Summary of study methods

The study was conducted in six stages. Each stage was tailored to the needs of
the study, requiring a mix of methods of data collection and sample populations.
These are set out in Table 1.1 below. All questionnaires and interview schedules
were approved by BCAT prior to use. Copies of these are available on request.

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1.5 Definitions and Concepts

The methodology of calculating needs is derived from the Scottish Alcohol Needs Assessment\(^2\). This in turn uses the definitions and concepts set out in the Alcohol Needs Assessment Research Project (ANARP) conducted by Drummond and colleagues in England\(^3\).

In order to ensure consistency and comparability, these definitions and concepts have been adopted for use in this report. This chapter details the following terms as they apply to this report:

- Specialist alcohol and drug treatment
- Needs Assessment
- Need
- Assumptions in Needs Assessment for Alcohol and Drug Use Disorders

1.5.1 Specialist Alcohol and Drug Treatment

This refers to a wide range and intensity of interventions from, for example, one or more sessions of Motivational Enhancement Therapy through to intensive residential rehabilitation lasting up to 12 months. What these interventions have in common is that they are provided for patients actively seeking help for substance misuse disorders, and the interventions are provided by specialist staff trained to provide them.

Specialist treatment is primarily targeted at people with alcohol or drug dependence, and the more intensive forms (e.g. inpatient or residential treatment) are generally reserved for people with more severe dependence and/or significant psychiatric comorbidities or social problems. Both alcohol and drug-related harm and dependence exist on a continuum of severity and, although they are categorized within ICD-10, the precise point at which dependence or harm reach a threshold requiring a specialist intervention is, in practice, difficult to determine.

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1.5.2 Needs Assessment

In broad terms, health care needs assessment (HCNA) is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way. It involves methods to describe the health problems of a population, identify inequalities in health and access to services, and determine the priorities for the most effective use of resources.

Health care needs assessment has become important as the costs of health care are rising and resources for health care are, at the same time, limited. In addition, there is a large variation in availability and use of health care by geographical area and point of provision (Andersen and Mooney, 1990)\(^4\).

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

Doctors, sociologists, philosophers, and economists can all have different views of what ‘needs’ are, depending on definitions of ‘need’. In recognition of the scarcity of resources available to meet these needs, health needs are often differentiated as needs, demands and supply (or capacity).

In Canada, Rush (1990) has presented a model of alcohol needs assessment, which influenced the HCNA review and has been influential in alcohol needs assessment internationally\(^5\). Rush’s model suggests a range of access to specialist treatment: an access level of 1 in 10 (10%) alcohol dependent individuals entering treatment per annum is regarded as a ‘low’ level of access, 1 in 7.5 (15%) ‘medium’ and 1 in 5 (20%) ‘high’ (Rush, 1990). It is however important to note that Rush’s model is based on a large number of assumptions about the size of the ‘in-need’ population, the process of referral to various agencies and treatment drop-out. Rush’s study also used a large number of proxy measures rather than direct measurement of need and access. Therefore estimation of need for alcohol treatment and access would be improved by actual data from surveys as in the work presented in this report. In this study, we have followed the methodology recommended in the Health Care Needs Assessment Review of Alcohol Misuse (Cook, 2004)\(^6\).

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1.5.3 Need

In health care, need is commonly defined as ‘the capacity to benefit’. If health needs are to be identified then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available (Wright, Williams & Wilkinson, 1998). The definition of need used in this study is ‘the number of individuals in the general population with alcohol or drug dependence who could benefit from intervention’.

There are several challenges in estimating the prevalence of alcohol and drug dependence in the general population involving the definition of dependence and the methods used to obtain the estimate.

The estimates used for the drug component of this study are taken from the national prevalence study conducted by the Centre of Drug Misuse Research at University of Glasgow. However these refer to a definition of problem drug use rather than dependence and are limited to opiate and benzodiazepine use, excluding primary stimulant misuse.

As stated in the SANA report, without carrying out a specific survey of alcohol dependence and need for specialist treatment, the next best method to do this is to use data from a general population survey, as is the case in the alcohol component of this study, and the recommended methodology for needs assessment.

1.5.4 Assumptions in Needs Assessment for Alcohol and Drug Use Disorders

Clearly the above definition of need is based on a number of assumptions. As in standard needs assessment methodology described above, it does not take account of natural remission: that is the proportion of people with alcohol or drug dependence who will recover without formal specialist or other interventions. This has been estimated in general population follow-up studies and using other methods, primarily in the US, and different studies have provided different estimates. We have not incorporated natural remission into the estimates since no specific estimates are available for Scotland. Furthermore, while there is evidence of natural remission of alcohol dependence over time, we have no way of knowing at present what proportion of people who eventually recover without specialist intervention would have had the course of the disorder shortened by a timely specialist intervention had it been available and accessible.


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Another assumption is that the treatment provided is universally effective. This is clearly unlikely to be the case, but it is not possible to assess this within the scope or methodology of the research brief. Thirdly, not everyone who is offered treatment, assuming it is widely available, would want or accept treatment. Not everyone who a health professional would wish to refer to specialist treatment would necessarily be willing to accept referral as they may not be in an ‘action’ stage of motivational readiness to change (Prochaska & DiClemente, 1987). The subgroup of those in need who wish treatment is sometimes referred to as the ‘potential demand’ for treatment.

Fourthly, not everyone who indicates in a survey that they would potentially wish treatment, will actually access treatment. This may reflect partly a gap between what people say in surveys and what they actually do, and the barriers (real or perceived) to people actually accessing the services they need and want. Therefore, in line with previous alcohol needs assessments, in this study we have studied the ‘access’ to treatment which is defined as ‘the number of people with alcohol dependence who actually access treatment within a given year’. This is also referred to here as ‘Service Utilisation’. Some US surveys have attempted to estimate potential demand as distinct from need, based on survey questions as to whether people with alcohol dependence would want to access treatment if it was available. However, no comparable estimate is available in Scotland.

Clearly accessing treatment is not synonymous with receiving the full programme or course of treatment on offer, as some people will disengage prematurely. Also, within the limitations of the methodology we are unable to differentiate between people accessing treatment who are harmful drinkers as opposed to dependent drinkers.

1.6 Limitations and Assumptions

There are a number of factors which should be taken into account when reading this report. These are;

- The views of stakeholders interviewed are given in good faith and are representative of their organisation;

- The views of service users are drawn from those currently engaged with the services. This “self-selecting” group are likely to be positively disposed towards the service, its staff and the interventions that they provide. In that respect the views of those who are disenfranchised with services are not heard;

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All fieldwork relating to the SANA GP report was carried out between March 2008 and October 2008. Since this time the HEAT brief interventions target has seen a more systematic approach to the delivery of brief interventions in primary care (and other settings). This has included national guidance and training on the delivery of interventions, the establishment of Local Enhanced Service contracts between Health Boards and GP practices to ensure consistent delivery across the country and the establishment of a Delivery Support Team. This is, and will continue to, influence how and to what extent brief interventions are being delivered in Scotland.
CHAPTER 2: PREVALENCE AND TRENDS OF DRUG AND ALCOHOL USE IN THE SCOTTISH BORDERS

2.1 Introduction and Aims
The aim of this element of the project is to review existing datasets to provide a backdrop for the mapping exercise and to identify the prevalence and trends of alcohol and drug use in the Borders.

2.2 Method of Data Collection
Information was identified and drawn together from a range of local and national sources on prevalence and trends in the consumption of alcohol and drugs in Scotland over the past five years.

2.3 Demographic Information

2.3.1 Population
- The 2008 Community Health and Wellbeing Profile estimates the population of the Borders to be approximately 111,430 people.\(^\text{10}\) More recent population estimates from GROS suggest that the number of people living within NHS Borders is slightly higher, at 112,430.\(^\text{11}\)
- The Borders is one of the most rural and remote NHS board areas in Scotland, with just over half of its population classified as living in rural areas (i.e., living in settlements of less than 3,000 people), and around a third of the population classified as 'remote' (i.e., living more than 30 minutes drive-time away from a settlement of 10,000 or more people).\(^\text{12}\)
- Ethnic minorities make up 0.6% of the population, significantly lower than the Scottish average of 2%.\(^\text{13}\)
- The proportion of Borders residents aged under 15 years is similar to the Scottish average. According to GROS, the proportion of Borders residents aged 15 or under is 17.9%, compared to 17.7% of the Scottish population.\(^\text{14}\)

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\(^\text{10}\) Scottish Borders: Health and Well-Being Profile 2008, Scottish Public Health Observatory 2008
\(^\text{11}\) General Register Office for Scotland, Mid-2008 Population Estimates
\(^\text{12}\) Scottish Government Urban Rural Classification (SGURC) 2007-2008. Scottish Government
\(^\text{13}\) As 10
\(^\text{14}\) General Register Office for Scotland, Mid-2008 Population Estimates

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• The proportion of Borders residents aged over 65 years is higher than the Scottish average. GROS estimates that as of 2008, the proportion of Borders residents aged 65 and over was 18.2%, compared to 15.5% of the Scottish population.\textsuperscript{15}

• The proportion of working age adults (16-65 years) in the Borders is lower than Scottish average; 63.9%, compared to 66.8% in Scotland.

• Life expectancy for both males and females in the Borders is higher than the Scottish average.\textsuperscript{16} According to GROS data on life expectancy for 2005-2007, life expectancy at birth is 78.7 in the Borders, compared to the Scottish average of 77.4.\textsuperscript{17} In fact, the population in NHS Borders has the highest life expectancy of all the geographical Health Board areas bar Shetland.

\subsection*{2.3.2 Employment}

\begin{itemize}
\item The 2008 Scottish Borders Health and Well-Being Profile shows that the Borders enjoys a significantly higher rate of employment than the Scottish average, and has a significantly lower than average proportion of working age adults claiming Jobseeker’s allowance.

\item However, the most recently available unemployment data shows that the Scottish Borders had the second highest increase of any council area in numbers of people claiming Jobseeker’s Allowance – an increase from March 2008-March 2009 of 111%. Despite this, the percentage of the Borders population claiming Jobseeker’s Allowance remains lower than the Scottish average (Borders 3.1%; Scotland 3.9%).\textsuperscript{18}

\item Between October 2007 and September 2008, 56,100 people were in employment in the Scottish Borders, representing 82.4% of the working age population. During the same period 76.3% of working age people in Scotland were in employment. At this time, the proportion of people in Borders who were unemployed was lower than the proportion of people unemployed in Scotland as a whole; 3% in Borders compared to 4.5% in Scotland.\textsuperscript{19}

\item Compared to national averages, Scottish Borders has relatively high proportions of people employed in manufacturing (Borders 14.3%,

\textsuperscript{15} General Register Office for Scotland, Mid-2008 Population Estimates
\textsuperscript{16} As 1
\textsuperscript{17} General Register Office for Scotland, Life Expectancy for Administrative Areas within Scotland 2005-2007
\textsuperscript{18} Unemployment Bulletin – March 2009, Economic Development Service
\textsuperscript{19} Nomis Labour Market Statistics, available at https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx. Figures cited are the most recent available as at 30/06/09.
Scotland 9.2%)\(^{20}\), construction (Borders 7.1%, Scotland 5.7%)\(^{21}\) and ‘agriculture, fishing, energy and water’. Meanwhile, the proportion of the workforce employed in ‘transport and communications’ and ‘banking, finance and insurance’ were lower than for Scotland as a whole.\(^{22}\) Just 9.7% of employees in the Scottish Borders work in finance, IT and other business activities, compared to 18.8% in Scotland overall.

- Scottish Borders has a significantly lower proportion (35.4%) of its population engaged in management, professional and technical occupations than the Scottish average (40.7%). This is partly related to the smaller financial and IT sector in the area. The number of people working in banking, finance and insurance in the Scottish Borders reached its peak in 2000 (5,500 employees). This figure dropped to 3,500 in 2003, but since then has recovered somewhat. The five year period 2003-2007 saw increases of around 20% in the number of employees in this sector.\(^{23}\)

- The construction industry in the Borders has witnessed a similar growth (23%) in the number of people employed in the sector between 2003-2007.\(^{24}\)

- Significant falls in employment have been seen in manufacturing industries; since 1995 more than 4,000 jobs have been lost in the Borders, representing a decline of almost 40%. In addition, the number of people employed in ‘distribution, hotels and restaurants’ has also dropped to 9,500, from a peak of 11,900 in 2003.\(^{25}\)

### 2.3.3 Deprivation

- The Borders has a significantly lower level of deprivation than much of Scotland, with just 3.1% of its population living in the 15% most deprived areas of Scotland.\(^ {26}\)

- In 2005, the percentage of the total population who were income deprived was 9.3%, significantly better than the national level of 13.9%.\(^ {27}\)

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\(^{20}\) As 10  
\(^{21}\) As 10  
\(^{22}\) As 10  
\(^{23}\) As 10  
\(^{24}\) As 10  
\(^{25}\) As 10  
\(^{26}\) Scottish Government, Scottish Index of Multiple Deprivation 2006  
\(^{27}\) As 17

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2.4 Alcohol Consumption

Alcohol misuse is a considerable and increasing problem in Scotland in terms of mortality, morbidity and social harm. From 2001 to 2005\textsuperscript{28}, alcohol-related deaths rose by 15% and general hospital admissions by 7%. In addition, recent results from the Scottish Crime and Victimisation Survey indicate that people view alcohol misuse as a more serious social problem than antisocial behaviour or crime in general.\textsuperscript{29,30}

The UK government has produced sensible drinking guidelines recommending safe weekly limits based on units of alcohol. The current recommended weekly limit is 21 units for men and 14 units for women. High levels of alcohol consumption have been linked with many harmful consequences both for the individual and the wider community\textsuperscript{31}.

Data on alcohol consumption for the Borders, suggest that the average weekly alcohol consumption level for males in this area is among the lowest in Scotland (see Table 2.1). Average weekly alcohol consumption levels for females in the Borders are similar to those seen in Scotland as a whole.

| Table 2.1: Estimated usual weekly alcohol consumption level, Health Board/Sex\textsuperscript{32 33} |
|--------------------------------------------------|------------------|------------------|
| Male mean units per week | Female mean units per week |
| Ayrshire & Arran | 19.3 | 9.2 |
| Borders | 18.2 | 9.3 |
| Dumfries & Galloway | 17.6 | 8.6 |
| Fife | 17.5 | 8.3 |
| Forth Valley | 20.1 | 7.2 |
| Grampian | 17.2 | 8.9 |
| Greater Glasgow & Clyde | 21.6 | 9.2 |
| Highland | 19.8 | 8.4 |
| Lanarkshire | 23.4 | 8.1 |
| Lothian | 21.5 | 11.9 |
| Orkney, Shetland, Western Isles | 15.3 | 7.8 |
| Tayside | 19.7 | 8.3 |
| Scotland | 20.3 | 9.1 |

\textsuperscript{28} How Much Are People in Scotland Really Drinking? Public Health Observatory Division, Health Scotland. 2008.
\textsuperscript{30} Alcohol Statistics Scotland 2009. ISD Scotland.
\textsuperscript{32} Scottish Health Survey 2003
\textsuperscript{33} Scottish Health Survey (2008), Revised Alcohol Consumption Estimates 2003 (Scottish Government)
Data on from the Scottish Health Survey suggests that excessive drinking is less common in the Scottish Borders than in other parts of Scotland and in Scotland as a whole. As seen in Table 2.2 below, the percentage of males resident in Borders consuming over the recommended level of alcohol units per week is lower than the Scottish average. This holds both for the percentage of males drinking over 21 units per week and for the percentage of males drinking over 50 units per week, where the Borders recorded the joint lowest proportion in Scotland. The percentage of women in the Borders drinking over 21 units per week is similar to the Scottish average; the percentage of women in the Borders drinking more than 50 units per week is significantly lower than the Scottish average. Consumption levels can be seen in Table 2.2; data from other health board areas are provided for comparison.

