# Needs Assessment

## Reducing Drug and Alcohol Related Harm in Highland

Highland Alcohol and Drugs Partnership
February 2016

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Contributions from the HADP steering group

**Contents**

## Executive Summary

The population of Highland continues to have a difficult relationship with alcohol evidenced by the percentage of the population drinking more than what is recommended on a daily or weekly basis. Furthermore social norms continue to change, for example, online purchasing has increased the availability of alcohol and drug products in the home whereas drinking in a licensed premise is now tightly regulated. It should be noted, from April 1st 2016 the UK Chief Medical Officers, have updated the alcohol guidelines[i] to reflect new evidence about the health risks associated with drinking, and cancer in particular. To keep health risks from drinking alcohol to a low level, the new guidance states that men and women should not regularly drink more than 14 units per week. It has not been possible to recalculate all the information in this document particularly the prevalence data.

This needs assessment has been an ambitious piece of work because it has collated information and data from a range of community planning sources, for example, health and social care, the criminal justice system, the police, and the fire and rescue service. Furthermore it provides information across the life course from birth to death and the potential harms arising from alcohol and drug misuse. The consultation process carried out through surveys and focus groups has added a rich variety of data.

The first chapter outlines the context for the needs assessment and provides information about the national and local policy context and the various data sources. A key driver for current and future work is the *Quality Principles*[ii], an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that will evidence the outcomes people are achieving.

Chapter two provides information about demographic and prevalence data which is divided into two sections to highlight the differences between children and young people, and adults. In recent self reported surveys completed by children and young

people there are encouraging downward trends in the misuse use of alcohol and drugs. Self reported alcohol consumption by adults is above the recommended daily limits remains of concern at 40% (old guidance).

Health harms arising from alcohol and drug misuse such as foetal alcohol syndrome, hepatitis C and blood borne viruses is the topic for chapter three. This chapter also includes information about the links between alcohol and drug misuse, and mental health.

Mortality data is presented in chapter four and shows the rates of alcohol related mortality to be much higher than drug related mortality. To be interpreted with caution, recent data are showing for alcohol related mortality rates an upward trend. Community safety outcomes for alcohol and drug misuse are presented in chapter five and include data for drug treatment and testing orders (DTTO). These figures have not changed significantly since DTTO were introduced in 1998. It is encouraging that most figures for crime show a downward trend.

Chapter six is about the local environment and provides information about young people and drug misuse for example the downward trend for rowdy behaviour. This chapter also covers information about people's living circumstances for example if they are homeless or roofless.

Information and data are presented about vulnerable groups in chapter seven focusing mostly on individuals involved with the criminal justice services and HMP Inverness. Addiction Prevalence Testing of the prison population is data presented for the year 2014-2015.

Recovery orientated systems of care (ROSC) is the focus of chapter eight; the definition includes being patient centred and asset based. Mutual Aid is also covered in this chapter.

Chapter nine provides an overview of the Substance Misuse Services and provides examples of person centred interventions. The substance misuse services are responsible for delivery of the Scottish Government's HEAT standard for drug and alcohol treatment, which states that 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery.

Whole population approaches are the subject of chapter ten and information and data are provided for alcohol brief interventions and alcohol licensing.

Service users, the public and agencies through surveys and focus groups were asked their views about what should be prioritised. Views and opinions are very wide ranging and in general gave a positive endorsement of the current services, a desire to see more choice of service, a move to family orientated services and an ongoing commitment and support for whole population based approaches and prevention. The problem of stigma and discrimination was highlighted as an ongoing issue. A summary of the key messages is provided.

Chapter twelve provides an overview drawn from the needs assessment of work to be progressed and perceived gaps in services, projects or programmes.

Finally, chapter thirteen provides a table of recommendations arising from the needs assessment to be considered by the HADP.



## 1. Introduction, background and context

This needs assessment was undertaken to inform strategic decision making by the Highland Alcohol and Drug Partnership (HADP). This partnership provides strategic leadership to a number of community planning partners including NHS Highland, Police Scotland, Fire and Rescue, Highland Business Sector and Third Sector Partners in relation to alcohol, illicit drugs, and other substances. The overall aim is to improve the population's social, mental and physical health[iii], to provide appropriate services and to protect the population's health.

The needs assessment focuses on alcohol, drugs, and other substances, as causative agents of physical, mental, and social harms. Data was sought in relation to exposure to these agents regardless of whether harms have yet arisen and how they might lead to demand on a range of services and need for interventions.

The current HADP strategic Plan 2012 -2015[iv] is due for updating and the new strategic plan will be based on a current needs assessment. A further development will be a commissioning intentions document as the HAPD moves towards a commissioning model for service procurement[v]

### 1.1 Key data sources

Demographic data, including population estimates, and alcohol and drug related mortality statistics were obtained from the National Records of Scotland (NRS) website www.nrscotland.gov.uk/.

Population health data, including assessments of alcohol and drug use prevalence, were obtained from the Scottish Public Health Observatory (www.scotpho.org.uk) or from the NHS National Services Scotland Information Services Division (ISD) website

(www.isdscotland.org), and from the Scottish Crime and Justice Surveys (www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/crime-and-justice-survey), Scottish Health Surveys (www.scotland.gov.uk/Topics/Statistics/Browse/Health/scottish-health-survey/Publications), and the Scottish Schools Adolescent Lifestyle and Substance Use Surveys (www.isdscotland.org/Health-Topics/Public-Health/SALSUS/).

NHS health service data, including hospital admission statistics, were obtained from the NHS National Services Scotland Information Services Division (ISD) website (www.isdscotland.org), or from NHS Highland Information and Intelligence and the HADP.Community planning partners also contributed to the needs assessment by providing data from a variety of services such as Fire and Rescue, Homelessness and Police Scotland. In addition information from the consultation exercise was collected either through on line surveys and from discussions held with local Alcohol and Drug Groups which has been incorporated throughout the document. Both the online surveys and discussion groups enabled the voice of the service user to be heard and their views incorporated into the needs assessment. In the development of future needs assessments, strategic plans and other documents it is recommended that service user involvement continues to be central to all documents.

### 1.2 Methodology

The needs assessment was undertaken by applying systematic procedures to the collation of a broad range of data, much of which is already used to evaluate local and national core indicators and regularly monitor prevalence and trends. There is an extensive range of information available on drug and alcohol related harm, however the sources utilised in the needs assessment were considered more reflective of the HADP strategic priorities. The main study methods applied were as follows:

**Table 1: Methodology - summary**

| Stage | | Methods | |
|---|---|---|---|
| 1 | Quantitative<br>Review of existing datasets | Desk-based review of national and local datasets | |
| 2 | Qualitative<br>Community consultation | Semi-structured questions<br>Group participatory appraisal | Sample<br>Service workers, Service users, Third Sector, Drug & Alcohol Forums, Community groups |
| 3 | Quantitative & Qualitative<br>Public survey | Semi-structured questions<br>Survey monkey of public | Members of public |
| 4 | Quantitative & Qualitative<br>Performance Management Survey | Semi-structured questions<br>Questionnaire | Citizens Panel |

### 1.3 Policy context

HADP strategy

Alcohol and drug activity at local level is driven by the current HADP strategy which has four key strands: Maximising Health, Recovery, Protecting Communities and Children and Families. The strategy is aligned to the Single Outcome Agreement (SOA) and links across to range of other relevant local policies on associated issues such as; violence against women, child and adult protection, youth justice and community safety. The main national drivers are:

National alcohol strategy

The Scottish Government published *Changing Scotland's Relationship with Alcohol: A Framework for Action* in March 2009[vi], setting out the strategic approach to tackling alcohol misuse in Scotland. The framework proposed sustained action in four areas:

- Reduced alcohol consumption
- Supporting families and communities
- Positive public attitudes toward alcohol and individuals better placed to make positive choices about the role of alcohol in their lives
- Improved treatment and support

Key elements of the strategy included a national programme (including setting targets which are now standards for alcohol brief interventions (ABIs) and drug and alcohol treatment waiting times) and an intention to pursue whole population approaches.

National drugs strategy

The Scottish Government published *The Road to Recovery* in 2008[vii] and the strategy continues to receive cross-party support from the Scottish Parliament. Central to the strategy is the concept of recovery that is defined as; a process through which a person is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society. Recently the partnership for action on drugs in Scotland (PADS) group has been set up to reduce problem drug use and complement the ongoing work of the Road to Recovery strategy. The group will focus on three priorities:

- building communities focused on recovery and tackling stigma
- quality and consistency of service planning and delivery
- harm reduction and reducing drug-related deaths

The Quality Principles - Standard Expectations of Care and Support in Drug and Alcohol Services 2014[viii]

The Scottish Government has developed an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that will evidence the outcomes people are achieving. The Quality Principles have been based on consultation with service users as well as those who deliver the services.

**1.4 Definitions**[ix]

Alcohol consumption is usually represented on a continuum, from low risk drinking though hazardous and harmful drinking to alcohol dependence. The term ‘low risk’ drinking is deliberate as there is no such thing as ‘no risk’ alcohol consumption given health harms and/or environmental harms. At this level, however, the risks might be judged to be balanced against the perceived benefits of alcohol consumption.

Alcohol consumption can be represented on a continuum, from low-risk drinking, through hazardous and harmful drinking, to alcohol dependence (‘addiction’).

The term **low-risk drinking** acknowledges that there may be no such thing as ‘no risk’ alcohol consumption. At this level, however, the risks might be judged to be balanced against the perceived benefits of alcohol consumption.

**Hazardous drinking** is usually defined in terms of alcohol consumption that exceeds recommended daily or weekly limits with no requirement for existing alcohol-related harm. The Scottish Health Survey defines hazardous drinking as the consumption of between 15 and 34 units of alcohol per week for women, and between 22 and 49 units per week for men. Hazardous drinking is also sometimes defined in relation to a score greater than or equal to eight on the Alcohol Use Disorders Identification Test (AUDIT).

**Harmful drinking** involves drinking at similar consumption levels to hazardous drinking, but where actual physical or mental harm has occurred. The Scottish Health Survey, however, which defines it as the consumption of greater than 34 or 49 units of alcohol per week for women and men respectively.

**Alcohol dependence**, is a diagnostic syndrome involving “a cluster of physiological, behavioural, and cognitive phenomena” (such as increased tolerance, withdrawal symptoms, and cravings) such that the use of alcohol takes precedence over other previously valued activities.

# 2. Demographics and prevalence data

## 2.1 The population of Highland

The population of Highland in 2014 was estimated to be 233,100, four percent of the national population in an area that cover a third of the landmass of Scotland. The geographical area covered is diverse; including the growing populations of Inverness and the Inner Moray Firth as well as the most remote communities in both island and mainland locations. The general epidemiological picture is similar to that nationally and is one in which adult mortality predominates and chronic and degenerative diseases are the most common form of morbidity.