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21+ units</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>29.6</td>
</tr>
<tr>
<td>Borders</td>
<td>30.1</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>28.6</td>
</tr>
<tr>
<td>Fife</td>
<td>31.9</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>33.8</td>
</tr>
<tr>
<td>Grampian</td>
<td>27.9</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>36.7</td>
</tr>
<tr>
<td>Highland</td>
<td>35.2</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>36.3</td>
</tr>
<tr>
<td>Lothian</td>
<td>39.9</td>
</tr>
<tr>
<td>Orkney, Shetland &amp; Western Isles</td>
<td>18.6</td>
</tr>
<tr>
<td>Tayside</td>
<td>32.4</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td><strong>34.1</strong></td>
</tr>
</tbody>
</table>

34 As 33

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2.5 Effect of Deprivation on Alcohol/Drug Consumption

Deprivation has been linked to problem drug use in that individuals who are socially and economically marginalised are seen as most at risk of developing drug problems. The association between alcohol misuse and deprivation is not as clear and in fact several studies show that the more deprived the neighbourhood, the lower the alcohol consumption level.

However, Scottish data currently suggests that although weekly alcohol consumption levels are higher for the least deprived communities, consumption over the daily recommended limits in one sitting is higher for individuals in the most deprived communities. Data from Alcohol Statistics Scotland shows that individuals living in the most deprived communities are approximately six times more likely to be admitted to hospital as a result of alcohol misuse than individuals in the least deprived areas.

Figure 2.1 displays alcohol-related general acute inpatient discharges by deprivation quintile for 2006/07 for both Scotland and the Scottish Borders. (1=least deprived; 5=most deprived). It can be seen that the trend in the Scottish Borders differs significantly from the Scottish pattern in the same year. In Scotland overall, the largest proportion of total discharges with an alcohol-related diagnosis fell into the most deprived quintile. However, in the Scottish Borders the largest proportion of discharges fell into the second and third quintiles. Therefore individuals living in some of the least deprived and averagely deprived areas were more likely to be experiencing problem drinking. It is not clear if problem drinking is more common than average among these populations; there may be other explanations, for example individuals from these populations may be more likely to admit themselves to hospital or be admitted by others.

35 Drugs and poverty: A literature review. Published by Scottish Drugs Forum on behalf of the Scottish Association of Alcohol and Drug Action Teams. 2007.

36 Neighbourhood deprivation and alcohol consumption: does the availability of alcohol play a role? Pollack, Craig Evan; Cubbin, Catherine; Ahn, David; Winkleby, Marilyn. International Journal of Epidemiology, Volume 34, Number 4, August 2005, pp. 772-780(9)


38 Alcohol Statistics Scotland 2009, NHS National Services Scotland, ISD Publications

39 Local Alcohol and Drugs Information, ISD Scotland, Health Har, Table 3.4
2.6 Alcohol Consumption– Health Harm

Evidence from clinical and epidemiological studies shows a relationship between heavy drinking and certain clinical presentations (for example injuries, physical and psychiatric illnesses, frequent sickness absence) and social problems. Following are some figures illustrating the extent of health-related harm due to alcohol misuse in Scottish Borders.

Hospital discharges (alcohol-related/attributionable conditions) in the Borders have been significantly lower than the national average. According to the Scottish Borders Health and Well Being area profile report, between 1997/99 and 2004/06 an average of 788 people per 100,000 population per year were discharged from hospital with an alcohol-related diagnosis in the Borders, compared to the Scottish average of 859 people per 100,000 population per year over the same period.

---


41 As 1

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Table 2.3 presents figures for alcohol-related hospital discharges between 2003/04 and 2007/08 in Scotland and the Scottish Borders. As can be seen in the table, since 2003 the number of discharges in the Borders has increased by around 150 cases or 30%. However, notably, year on year the Borders have had a consistently lower rate of general acute inpatient discharges with an alcohol-related diagnosis than the national rate.

**Table 2.3: General acute inpatient discharges with an alcohol related diagnosis, Scotland and the Scottish Borders, 2003/04 to 2007/08**

<table>
<thead>
<tr>
<th></th>
<th>Scotland</th>
<th>Scottish Borders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of discharges</td>
<td>Rate of discharge per 100,000 population</td>
</tr>
<tr>
<td>2003/04</td>
<td>35,396</td>
<td>666</td>
</tr>
<tr>
<td>2004/05</td>
<td>38,006</td>
<td>705</td>
</tr>
<tr>
<td>2005/06</td>
<td>37,810</td>
<td>698</td>
</tr>
<tr>
<td>2006/07</td>
<td>39,700</td>
<td>729</td>
</tr>
<tr>
<td>2007/08</td>
<td>42,430</td>
<td>777</td>
</tr>
</tbody>
</table>

Table 2.4 below presents details of specific diagnoses of alcohol-related hospital discharges in the Scottish Borders. Figures from the Borders have been compared with figures for South Ayrshire, East Lothian and Dumfries and Galloway; although the population of these areas varies somewhat, they are all relatively similar in size. As can be seen in the table, of the four authorities, the Borders recorded the lowest numbers of discharges due to alcoholic liver disease and the toxic effect of alcohol and an average number of discharges relating to mental and behavioural disorders due to alcohol.

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42 Alcohol Statistics Scotland, 2009, Table 4.2
43 As 32, Table 4.3

Needs Assessment of Drug and Alcohol Problems in the Scottish Borders

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Table 2.4: General acute inpatient discharges with an alcohol-related diagnosis, specific diagnosis: 2007/2008

<table>
<thead>
<tr>
<th></th>
<th>Borders</th>
<th>South Ayrshire</th>
<th>East Lothian</th>
<th>Dumfries and Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mental and behavioural disorders due to alcohol</td>
<td>583</td>
<td>835</td>
<td>349</td>
<td>471</td>
</tr>
<tr>
<td>Alcoholic liver disease</td>
<td>91</td>
<td>93</td>
<td>144</td>
<td>135</td>
</tr>
<tr>
<td>Toxic effect of alcohol</td>
<td>58</td>
<td>190</td>
<td>161</td>
<td>96</td>
</tr>
</tbody>
</table>

In 2007, 23 alcohol-related deaths were recorded in the Borders; 14 were men and 9 were women.\textsuperscript{44}

According to the Alcohol Statistics Scotland 2009, the areas with the greatest increase in standardised mortality rates for men were Fife and the Borders, 10.5 per 100,000 (2003) to 18.4 per 100,000 population (2007) and for women the Borders had the greatest increase from 8.6 per 100,000 population to 14.4 per 100,000. These 2007 rates are lower than the Scottish average for both sexes; 35.2 per 100,000 population for men and 14.8 per 100,000 population for women.

Looking at patterns and trends over this five year period, average number of alcohol-related deaths in Scottish Borders during this time, of 14.8 per 100,000 was statistically significantly lower than the Scottish average of 38.1 per 100,000 and is also one of the lowest alcohol-related death rates of all of the Community Health Partnership areas.\textsuperscript{45}

Figure 2.2 shows the relative rates of alcohol related mortality between Borders Fife and Scotland per year between 2003 and 2007. It can be seen from this that although Fife displays an increase in alcohol related mortality year on year the Borders rate fluctuates and cannot be seen to represent a pattern or increasing trend. It would therefore not be advisable to regard the difference between 2003 and 2007 rates as a significant factor in decision making regarding the funding or provision of alcohol treatment services however it does merit continued surveillance over time.

\textsuperscript{44} As 32, Table 4.14
\textsuperscript{45} As 32, Table 4.14
2.7 Alcohol Consumption - Social Harm

Alcohol consumption is associated with a substantial burden of social harm and estimates from some countries suggest that it is roughly equal to the burden of health harm.\(^{46}\) Alcohol misuse is estimated to have cost Scotland around £2.25 billion in 2006/07\(^ {47}\). It should be pointed out that this cost refers only to the financial burden of alcohol and not to the many other types of social harm associated with alcohol misuse.

2.7.1 Drunkenness Offences

Table 2.5 below shows the number of drunkenness offences committed in the Borders since 1996/1997. An average of around 40 drunkenness offences per year has been recorded in the Borders. This is significantly lower than the number of drunkenness offences recorded in local authority areas of a similar population size; for example Angus recorded an average of around 65 drunkenness offences per year, South and East Ayrshire around 170, and Dumfries and Galloway around 110.\(^ {48}\)


Table 2.5: Drunkenness Offences by Local Authority Area, 1996/7 – 2006/7

<table>
<thead>
<tr>
<th>Year</th>
<th>Borders</th>
<th>Angus</th>
<th>South Ayrshire</th>
<th>East Ayrshire</th>
<th>Dumfries &amp; Galloway</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996/1997</td>
<td>35</td>
<td>112</td>
<td>268</td>
<td>215</td>
<td>211</td>
</tr>
<tr>
<td>1997/1998</td>
<td>50</td>
<td>94</td>
<td>256</td>
<td>207</td>
<td>200</td>
</tr>
<tr>
<td>1998/1999</td>
<td>46</td>
<td>67</td>
<td>218</td>
<td>181</td>
<td>130</td>
</tr>
<tr>
<td>1999/2000</td>
<td>35</td>
<td>77</td>
<td>134</td>
<td>202</td>
<td>80</td>
</tr>
<tr>
<td>2000/2001</td>
<td>48</td>
<td>40</td>
<td>165</td>
<td>192</td>
<td>101</td>
</tr>
<tr>
<td>2002/2003</td>
<td>63</td>
<td>50</td>
<td>177</td>
<td>169</td>
<td>76</td>
</tr>
<tr>
<td>2003/2004</td>
<td>57</td>
<td>63</td>
<td>171</td>
<td>152</td>
<td>44</td>
</tr>
<tr>
<td>2004/2005</td>
<td>31</td>
<td>54</td>
<td>120</td>
<td>136</td>
<td>64</td>
</tr>
<tr>
<td>2005/2006</td>
<td>44</td>
<td>54</td>
<td>177</td>
<td>157</td>
<td>91</td>
</tr>
<tr>
<td>2006/2007</td>
<td>24</td>
<td>63</td>
<td>140</td>
<td>137</td>
<td>90</td>
</tr>
</tbody>
</table>

In 2007/2008, 284 drunkenness offences were recorded by Lothians and Borders police (therefore including drunkenness offences committed in the Lothians and Edinburgh as well as the Borders). The rate of drunkenness offences per 10,000 population recorded in the Lothian and Borders Police Force Area during 2007/2008 was lower than in any other police area in Scotland and more than four times smaller than the Scottish average.  

Table 2.6: Drunkenness Offences by Police Force, 2007/2008

<table>
<thead>
<tr>
<th>Police Force</th>
<th>No. of drunkenness offences</th>
<th>Rate of drunkenness offences per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007/2008</td>
<td></td>
</tr>
<tr>
<td>Strathclyde</td>
<td>4,156</td>
<td>19</td>
</tr>
<tr>
<td>Northern</td>
<td>866</td>
<td>30</td>
</tr>
<tr>
<td>Tayside</td>
<td>409</td>
<td>10</td>
</tr>
<tr>
<td>Fife</td>
<td>392</td>
<td>11</td>
</tr>
<tr>
<td>Lothian and Borders</td>
<td>284</td>
<td>3</td>
</tr>
<tr>
<td>Grampian</td>
<td>262</td>
<td>5</td>
</tr>
<tr>
<td>Central</td>
<td>198</td>
<td>7</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>135</td>
<td>9</td>
</tr>
<tr>
<td>SCOTLAND</td>
<td>6,702</td>
<td>13</td>
</tr>
</tbody>
</table>

49 As 38
50 As 38

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2.7.1 Drunk Driving Offences

While the Lothian and Borders area recorded the second highest number of drunk driving offences in Scotland in 2007/2008, the rate of drunk driving offences recorded in this area per 10,000 population is the lowest in Scotland, at 18 per 10,000 population, as shown in Table 2.7 below.⁵¹

Table 2.7: Drunk driving offences by Police Force, 2007/2008⁵²

<table>
<thead>
<tr>
<th>Police force</th>
<th>No. of drunk driving offences 2007/2008</th>
<th>Rate of drunk driving offences per 10,000 population 2007/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strathclyde</td>
<td>4,538</td>
<td>21</td>
</tr>
<tr>
<td>Lothian and Borders</td>
<td>1,626</td>
<td>18</td>
</tr>
<tr>
<td>Grampian</td>
<td>1,129</td>
<td>21</td>
</tr>
<tr>
<td>Northern</td>
<td>863</td>
<td>30</td>
</tr>
<tr>
<td>Tayside</td>
<td>837</td>
<td>21</td>
</tr>
<tr>
<td>Fife</td>
<td>783</td>
<td>22</td>
</tr>
<tr>
<td>Central</td>
<td>620</td>
<td>21</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>301</td>
<td>20</td>
</tr>
<tr>
<td>SCOTLAND</td>
<td>10,697</td>
<td>21</td>
</tr>
</tbody>
</table>

At local authority level, an average of around 210 drunk driving offences are recorded in the Scottish Borders every year, representing just over a tenth of the offences recorded throughout the Lothian and Borders Police area. The highest proportion of offences in this Police area is recorded in the City of Edinburgh, followed by West Lothian. Table 2.8 presents the data for this area by local authority over the five year period between 2002 and 2007.

Table 2.8: Drunk driving offences by Local Authority, Lothian and Borders Police Area, 2002/2003 to 2006/2007⁵³

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Edinburgh</td>
<td>881</td>
<td>767</td>
<td>811</td>
<td>887</td>
<td>836</td>
</tr>
<tr>
<td>West Lothian</td>
<td>388</td>
<td>349</td>
<td>335</td>
<td>366</td>
<td>382</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>209</td>
<td>215</td>
<td>205</td>
<td>213</td>
<td>205</td>
</tr>
<tr>
<td>Midlothian</td>
<td>185</td>
<td>190</td>
<td>147</td>
<td>140</td>
<td>184</td>
</tr>
<tr>
<td>East Lothian</td>
<td>110</td>
<td>143</td>
<td>121</td>
<td>147</td>
<td>152</td>
</tr>
</tbody>
</table>

2.8 Drug Use

Illicit drug use causes significant problems for Scotland in terms of social harm in areas like antisocial behaviour, violence and crime, prostitution, homelessness

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⁵¹ As 38  
⁵² As 38  
⁵³ Local Drugs and Alcohol Information, ISD Scotland, Alcohol and Social Harm: Drunk Driving  

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and family breakdown. In addition, there is a substantial financial cost attached to drug misuse which is an estimated £2.6 billion per year.\textsuperscript{54}

### 2.8.1 Prevalence and Characteristics of Drug Use in the Scottish Borders:

- In 2007/08, 182 ‘new’ individuals in the Borders were reported to the Scottish Drugs Misuse Database (SDMD). This represents a significant increase of more than 40% on the previous year and is higher than the average of around 150 individuals reported to the Database each year since 2001.\textsuperscript{55}

- As in Scotland, the two main sources of referral in the Borders were self-referral and referral by a health service, such as a GP or mental health service. However, a smaller than average proportion of individuals in the Borders self-referred in 2007/08; around a quarter compared with a Scottish average of more than a third. In contrast, almost 60% of individuals in the Borders were referred by a health service in 2007/08, compared to the Scottish average of just over a third.\textsuperscript{56}

- 55% of ‘new’ individuals had consumed alcohol in the previous month, with 30% reporting alcohol consumption on a daily basis.\textsuperscript{57}

- More than three quarters (77%) of individuals were unemployed, higher than the Scottish average of 70%. A similar proportion (78%) funded their drug use with benefits compared to the Scottish average of 67%. A fifth of individuals in the Borders indicated that crime was the source of their funding, compared to a Scottish average of just over a quarter (27%).\textsuperscript{58}

- 38% of ‘new’ individuals lived alone and 18% reported that they live with other drug users.\textsuperscript{59}

- More than half of ‘new’ individuals reported heroin as being their main drug of choice; however, data suggests that many of them use other substances along with heroin, predominantly cannabis (40%) and Diazepam (29%).\textsuperscript{60}

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\textsuperscript{55} NHS Scotland National Services, National Statistics, Drug Misuse Statistics Scotland 2008

\textsuperscript{56} As 45

\textsuperscript{57} As 45

\textsuperscript{58} As 45

\textsuperscript{59} As 45

\textsuperscript{60} As 45

 Cần Xem Trích Trích Người Đây và Nhóm Problema trong Hệ Thống Bờ Biển Scotland Needs Assessment of Drug and Alcohol Problems in the Scottish Borders Page 23 of 98
2.9 Drugs - Health-Related Harm

There were a total of 66 general acute inpatient discharges with a diagnosis of drug misuse in Scottish Borders between 2007 and 2008. This represents an increase of almost 60% on discharges recorded in 2003. However, as can be seen in Table 2.9 below, the rate of discharges per 100,000 population remains lower than the Scottish average.

Table 2.9: General Acute Inpatient Discharges with a Diagnosis of Drug Misuse 2003/04 -2007/08

<table>
<thead>
<tr>
<th>Year</th>
<th>Scotland No. of discharges</th>
<th>Rate of discharges per 100,000 population</th>
<th>Scottish Borders No. of discharges</th>
<th>Rate of discharges per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>4,434</td>
<td>91</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>2004/05</td>
<td>4,449</td>
<td>91</td>
<td>41</td>
<td>48</td>
</tr>
<tr>
<td>2005/06</td>
<td>4,366</td>
<td>89</td>
<td>49</td>
<td>60</td>
</tr>
<tr>
<td>2006/07</td>
<td>4,764</td>
<td>97</td>
<td>45</td>
<td>58</td>
</tr>
<tr>
<td>2007/08</td>
<td>5,363</td>
<td>108</td>
<td>66</td>
<td>80</td>
</tr>
</tbody>
</table>

Of the data recorded in 2007/08, fewer than 5 admissions were elective and all others were emergency, reflecting the wider Scottish trend. The majority of hospital stays with a diagnosis of drugs misuse in the Borders lasted less than a week. During 2006/2007, there were 35 psychiatric discharges with a diagnosis of drug misuse in the Scottish Borders. Since 2002, the rate of psychiatric discharges with a diagnosis of drug misuse in the Borders has been significantly higher than the Scottish average, as is illustrated by Table 2.10 below.

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61 NHS National Services Scotland, Drug Misuse Statistics 2008, Table B1.1
62 As 51
63 As 51, Table B1.5
64 As 51, Table B1.6
65 As 51, Table B2.1

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There were seven drug-related deaths in the Scottish Borders during 2008, representing less than 1% of the total number of drug-related deaths in Scotland (574). This figure is comparable with that of other local authorities with a similar population size, for example Angus (8 deaths), South Ayrshire (12 deaths) and East Lothian (7 deaths). In three of the seven cases concerned, heroin was involved, in two cases diazepam was involved, cocaine was reported in one case and alcohol in another two.

2.10 Drugs - Social Harm

In 2007/08, 708 drug-related offences were recorded in the Scottish Borders. This represents a small increase of 4% on the number of offences recorded in 2003/4. Over the same time period, the rate of drug-related offences per 100,000 population in the Scottish Borders has been consistently lower than the Scottish average.

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66 As 51, Table B2.2
67 General Register Office for Scotland, Drug-related deaths in Scotland in 2008
68 As 57
69 As 51, Table C1.1

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Table 2.1: Recorded Drug–Related Offences and Rate of Recorded Drug–Related Offences, Scotland and Scottish Borders, 2003/04 to 2007/08

<table>
<thead>
<tr>
<th></th>
<th>Scotland</th>
<th></th>
<th>Scottish Borders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of</td>
<td>Rate of</td>
<td>No. of</td>
<td>Rate of</td>
</tr>
<tr>
<td></td>
<td>offences</td>
<td>offences per</td>
<td>offences</td>
<td>offences per</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100,000</td>
<td></td>
<td>100,000</td>
</tr>
<tr>
<td>2003/04</td>
<td>42,275</td>
<td>836</td>
<td>683</td>
<td>631</td>
</tr>
<tr>
<td>2004/05</td>
<td>41,823</td>
<td>824</td>
<td>748</td>
<td>685</td>
</tr>
<tr>
<td>2005/06</td>
<td>44,247</td>
<td>868</td>
<td>806</td>
<td>735</td>
</tr>
<tr>
<td>2006/07</td>
<td>42,422</td>
<td>829</td>
<td>675</td>
<td>612</td>
</tr>
<tr>
<td>2007/08</td>
<td>40,746</td>
<td>792</td>
<td>708</td>
<td>635</td>
</tr>
</tbody>
</table>

Of the 708 offences recorded under the Misuse of Drugs Act in the Scottish Borders in 2007/08, just over a third (34%) were for possession with intent to supply, while almost two thirds were for possession only. The proportion of offences falling into the category of possession with intent to supply in the Borders is significantly higher than the Scottish average, which stands at just under a quarter (23%). In contrast, the proportion of drug–related offences falling into the category of possession was lower than average: 63% in the Scottish Borders, compared to 75% in Scotland overall.70

Table 2.12: Recorded drug–related offences: Type of offence, Scotland and Scottish Borders, 2007/2008

<table>
<thead>
<tr>
<th></th>
<th>Scotland</th>
<th></th>
<th>Scottish Borders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Possession with intent to supply</td>
<td>9,328</td>
<td>23%</td>
<td>243</td>
<td>34%</td>
</tr>
<tr>
<td>Possession</td>
<td>30,559</td>
<td>75%</td>
<td>449</td>
<td>63%</td>
</tr>
<tr>
<td>Other</td>
<td>859</td>
<td>2%</td>
<td>16</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>40,746</td>
<td>100%</td>
<td>708</td>
<td>100%</td>
</tr>
</tbody>
</table>

70 As 51, Table C1.2

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It should be noted that offences recorded under the Misuse of Drugs Act fail to capture other drug-related offences, such as housebreaking, prostitution and personal assault.

2.11 Key Findings

2.11.1 Population

- Residents in the Scottish Borders have a significantly higher life expectancy than the Scottish average. However, the region has a higher than average proportion of people aged 15 and under as well as a higher than average proportion of people aged 65 and over. This population structure may have implications in terms of the demand on health care services, etc., and, as a result, the resources in this area may be affected.

2.11.2 Employment

- Scottish Borders has higher than average employment rates. However, the region has a lower proportion of professional and management employees and the traditional employment base of manufacturing has been disappearing. This may leave unskilled workers without employment, with potential implications for alcohol consumption and drug use.

2.11.3 Deprivation

- Scottish Borders is among the least deprived regions of Scotland. Less than 5% of the area falls into the most deprived category of the Scottish Index of Multiple Deprivation.

- Data shows that in Scotland individuals from the most deprived circumstances/communities are more likely to be admitted to hospital for alcohol-related conditions. However, data for the Borders during 2006/2007 indicate a slightly different pattern, with the second least deprived and averagely deprived areas recording more discharges for alcohol related conditions.

2.11.4 Alcohol

- Data on alcohol consumption levels in the Scottish Borders indicate that consumption is generally lower or equal to the Scottish average. The proportion of people drinking over the recommended weekly amount is lower than the Scottish average.
Between 2003/04 and 2007/08, the Scottish Borders had a consistently lower rate per 100,000 population of general acute inpatient discharges with an alcohol-related diagnosis than Scotland.

There were 23 deaths from alcohol in 2007/08. The rate of alcohol related deaths per 100,000 population in the Scottish Borders is lower than the Scottish average for both men and women.

The number of drunkenness offences recorded in the Scottish Borders is lower than the number recorded in other local authorities of a similar size. The rates of both drunkenness and drunk driving offences per 10,000 population in the Lothian and Borders Police Area are the lowest in Scotland.

2.11.5 Drugs

In 2007/08, a higher than average number of 182 ‘new’ individuals in the Borders were reported to the Scottish Drugs Misuse Database.

The individuals reported to the SDMD in the Borders are more likely to be referred by a health professional or health service than drug users throughout Scotland. A lower proportion of drugs users in the Borders self-refer to drug treatment services.

More than three quarters of individuals reported to the SDMD in the Borders were unemployed and funded their addiction through benefits, a higher proportion than the Scottish average. A lower than average proportion of individuals in the Borders said that they funded their addiction through crime.

A higher than average rate of psychiatric discharges related to drug misuse per 100,000 population was recorded in the Borders between 2002/03 and 2006/07.

There were seven drug-related deaths in the Borders in 2008. Of these, three heroin, two Diazepam, one cocaine and two involved alcohol (note that multiple drug use is implicated, hence more drugs than deaths).

The rate of drug-related offences per 100,000 population in the Scottish Borders has been consistently lower than the Scottish average. However, a higher proportion of arrests in the Scottish Borders related to possession with intent to supply than in Scotland as a whole.
CHAPTER 3: PROFILE OF CURRENT SERVICE PROVISION

3.1 Introduction
This chapter sets out the information provided by managers of drug and alcohol services in the Borders. An online questionnaire was sent to all service managers in May 2009. Responses were received from all services although the response from Alcohol Liaison Service was partially completed. This is because many of the answers are covered in the response by BCAT.

The questionnaire covered a range of topics; demographic profile of clients group; nature and extent of contacts; nature of interventions provided and capacity of services. The responses were descriptively analysed and are summarised below.

3.2 Areas Served
All services cover the whole of Borders.

3.3 Service Users Profile

3.3.1 Gender of Users
Figure 3.1 below shows that overall 67% of service users are male. F2F is the most gender balanced where 56% of users are male.

![Service users by gender (%)](image)
3.3.2 Age of Users

Figure 3.2 shows that there is significant variation among services by age of service users they cater for. For example, 64% of all F2F users are under 15 years old the remaining 36% are largely accounted for by the BAPFO project which has an educational rather than care and treatment focus. Conversely, ALS caters for proportionately older service users where 42% are over 55 years of age. BCAT and BRP largely cater for service users aged 25-34, with 39% and 53% of their service users found within this age category.

These profiles mirror the target populations of each individual service and demonstrate a balance between choice and coverage.

3.3.3 Ethnic Origin of Users

Although ALS did not report data of its service users’ ethnicity (BCAT and F2F gave estimates), the overwhelming majority of other services’ users are White Scottish (e.g. 92% BCAT, 100% F2F) a few users occupy other ‘White’ categories. There are records of 1 African service user and 2 from ‘other’ ethnic groups.

3.3.4 Percentage of Dependent Children

BCAT stated that 67% of their service users have dependent children, compared to 54% of BRP, 32% of Addaction and 5% of F2F.
3.3.5 Economic Activity

All respondents provided estimates of the economic activity status of their service user groups. It is estimated that 45% of all service users are unemployed. BCAT and BRP have the largest percentages of users who are unemployed, 73% and 50% respectively. F2F has the largest number of users who are still at school (64%). BRP also has the largest proportion of users who are long-term sick or disabled (35%).

Figure 3.3: Profile of service users in Borders Drug and Alcohol services – by economic activity status

3.3.6 Legal Status of Users at First Contact

Where legal status was recorded by services, the majority of users are thought to have no contact with Criminal Justice Services (69%). The exception to this is BRP where only 45% of service users have no contact in comparison to 45% who have a case pending. F2F also has a higher proportion of service users who are on probation/supervision orders (30%) although the majority of these will be seen at the BAPFO project.
3.3.7 Accommodation Status of Users

The overwhelming majority of service users from all services own/rent their accommodation (88%). However, it should be noted that a significant proportion of Addaction service users are homeless or roofless (32%).
### 3.3.8 Percentage of Users with Mental Health Problem

All services recognise that a percentage of their users have mental health problems. This was most prevalent for BCAT where 70% of its service users have mental health problems. BRP, F2F and Addaction stated that 17%, 1% and 33% respectively of their service users have mental health problems.

### 3.3.9 Duration of Service User Contact

Figure 3.6 below shows considerable variation between services by the duration of service user contact. Overall there is a trend towards longer-term contact, 52% of all service users are in contact for more than 3 months. Although showing much the same overall trend as the other services, BRP is notable as 33% of its users are single contact service users. This may be evidence of the service catering for two quite distinct client groups; one whose needs are met through a single contact i.e. Needle Exchange clients, another through longer contact.
3.3.10 Reasons for Closed Contact

Figure 3.7 below shows that the majority of case closures are planned (61%). However, BCAT and BRP have lower percentages of planned closure, 52% and 44% respectively and higher proportions of cases being closed for failure to attend (16% and 33%) and unplanned closures (28% and 23%) among their service users. Overall few cases were closed for misconduct.
3.4 Services Provided

3.4.1 Nature of Service

Four out of five of the services are community based. ALS sees patients primarily within Borders General Hospital inpatient wards.

3.4.2 Referral Sources

F2F has the most comprehensive range of referral sources. Service users can be referred by any agency, self refer, be referred by a GP, Health Professional, Social Work, Court, Schools, Police, Parents and Relatives and Young Offenders. The other services state a mix of referral sources, BCAT, Addaction and BRP allow users to self refer, and ALS only accepts referrals through in-patient and Health Professionals.

3.4.3 Service User Groups

Table 3.1 below illustrates the service user groups catered for (by service).

<table>
<thead>
<tr>
<th>SERVICE USER GROUP</th>
<th>BCAT</th>
<th>ALS</th>
<th>BRP</th>
<th>F2F</th>
<th>ADD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>16-18</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>18+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>21+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Men Only</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Women Only</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Both Sexes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Couples</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Women with Children</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Couples with Children</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Men with Children</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

F2F caters for all client groups, notably this service is the only one to cater for users under the age of 16. All other services cater for 18+ users and for both sexes. Other than ALS, all services cater for users with children.
3.4.4 Operating Hours

Four out of five of the services operate under normal business hours (9am-5pm, Monday to Friday), apart from ALS which only operates in the morning. Afterhours services are provided by BCAT on a case-by-case basis through ‘normal NHS protocols’ such as Lone Working Policy, by BRP offering an additional needle exchange from 5-8pm on Thursdays and by F2F operating an answering machine service, website enquiry and text messaging service.