**Table 2 : Highland population age structure by age group and sex in 2014**

| Age | Gender | | Total |
|---|---|---|---|
| | **Male** | **Female** | **Total** |
| **00-15** | 20,618 | 19,518 | 40,136 |
| **16-29** | 17,809 | 16,707 | 34,516 |
| **30-44** | 19,815 | 21,257 | 41,072 |
| **45-64** | 33,956 | 35,405 | 69,361 |
| **65-74** | 13,259 | 13,983 | 27,242 |
| **75-84** | 6,729 | 8,528 | 15,257 |
| **85-89** | 1,318 | 2,271 | 3,589 |
| **90** | 564 | 1,363 | 1,927 |
| **Total** | **114,068** | **119,032** | **233,100** |

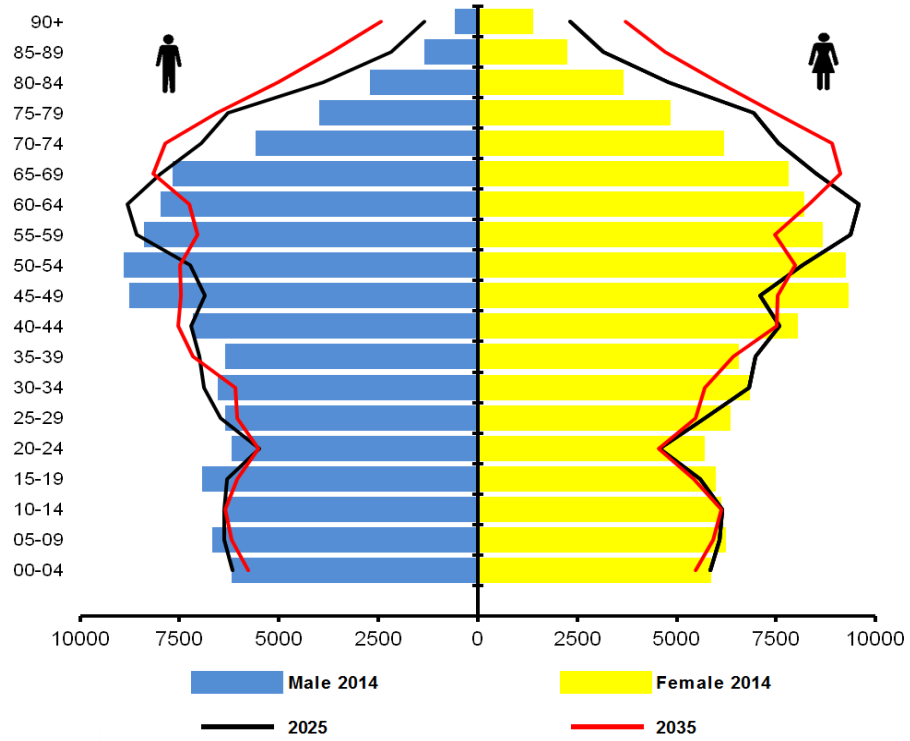
Source: National Records of Scotland Mid-year estimate population 2014

The latest available population projection for Highland suggests that the total population will increase by 4 percent to around 244,000 over the next 25 years with net migration 'replacing' population loss resulting from negative natural change as deaths exceed births[x]. The projected growth is the equivalent of adding the population of Fort William to the Highland population total over the period.

## Population Projections

All the variants of the population projections for the Highland area highlight that the population is projected to age considerably as the numbers of older individuals make up proportionately larger shares of the population over time[xi]. Primarily as a result of past trends in fertility, although falling mortality at older ages is increasingly important, larger cohorts are moving into older age groups and themselves being followed by smaller numbers at younger ages.

**Figure 1: Projections for Scottish Areas (2012 based) – Principal Projection 2012 -2037**




Source: National Records of Scotland

## 2.2 Children and Young People

The use of alcohol and other drugs in young people is important not only due to the immediate risks of harm, but because patterns of use into adulthood can be established at this time. Furthermore it is important to understand how these patterns of behaviour are learnt in order to develop appropriate interventions.

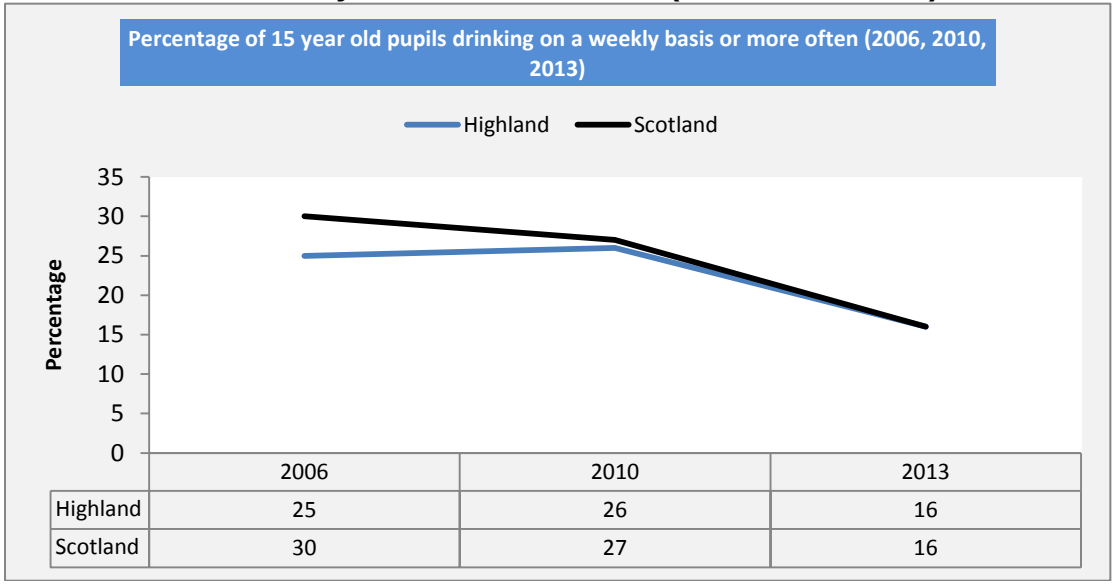
In this section there are data from two sources the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)[xii] and the Highland Lifestyle Survey[xiii] carried out with P7, S2 and S4 pupils in 2009, 2011 and 2013.

### 2.2.1 Alcohol prevalence

The Highland ADP area prevalence rate has decreased between 2006 and 2013 for 15 year olds who drank on a weekly basis or more. Highland is now equal to the national average. The Highland target for 2015 is to continue the trend of reducing prevalence in THE Highland ADP area.

SALSUS is a Scottish Government commissioned survey of secondary school students. The data is self reported but provides a wealth of information that shows current behaviours and also changes over time.

**Figure 2: Percentage of 15 year old pupils drinking on a weekly basis or more often (2006, 2010, 2013)**




| | 2006 | 2010 | 2013 |
|---|---|---|---|
| Highland | 25 | 26 | 16 |
| Scotland | 30 | 27 | 16 |

Source: SALSUS, 2006, 2010, 2013

There has been a steady downward trend from 2009 to 2013 in the proportion of P7, S2 and S4 pupils self-reporting alcohol use (from 10.4% to 2.9% for P7 pupils, from 29.7% to 12.8% for S2 pupils and from 52.9% to 31.0% for S4 pupils). Please note that some P7 responses have been combined or omitted due to insufficient numbers as per ISD Statistical Disclosure Control Protocols.

**Table 3: Pupil responses to – Which one of these statements best describes you last week (2013)**

| Age | I didn't drink any alcohol | I drank a few alcoholic drinks | I drank a little alcohol | I drank a lot of alcohol |
|---|---|---|---|---|
| P7 | 97.1% | 2.9% | | |
| S2 | 87.2% | 2.2% | 9.1% | 1.5% |
| S4 | 69% | 9.2% | 13.9% | 8% |

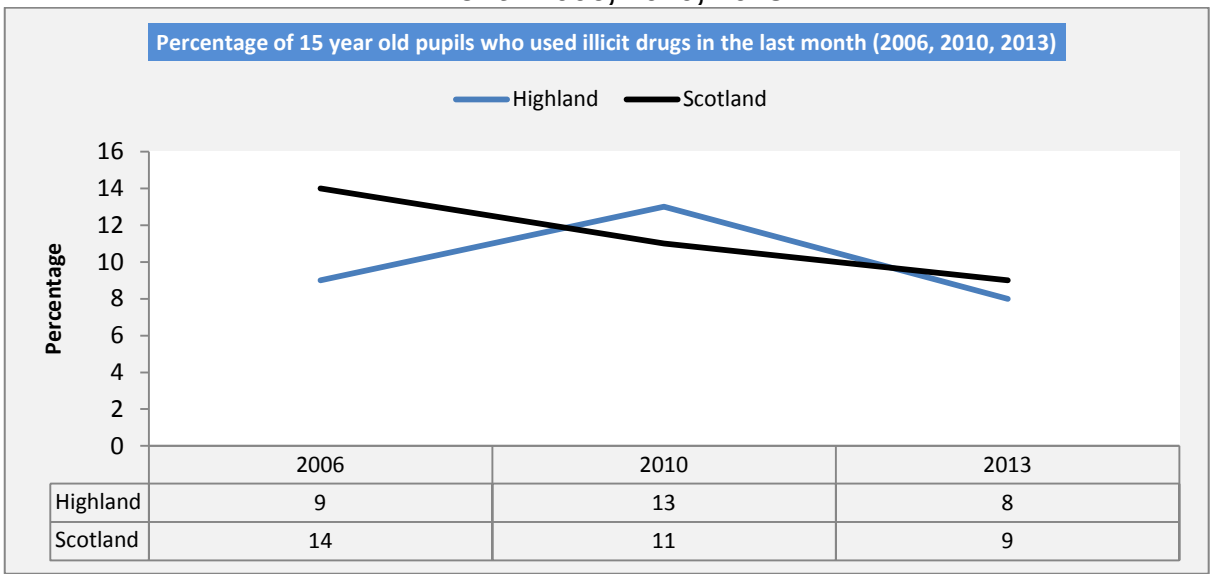
Source: Highland Lifestyle Survey 2015

The above responses relate mostly to a 'typical week' for the pupils who don't drink alcohol.

### 2.2.2 Drug Prevalence

The Highland ADP area prevalence rate has increased between 2006 (9%) and 2010 (13%) to a slightly higher level than the national average, which has decreased over the same period. In 2013 The Highland figure had fallen below the national average (8%).

**Figure 3: Percentage of 15 year old pupils who used illicit drugs in the last month 2006, 2010, 2013**




| | 2006 | 2010 | 2013 |
|---|---|---|---|
| Highland | 9 | 13 | 8 |
| Scotland | 14 | 11 | 9 |

Source: SALSUS, 2006, 2010, 2013

The Highland Lifestyle survey shows the Percentage of 15 year old pupils who used illicit drugs in the last year. The Highland ADP area prevalence rate has increased between 2006 and 2010 to a slightly higher level than the national average, which has decreased over the same period. In 2013 the Highland percentage had fallen below the national average.