3.4.5 Service Access Methods

Table 3.2 below illustrates the means by which the services engage with service users. Most commonly, services use an appointments system, though F2F and Addaction operate a home visit system. Although F2F base do not have disabled access at their offices, the majority of clients are not seen at their offices and they provide disabled access to the service through a network of premises across the Scottish Borders.

<table>
<thead>
<tr>
<th>ACCESS METHODS</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment</td>
<td>BCAT</td>
</tr>
<tr>
<td></td>
<td>BRP</td>
</tr>
<tr>
<td></td>
<td>F2F</td>
</tr>
<tr>
<td></td>
<td>ADD</td>
</tr>
<tr>
<td>Home Visit</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Disabled Access</td>
<td>✔️</td>
</tr>
<tr>
<td>Contact Address</td>
<td>✔️</td>
</tr>
<tr>
<td>Telephone Helpline</td>
<td>✔️</td>
</tr>
</tbody>
</table>

3.4.6 Substances Treated

Table 3.3 below shows that only F2F treated problem users of all substances. The table reflects the remit and expertise of each service, BRP for example covers all substances except alcohol, whilst Addaction specialises in this area.
Table 3.3: Profile of substances treated in Borders Drug and Alcohol services

<table>
<thead>
<tr>
<th>SUBSTANCES TREATED</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCAT</td>
</tr>
<tr>
<td>All</td>
<td>x</td>
</tr>
<tr>
<td>Alcohol</td>
<td>✓</td>
</tr>
<tr>
<td>Heroin/Opiates</td>
<td>✓</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>✓</td>
</tr>
<tr>
<td>Cannabis</td>
<td>x</td>
</tr>
<tr>
<td>Cocaine</td>
<td>✓</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>x</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>✓</td>
</tr>
<tr>
<td>Over the Counter (OTC)</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription</td>
<td>✓</td>
</tr>
<tr>
<td>Solvents/Volatile Substances</td>
<td>✓</td>
</tr>
<tr>
<td>Others</td>
<td>x</td>
</tr>
</tbody>
</table>

3.4.7 Service Provision

Table 3.4 below illustrates that each service provides a wide range of interventions to its service users. Most commonly, advice (4 services offer this service), outreach (3 services offer this service), Detox/abstinence and rehabilitation (2 services offer these services). Interestingly, none of the services offer counselling services and only F2F offers Family Services. BCAT is the only one that offers a prescribing service, although this is done in conjunction with primary care where possible. At the time of this report BCAT were about to commence an advice, testing and vaccination service for blood-borne virus (BBV).

Table 3.4: Profile of service provision within Borders Drug and Alcohol services

<table>
<thead>
<tr>
<th>SERVICES PROVIDED</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCAT</td>
</tr>
<tr>
<td>Advice &amp; Information</td>
<td>✓</td>
</tr>
<tr>
<td>Counselling</td>
<td>x</td>
</tr>
<tr>
<td>Detox/Abstinence</td>
<td>✓</td>
</tr>
<tr>
<td>Family Services</td>
<td>x</td>
</tr>
<tr>
<td>HIV/Hepatitis</td>
<td>x</td>
</tr>
<tr>
<td>Needle Exchange</td>
<td>x</td>
</tr>
<tr>
<td>Outreach</td>
<td>x</td>
</tr>
<tr>
<td>Prescribing</td>
<td>✓</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>✓</td>
</tr>
<tr>
<td>Other</td>
<td>x</td>
</tr>
</tbody>
</table>
3.4.8 Range of Detoxification/Abstinence Services and Prescribing Services

BCAT and BRP provide detoxification/abstinence services. These are provided through in-patient, out-patient and home based Detox.

3.4.9 Rehabilitation and Other Services

Table 3.5 below illustrates the range of rehabilitation and other services offered by each service. Most commonly, services offer Peer Volunteer Support and Groupwork (3 Services), though Education and Training is offered by BCAT and F2F. Only BCAT offers Aftercare, F2F Drop in Sessions and Addaction a Day Programme.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BCAT</th>
<th>BRP</th>
<th>F2F</th>
<th>ADD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Accommodation</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Aftercare</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Drop-in Sessions</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Peer Volunteer Support</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Groupwork</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Structured Day Programme</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Other</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

3.4.10 Aftercare

Only BCAT stated that they felt there was enough aftercare available for service users. Respondents made the following comments about aftercare:

I would like such patients [who are treated in primary care] being referred to Big River to enable them to experience a shift in focus from treatment to recovery, to holistically meet their needs. (BRP)

Criminal Justice clients continue on probation support but there is a lack of counselling support for chronic users. Young people would benefit from 1:1 diversionary support to assist with maintaining the changes they have made. (F2F)

[We need] More employment services with greater real work and training opportunities. But overall there is quite a bit. (Addaction)
### 3.4.11 Accessibility Barriers

Table 3.6 below shows that only BRP and Addaction expressed some concerns that their service users might have difficulty accessing their services. For BRP, these concerns centred around distance to travel to the service, the cost of public transport and its availability. Addaction expressed concerns about the capacity of the service to meet service user needs, cost of public transport, its availability and also confidentiality.

<table>
<thead>
<tr>
<th>ACCESSIBILITY BARRIERS</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCAT</td>
</tr>
<tr>
<td>Opening Hours</td>
<td>x</td>
</tr>
<tr>
<td>Waiting List</td>
<td>x</td>
</tr>
<tr>
<td>Referral Criteria</td>
<td>x</td>
</tr>
<tr>
<td>Funding</td>
<td>x</td>
</tr>
<tr>
<td>Capacity</td>
<td>x</td>
</tr>
<tr>
<td>Distance to Travel</td>
<td>x</td>
</tr>
<tr>
<td>Cost of Travel</td>
<td>x</td>
</tr>
<tr>
<td>Availability of Public Transport</td>
<td>x</td>
</tr>
<tr>
<td>Confidentiality Concerns</td>
<td>x</td>
</tr>
<tr>
<td>Other</td>
<td>x</td>
</tr>
</tbody>
</table>

### 3.4.12 Staff Composition

BCAT has, by far, the greater number of staff working in drug and alcohol services in Borders. Nurses make up the largest professional group. There are currently no Social Workers or Psychologists working in addiction services.

<table>
<thead>
<tr>
<th>STAFF COMPOSITION</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BCAT</td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Nurse(s)</td>
<td>14</td>
</tr>
<tr>
<td>Manager</td>
<td>1</td>
</tr>
<tr>
<td>Service Coordinator</td>
<td>0</td>
</tr>
<tr>
<td>Admin Officer</td>
<td>0</td>
</tr>
<tr>
<td>Support Worker</td>
<td>2</td>
</tr>
<tr>
<td>Addictions G.P.</td>
<td>1</td>
</tr>
<tr>
<td>Secretarial Staff</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>22</td>
</tr>
</tbody>
</table>
3.4.13 Capacity and Duplication of Services

Respondents were asked for their opinions on service capacity and duplication of services. These are presented below.

**Capacity**

No. At BCAT there is a 15 week waiting list for treatment and we are currently liaising with BCAT as to how The Big River can support BCAT in reducing this in relation to patients presenting with drug issues. The Big River is nearing capacity in relation to demand from self referrals and the staffing profile particularly in relation to developing the service to reach clients who are not currently engaging with service. (BRP)

I feel there is a gap for the chronic long term alcohol users who used to benefit from specialist counselling support prior to the closure of this service. (F2F)

In Addaction better more in-depth work could be done with more resources in terms of service working staff, it is quite likely that more referrals could also be gained if resources where available. BCAT bit of a wait for detox but getting better don’t know if this is a capacity issue. (ADDACTION)

**Duplication**

There is a minor crossover in age ranges between Face-2-Face and the Big River Project in the 16-18 age range and how we at the Big River manage this is that if a client in that age range engages with our service we also inform them of the services that face to face offer so that they have the freedom of informed choice as to the service that they feel would be best suited to meet there need. (BRP)

Some confusion around the 16-18 year group. The split in adult drug and alcohol services can mean some overlap where clients have dual usage. (F2F)

Not really [any duplication], although the split between drug and alcohol services (voluntary organisations) could be seen as inefficient in terms of resources but possibly good for service users. (Addaction)

3.5 Key Findings

- Between them, BCAT, Addaction, Face2face and Big River Project offer a choice of age-appropriate services.
- It is estimated that over two-thirds of service users have no contact with Criminal Justice Services.
• Across the area the majority (61%) of case closures are planned and there is a range of contact duration periods, from single visits to over 6 months. This is indicative of flexible, person-centred care planning and delivery.

• Apart from the needle exchange service offered by BRP on a Thursday evening there is no out-of-hours service provision.

• None of the services state that they provide a counselling service.

• None of the services consider the current opening hours or waiting times as a barrier to accessing services.
CHAPTER 4: THE GAP BETWEEN NEED AND ACCESS

4.1 Introduction

This phase of the study used data derived from Chapter 2 on the prevalence of alcohol and drug dependence in Scottish Borders, combined with the estimated access to treatment set out in Chapter 3. The ratio of need to access is defined by Oyefeso et al as the Prevalence-Service Utilisation Ratio (PSUR). The PSUR provides a numeric estimate of the local or national gap between need for and access to treatment. This can also be expressed in terms of specifics, such as age, gender or ethnic groups.

The key data from the agency survey for this gap analysis is the number of people reported to access treatment. This is set out in Table 4.1 below.

Table 4.1: Number of people accessing drug and alcohol services in Scottish Borders 2008/09

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of active alcohol clients</th>
<th>Number of active drugs clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addaction Borders</td>
<td>298</td>
<td>N/A</td>
</tr>
<tr>
<td>BCAT</td>
<td>171</td>
<td>89</td>
</tr>
<tr>
<td>Big River Project</td>
<td>N/A</td>
<td>99</td>
</tr>
<tr>
<td>Face-2-Face</td>
<td>114</td>
<td>28</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>583</strong></td>
<td><strong>216</strong></td>
</tr>
</tbody>
</table>

The Scottish Needs Assessment for Alcohol (SANA) established from the agency survey that across Scotland 8.2% of people accessing treatment were referred by other alcohol treatment agencies. This ‘double counting’ provided an over-estimate of the total number of people accessing treatment. We have replicated the SANA methodology and therefore adjusted the estimated access to services in Borders by -8.2%. We were also able to establish from the survey of Service Managers in the Borders that 67% of people accessing treatment were male and 33% were female. This was the same as the national needs assessment ratio.

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Using this data we were able to provide an adjusted estimate of the number of males and females accessing treatment.

4.2 Benchmarking

Previous studies have shown that at any given time, the number of people who need treatment greatly exceeds the number who actually access treatment. In North America a “low” level of access is considered to be 10% or one in ten people in need accessing treatment per annum. 15% is considered to be a “medium” level of access, and 20% a “high” level of access (Rush, 1990). However, it should be noted that in the drug misuse field which has seen a large increase in availability of treatment in recent years, through considerable investment in expanding services in England, the level of treatment access for ‘problem drug misusers’ per annum is currently approximately 50% equating to a PSUR ratio 1:2 (National Audit Office, 2008). The Reducing Harm; Promoting Recovery Report produced by SACDM in 2007 states that:

“The Scottish Executive estimates that 18,017 (34.9%) [Of the 51,182 PDUs] were receiving methadone in 2003, though, no definitive audit of drug users in treatment has ever been carried out in Scotland. The prevalence study [Hay et al, 2005] also reviewed drug treatment databases in every council area in Scotland and identified a total of 18,037 individuals in treatment.”

This report postulated that if the PSUR for drug services in Scotland was the same as that found in England (50%), the percentage of those in contact with services who were prescribed methadone would be in excess of 70% (18,000/25,600).

The level of access and PSUR should be used to compare relative levels of access in different areas or countries, and between different demographic groups, rather than there being particular value in studying or applying the absolute levels to service planning or development. In this respect the alcohol PSUR for Borders is presented in comparison to the Lothian, Fife, Borders composite rate and also against the Scottish overall rate.

The estimated number of people in the population with alcohol or drug dependence is compared to the number accessing treatment. As shown in Tables 4.2 and 4.3 below, this can be expressed in two ways. First, in terms of the prevalence-service utilisation ratio (PSUR), a ratio of the number of people needing treatment compared to the number actually accessing treatment, which for Scotland as a whole is 12.1:1 (Alcohol). Second, this can be expressed as a

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percentage of the alcohol or drug dependent population that is accessing treatment.

### 4.3 Alcohol: Percentage Accessing Treatment

Table 4.2 sets out the PSUR for alcohol services in the Borders. The total population of Borders has been adjusted to reflect the age ranges appropriate to specialist alcohol services (15-54, 55+). The raw number accessing treatment was provided by the services as set out in Table 4.1 above. From this a calculation has been made to compensate for double-counting i.e. clients attending more than one service at a time. The PSUR is calculated between the adjusted prevalence figure and the adjusted access figure.

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Adjusted prevalence alcohol dependence</th>
<th>Adjusted by age</th>
<th>Raw number accessing treatment</th>
<th>Adjusted number accessing treatment (-8.2%)</th>
<th>PSUR</th>
<th>Percent accessing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>112,430</td>
<td>5.0</td>
<td>5,600</td>
<td>2,700</td>
<td>583</td>
<td>535</td>
</tr>
<tr>
<td>Male</td>
<td>54,451</td>
<td>6.7</td>
<td>3,700</td>
<td>1,800</td>
<td>391</td>
<td>359</td>
</tr>
<tr>
<td>Female</td>
<td>57,979</td>
<td>3.3</td>
<td>1,900</td>
<td>900</td>
<td>192</td>
<td>176</td>
</tr>
</tbody>
</table>

These calculations show a PSUR ratio of 1:8.6, meaning that 11.6% of alcohol dependent people in the borders are accessing specialist alcohol services as defined earlier in this report. This is a higher rate of access than both the regional rate (8.1%) and the Scottish rate (8.2%). This is based on the assumption that the 583 people accessing specialist alcohol services are alcohol dependent. This would be regarded as being a ‘Low’ level of access in comparison to the American benchmark set by Rush.

The national needs assessment research found that 81.1% of people attending community alcohol services were defined as moderately or severely dependent. However this was based on a small number of responses. Adjusting the figures using this factor would yield a PSUR ratio of 1:10.6, equivalent to 9.4% access rate.
4.4 Drugs: Percentage Accessing Treatment

The calculation for PSUR for drug services is similar to that of alcohol service except in calculating the age adjusted prevalence figure. The standard age range commonly accepted for drug prevalence is 15-54 years; this range was used in both the 2000 and 2003 prevalence studies in Scotland (published in 2003 and 2006 respectively) however this was changed to 15-64 in the 2009 prevalence study to bring the Scottish data into line with other European countries. Table 4.3 sets out the PSUR calculations based on the 2003 prevalence and age criteria and Table 4.4 sets out the data using this newer prevalence rate and wider age range used in the 2006 report. Unlike previous studies, the 2009 prevalence study did not provide breakdowns by gender in each area but provided an estimated national average of 70% males and 30% females. This is significantly different from the more accurate and locally useful 2003 data. These three variations; prevalence rate, age range and gender ratio, result in significant differences in PSUR values.

Table 4.3: Prevalence Service Utilisation Ratio – Drugs (2003 data)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Prevalence of problem drug use</th>
<th>Adjusted by age</th>
<th>Raw number accessing treatment</th>
<th>Adjusted number accessing treatment (-8.2%)</th>
<th>PSUR</th>
<th>Percent accessing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>15-54 (48.4%)</td>
<td>Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>112,430</td>
<td>1.25</td>
<td>1,400</td>
<td>700</td>
<td>198</td>
<td>1:3.5</td>
</tr>
<tr>
<td>Male</td>
<td>54,451</td>
<td>2.01</td>
<td>1,100</td>
<td>550 (67%)</td>
<td>133</td>
<td>1:4.1</td>
</tr>
<tr>
<td>Female</td>
<td>57,979</td>
<td>0.55</td>
<td>300</td>
<td>150 (33%)</td>
<td>65</td>
<td>1:2.3</td>
</tr>
</tbody>
</table>

Table 4.4: Prevalence Service Utilisation Ratio – Drugs (2006 data)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Prevalence of problem drug use</th>
<th>Adjusted by age</th>
<th>Raw number accessing treatment</th>
<th>Adjusted number accessing treatment (-8.2%)</th>
<th>PSUR</th>
<th>Percent accessing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>15-64 (63.8%)</td>
<td>Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>112,430</td>
<td>0.66</td>
<td>742</td>
<td>473</td>
<td>198</td>
<td>1:2.4</td>
</tr>
<tr>
<td>Male</td>
<td>54,451</td>
<td>70%</td>
<td>519</td>
<td>331 (67%)</td>
<td>133</td>
<td>1:2.5</td>
</tr>
<tr>
<td>Female</td>
<td>57,979</td>
<td>30%</td>
<td>223</td>
<td>138 (33%)</td>
<td>65</td>
<td>1:2.1</td>
</tr>
</tbody>
</table>
It can be seen from Table 4.4 that the percentage accessing drug treatment (41.9%) is relatively higher than the access to alcohol service (11.6%). The expectation, based on the NTA guidance in England and the SACDM report in Scotland, is that the access to drug services should be 50%. In this regard, there is a small gap (16%) between the prevalence of problem drug use in the Borders and the capacity of available services. On further examination, it can be seen that the gap is more in relation to males accessing services (40.2%) than females (47.1%).

The prevalence of problem drug use, as defined by Hay et al\textsuperscript{73}, relates to the use of opiates and benzodiazepines. The assumption that the above calculations are based on is that all people attending drug services in the Borders fit into this criteria. The Drug Misuse Statistics (ISD, 2008) state that of the 182 new notifications in the Borders, 127 (70%) reported using heroin, methadone or Dihydrocodeine and 59 (32%) reported using benzodiazepines (e.g. diazepam)\textsuperscript{74}. This has possible implications for the calculation of identifying gaps; if the 473 (opiate and benzodiazepine) PDUs identified represent 70% of those accessing services then the actual prevalence of problem drug use, with a wider definition than that applied by Hay et al, is 676. This would result in the PSUR being 1:3.4, or 29.3% accessing treatment, rather than the 41.9% calculated using Hay’s definition of PDUs.

4.5 Waiting Times

A proxy measure of the synergy between service provision and demand is the extent to which waiting times exceed a reasonable administrative period. It is not unreasonable to expect a length of time to elapse between a referral being made and the provision of treatment or care.

The National Waiting Times Framework sets out the key stages between which waiting times should be calculated.
A HEAT target for drug service waiting times is currently being devised by Scottish Government and is due for implementation in 2010/11. At this time this process refers to drug services only.

4.6 Waiting times in Scottish Borders

There is currently no delay in accessing services provided by Addaction, Big River and Face2face. The Alcohol Liaison Service, by definition, sees people who are already in contact with other parts of the health system, mainly acute medical wards.

The waiting time for BCAT has been around 9 weeks however it is currently about 12 weeks from receipt of referral to the offer of first appointment. Although this is lower than most other parts of the country (and the Scottish average) it is still a longer delay than the standard that BCAT wish to provide.
4.7 Key Findings – Gap Analysis

- In Borders there are approximately 535 people accessing alcohol services and 200 accessing drug services.
- The ratio of need for alcohol services in relation to the provision of services is 1:8.6. This is equivalent to 11.6% of people in need accessing service. This is higher than both the regional and the national rate.
- By North American standards, this would equate to a low/medium level of access.
- The ratio of need for drug services in relation to the provision of services is 1:2.4. This is equivalent to 41.9% of people in need accessing services. This ratio may be as high as 1:3.4 by adopting a wider definition of problem drug use.
- The medium (mean) level of access to drug services, according to NTA and SACDM, would be a PSUR of 1:2, or 50% access rate. By comparison Borders would have a medium level of access.
- The small gap between need and provision of drug services is largely attributable to males (1:2.5) rather than females (1:2.1).
- Waiting times for drug and alcohol services in Borders are lower than many areas of Scotland.
- Despite drug and alcohol services in Borders setting themselves high standards for minimising waiting times, the current waiting time for BCAT reflects an imbalance between need and capacity. This is identified and quantified through the PSUR process.
CHAPTER 5: WIDER STAKEHOLDER CONSULTATION

5.1 Introduction and Aim

The purpose of this element of the research was to seek the views of wider stakeholders on current provision of alcohol and drug services available in the Borders and identify the nature and extent of future requirements.

A number of themes had emerged from the interviews and they are discussed below under the following subheadings:

1. Perceptions of current alcohol service provision
   - Range of services & interventions
   - Capacity of services
   - Quality of services
2. Types of interventions offered
3. Rehabilitation service provision: community & residential
4. Perceptions of partnership working
5. What works well in current service provision
6. Gaps in service provision and scope for future investment

5.2 Method

Face-to-face interviews were held with ten stakeholders from a range of agencies in the Borders that are either directly or indirectly involved in alcohol and/or drug service provision, including NHS, social work, Police and a number of statutory, voluntary service providers in the area. The list of interviewees was agreed with the contract manager and is set out in Table 5.1. A focus group style interview was also conducted with five social work managers from the Borders; this element used the same interview schedule as used for the one-to-one interviews. The interview schedule was devised based on findings from earlier stages of the research including the analysis of activity and needs assessment.
5.3 Perceptions of Current Services

5.3.1 Range of Services

Stakeholders were asked to comment on the range of services currently available in the Borders for drug and alcohol users. The key feature of almost all of the interviews was that stakeholders are well-informed and aware of the services currently available in their area. Stakeholders all identified some or all of the statutory and non-statutory services for drugs and/or alcohol, and were aware of the service available specifically for young people. Table 5.2 below demonstrates the available services in the Borders and the groups of individual that they cater for.

### Table 5.1: List of stakeholders interviewed by service

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Sandy Morris</td>
<td>NHS Borders (Primary Care)</td>
</tr>
<tr>
<td>Inspector Paula Clark</td>
<td>Borders Police</td>
</tr>
<tr>
<td>Ishbel McKenzie</td>
<td>DTTO</td>
</tr>
<tr>
<td>Jacque Kerr</td>
<td>NHS Borders (A&amp;E Dept.)</td>
</tr>
<tr>
<td>Linda Mays</td>
<td>NHS Borders (Addiction Services)</td>
</tr>
<tr>
<td>Sherriff Drummond</td>
<td>Criminal Justice</td>
</tr>
<tr>
<td>Suzie Asquith</td>
<td>NHS Borders (Alcohol Liaison Service)</td>
</tr>
<tr>
<td>Dr Joanna Smith</td>
<td>NHS Borders (Mental Health Services)</td>
</tr>
<tr>
<td>Robert Jamieson</td>
<td>Youth Justice Service</td>
</tr>
</tbody>
</table>
Table 5.2: Services in Borders by targeted service user groups

<table>
<thead>
<tr>
<th>Service</th>
<th>Alcohol Adults</th>
<th>Drugs Adults</th>
<th>Drugs &amp; Alcohol Adults</th>
<th>Young People</th>
<th>Family Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big River Project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borders Community Addictions Team (BCAT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face2face</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Carers Drug &amp; Alcohol Project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QUEST Family Support Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Al-Anon Family Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress 2 Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needle Exchange Services</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Other services, which although not specifically designed solely for drug or alcohol users, were also identified as being available in the Borders for people with substance misuse problems. Many of these more generic services offer additional support for substance misusing individuals, for example within the Learning Disabilities service, one-to-one training and support are offered. This service can be utilised for individuals with drug and/or alcohol problems. Similarly it was identified that community justice services provide a range of services that can be tapped into to meet the needs of drug and alcohol users.

### 5.3.2 Types of Interventions

Stakeholders were asked to comment on the types of treatments and interventions that they are aware of being used in the Borders. Generally it was felt that there is a good range of both pharmacological and non-pharmacological interventions available between the various services in the Borders. Stakeholders indicated that services offer interventions specific to their service, for example non-statutory services tend to offer counselling, support based interventions, whilst pharmacological interventions are typically managed by BCAT.
One stakeholder however did indicate that they felt that there was not the range of services available in the area that would be desirable, and that this would sometimes mean fitting the client to a service instead of the other way around.

_We do have services, and we have a range of services, but it’s not as wide and it maybe ... doesn’t offer the range. So it’s about saying ‘right this is the situation with this person, which of these 10 services would they be best to go to?’_

In terms of pharmacological treatments and interventions, a wide range were identified as being available and used in the area. BCAT was identified as the service responsible for the provision and management of this, with one GP practice indicating that they offer substitute prescriptions only to those who are monitored by BCAT.

_We’ve got a very low benzodiazepine prescribing rate for all patients, and we don’t prescribe substitute prescriptions for opiate addiction unless the patient’s being monitored by BCAT. So we don’t embark upon methadone or dihydrocodeine prescriptions._

Stakeholders indicated that several non-pharmacological interventions for both drug and alcohol users are available in the Borders, provided by both BCAT and non-statutory services, and that in fact this provision would increase in the near future. It was however mentioned that although provision is good, there may be room for a more cohesive, coordinated approach.

_We’re actually advertising a psychology post so there are quite a lot of options and we’ve got somebody doing CBT and people training in Family Therapy and such like. So yes it is happening, but it’s happening in a bit of a spattering way._

In terms of specific non-pharmacological interventions available, Cognitive Behavioural Therapy (CBT) was also mentioned as a treatment intervention available to a certain extent in the Borders; however it was felt that although staff (mental health workers) may have received training in cognitive behavioural techniques, they may not necessarily be fully trained in CBT. However as mentioned in the quote above, a CPN working for BCAT is trained in CBT. There was awareness regarding the effectiveness of Brief Interventions, with stakeholders commenting on the commitment in the area to further the availability and use of Brief Interventions.

_Brief interventions are...something we’re planning to be doing. It’s the subject of a local scheme in the Borders, and we’re planning to take part in that. Brief interventions are something we would then be expanding... It’s actually something that’s happening, that’s work in progress for 2009, the systematic use of FAST which our practice nurses have started._

However it was recognized that even although this intervention is designed to be delivered in minimal time, in certain services, where the application of Brief
Interventions would be extremely appropriate, for example in Accident & Emergency Departments, implementation has not yet happened.

*As far as brief interventions and alcohol are concerned, we’re well aware of this and we’re…aware of the FAST questionnaire in packs and that kind of thing, but you know, it’s implementing these things, and there was some discussion back in November last year to get to offer some training to the A&E staff to use the FAST questionnaire, but so far nothing’s happened with that…*I think that’s something that would really need to be addressed in the formal training for the A&E staff.

One stakeholder stated that although services in the Borders offer a good range of interventions, it would be desirable to have staff with a good skill mix but that this had training implications which would need to be borne in mind.

*I think it’s important that we have a skills base amongst the staff team, statutory and non-statutory. I think that’s not bad. I think opportunities for significant training are less in this area. I think that is because it is a small population and when you send one staff member out for a long period of time that depletes the service quite markedly. I probably would like to see the opportunities for staff improving in that respect in significant training, but we’re already looking at that I have to say.*

Several stakeholders mentioned that voluntary agencies in the Borders provide additional support for individuals experiencing drug and alcohol problems, such as employment training and support. It was noted that AA meetings are running in most of the towns in the Borders. Support for family members and/or carers of individuals with substance misuse problems is also provided in the area, by QUEST and Al-Anon.

One stakeholder pointed out that although these is generally a good provision of interventions available, due to the geography, population and needs of the area oftentimes resources would be utilised for drugs and alcohol from other fields, for example mental health. However this was not regarded as a weakness, in fact more of a strength of the area that services are utilised in this way.

*We have to tap into other resources so you might find there’s a little bit of mental health or something like that, so it’s not always direct, the services that have been set up for people, or we tap into the education system or whatever.*

5.3.3 Provision of Services

Although it was recognised that the Borders as an area does not experience the same magnitude of drug and alcohol misuse as for example the cities do, several stakeholders did indicate that demand for certain services is high and in some cases the service provision does not meet this demand, causing long waiting times.

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There’s a problem with the timing of provision... the delay between a patient requesting it and it being delivered. That’s one of the problems that BCAT has intrinsically always had; it’s running to a 2-3 month waiting list time, and patients often come into us for various reasons, committed at the time to make change...but the delay in getting to the BCAT system generates a problem which...substance abusers particularly are aware of and don’t like. I think that they wish to start substitute prescribing when they present, and it always a source of disappointment when they can’t.

It was stated by some stakeholders that the current provision of services does not currently meet the demand.

The resources available do not go anywhere near meeting the level of need. That is a very clear impression. It is something on which I can be unambiguous...I am routinely told ‘he has been waiting for X months’, ‘he can’t get onto the waiting list’, ‘he will be now getting onto the waiting list’, I hear that as a matter of daily routine.

And in particular service provision for young people was commented on as being an area which experiences high demand, the burden that this places on the service then limits the scope of what the project can offer.

For young people, I think the demand is very high, and sometimes I think that the quality of the communication...is compromised because of that demand.

In terms of addressing the gap between the need for alcohol services and the provision of such services, it was indicated that it would be advantageous for there to be the facilities to be able to offer a rapid access clinic at Borders General Hospital to be able to pick up individuals seen by the alcohol liaison nurse who would otherwise have to be added to a waiting list to be seen. This element of rapid access would tap into the gap whereby patients presenting at A&E with alcohol related problems may be more receptive to seeking help. It was suggested that this clinic could also run in the early evening and would allow for as wide an audience as possible, with the provision of community follow-up appointments also being a feature.

On the whole no specific interventions were identified as being needed but not currently provided in the Borders, rather it is more about either increasing the capacity and/or range of current services in order to tackle difficulties with waiting lists etc.

5.3.4 Groups Not Well Catered For

Stakeholders were asked if there are any groups of people that they are aware of which services do not cater for. It was noted that in some cases due to the nature of the six main services offered there may be individuals or groups of people who are not well catered for because of the limited choice of services and
their specific remits. Specific groups mentioned included, young people, elderly people, dual-diagnosis and ethnic minorities. It was also felt that there is not sufficient provision for individuals with learning difficulties who also have drug or alcohol problems. The nature of these comments regarding lack of service provision for each of the groups is demonstrated below:

Certainly I would say the more prevalent issue in the Borders is alcohol use by young people, not drug use. It seems to be... permissible for young people to drink...and there seems to be a...lack of organisation around services, and the different inputs, and different levels of input that different agencies, whether it’s health or education, police kind of put in to young people.