The majority of P7s (98.1%), S2s (95.6%) and S4s (91.9%) did not take illegal drugs in the last week. 2.5% of S2s and 3% of S4s took New Psychoactive Substances (previously known as legal highs).

**Table 4: Pupil responses to – When it comes to Illegal Drugs and New Psychoactive Substances which of these statements best describes you last week?**

| Age | I didn't take illegal drugs | I took a 'legal' drug which was for recreational use | I took illegal drugs on one occasion | I took illegal drugs on more than one occasion |
|---|---|---|---|---|
| P7 | 98.1% | 1.9% | | |
| S2 | 95.6% | 2.5% | 0.9% | 1% |
| S4 | 91.9% | 3% | 2.1% | 3% |

Source: Highland Lifestyle Survey 2015

The above responses relate mostly to a 'very typical week' for the pupils who don't take illegal/legal drugs.

## 2.2 Adults

### 2.3.1 Alcohol prevalence

The Scottish Health Survey[xiv] is a national survey that reports alcohol consumption in relation to daily and weekly recommended limits at a national level. It is known that the self-reported alcohol consumption in the Survey accounts for only half of the alcohol available for sale in Scotland in the same year and because of this fact the figures are likely to be an underestimate.

**Population exceeding weekly and/or daily limits**

**NOTE:** From April 1st 2016 the UK Chief Medical Officers have updated the alcohol guidelines[xv] to reflect new evidence about the health risks associated with drinking, and cancer in particular. To keep health risks from drinking alcohol to a low level, men and women should not regularly drink more than 14 units per week. The following information is based on the old guidance that women should not regularly drink more than 14 units per week and men should not regularly drink more than 21 units per week.

The indicator for exceeding weekly and/or daily limits is if an individual drank more than 4 units (men) or 3 units (women) on heaviest drinking day, and/or drank more than 21 units (men) or 14 units (women) in usual week. Figures show that locally and nationally men exceeded daily/weekly limits more than women. In total the NHS Highland rate is lower than the Scottish percentage. Neither males nor females in Highland differ significantly from the national average. There is no time trend data for this indicator as it is a four year aggregate figure. This is calculated by NHS Board and is not broken down to ADP level.

**Table 5:The proportion of individuals drinking above daily and/or weekly recommended limits, 2008, 2009, 2010, 2011**[i]
***Aged 16 and over (Figures based on all survey respondents) NHS Board***

| NHS Board | Men | Women | Total |
|---|---|---|---|
| **Highland** | 44.5 | 36.8 | 40.5 |
| **Scotland** | **48.7** | **38.6** | **43.4** |

Source: Scottish Health Survey

**Proportion of individuals drinking above twice daily recommendations**

The indicator for drinking above twice the daily recommendations is drinking more than 6 units on one occasion for women and more than 8 units for men. Locally and nationally men drink twice above recommended limits more than women. NHS Highland has a lower rate than Scotland in total. Males in Highland were statistically significantly 'better' than the national average; females did not differ significantly from the national average. There is no time trend data for this indicator as it is a four year aggregate figure. This is calculated by NHS Board and is not broken down to Alcohol Drugs Partnership level.

**Table 6: The proportion of individuals drinking above twice daily ("binge" drinking) recommended limits, 2008, 2009, 2010, 2011**[i] ***Aged 16 and over and current drinker***

| NHS Board | Men | Women | Total |
|---|---|---|---|
| **Highland** | 19.1 | 15.2 | 17.1 |
| **Scotland** | **26.0** | **16.7** | **21.1** |

Source: Scottish Health Survey

**Alcohol dependence**

As a measure of alcohol dependence the below data presents the proportion of problem drinkers, derived from responses to the CAGE[xvi] questionnaire which highlights up to six indicators of problem drinking, including three indicators of physical dependency on alcohol. Prevalence of problem drinking is measured by agreement with two or more problem drinking indicators. Men are more likely than women, locally and nationally to have 2 or more problem drinking indicators. NHS Highland has a lower rate of problem drinking than Scotland. To address these issues there is increased engagement with treatment services and the capacity of the Third Sector partners is being enhanced.

**Table 7: Proportion of people with potential problem drinking, 2008, 2009, 2010, 2011' *Aged 16 and over and current drinker***

| | Two or more Problem Drinking Indicators | | |
|---|---|---|---|
| **NHS Board** | **Men** | **Women** | **Total** |
| **Highland** | 9.4 | 7.2 | 8.4 |
| **Scotland** | **13.9** | **9.5** | **11.7** |

Source: Scottish Health Survey

The Scottish Drugs Misuse Database (SDMD)[xvii] gathers data on the frequency of which those who consume alcohol drink. The percentage of those who drank every day has increased between 2008/09 (20%) and 2012/13 (26%). The percentage of those who only drink on 2-3 days per month has decreased from 17% in 2008/09 to 12% in 2011/12. The percentage for 2012/13 was not reported as the number was too small and may be identifiable.

**Table 8: Frequency of alcohol consumption: years ending 31 March 2009 to 2013**

| | Individuals | Alcohol Consumed Past Month | | Alcohol Frequency | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Every Day | | 5-6 Days per week | | 3-4 Days per week | | 1-2 Days per week | | 2-3 Days per month | | 1 day per month | | Less Often | |
| | n | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Highland | 2008/09 | 224 | 127 | 57% | 25 | 20% | * | * | 22 | 17% | 36 | 28% | 22 | 17% | * | * | * | * |
| | 2009/10 | 290 | 126 | 43% | 15 | 12% | * | * | 16 | 13% | 39 | 31% | 18 | 14% | * | * | - | - |
| | 2010/11 | 295 | 109 | 37% | 31 | 28% | * | * | 15 | 14% | 20 | 18% | 13 | 12% | * | * | - | - |
| | 2011/12 | 318 | 130 | 41% | 36 | 28% | 13 | 10% | 21 | 16% | 26 | 20% | 16 | 12% | 13 | 10% | - | - |
| | 2012/13 | 306 | 117 | 38% | 30 | 26% | 11 | 9% | 23 | 20% | 29 | 25% | * | * | * | * | - | - |

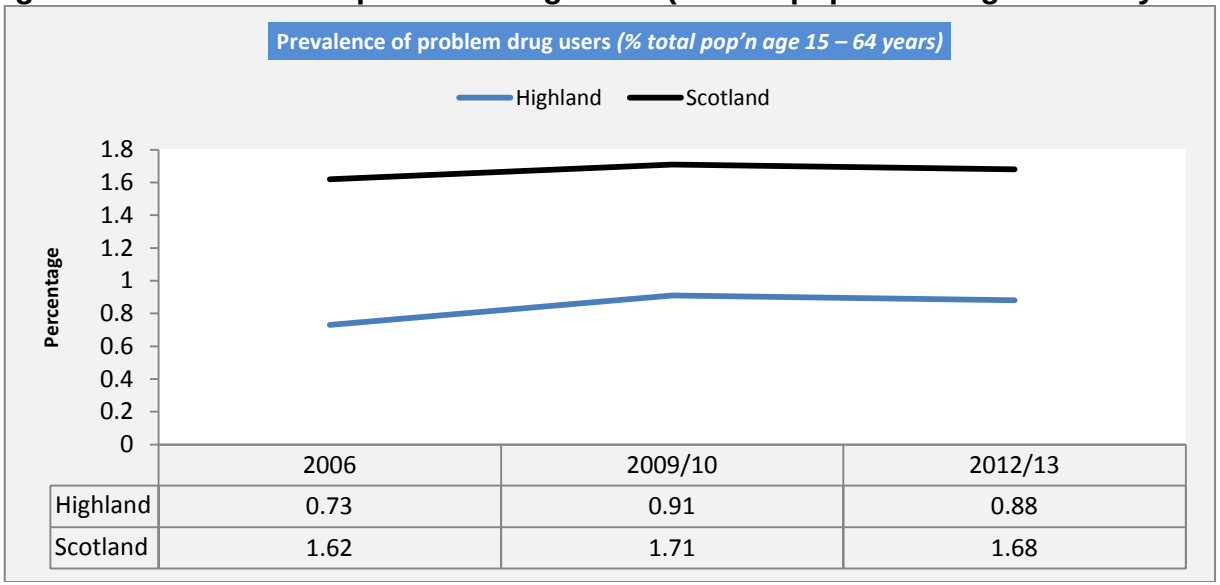
Source: Scottish Drugs Misuse Database – ADP Breakdown

### 2.3.2 Drugs prevalence

**Estimated prevalence of problem drug use amongst 15-64 year olds**

The Highland ADP area prevalence of problem drug users has decreased between 2009/10 (0.91) to 2012/13 (0.88). Over the same period the national rate has also decreased. Highland is statistically significantly 'better' than the national average.

**Figure 4: Prevalence of problem drug users (% total population aged 15-64 years)**




| | 2006 | 2009/10 | 2012/13 |
|---|---|---|---|
| Highland | 0.73 | 0.91 | 0.88 |
| Scotland | 1.62 | 1.71 | 1.68 |

Source: Information Services Division

Prevalence of male drug users was broken down by age for Highland for 2012/13. It was not possible to provide estimates by age group for females due to smaller numbers involved. The below table illustrates an aging population of problem drug users.

**Table 9: Estimated number of males with problem drug use in Highland ADP area and age group (ages 15 to 64); 2012/13**

| ADP Area | 15-24 | 25-34 | 35-64 |
|---|---|---|---|
| **Highland** | 200 | 340 | 430 |
| **Scotland** | 6600 | 14300 | 21400 |

Source: Information Services Division

The table below shows a summary of the number of known individuals with problem drug use identified in each of the data sources used to produce these estimates. Individuals were identified from multiple records by matching initials, date of birth, gender and

Council area of residence. It is possible therefore that there has been some under or over counting of individuals if these details were the same for different individuals or if an individual had records in more than one Council area.

**Table 10 : Summary of data on problem drug use by Council area 2012/13**

| ADP Area | Treatment | Hospital Admissions | Social Enquiry Reports | Police | Any |
|---|---|---|---|---|---|
| **Highland** | 541 | 130 | 110 | 63 | 728 |
| **Scotland** | 15000 | 4163 | 3916 | 4455 | 23255 |

Source: Information Services Division

Treatment data includes SDMD 2012/13 records and additional data collected from treatment services. 'Any' refers to the number of individuals present in one or more data sources.

The SDMD[xviii] collects information around which drugs are being used. In summary:

- the use of heroin was at its lowest (since 2009/09) in 2012/13 when 53% of individuals who use drugs had used it
- methadone use has increased overall by 4% since 2008/09, however has begun to decrease between 2010/11 (11%) and 2012/13 (9%)
- diazepam use has increased by 7% between 2008/09 and 2012/13
- Over the same period cannabis use has decreased by 13%. Figures for crack cocaine, ecstasy, and mephedrone have been extracted as they were too small to report.