In Galashiels and Hawick we have a lot of alcohol related injuries, especially weekend nights, and you tend to think of younger populations, well they’re going to drink anyway, you know, young people get drunk, ... but they may be running into problems or set themselves up for later life problems.

I think the elderly are one population which we would need to think about in the Borders, given that it’s an increasingly common place to retire to, and ... we’ve got a higher population of elderly, compared to the rest of the country, so I think they’re a group which merits interventions.

I think the challenge is going to be in the dual diagnosis category...potentially the biggest dual diagnosis category is actually the elderly.

Dementia assessment is another thing which is...on the increase at the moment, for which there’s an impetus to increase the screening for and the treatment of dementia, and increasingly there are going to be a number of patients who have a mixture of...dementing process and alcohol brain damage, and I’m not quite sure how we’re going to work out.

In terms of provision of services for young people, although it was recognized that there is a service currently dedicated to that group, issues around the transition of individuals aged 16-18 from young person specific services to adult services was also highlighted as an area which requires attention.

5.3.5 Detoxification and Rehabilitation Service Provision

Stakeholders were asked to comment on the provision of and access to detoxification services in the Borders. Most of the stakeholders indicated that they were aware that there were two designated detox beds to serve the area, but that there had historically been problems with community based detoxification provision.
Yes there are 2 detox beds historically, but to my knowledge, unless this has changed, there were 2 detox beds for the whole Borders, which isn’t a whole lot really.

We did need to improve detoxification services. They’re not brilliant and we’re still doing that.

Outpatient detox services are an issue.

Stakeholders indicated that although there had in the past been unsuccessful attempts to facilitate home and/or community based detoxification, efforts were being made to put in place measures for home detoxification.

We’re looking to provide a home detox option, because although they’ve talked about it here and they set up post before for it, they never actually implemented it. There was a number of reasons; they couldn’t engage GPs, we still can’t engage GPs but we can do it ourselves because we’ve got our own little budget now for it, so I think there’s a tremendous opportunity to actually offer this and do this in people’s own home, and in their community or whatever.

Similarly stakeholders were asked to comment on the provision and access to rehabilitation services available. It was recognized that due to the geography and demographics of the area, a specific residential rehabilitation service for the area would not be practical, and that instead the provision of residential rehabilitation elsewhere in Britain could be utilized to meet future needs.

5.3.6 Service Access

Various factors influence the accessibility of services, ranging from how well the services are advertised, to waiting times for services. The Stakeholders were asked to comment on these factors with regards to access to services, the nature of the responses can be seen below.

Advertising

I think things are well advertised. The agencies seem to be very good and very pro-active about sending out information.

Well we have these...information cards; they’re very much designed for opiate misuse. I couldn’t honestly say there’s much in the way of publicity for alcohol misuse in the A&E department.

There are posters everywhere in the stations, behind the cell doors. There were posters specifically made but as to whether the individuals actually take that with them is another story.

Referral

I think GPs are also very good at referring people in particular. I think the workers here have got a very clear perspective and
perception, of the different types of services available, and what’s the appropriate service...and people can refer themselves as well.

If we made a referral to alcohol liaison it wouldn’t happen there and then. It’s something that we go through Huntlyburn, and then they would offer the patient an appointment.

BCAT actually doesn’t have open access; it’s mainly GPs and other services that refer.

Well I think with the voluntary service some of them are accessing for themselves.

It was also noted that access to services can be patchy, and in many cases can depend on the knowledge and experience of individual practitioners or managers in terms of where to get help.

Waiting Times

BCAT has a waiting list but... I’m really optimistic that by the changes we’ve had and starting to evolve, that we should be able to challenge that waiting list...We are down to 12 weeks, and I know that’s well within [HEAT targets]...however, I think with the resources we’ve had, the improvement we’ve had, the partnership working, all that could be challenged.

I would say generally, for services for young people, when we make a referral it’s dealt with quickly.

I think we should be more open door, so any waiting list is not reasonable. It prevents people from getting the help they need when they require it.

Physical Access

I think in Borders one of the problems is always about where the service is located versus where the clients live, and I think that’s always an issue, I don’t quite know how you address that because there are not sufficient numbers to be holding clinics and sessions in all the places that might be easier for access, so I do think there’s the rurality of the Borders.

Due to the geographical structure of the Borders, there are issues regarding transport, particularly for people with physical problems and those who are homeless, however home visits are conducted by Addaction, BCAT and Mental Health and Social Care services as required.

5.3.7 Joint Working

Stakeholders were asked how well services work together in the area, in terms of joint assessment, care-planning and review. Overall joint working emerged as one of the most positive aspects of service provision in the Borders, most of the
stakeholders recognised that agencies work together both formally and informally very well. Some of the positive comments made regarding the joint working are as follows:

There’s hardly a month goes by that there’ll not be a case conference of some description around a patient with alcohol or substance misuse issues, so I take it the system must be coordinated reasonably well.

We have a strong partnership working throughout the Scottish Borders; we’ve got some really good working relationships set up, so I think that’s certainly there.

I think services do work together. We’ve got the drug and alcohol team, you know, we have meetings about various issues, we liaise with the Scottish Government, Joe Griffin came down from Edinburgh, he’s the head of Scottish Drugs Policy, and gave a talk on the road to recovery. We discussed the HEAT targets and, you know, we’re all kind of mucking in together. We have good relations with the police. We’ve got good relations with Sherriff Drummond, and he takes a very, very heavy hand on misbehavers in the Borders. He’s wonderful. So we’ve got pretty good relations with police, medicine, you know, all the different services, psychiatry and social work.

With young people I think it’s quite good, well especially if the young person goes to a children’s hearing, and that’s really where there would be outcome based kind of action plans kind of produced...So there’s a good mechanism for I guess a strategy to divide responsibility, produce action plans and that necessitates having to work with another agency, then we will as well. So I think it’s quite good.

I think it does. I think it’s one of the benefits of being a small cluster actually.

Although all of the stakeholders regarded the joint and partnership working in the Borders as very positive, it was mentioned that currently, much of this happens in an informal way, and could benefit from written guidelines being implemented.

We all provide our little chink and we come together to make that journey for the patient or client. A good journey that meets needs, and we just need to be clear and constantly communicating, re-evaluating, but any partnerships I’ve worked up in the past...always had operational clarity, and documents to actually show where each responsibility is, and you met regularly to make sure that communication prevailed, and you reviewed that operational guidance to make sure it was still online. So I think they need to do that in the Borders as well. I would like to see them do that. I think they do try to work together, but I don’t think they defined it well...
enough. A lot of it is informal, and that’s all very well, but as things start to get bigger, informal methods don’t necessarily work.

Problems around the Single Shared Assessment were also identified, there was a feeling that this needs to be streamlined and that some further training for staff regarding the new core adult assessment documentation is required.

5.3.8 Effective Current Provision

Stakeholders were asked if there was anything that they felt works well in terms of the local provision of drug and alcohol services. In general, several stakeholders identified that they considered that the area itself (the size and number of services etc) to be something that lends itself well to service provision, in that, compared with large towns and cities, services are all very much aware of each other and communicate well with each other.

Well, what works well in local provision is… the beauty of this small...relatively small area is a more personal [setup]...you can actually speak to people, clinicians that you know, and it’s a less impersonal experience than it would be in a city...It’s a more personal thing, potentially there’s, you know, more interaction, and you know, people are more willing to pick up the phone and have personal discussions about patients. So that’s an advantage.

I think the partnership working is really, really good, it’s really strong, but then we’ve probably got the opportunities to do it because we certainly don’t have the same issues that you have perhaps in bigger cities at the end of the day.

I think the Borders is a really close-knit community. It’s very rural and very disparate in terms of the size of the place. But it does work really well together, we all sing from the same hymn sheet.

Another element of service provision which was identified as working well in the area was the service providers themselves and the collective motivation to improve services for drugs and alcohol in the Borders.

I think that the good will of the individuals employed within the service. Over the past year I’ve seen quite a significant change in attitude, in willingness, and you know, I think it’s been a very positive journey where addictions are concerned. I think the DAT work very well here ...and I think that they’re very fortunate to have some very good managers of services too, very committed people.

It’s the will to actually get on and get it done more than anything, and just having that awareness of, not necessarily in depth knowledge, but a general awareness of what is available.
In answering this initial question about what is working well in terms of service provision in the Borders, some of the stakeholders also touched upon areas which do not work so well, and/or things which are currently being improved. These opinions are presented below.

*NHS and council particularly need to be more willing to see things as partnerships instead of one buying the other. There needs to be a greater understanding.*

*I think the Borders probably are the last to take on this kind of integrated working concept. I think they’ve been a bit in a cocoon. So if you were to ask me, what is slow and is not working so well, it’s that integrated view. But with having managers come in from outside who are used to working in an integrated way, I think it’s a great asset, and there’s loads of opportunity.*

*I think there will be improvement in social work, and some of the education services are realigning themselves to be more locality based, so there are 5 different areas in the Borders, at the moment the different teams don’t fit in those 5 different kind of groups, so very quickly over...the next year, if not the next 6 months, they’re going to move to a much more locality based kind of model, and within each model, health, education, social work, police sit around in the same office at times, so I think communication will improve, and obviously what I think will happen is, issues which have been picked up locally will be addressed an awful lot quicker, and locally as well. So I think that’s something that will continue to improve.*

It was mentioned that although there is some work starting around early intervention for alcohol problems, in terms of brief interventions provided in primary care, no evidence has emerged as yet suggesting that this is being provided on a wider scale and no similar measures are being implemented for drug problems.

Stakeholders were also asked what the key issues/gaps are that need to be addressed in terms of drug and alcohol service provision in the area. Overall no one theme emerged from the interviews as being a clearly identifiable gap in service provision in the Borders, however stakeholders did mention specific areas which they felt could be improved. In terms of access to services, some stakeholders did indicate that service provision could be improved if there was a way to provide interventions more rapidly, particularly if the individual had shown up either in police custody or at A&E due to alcohol or drug use.

*I think just a case of getting services at the front door, and if you want to pick the patients up, getting them...what is it 11% of A&E attendances are related to alcohol, if you want to pick the patients up at the front door, you’ve got to have more awareness and more capacity*
If there was something available within, you know, the custody suite from one of the services providers then I think that would be obviously beneficial.

Similarly, waiting lists were indicated as one of the key issues around the provision of services in the borders. Better communication between services and also the provision of rapid access clinics were suggested as ways that can attempt to help with this.

By the time they do see BCAT their motivation has sometimes changed and they’re reverting to the behaviours which they were using prior to them seeing us, so yeah, it’s about perhaps us improving what gets done before they see BCAT on the one hand, and also being aware of the demands on BCAT and two-way communication about our use of the service and their provision of the service.

It was also identified by one stakeholder that there is a crucial gap in service provision for individuals who use substances and experience mental health problems.

Co-morbidity is not addressed at all really in any meaningful way. We’ve been fighting that battle. The amazing thing about the Borders which is unlike other places is that they do actually have an individual who... works in severe and enduring rehabilitation, but who actually is dual qualified in addictions and mental health, and has actually worked on both sides. Now that’s unusual to have that level of expertise in a small rural area, and yet we have no resource to develop it, and you know, actually utilise the expertise that sits there, so yeah, that is a bit disappointing. I would like to see co-morbidity move some way in the future.

Stakeholders were asked to rate the following three points in order of importance as to where they would like to see future investment go:

- Expanding the range of interventions provided
- Increasing capacity of services
- Improving the quality of services

A few of the stakeholders indicated that they felt these three points are so closely related that it would be difficult to identify one above the others as a priority, similarly it was stated that to some degree, if one of the three was to improve, by default so too would the others. However, stakeholders did make some interesting points and did manage to identify at least the point which they felt was most important of the three.

Increasing the capacity of the services... goes hand in hand with improving the quality of the service as well, and I mean they are quite closely linked, but certainly I would say increasing the capacity of the services at the end of the day.
I would be loathe to use the word quality as being a problem here as I think we’ve got good quality, I think it just be...not a re-shuffling, we need to extend the services. So I guess it’s a version of increasing capacity comes first, and then interventions then quality would be my batting order.

Expanding the range of interventions provided; well I do think we need to develop on co-morbidity, we need to develop in rehabilitation, drugs, and we need to invest more in the education...significant qualifications in educating our workforce, and invest more money in that...to recognise the speciality and the difficulties of working with this client group. Increasing capacity of services, particularly for Addaction and Big River. I don’t feel at the current time that BCAT requires any more, they need to be working with what they’re working with and challenge it that way. Improving the quality of service; I definitely think that could be improved by clear partnership working, and by the training. So I think they’re intertwined really.

I’d probably put improving the quality of services as one. Increasing capacity of services second, and expanding the range third, because I think you could have as many services as you want, but unless they’re good quality, and unless that good quality is available to a range of people.

In terms of specific elements of service provision that would require future resource allocation, along with the ability to have facilities to run a rapid access clinic in the Borders, it was also mentioned that there is a need within Borders Council Social Work department for a specialist post which would primarily have a liaison function but could potentially carry some case load as and when required. The key parts of that role would be to support, consult and refer on as appropriate to other services. Similarly there was discussion around the need for an additional resource within the Learning Disabilities Team to deal with drug and alcohol problems, as this area was seen as an important gap in service provision.

Finally stakeholders were asked to add anything that they felt had not been covered, the majority of the respondents reiterated some of the points and issues made throughout the interview and stated that they were aware of measures being in place to address some of these issues, for example new money for alcohol liaison nurses. It was also suggested that although there appears to be more of a problem with alcohol misuse, attention and resources do need to be directed to drug misuse in the Borders and the same level and quality of service provision should be available for individuals who misuse drugs as those who misuse alcohol. Lastly, it was mentioned that there is a need to integrate drug and alcohol services to be able to look at the person from a more client centred perspective rather than being so service led.
Overall, the stakeholders seemed to share an opinion that service provision for drugs and alcohol in the Borders does work well and that partnership working is a particularly positive element of local provision. In general, staff working in drug and alcohol service provision in the Borders were highly regarded, nevertheless it was highlighted that there are still areas where training and access to training need to be improved and that it is vital that existing staff are able to develop knowledge, skills and experience. Ultimately, although several aspects of service provision which could be improved were highlighted, many good factors, such as the attitude and expertise of staff from the services, were also a strong feature of the stakeholder interviews.

5.4 Key Findings – Stakeholders’ Views

- Stakeholders were well-informed about the range of services available in the Borders.
- Stakeholders felt that there was a good range of both pharmacological and non-pharmacological interventions available in the area, although more should be done to invest in and implement Brief Interventions into appropriate services.
- Services do not currently have the capacity to meet demand, causing some groups to be left behind.
- Opportunities for providing detoxification in the community should be acted upon.
- Referral can sometimes depend on the knowledge or expertise of a particular individual or practitioner, whereas processes should be more widely known.
- There is good joint working in the Borders which is facilitated by the small team and the perception of a close-knit community. Processes are often undertaken informally; as the services expand there may be some value in formalising these.
- Suggested improvements centred around introducing brief interventions, reducing waiting times and developing services to respond to individuals who experience both mental health problems and substance misuse.
CHAPTER 6: GP CONSULTATION

6.1 Introduction and Aim

GP’s are often the first point of contact for individuals experiencing substance misuse problems, and typically have a degree of involvement in the patient’s continued care related to their substance use. It is important therefore, to garner the views of GP’s in the Borders regarding the provision of services at their disposal for service users.