The SDMD also publish data relating to injecting behaviours. The overall percentage of those who had injected within the past month has decreased between 2008/09 (34%) and 2012/13 (28%). In 2012/13 the age group with the highest percentage of problem drug users who had injected in the past month was 30-34 years (36%), followed by the 25-29 age groups (32%).

**Table 11: Injecting behaviour: years ending 31 March 2009 to 2013**

| | | Injecting behaviour | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Individuals | Total | | Injected in the past month | | Injected in the past, but not in the previous month | | Has never injected | |
| | | n | n | % | n | % | n | % | n | % |
| Highland | 2008/09 | 224 | 218 | 97% | 75 | 34% | 47 | 22% | 96 | 44% |
| | 2009/10 | 290 | 278 | 96% | 114 | 41% | 72 | 26% | 92 | 33% |
| | 2010/11 | 295 | 275 | 93% | 70 | 25% | 93 | 34% | 112 | 41% |
| | 2011/12 | 318 | 286 | 90% | 80 | 28% | 105 | 37% | 101 | 35% |
| | 2012/13 | 306 | 287 | 94% | 79 | 28% | 103 | 36% | 105 | 37% |

Source: Scottish Drugs Misuse Database – ADP breakdown

## Injecting Equipment Provision (IEP) outlets[xix]

The number if IEP outlets in the NHS Highland area from 2009/10 to 2013/14 have remained fairly constant, only increasing slightly. The national number has consistently increased over the same time period.

Table 12: **Number of IEP outlets 2009/10 – 2013/14**

| | **2009/10** | **2010/11** | **2011/12** | **2012/13** | **2013/14** |
|---|---|---|---|---|---|
| NHS Highland | 19 | 20 | 23 | 22 | 23 |
| Scotland | 255 | 269 | 292 | 290 | 299 |

Source: Scottish Drugs Misuse Database – ADP breakdown

The total number of attendances at IEP outlets in the NHS Highland area has fluctuated from 2010/11 to 2013/14; the last three years show a downward trend from 8048 attendances (2011/12) to 6561 (2013/14).

Table 13: Total number of attendances reported at IEP outlets 2010/11 – 2013/14

| | **2010/11** | **2011/12** | **2012/13** | **2013/14** |
|---|---|---|---|---|
| NHS Highland | 5310 | 8048 | 7522 | 6561 |
| Scotland | 234,127 | 219,384 | 213,098 | 226,056 |

Source: Scottish Drugs Misuse Database – ADP breakdown

# 3: Health harms

## 3.1 Children and young people

### 3.1.1 Children Affected by Parental Substance Misuses (CAPSM)/Families

Obtaining actual numbers of children affected by parental substance misuse is difficult. The Scottish Governments 2010/12 CAPSM strategy[xx] cites estimates of 40,000-60,000 children (equivalent to approximately 5%) affected by parental (one or both) drug misuse of which 10,000-20,000 may be living with at least one parent with drug misuse. It also includes an estimate of 65,000 (about 7%) of children affected by parental alcohol misuse in Scotland. Extrapolation of these rates to our own under 16 year old populations suggests the numbers in the table below.

**Table 14: Estimated number of Children aged under 16 years Affected by Parental Substance Misuse by area, 2010/12**

| Area | Estimated numbers of CAPSM | |
|---|---|---|
| | Parental Drug Misuse | Parental Alcohol Misuse |
| Highland ADP | 1,750-2,500 | 2,900 |
| NHS Highland | 2,350-3,400 | 3,800 |
| Scotland | 40,000-60,000 | 65,000 |

Source: CAPSM strategy and estimates calculated by the NHS Highland Health Intelligence Team

The SDMD[xxi] gathers information from clients in treatment services about if they have children. The percentage of individuals who have dependent children has risen steadily from 2008/09 (33%) to 2012/13 (45%).

**Table 15: Individual with Dependent Children: years ending 31 March 2009 to 2013**

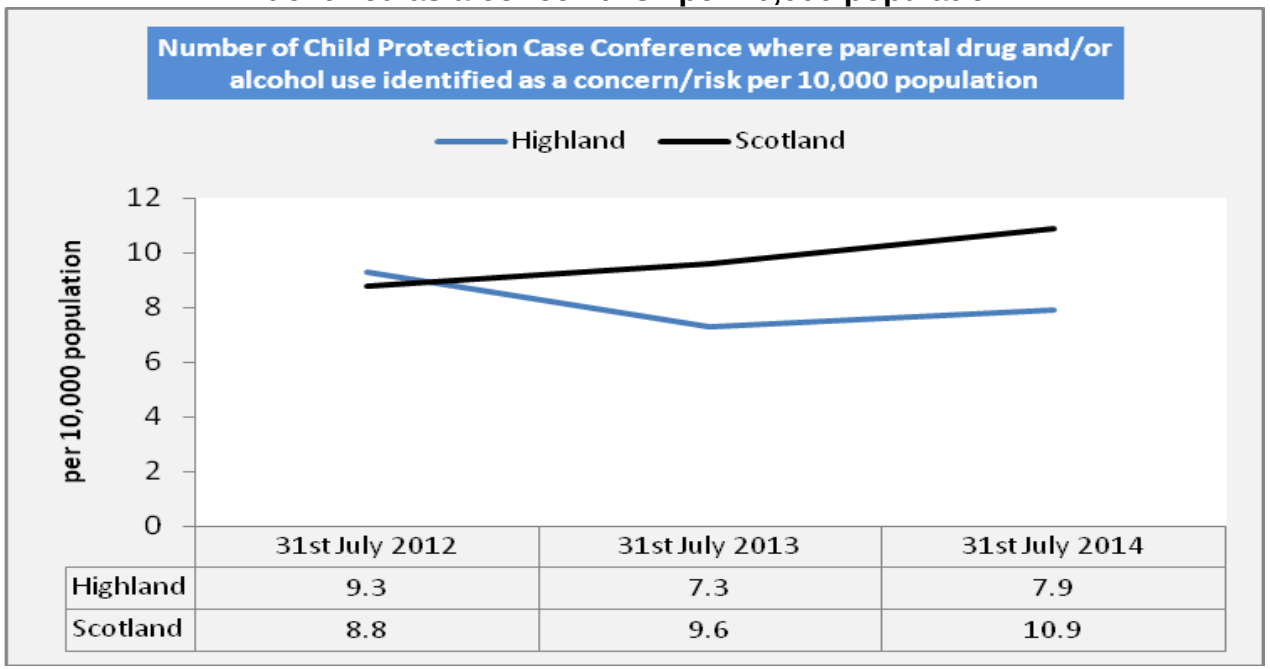
| | | Individuals | Individual has Dependent Children | |
|---|---|---|---|---|
| | | n | n | % |
| Highland | 2008/09 | 224 | 73 | 33% |
| | 2009/10 | 290 | 98 | 34% |
| | 2010/11 | 295 | 106 | 36% |
| | 2011/12 | 318 | 129 | 41% |
| | 2012/13 | 306 | 139 | 45% |

Source: Scottish Drugs Misuse Database – ADP breakdown

### 3.1.2 Child protection

In relation to the number of Child Protection Case Conference where parental drug and/or alcohol use identified as a concern/risk Highland is statistically not significantly different from national average. The Highland ADP rate per 10,000 population has decreased between 2012 and 2014, and in the same time period the national rate increased[xxii].

**Figure 5: Number of child protection case conference where parental drug and/or alcohol use Identified as a concern/risk per 10,000 population**




| | 31st July 2012 | 31st July 2013 | 31st July 2014 |
|---|---|---|---|
| Highland | 9.3 | 7.3 | 7.9 |
| Scotland | 8.8 | 9.6 | 10.9 |

Source: ScotPho Children and Young People Profiles

**Child Protection Register**

Children, as a result of various circumstances are taken into care or placed on the child protection register or both.

Statistics on children in care and on the child protection register are collected and submitted by local authorities. At local authority level, some of the data are published by the Scottish Government as additional tables. Other data are obtained by interrogation of the Child First system and derived from the individual submissions made.

The following table[xxiii] shows that during 2009/10 to 2012/13 in Highland Council (ADP Area), nearly three quarters (72%) of investigations resulted in no action taken but this proportion decreased to 66% in 2012/13.

**Table 16: Main statistics relating to Child Protection by year and Local Authority: Health Board by summation**

| | 2009/10[1] | | | 2010/11 | | | 2011/12 | | | 2012/13[2] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A & B | HC | NHS H | A & B | HC | NHS H | A & B | HC | NHS H | A & B | HC | NHS H |
| Nos. of investigations for CP[3] | 181 | 611 | **792** | 164 | 626 | **790** | 185 | 601 | **786** | 185 | 538 | **723** |
| % investigated with no action to be taken | na | 72% | - | 31% | 69% | **61%** | 21% | 68% | **57%** | 21% | 66% | **55%** |
| Nos. of registrations | 80 | 146 | **226** | 65 | 168 | **233** | 63 | 159 | **222** | 49 | 150 | **199** |
| Nos de-registered | 71 | 121 | **192** | 68 | 175 | **243** | 67 | 147 | **214** | 80 | 186 | **266** |
| Nos on the register as at reporting year end[1] | 43 | 99 | **142** | 39 | 97 | **136** | 48 | 116 | **164** | 17 | 80 | **97** |

Data source: Local Authority CP Returns to SG

For each child registered there may be a number of reasons for child protection registration. Nationally over one fifth report parental substance misuse and nearly one quarter report emotional abuse and neglect. During 2011/12, the proportions reported in both Highland and the Argyll & Bute councils are higher than the national average (29% and 27% respectively) for parental substance misuse.

**Table 17: Proportions of children registered on the child protection register during the year by the types of concerns by area for 2011/12 and 2012/13[xxiv]**

| Concern [1] | % of number registered during 2011/12 | | | | % of number registered during 2012/13 | | | |
|---|---|---|---|---|---|---|---|---|
| | A & B | HC | NHS H | Scotland | A & B | HC | NHS H | Scotland |
| Domestic Abuse | 25% | 25% | 25% | 18% | ds | 13% | N/K | 21% |
| Parental Alcohol Misuse | 27% | 16% | 19% | 13% | ds | 13% | N/K | 12% |
| Parental Drug Misuse | ds | 16% | N/K | 14% | ds | 12% | N/K | 16% |
| Parental substance Misuse | 29% | 27% | 27% | 22% | ds | 23% | N/K | 23% |
| Non-Engaging Family | ds | 9% | N/K | 11% | 0% | 9% | 7% | 13% |
| Parental Mental Health Problems | 11% | 17% | 15% | 12% | 0% | 16% | 12% | 14% |
| Child at self-risk | ds | ds | N/K | 1% | 0% | ds | N/K | 1% |
| Sexual Abuse | 0% | 4% | 3% | 6% | ds | 8% | N/K | 5% |
| Physical abuse | 13% | 14% | 14% | 11% | 0% | 7% | 5% | 13% |
| Emotional abuse | 46% | 13% | 23% | 24% | ds | 11% | N/K | 24% |
| Neglect | 27% | 14% | 18% | 24% | 14% | 20% | 19% | 24% |
| Child at self-risk | ds | ds | N/K | 1% | 0% | ds | N/K | 1% |
| Child Exploitation | ds | 0% | N/K | 0% | 0% | 0% | 0% | 0% |
| Other concern | 41% | 14% | 22% | 7% | 0% | 0% | 0% | 7% |
| **Total number of children** | **63** | **159** | **222** | **4,155** | **49** | **150** | **199** | **4,270** |

Types of concerns identified at case conferences of those who were registered as a result; these are not mutually exclusive and each child may have multiple concerns

Data source: Local Authority CP Returns to SG Statistics

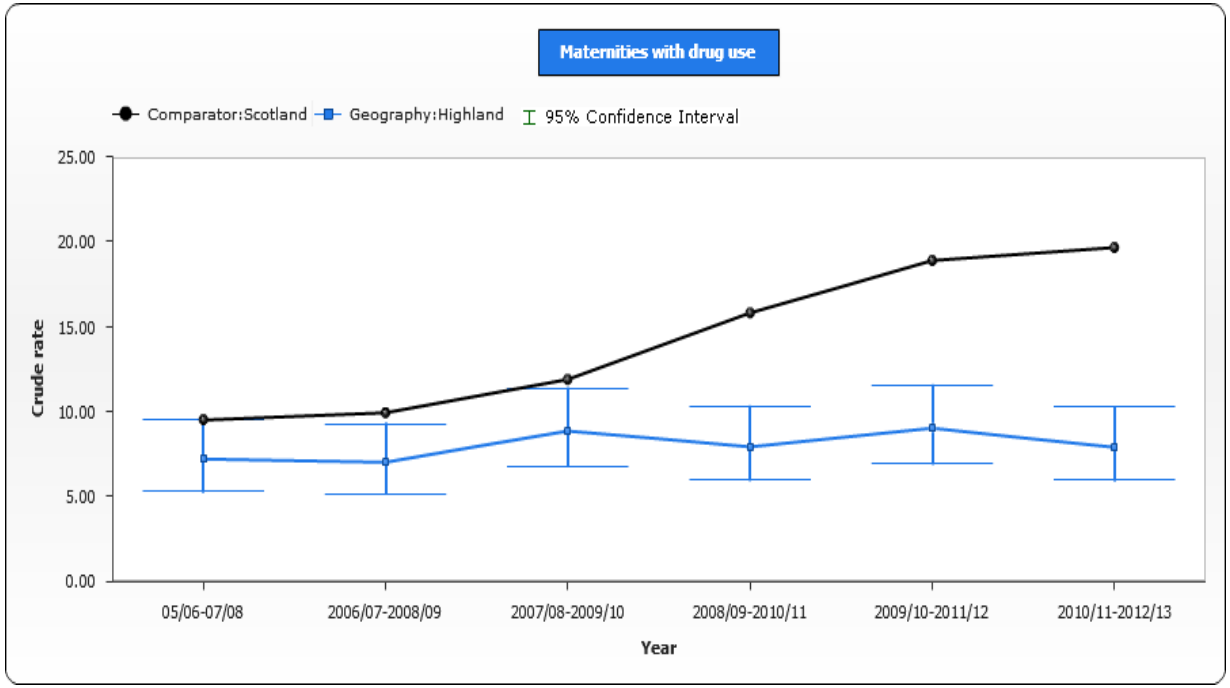
### 3.2: Rate of maternities recording drug use

There has been a notable increase in problem drug use in Highland as well as nationally and internationally since the 1980s. This increase has been disproportionately high among women of childbearing age. For many women and their partners, substance misuse creates significant problems in functioning and in their ability to manage their day-to-day life, employment, parental and

family responsibilities. Because of this, a significant number of children will have their health and wellbeing affected by their parent's use of substances. The effects of drugs on the baby include intra-uterine growth restriction, pre-term delivery, increased rates of still birth, neo natal death and sudden infant death.[xxv]

The Highland ADP area 3 year rolling average has been variable since 2004/05, showing a decrease between 2007/08 to 2010/11, rising slightly again by 2011/12, and falling again by 2012/13. Nationally the rate has steadily increased since 2005/06. Highland is statistically significantly 'better' than the national average[xxvi].

**Figure 6: Maternities with drug use**




Source: ScotPHO

**Table 18: Rate of maternities (per 1,000 maternities) recording drug misuse. Financial years 2004/05 - 2010/11, three year rolling average**

| ADP area | 2005/06-2007/08 | 2006/07-2008/09 | 2007/08-2009/10 | 2008/09-2010/11 | 2009/10-2011/12 | 2011/12-2012/13 |
|---|---|---|---|---|---|---|
| **Highland** | 7.2 | 7.0 | 8.9 | 7.9 | 9 | 7.9 |
| **Scotland** | 9.5 | 9.9 | 11.9 | 15.8 | 18.8 | 19.7 |

Source: ScotPHO

**Rate of maternities recording alcohol use**

There is no data to provide a time-trend for this indicator. This indicator should be interpreted with caution as it may not provide a complete picture of alcohol use in maternities. *Women Pregnancy and Substance Misuse: Good Practice Guidelines*[xxvii] continue to be monitored, and ABI delivery in antenatal settings is being sustained. Work has been initiated on FAS pathway, e.g. roll out of regular alcohol & pregnancy awareness initiatives e.g. Pregnant Pause events with coverage in local media.

### 3.2.1 Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorder (FASD)

The consumption of alcohol during pregnancy can cause damage to the fetus, and lead to fetal alcohol syndrome. The Scottish Government and Chief Scientist's Office have co-funded a four year surveillance study on FAS that has just entered its third year of operation and is collating information incidences among children under six years of age. The study group is also funded to raise awareness of fetal alcohol harm[xxviii].

It is extremely difficult to gauge the extent of FAS in the UK, this is mainly due to the lack of robust and reliable data collected. It is complicated to diagnose and due to the potential guilt felt by mothers who drink alcohol during pregnancy, the amount of alcohol consumed is considered to be under-reported. There is no 'safe' level of alcohol consumption during pregnancy, but drinking within the first or third trimesters is considered to be the most dangerous to the fetus. Whilst there is no cure for FAS, it is preventable. Work undertaken by NHS Highland, Health Intelligence Team suggests the prevalence of FAS in Highland is 1-2 in 1000 births, this equates to between 2-5 occurrences per year.

FASD is thought to far more prevalent than FAS and can resemble other conditions making it difficult to diagnose. The number of children in the UK with FASD is not accurately known but the Scottish Government estimate that FASD occurs in as many as 1 in 100 live births. There are currently no estimates of the numbers of children and young people likely to be affected in Highland.

### 3.2.2 Neonatal Abstinence Syndrome (NAS)

NAS can occur in infants born to mothers dependent on certain drugs including opioids, benzodiazepines, alcohol and barbiturates. It is characterised by central nervous system irritability, gastrointestinal problems and autonomic hyperactivity and symptoms normally present within the first 24-72 hours after birth, but may occur up to 7-10 days later. There appears to be little correlation between the amount of maternal drug use and the severity of NAS, although there is a correlation between methadone dose and NAS[xxix] .

Data on the numbers of babies born with a diagnosis of NAS in Highland are unable to be reported as a result of data protection issues.

### 3.2.3 Proportion of positive ABI screenings in ante-natal setting

2% of all ABIs in the NHS Highland area were delivered in an antenatal setting in both 2012/13 and 2013/14. Work is ongoing to increase the confidence and skills of midwives to deliver ABI's and embed them in to routine practice[xxx].

**Table 19: Proportion of positive ABI screenings in ante-natal setting, 2013/14**

| NHS Board | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| **Highland** | 120 (2%) | 86 (2%) | 108 (1%) |
| **Scotland** | 3591 (4%) | 2191 (2%) | 2492 (3%) |

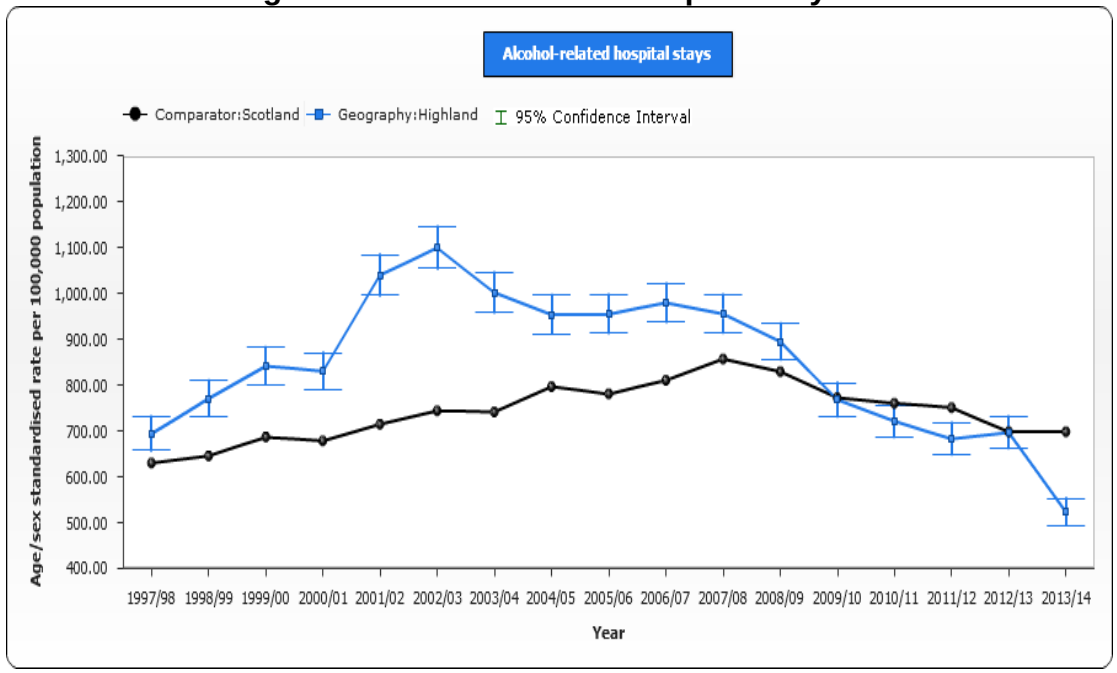
Source: Information Services Division

## 3.3 Adult

### 3.3.1 Alcohol related hospital stays[xxxi]

In relation to alcohol related stays Highland is statistically significantly better than the National average. Both local and national figures have decreased since 2007/08, Highland at a greater rate than Scotland.