6.2 Method

On-line questionnaires were formulated using Survey Monkey, and links were sent out to all GP’s by BCAT at the beginning of June 2009. Although six GP’s in the Borders submitted a response, only three were completed. The nature of the responses from the three GP’s can be seen in the subsequent section.

In order to supplement the information collected through this questionnaire, the information collected from Borders GPs by Figure 8 last year as part of the Scottish Alcohol Needs Assessment (SANA) was also analysed and is presented here.

6.3 Results

Q1: Firstly GP’s were asked to indicate which specialist services for drugs and alcohol misuse that they were aware of in the area. All three GP’s indicated that they were aware of Borders Community Addiction Team (BCAT), however only one GP indicated that they were aware of:

- Al-Anon
- Addaction
- Huntlyburn
- Castlecraig
- Breathing Space
- GP surgeons
- A&E

Q2: GPs were asked if they were happy with the amount of information they received about specialist services in their area. Of the three respondents, two
indicated that they were “not sure”, whilst the other stated that “Yes” they are happy with the amount of information.

**Q3:** Similarly GPs were asked whether they were happy with the level of communication between them and specialist drug and alcohol services. Responses indicate that opinions are split on this matter, with the responses being “Yes”, “No” and “Not sure” being indicated by all of the GPs respectively.

**Q4:** Regarding capacity of services, GPs were asked if they consider services to have sufficient capacity to meet the needs of patients. Whilst two of the GPs indicated that they were “Not sure”, one GP stated that they did not think that the specialist services had sufficient capacity to meet the needs of patients.

**Q5:** GPs were asked if they were aware of referral procedures and criteria for substance misuse services in their area, one GP stated "No” they were not aware, whilst two indicated that they were.

**Q6:** When asked if there are formal referral protocols in place in their area, all three GP’s indicated yes.

**Q7:** GP’s were asked if any of the following were barriers to the access of local specialist care services:

<table>
<thead>
<tr>
<th>Barriers to service access</th>
<th>GP 1 comments</th>
<th>GP 3 Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening hours</td>
<td>Yes – problems appear often during the evening and night</td>
<td>Yes</td>
</tr>
<tr>
<td>Waiting lists</td>
<td>Yes – Patients get frustrated if they have to wait</td>
<td>Yes – definitely, especially alcohol</td>
</tr>
<tr>
<td>Referral/Exclusion Criteria</td>
<td>No – I think that it is fair that each service decides</td>
<td></td>
</tr>
<tr>
<td>Distance to service</td>
<td>Could be</td>
<td></td>
</tr>
<tr>
<td>Cost of Travel</td>
<td>Yes – Patients with alcohol problems often have financial problems as well</td>
<td></td>
</tr>
<tr>
<td>Availability of Public Transport</td>
<td>No – Public transport quite good in Borders</td>
<td></td>
</tr>
<tr>
<td>Concerns about Confidentiality</td>
<td>Not Sure</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Could be better as otherwise end up in A&amp;E /medical admissions</td>
<td>Yes</td>
</tr>
<tr>
<td>Capacity</td>
<td>Reflected in waiting times</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Q8: Finally GP’s were given the opportunity to state any other information about substance misuse service provision in the Borders. Two of the GP’s answered this question, the nature of their responses can be seen below:

“\textit{I am sure that there is great work being done, that was my experience in the in-hours practice, when I saw lots of letters demonstrating attempts at engaging with patients. However in the Out-of-Hours practice, we are often ‘stuck’ with these patients and have very little to offer them. At which point they get angry/upset/stressed and we are left handling it – this is often time consuming. I can think of at least five people almost immediately when it came to this question whom I have had to turn away when they requested admission to Huntlyburn because they were so desperate for detox.”}

“\textit{Not enough Psychologists.”}

6.4 Responses from Borders GPs to Scottish Alcohol Needs Assessment

One of the objectives of the Scottish Alcohol Needs Assessment was to determine GPs’ views on the number of problematic drinkers seeking treatment or being opportunistically screened in the primary care setting, and to determine the assessment, support and treatment currently provided to this group.

An online questionnaire was sent to all GP practices in Scotland between March 2008 and October 2008. In total 232 responses were received as set out in Table 6.2 below.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
\textbf{Area} & \textbf{Number Of Respondents} & \textbf{Percentage} \\
\hline
Forth Valley     & 38  & 16.4   \\
Ayrshire and Arran & 32  & 13.8   \\
Greater Glasgow and Clyde & 31  & 13.4   \\
Borders          & 29$^1$ & 12.5   \\
Grampian         & 24  & 10.3   \\
Highland         & 24  & 10.3   \\
Lothian          & 15  & 6.5    \\
Fife             & 12  & 5.2    \\
Lanarkshire      & 11  & 4.7    \\
Tayside          & 11  & 4.7    \\
Shetland         & 3   & 1.3    \\
Orkney           & 1   & 0.4    \\
Dumfries and Galloway & 1 & 0.4    \\
Western Isles     & 0   & 0      \\
\hline
\textbf{TOTAL}   & 232 & 100    \\
\hline
\end{tabular}
\caption{Geographical spread of GP survey respondents}
\end{table}

$^1$ Included one non-completed return

\textbf{Needs Assessment of Drug and Alcohol Problems in the Scottish Borders}

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Responses from Borders GPs accounted for 12.5% of all returns across Scotland and represent 16 practices across the area. The data relating to Borders GP responses has been extracted from the national dataset and descriptively analysed for the purpose of this needs assessment. The key findings from this are set out below:

- 27 of 28 GPs were aware of alcohol services in their area.
- In total, the 28 GPs reported seeing 98 people (3.5 per GP on average) in the last four weeks who had approached them with an alcohol problem.
- The 28 GPs concerned estimated that they had seen a further 116 people in the last 4 weeks who they identified as having an alcohol problem, but who had come to see them for another reason (an average of 4.1 each).
- 8 GPs used a systematic screening tool of which 7 CAGE and 1 AUDIT. 19 did not use any screening tool.
- 10 GPs said that they treated more than 75% in the practice including 4 who said that they treated 100% in the practice. 4 did not treat any alcohol patients in the practice.
- In terms of criteria for deciding whether to treat patients in house:
  - 5 of 28 had a specialism within the practice;
  - 10 of 28 said appropriate treatment was not available locally;
  - 22 of 28 indicated that if the patient wished to be treated in the practice they would accommodate this;
  - 13 of 28 said that waiting list length would affect their choice.
- 11 of 28 GPs indicated that there were specialist alcohol services available in their surgery, either via an in house or visiting worker.
- In terms of interventions, 22 GPs indicated that specialist assessment was needed and 17 had it available.
- 17 GPs of 28 indicated that they were fairly or very dissatisfied with the range of treatment options available to them as a GP.
- However, 17 of 28 GPs indicated that they were fairly or very satisfied with the quality of specialist alcohol services in their area.
- In terms of barriers to accessing specialist alcohol services:
  - 24 of 28 GPs said that the waiting list was too long – 22 of 28 indicated that this was the most common barrier;
  - Also mentioned, 9 of 28 said that there were no spaces for patients in alcohol specialist services and 6 of 28 that there were no appropriate services in their area.

6.4.1 Limitations

All fieldwork for the SANA GP survey was carried out between March 2008 and October 2008. Since this time the HEAT brief interventions target has seen a
more systematic approach to the delivery of brief interventions in primary care (and other settings). This has included national guidance and training on the delivery of interventions, the establishment of Local Enhanced Service contracts between Health Boards and GP practices to ensure consistent delivery across the country and the establishment of a Delivery Support Team. This is, and will continue to, influence how and to what extent brief interventions are being delivered in Scotland.
CHAPTER 7: SERVICE USER CONSULTATION

7.1 Method

A short, simple survey form was created to assess the views of service users about the services they attend in the Borders. Copies of the survey were made available to patients visiting the unit, along with a ‘ballot-box’ for them to post completed forms.

As an incentive to participate, respondents were offered the chance to be entered into a prize draw for a £50 shopping voucher. In order to allow entry into the draw but still maintain anonymity, a detachable slip was provided on each form for participants to write down their contact details.

Boxes and forms were provided to the six main alcohol and drugs services in the Borders, namely: BCAT, Addaction, Big River, Alcohol Liaison Service, Face-2-Face and the DTTO service. Boxes were available for approximately four weeks, after which point, a member of the research team collected the box and its contents. A total of 39 completed forms were received, and the responses entered into SPSS for analysis. A thematic analysis was conducted on responses to the two open-ended questions using NVivo software.

7.2 Results

7.2.1 Statement Ratings

The first question in the survey asked service users to rate their agreement with a set of 17 statements. These statements were derived from the QUADS\(^{75}\) standards measured in the process evaluation phase of the study (see Chapter 9) and then mapped against the National Quality Standards for Scotland\(^ {76}\). Respondents were asked to rate the extent to which they agreed with each statement on a 5 point scale: “Strongly Agree – Agree – Don’t Know – Disagree – Strongly Disagree”. For the analysis, ratings were scored from 1 (strongly disagree) to 5 (strongly agree). Table 6.1 below demonstrates the 17 statements and the percentages of participants who rated between one and five on the scale of agreement.

---


Table 7.1: Service User agreement ratings

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Don’t Know</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services have clearly explained their confidentiality policy to me</td>
<td>67%</td>
<td>33%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I feel safe and comfortable when I attend services</td>
<td>67%</td>
<td>31%</td>
<td>3%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The services treat everyone equally no matter what their race, disability, age or belief system</td>
<td>58%</td>
<td>29%</td>
<td>11%</td>
<td>-</td>
<td>3%</td>
</tr>
<tr>
<td>Services have been good at helping when my needs change</td>
<td>54%</td>
<td>44%</td>
<td>3%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The services I use have helped me to make my situation better</td>
<td>54%</td>
<td>41%</td>
<td>5%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>When I was referred, my case was dealt with quickly</td>
<td>46%</td>
<td>44%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>They let me know about other services that might be useful to me</td>
<td>44%</td>
<td>49%</td>
<td>5%</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>The assessment I was given helped me to work out what my problems were and what I could do about them</td>
<td>39%</td>
<td>51%</td>
<td>8%</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>The services I use are good at working together with each other</td>
<td>39%</td>
<td>41%</td>
<td>21%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>They are good at finding ways to keep improving the service they provide</td>
<td>33%</td>
<td>51%</td>
<td>15%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>The staff have given good health advice and information, and helped me find health providers (e.g. GP, dentist, optician)</td>
<td>33%</td>
<td>51%</td>
<td>13%</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>The information I was given about services helped me to decide whether to come along</td>
<td>29%</td>
<td>68%</td>
<td>3%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I find it easy and convenient to get to substance misuse services</td>
<td>28%</td>
<td>59%</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>I have been told how I can make a complaint if I am not happy</td>
<td>28%</td>
<td>56%</td>
<td>10%</td>
<td>5%</td>
<td>-</td>
</tr>
<tr>
<td>The services have helped me to get ready for work, training, or volunteering</td>
<td>21%</td>
<td>44%</td>
<td>26%</td>
<td>10%</td>
<td>-</td>
</tr>
<tr>
<td>My family/partner/carer was allowed to let the services know what I need</td>
<td>13%</td>
<td>50%</td>
<td>29%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>I get to have a say in how services should be run</td>
<td>8%</td>
<td>42%</td>
<td>40%</td>
<td>8%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Clearly from the table above, the majority of service users who participated in the study positively regard the services that they use or had used in the past. In all cases, 50% or more of the statements garnered positive responses. The statements with which service users most strongly agreed related to confidentiality and safety and comfort; all service users agreed that the services had clearly explained their confidentiality policies and more than 95% felt safe and comfortable when attending services. In addition, more than 95% of service users felt that the services which they had accessed had been responsive to their changing needs and had helped to improve their situation.

However, there were several aspects of service provision which scored less highly among service users. Around 10% of service users disagreed that they had a say in how services should be run; similarly 10% of service users felt that services had not helped them to get ready for work, training or volunteering. Just under 10% of service users felt that services were not easy and convenient to reach, although this is likely in part to reflect the rural nature of the Scottish Borders. A further 8% of service users felt that their families had not been allowed to let services know what they needed.

In four cases, more than a fifth of respondents stated that they ‘did not know’ about a specific aspect of the service. These were:

- The services have helped me to get ready for work, training, or volunteering (26%);
- The services I use are good at working together with each other (21%);
- My family/partner/carer was allowed to let the services know what I need (29%);
- I get to have a say in how services should be run (40%).

Whilst it is not possible to conclude why individuals rated these statements this way, perhaps services should be aware that these are areas which may need attention.

7.2.2 Qualitative Comments

Service users were asked "If there was one thing about the services you could change, what would it be?" Nineteen out of the thirty nine respondents answered this question, seven of which simply stated that they would not change anything about the services saying for example “Nothing, I feel the services do their best to help with any queries or problems drug users have! They also provide a great support network and change, or do their best, to change people’s lives for the better!”

The other responses indicated areas which service users felt could be improved or had not worked well with them, the nature of these other responses can be seen below:
Access

More of them [services] in other towns in the Borders, for easier access.
Quicker access to medication.
There was a long waiting list when I was referred (1 year wait).
Out of Hours appointments would be useful as I work full time.
Visit the service more than once a week.
More staff as the need for services expands.

Emergency response

Would be more effective if crisis services responded more appropriately.
Quicker response, better liaising with other agencies.
Is there an emergency response team?
An on-call facility for when cravings become too much.

Attitudes towards Service Users

Not to be detached from the people’s needs and more accepting of their issues.
For services to trust people and treat them equally, not every person that took drugs are the same! TRUST!!

General

I think it is a bad idea that all the clients of the DTTO go to court on the same day, as I am half way through and am forced to have to speak to people that have just started and are still using.
A more detailed explanation on the different medications to replace the illicit drugs that are used by people. The ‘for and against’ – good and bad of the replacement prescribed drugs.
Going out for walks to clear people’s minds and get taken out for a coffee.

Service users were finally asked if there was anything else that they would like to say about their experiences with substance misuse services. Again 19 individual chose to answer this open-ended question, the majority of which all gave positive responses regarding their experiences of treatment provision. The nature of these responses can be seen below:

Been good to meet people with the same problem.
The experience I have had this time has been very good. I am not sure if it is because I have changed my attitude or whether I have discovered a new approach to move forward to achieving sobriety with the help of SMART recovery and Addaction.

I feel the services are great and I don’t know what I’d have done without them!

Without the services I would probably still be on drugs. Thanks to them am now drug free and looking towards the future.

Just to say that the staff at Borders Community Addiction Team have been absolutely fantastic. The service is run really well!

Everything has been good, BCAT, Addaction, Huntlyburn. Quite happy.

Every one of the services has been non-judgemental, caring and very understanding regarding my needs.

Have had excellent support from day one. Cannot fault the one-to-one help and the group support I have received. Has made great positive differences to my life and future.