**Figure 6: Alcohol related hospital Stays**




Source: ScotPHO

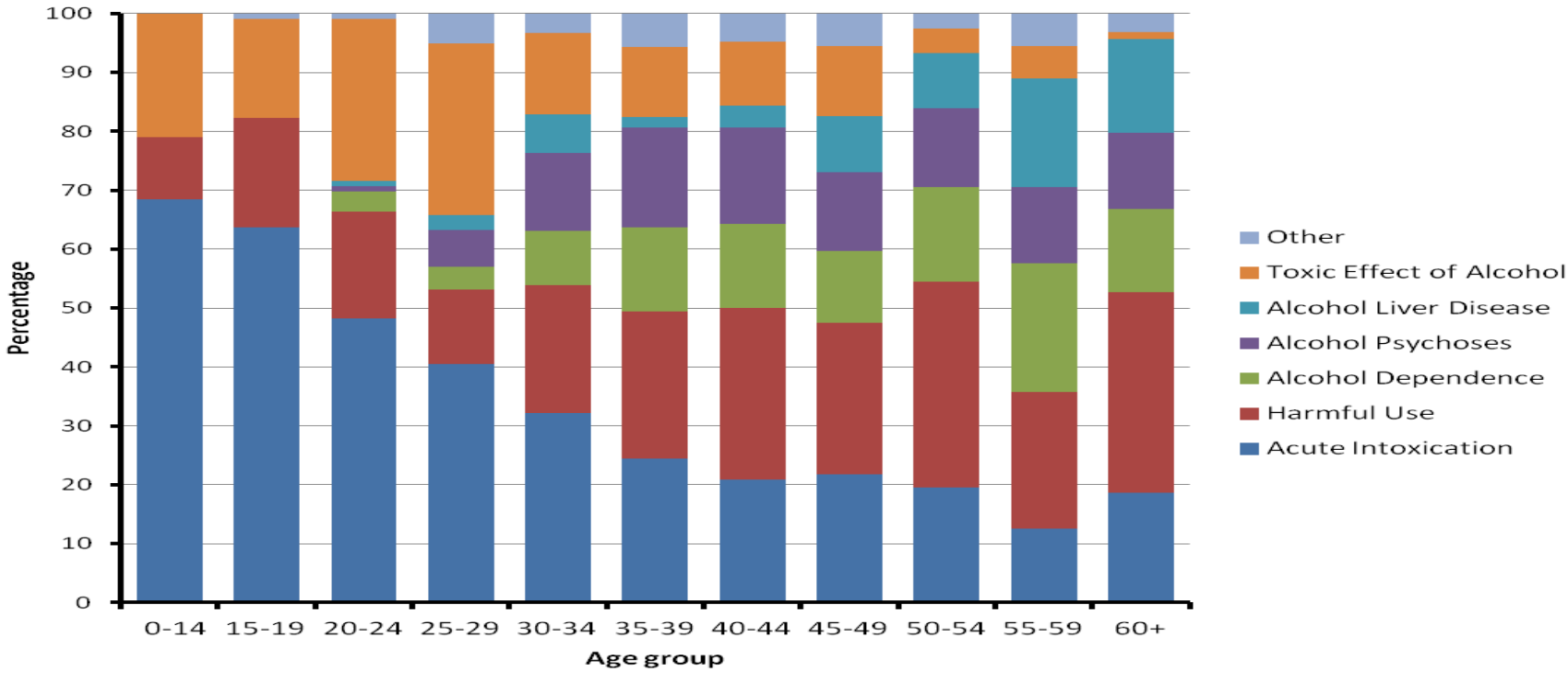
**Table 20: Alcohol related hospital discharges per 100,000 population**

| ADP | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|---|---|
| **Highland** | 978 | 954 | 894 | 767 | 720 | 681 | 694 | 522 |
| **Scotland** | 810 | 856 | 828 | 771 | 759 | 749 | 693 | 697 |

Source: ScotPHO

The graph below shows a breakdown of the alcohol related discharges for 2011-12 by diagnosis and age. A diagnosis of 'Toxic Effect of Alcohol' was most common in the 20-24 and 25-29 age groups. 'Alcohol Liver Disease' was most common in the over 55 age group. 'Alcohol Psychoses' diagnosis is similar from 30-34 age group through to the over 60s. 'Alcohol Dependence' does not appear to be very common amongst the younger age groups, but appears more often amongst those over 30. The age group where 'Harmful Use' was most often diagnosed was 50-54; it was also a common diagnosis in the 60+ age group. Almost 70% of under 15 year olds who were discharged from hospital due to alcohol had a diagnosis of 'Acute Intoxication'. The appearance of more chronic diseases associated with alcohol amongst the older age groups highlights the problems associated with long term misuse of alcohol.

**Figure 6: Percentage of general acute inpatient discharge diagnoses directly related to alcohol in any diagnostic position by age group, 2011-12 Highland residents**

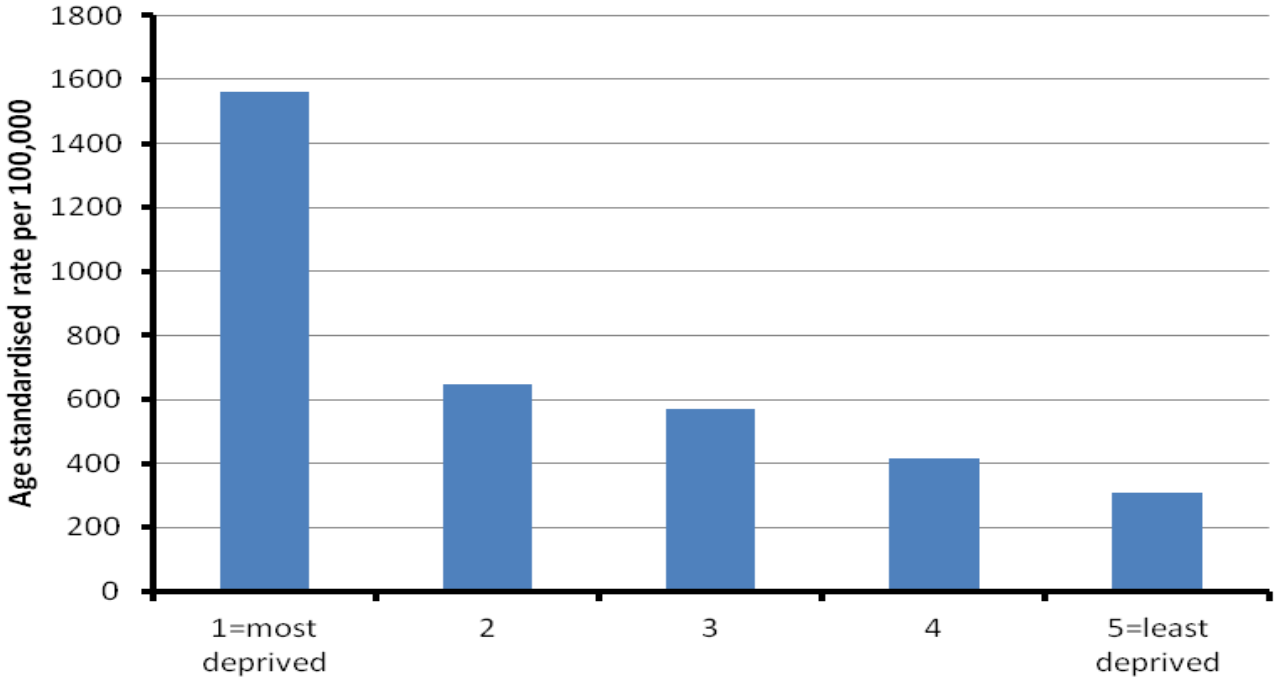



Source: NHS Highland SMR01 files

The gradient illustrated below is non-linear with the greatest burden of alcohol related harm concentrated in those who live in the most deprived areas in 2011-12. As illustrated in the figure above much of this activity is a consequence of conditions that often arise from years of alcohol-related chronic illness. These years are often associated with downward social mobility as chronic drinking results in the dislocation of work and family functions. Loss of employment and new living arrangements are common outcomes and there is frequently requirement for new housing. This accommodation is often necessarily found in the most deprived areas.

The following graph should therefore be interpreted with some caution. The pattern reflects the burden of disease resulting from long-term alcohol misuse but could mislead some into thinking that deprivation is an important marker for the onset of the condition.

**Figure 7: NHS Highland age standardised rates per 100,000 for general acute inpatient discharges with an alcohol-related diagnosis in any position of the hospital record by quintile of within Board deprivation, 2011-2012**




Source: NHS Highland SMR01 files

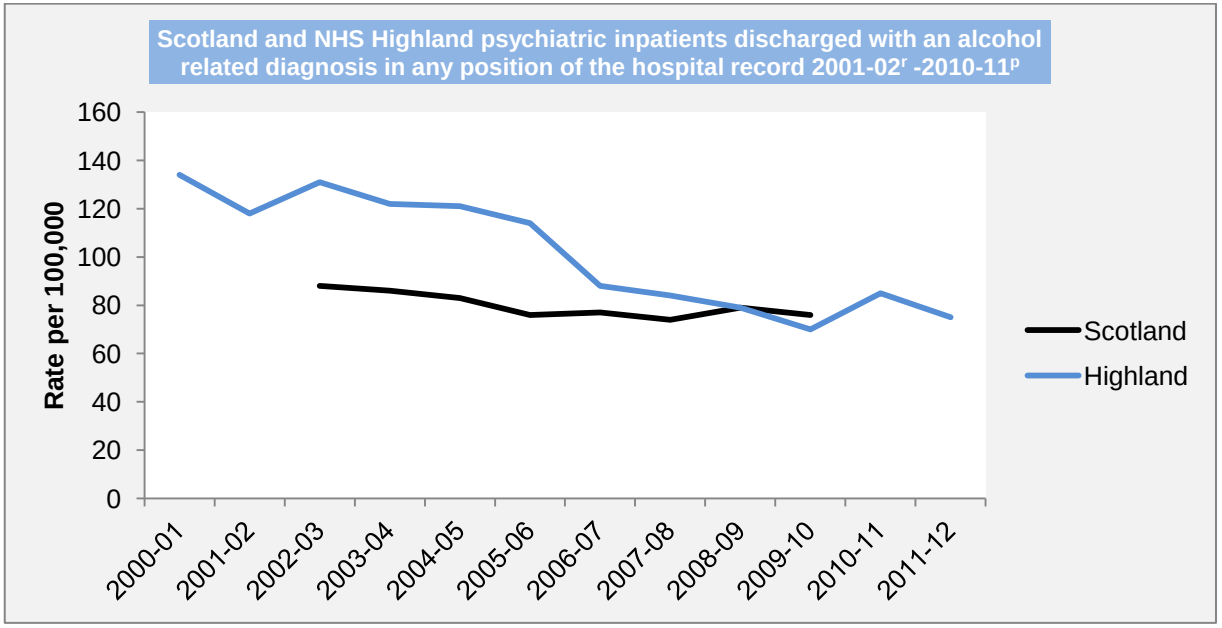
### 3.3.2 Alcohol related psychiatric inpatient discharges

The following data about psychiatric inpatient and day case recording has been extracted from the national SMR04 scheme for the Mental Health Specialties. As with activity in the acute sector it should be noted that recording of alcohol misuse is known to vary between hospital locations.

NHS Highland discharge rates in psychiatric care with an alcohol related diagnosis halved between 2001-02 and 2011-12. 70% of these discharges were for males in 2011-12. 80% of all discharges are aged under 60 years of age in 2011-12.

There has been a notable decrease in discharge activity in the acute psychiatric setting in NHS Highland and this has resulted in rates that are now very similar to those nationally. This change principally results from the modernisation of service provision and increasing community care. The variation in rates at Local Authority level will be partly explained by service supply factors.

**Figure 8: Scotland and NHS Highland psychiatric inpatients discharged with an alcohol related diagnosis in any Position of the hospital record 2001-02 – 2010-11**




Source: NHS Highland SMR04 files and Alcohol Statistics Scotland

**Table 21: Highland ADP and Scotland, psychiatric inpatients discharged with an alcohol related diagnosis in any position of the hospital record – number and directly standardised rates per 100,000 population by residence and financial year end period**

| | | 2000-01[r] | 2001-02[r] | 2002-03[r] | 2003-04[r] | 2004-05[r] | 2005-06[r] | 2006-07[r] | 2007-08[r] | 2008-09[r] | 2009-10[r] | 2010-11[p] | 2011-12[p] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SCOTLAND** | Number | | | 4590 | 4515 | 4394 | 4289 | 4068 | 3895 | 4179 | 4042 | | |
| | ***Rate per 100,000*** | | | ***88*** | ***86*** | ***83*** | ***76*** | ***77*** | ***74*** | ***79*** | ***76*** | | |
| **HIGHLAND ADP** | Number | 287 | 255 | 278 | 260 | 262 | 249 | 195 | 190 | 174 | 156 | 192 | 174 |
| | ***Rate per 100,000*** | ***134*** | ***118*** | ***131*** | ***122*** | ***121*** | ***114*** | ***88*** | ***84*** | ***79*** | ***70*** | ***85*** | ***75*** |

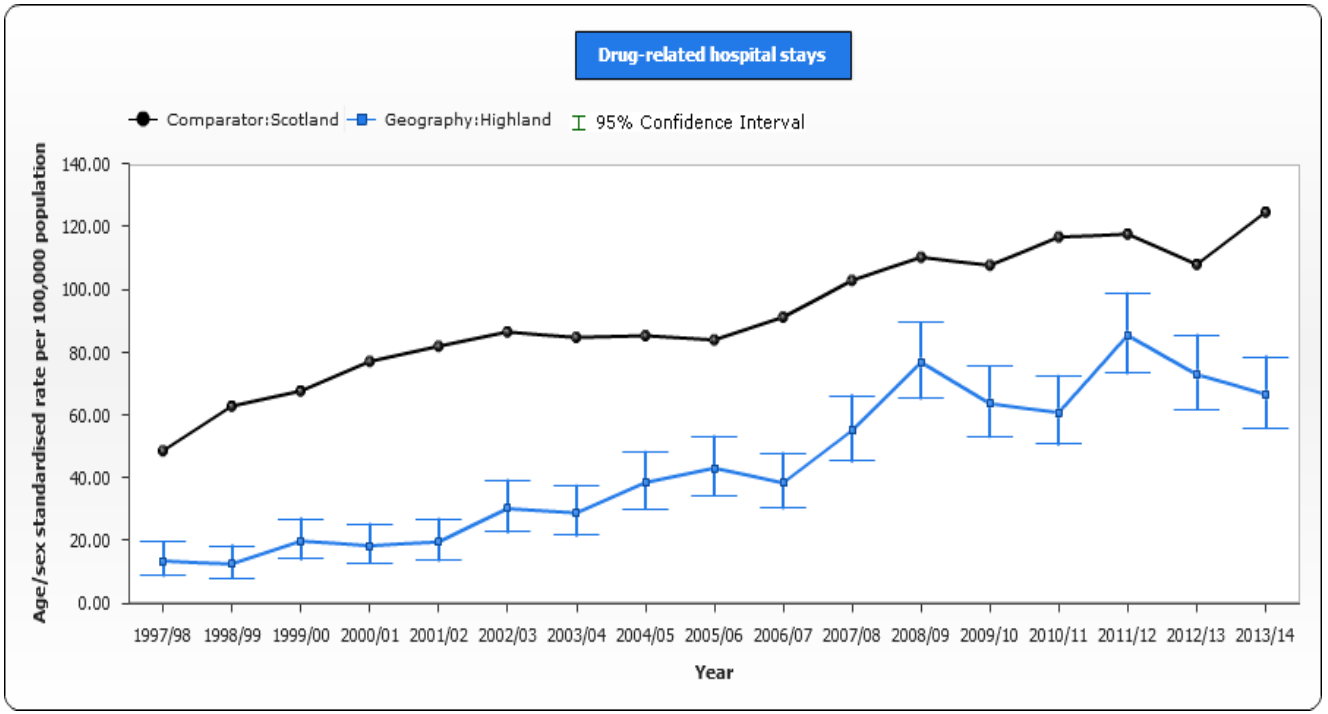
Source: NHS Highland SMR04 files and Alcohol Statistics Scotland
r. Revised
p. Provisional

### 3.3.3 Drug related hospital stays

Following a steady increase from 2006/07 to 2008/09 in Highland the figures began to decrease until 2010/11. There was a sharp increase between 2010/11 and 2011/12, which may in part be due to improvements in recording along with recognition and greater encouragement to disclose drug-related problems in Highland. Figures have since decreased again by 2013/14.

National figures have not varied as much as they have in Highland but show a similar trend between 2010/11 to 2012/13 with an increase between 2012/13 and 2013/14. Highland is statistically significantly 'better' than the national average.

## Figure 9: Drug related hospital stays[xxxii]




Source: ScotPHO

**Table 22: Drug related hospital stays per 100,000 population**

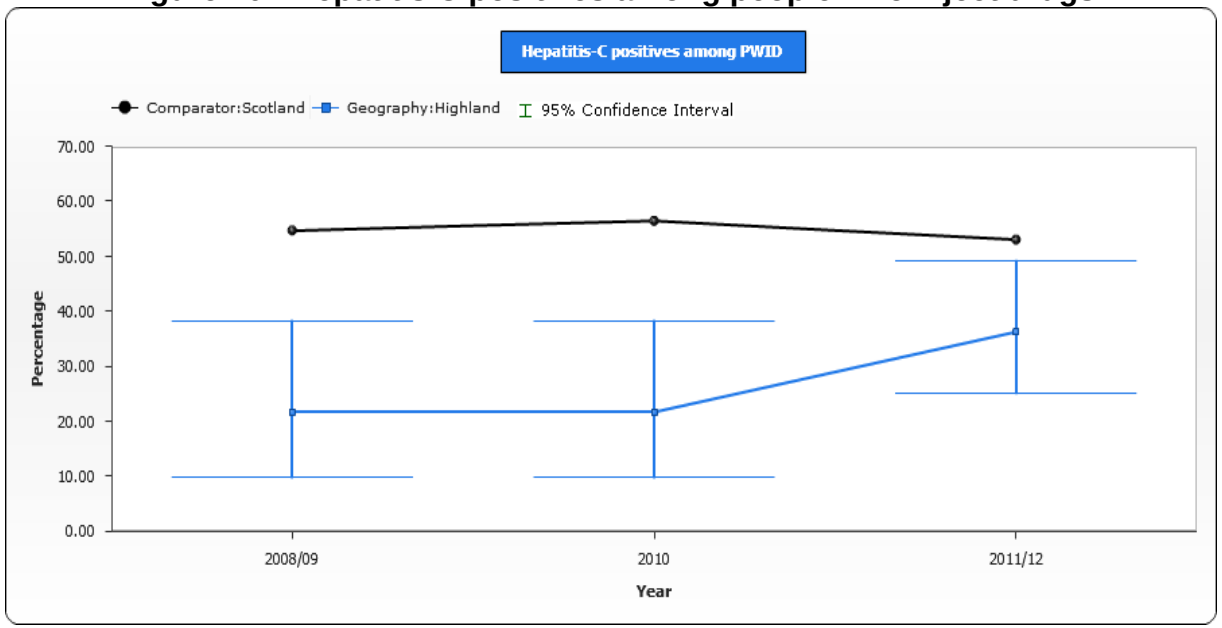
| ADP | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|---|---|
| **Highland** | 38 | 55 | 77 | 64 | 60 | 85 | 72 | 67 |
| **Scotland** | 91 | 103 | 110 | 108 | 116 | 118 | 107 | 125 |

Source: ScotPHO

### 3.3.4: Prevalence of hepatitis C among people who inject drugs[xxxiii]

Percentages, both locally and nationally, for Hepatitis C remained very similar/the same from 2008/09 to 2010. In 2011/12 the Highland percentage increased and the national percentage decreased. However, Highland is statistically significantly 'better' than National average.

**Figure 10: Hepatitis C positives among people who inject drugs**




Source: ScotPHO

**Table 23: Hepatitis C positives among PWID, percentage**

| ADP | 2008/09 | 2010 | 2011/12 |
|---|---|---|---|
| **Highland** | 22 | 22 | 36 |
| **Scotland** | 55 | 56 | 53 |

Source: ScotPHO

### 3.3.5 Blood Bourne Virus (BBV) testing[xxxiv]

The percentage of clients at substance misuse services *tested* for Hepatitis B has increased between 2008/09 (31%) and 2012/13 (44%). Over the same period there was also an increase in testing for Hepatitis C (33% to 46%), and HIV (28% to 40%).