I enjoy all meetings. They are very helpful and also very supportive.

I’ve always found them most helpful and respectful.

Have been very helpful and supportive.

Very forward thinking and professional.

I have had marvellous, supportive one-to-one support from Addaction which has been invaluable to me in remaining abstinent.

In total only four comments referred to either suggestions for improvements or to individuals own grievances. Two respondents indicated particular problems that they felt they had had with a service and/or a particular member of staff, this report does not include these statements however it may be of value for services to ensure that all service users fully understand the complaints procedure. Comments relating to ideas for service improvements were as follows:

24hr access to services would be good for when they are needed.

Cut waiting times for getting BCAT appointments, need to be quicker so that they can get people clean.

7.2.3 Services Used

Participants were asked to select which of the six main services available in the Borders that they had used, Table 7.2 below demonstrates the numbers of individuals who indicated that they had used a particular service.
Table 7.2: Numbers of respondents using Drug and Alcohol services

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of individuals who had used service</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCAT</td>
<td>20</td>
</tr>
<tr>
<td>Addaction</td>
<td>20</td>
</tr>
<tr>
<td>Big River Project</td>
<td>9</td>
</tr>
<tr>
<td>DTTO</td>
<td>7</td>
</tr>
<tr>
<td>Face-2-Face</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol Liaison Service</td>
<td>0</td>
</tr>
</tbody>
</table>

Clearly the most utilised services from the sample of participants surveyed are BCAT and Addaction. It is important to note that response numbers from each agency differed greatly and that individuals were instructed to select all services that they had used, therefore these figures represent only participants past use of services and are in no way indicative of activity levels of individual services.

7.3 Key Findings – Service Users’ Views

- Service users generally felt positively about the services which they were accessing. They reported that services were explaining their confidentiality policies clearly. Service users also felt safe and comfortable when they attended services and indicated that services were responsive to their changing needs. The great majority of service users said that services had helped them to improve their situation.

- However, there were some aspects of services which did not gain such positive feedback and may require some attention. Service users did not feel strongly that they were involved in the way in which services were run. Furthermore, service users were unsure as to how much services were assisting them to prepare them for education, training or employment. Waiting times were raised as an issue, as was out of hours emergency provision.
CHAPTER 8: CARERS CONSULTATION

8.1 Introduction and Aim

Individuals with severe substance misuse issues and/or other difficulties may have a carer or family member who provides care for them. These carers often are involved to some degree in a person’s contact with a service; therefore exploring the views of these carers is an important element of establishing the degree to which service provision in the Borders is meeting the need. Carers’ views were therefore sought regarding any problems or difficulties that they or the person they care for had experienced using services in the Borders, and also the elements of service provision that they had found to be positive. Finally carers were asked what they would like to see improved for the future provision of drugs and alcohol services.

8.2 Method

Questionnaires were distributed to individuals attending a carer’s support group in the Borders, participation was voluntary.

Participants were all carers for individuals with substance misuse problems, and resident in the Borders. In total 11 carers completed the survey, three of whom were from Galashiels and District, five were from Selkirkshire and three individuals were from Hawick and Denholm. It should be noted however that not all of the participants completed all of the questions.

Carers indicated that of the individuals in their care, five individuals had used illegal drugs, six had used alcohol and one carer stated that the person they provided care for had used both illegal drugs and alcohol.

8.3 Results

Participants were firstly asked which services that they had been in contact with in their role as a carer, the results are presented in Table 8.1 below:
Table 8.1: Numbers of respondents using Drug and Alcohol services

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of carers who had been in contact with the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>6</td>
</tr>
<tr>
<td>Addaction</td>
<td>5</td>
</tr>
<tr>
<td>Big River Project</td>
<td>4</td>
</tr>
<tr>
<td>Borders Community Addiction Team</td>
<td>3</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
</tr>
<tr>
<td>Quest</td>
<td>2</td>
</tr>
<tr>
<td>AA</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol Liaison Service</td>
<td>1</td>
</tr>
<tr>
<td>Homeless Services</td>
<td>1</td>
</tr>
<tr>
<td>Advocacy</td>
<td>-</td>
</tr>
<tr>
<td>DTTO</td>
<td>-</td>
</tr>
<tr>
<td>Face2face</td>
<td>-</td>
</tr>
</tbody>
</table>

As can be seen from the table above, GPs were indicated as being the service that most of the carers had been in contact with (n=6). The two main adult non-statutory services were the next most contacted services, with five individuals indicating that they had been in touch with Addaction, whilst four had been in contact with Big River.

Participants were then asked to rate the services that they had had contact with in terms of how well they met the needs of the person they care for. The number of participants who rated each service on each point on the scale can be seen in Table 8.2 below:

Table 8.2: Carers’ Ratings of Services Contacted

<table>
<thead>
<tr>
<th>Service</th>
<th>Very Good</th>
<th>Good</th>
<th>Adequate</th>
<th>Weak</th>
<th>Very Weak</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addaction</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Big River Project</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Borders Community Addiction Team</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol Liaison Service</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Face-to-Face</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>DTTO</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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Following on from this question, participants were asked whether the services had involved them as a carer. Responses indicated that five carers had felt that the services did involve them; however four indicated that they felt that the services did not involve them.

Participants were then asked if they had been involved, with which services and the way in which they had been involved. Four of the five respondents who had indicated that they felt they had been involved answered this question, the nature of the responses can be seen below.

- [By] Listening and talking to me.
- Help and support.
- QUEST – [offer] support and encouragement.
- Big River Project and BCAT [involved carer].

Carers were then asked if the person that they care for had ever experienced problems in accessing services. Seven participants answered this question, with four individuals indicating that the person in their care had not had any problems accessing services; however three respondents did state that the person that they care for had had difficulties with this. The one respondent who elaborated on the exact nature of these difficulties stated that the problem had been waiting lists.

Question 7 of the survey asked carers if they had ever had contact with a carers support service. Five respondents indicated that they had contact from QUEST; furthermore, the respondents indicated that the support that they got from this group helped by offering “help, support, encouragement and awareness”, and that the service had allowed them the opportunity to make friends which they found "very helpful".

Participants were also asked what help they needed most in order to care for the person they supported. The majority of respondents indicated that they felt that having someone to talk to and offer support would be most beneficial to them (n=6). One individual stated that they would like more information and advice to be available, whilst another respondent indicated that they had not been aware of support groups at a time when they needed it, indicating that perhaps better advertising and information distribution could be explored.

Finally, carers were asked what they would do to change the service provision for people in the Borders who have a substance misuse problem, in an ideal world. The nature of the responses is demonstrated below.

- Make it more public.
- Don’t know.
- Put service users in touch with people who have recovered and ask what they did.
- More services, no waiting lists and more detox beds.
Easier access and more help.
More awareness and education.
Work.

8.4 Key Findings – Carers’ Views

- Carers of people with substance misuse problems were most commonly in touch with GPs.
- Carers’ support services can provide them with help, encouragement and awareness.
- The aspects of services which carers valued were support, a listening ear and information.
CHAPTER 9: SUMMARY AND RECOMMENDATIONS

9.1 Overview

The purpose of this project has been to assist Borders DAAT in meeting the recommendations of the Delivery Reform Group report (2009) by providing an assessment of current specialist drug and alcohol services, as well as a health needs assessment of local needs and gaps.

The review team sought the views of people currently using the service as well as those working within the service and a wider range of stakeholders as identified by the Borders Drug and Alcohol Action Team.

Overall, the review team found all parties to be constructive and keen to engage in this process. All views were offered willingly and are assumed to have been given in good faith.

The concluding comments of the Review team are set out below and have been categorised into three main areas:

- Range of Services;
- Capacity of Services; and,
- Quality of Services.

9.2 Range of Services

Drug and alcohol services in the Borders provide a range of medical and psychosocial interventions for people with drug and/or alcohol problems. These are delivered in either one-to-one or group settings.

The majority of stakeholders agreed that Borders has an adequate range of services at its disposal however concerns were raised as to whether these were being used most appropriately or effectively. There were a number of specific examples of gaps in service given including;

- Absence of counselling service for people with alcohol or drug problems;
- Lack of services for helping people “Move On” to training and employment;
- Lack of adequate provision of community detoxification;
- Lack of systematic response to individuals who experience both mental health problems and substance misuse;
- Need to invest in an implement Brief Interventions for alcohol problems into appropriate settings; and,
• Absence of Psychology services within substance misuse services.

The feedback given by service users regarding the range of interventions that they receive from services was overwhelmingly positive although the constructive comments given related to the fact that they were unsure as to how much services were assisting them to prepare them for education, training or employment. Waiting times were raised as an issue, as was out of hours emergency provision.

9.2.1 Counselling Service

The use of counselling as part of a Combined treatment along with methadone maintenance shows more improvements and faster and greater improvements than methadone treatment alone.77

The review of the effectiveness of treatments for alcohol problems conducted by Raistrick, Heather and Godfrey (2006) cites the Mesa Grande study which is an ongoing systematic review of the effectiveness of different treatments for hazardous and harmful alcohol consumption, ranking the effectiveness of 48 different treatment modalities78. Eight of the top ten rated therapies internationally are counselling or cognitive behavioural interventions.

When asked to select from a list all the interventions that they provide, none of the service managers indicated that they provide counselling. Some stated that they use counselling skills or a counselling approach, neither of which would be considered to be a structured therapeutic process.

It was also noted that there is currently no psychology input into substance misuse services.

9.2.2 Out of Hours Service

The notion of providing a service after 5pm was raised a number of times by stakeholders, GPs and service users. While this identified an aspect of service that interviewees though would be useful, it is difficult to envisage what this would look like in terms of the volume of demand for service, the type of service and where this would be located. It would be difficult therefore to make a case for such a development in the absence of a clearly defined, specific need.

It would seem more appropriate to conduct an audit of the training needs of GPs, A&E staff and mental health nurses regarding the management of drug or alcohol users. Providing training and awareness raising would seem more likely to ensure effective management and onward referral.


There was a suggestion that services should be open later than 5pm to accommodate people that are employed. Whilst BCAT make efforts to accommodate this on an individual level and Big River host a needle exchange up to 8pm on a Thursday, there appears to be insufficient demand to merit a formal change to the existing provision.

### 9.2.3 Brief Interventions

Evidence from the stakeholder interviews and the GP survey indicated a need for greater roll-out of Brief Interventions. As stated in paragraphs 1.6 and 6.4.1 there is currently significant work taking place in this respect across all Health Boards. In light of this no recommendations are being made in this respect. It would be beneficial to conduct an evaluation of the extent to which screening and brief interventions are being conducted in primary care and wider settings (e.g. A&E, Antenatal Services) within the next 18-24 months.

### 9.2.4 Services for people with mental health problems and substance misuse

In December 2007, the Scottish Government published "Closing the Gaps, Making a Difference“ which sets out guidance on the management of people with mental health problems and substance misuse. No evidence was found of the development of local protocols for implementing this guidance. It was noted that this continues to be regarded as a gap in services locally.

### 9.2.5 Moving on to Training and Employment

The “Road to Recovery" emphasises the importance of helping people with drug and alcohol problems to access appropriate training and education opportunities. Service users and stakeholders identified this as a gap in services, one which could conceivably result in people remaining in treatment services longer than necessary.

The examples of initiatives contained in the *Road to Recovery* (p25-26) highlight how existing services are working together to provide opportunities for people who are ready to move on.

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9.3 Capacity of Services

The findings from the prevalence study (Chapter 2) suggest that the problems caused by alcohol and drug misuse, to the individual and the wider community in Borders are similar to, or less than, those of other comparable area populations. In the broader context the demographic profile of Scottish Borders provides some protective factors; higher life expectancy; lower unemployment; lower deprivation rates and lower levels of criminality than the Scottish average.

Equally the harm associated with alcohol misuse is relatively low.

- The proportion of people drinking over the recommended weekly amount is lower than the Scottish average.
- The rate of drunkenness offences in Borders is lower than the number recorded in other local authorities of similar size.
- The death rate in Borders, where alcohol was a known underlying or contributing cause of death, is lower than the Scottish average for both men and women.
- Scottish Borders had a consistently lower rate per 100,000 population of general acute inpatient discharges with an alcohol-related diagnosis than Scotland.

The issue of capacity has been raised in Sections 4.3 and 4.4 above. While it could be argued that the capacity of alcohol services is adequate to deal with the current demand placed upon it, it would be regarded as low in relation to the level of need in Scottish Borders. The current PSUR for drug services (41.9%), calculated from the 2006 prevalence figures, suggests a ‘Low/Medium’ level of access. This is in stark contrast to the ratio calculated using the earlier 2003 prevalence data which showed a PSUR of 28.3%.

There are increasing rates of new attendances at drug services, rates of drug-related psychiatric discharges are higher than the Scottish average and the number of drug deaths in Borders is low but increasing year on year.80

Within the context of considering the effectiveness of the service the question becomes “Can the capacity of the service be increased to maximise the use of current resources and reduce waiting times without compromising the quality of service delivery?”

From the information available to the review team it appears that there is a need for increasing the capacity of alcohol and drug treatment services in equal measure. The barometer of need in the first instance is waiting times although this only indicates the gap between capacity and demand, not capacity and need.

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80 As 66

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9.3.1 Reducing Waiting Times

One of the objectives of the review was to establish the extent to which the current model is responsive to the needs of stakeholders. Notwithstanding the issues raised earlier concerning the range of services provided, one of the areas raised as a point of concern with stakeholders is the waiting time for services, particularly those provided by BCAT. BCAT management confirmed that the waiting time for non-priority cases was 12 weeks. Priority cases could be seen within a week if required.

The majority of stakeholders interviewed had raised concerns over waiting times. The issue of waiting time management is not clearly defined, in terms of minimum standards and contingency planning. Discussion around capacity building should take cognisance of the fact that demand for service is not currently being met to the satisfaction of stakeholders and service users.

The management of waiting times should be regarded as a multi-agency responsibility. The development of a waiting times strategy should encompass minimising waiting times, managing waiting lists and developing contingency plans. Increasing the capacity of services will not deliver a maintainable standard of access unless coupled with a waiting times strategy.

9.5 Recommendations

The recommendations set out below are drawn from the evidence of current practice with regard to the range and capacity of alcohol services in Borders compared to the research and guidance referred to throughout this report. These are presented for the consideration of the Borders DAAT and its partner organisations.

9.5.1 Range and capacity of services

There is a need to ensure that a full range of evidence based interventions is available to meet the identified needs of alcohol and drug dependent people in Borders. This range of interventions would include access to counselling services. As this is a relatively low-cost, high quality service there would be merit in considering the re-provision of this intervention.

Evidence from the gap analysis, as well as the existence of waiting lists suggest that there is an under-resource in terms of drug and alcohol treatment provision. Evidence based on the national prevalence study points to a need for more

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services for men however no such distinction should be made on any additional resource put in place.

A multi-agency waiting times strategy should be developed and implemented. This should ensure that current resources are being utilised to maximum effect. Guidance on the development of a waiting times strategy is available at: http://www.drugmisuse.isdscotland.org/eiu/intcare/Cha3.pdf

Further exploration as to the level of joint working between substance misuse services and employment, training and further education services should take place. This should result in clear pathways being developed for drug and alcohol users to access the range of services available.