**Table 24: BBV testing information: years ending 31 March 2009 to 2013**

| | | Individuals | Information available of HEP B testing | | Tested for Hep B | | Information available of HEP C testing | | Tested for Hep C | | Information available of HIV testing | | Tested for HIV | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | n | n | % | n | % | n | % | n | % | n | % | n | % |
| Highland | 2008/09 | 224 | 113 | 50% | 70 | 31% | 116 | 52% | 75 | 33% | 113 | 50% | 62 | 28% |
| | 2009/10 | 290 | 176 | 61% | 118 | 41% | 178 | 61% | 119 | 41% | 175 | 60% | 112 | 39% |
| | 2010/11 | 295 | 153 | 52% | 120 | 41% | 153 | 52% | 120 | 41% | 151 | 51% | 114 | 39% |
| | 2011/12 | 318 | 175 | 55% | 138 | 43% | 173 | 54% | 137 | 43% | 171 | 54% | 132 | 42% |
| | 2012/13 | 306 | 163 | 53% | 134 | 44% | 169 | 55% | 141 | 46% | 153 | 50% | 122 | 40% |

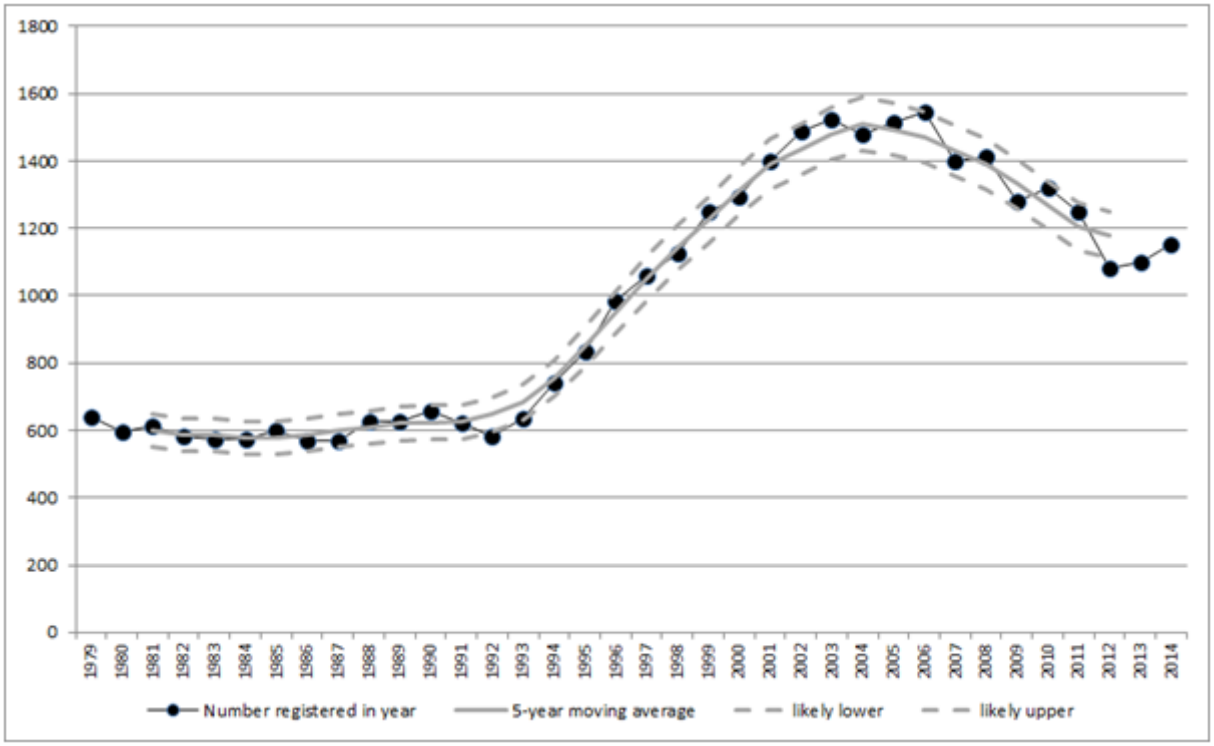
Source: Scottish Drugs Misuse Database – ADP breakdown

## 4: Mortality

### 4.1: Alcohol related mortality

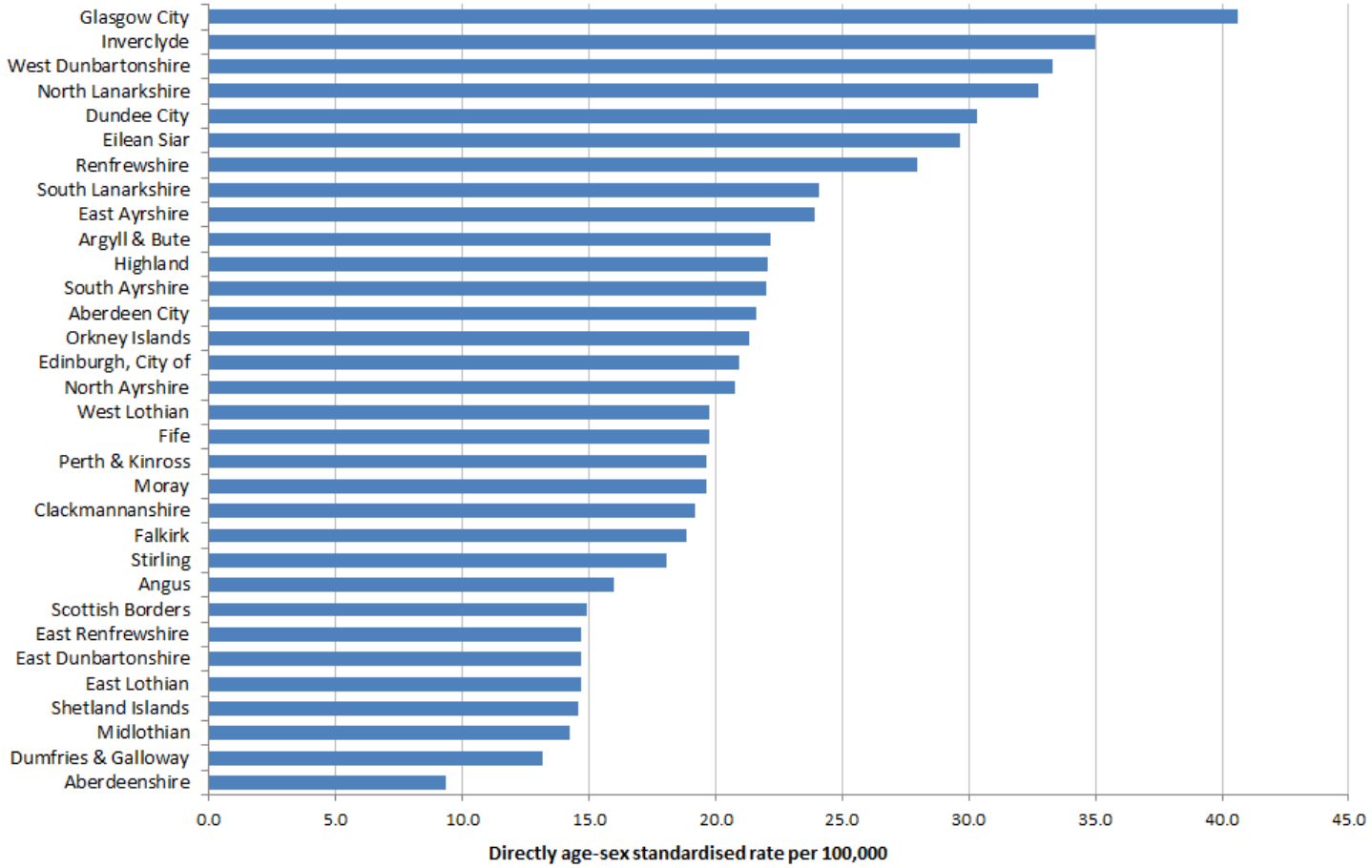
The recent downward trend in alcohol consumption reported earlier has coincided with a national downward trend in alcohol-related mortality. From 2012 there has been an upward trend but this should be interpreted with caution as this may be due to a change in reporting and also might not be sustained. The following figure shows that alcohol-related deaths in Scotland remain high relative to rates prior to the 1990s[xxxv].

**Figure 11: Alcohol related mortality**




**Source:** National Records of Scotland

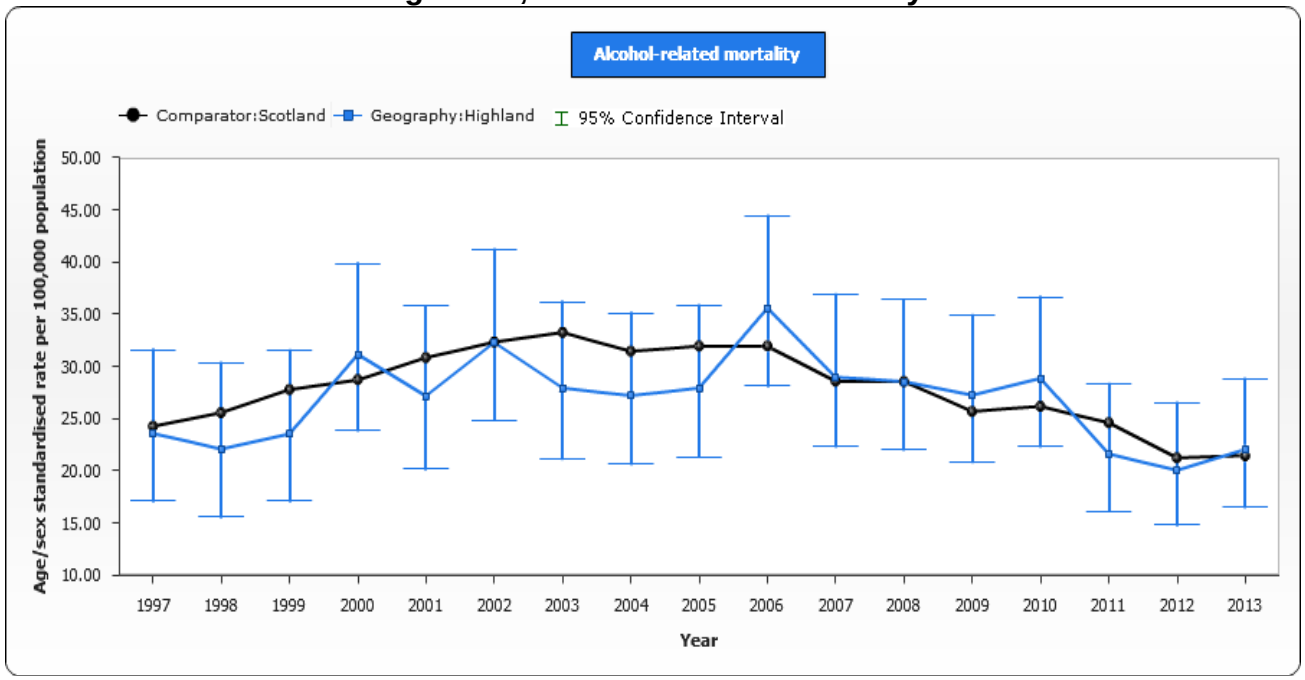
**Figure 12: Alcohol-related deaths by Local Authority 2010-2014 calendar year (rolling aggregate, directly age-sex standardised rate per 100,000 population[xxxvi].**




Source: National Records of Scotland, ScotPHO Online Health and Wellbeing Profiles

Although Highland was slightly above the national average for alcohol related mortality until 2011 it is not statistically significantly higher. In 2011 Highland fell below the national average, it has remained below by a very small margin in 2012. In 2013 Highland was again higher than the national average[xxxvii].

**Figure 13; Alcohol-related mortality**




Source: ScotPHO

**Table 25: Alcohol related mortality per 100,000 population**

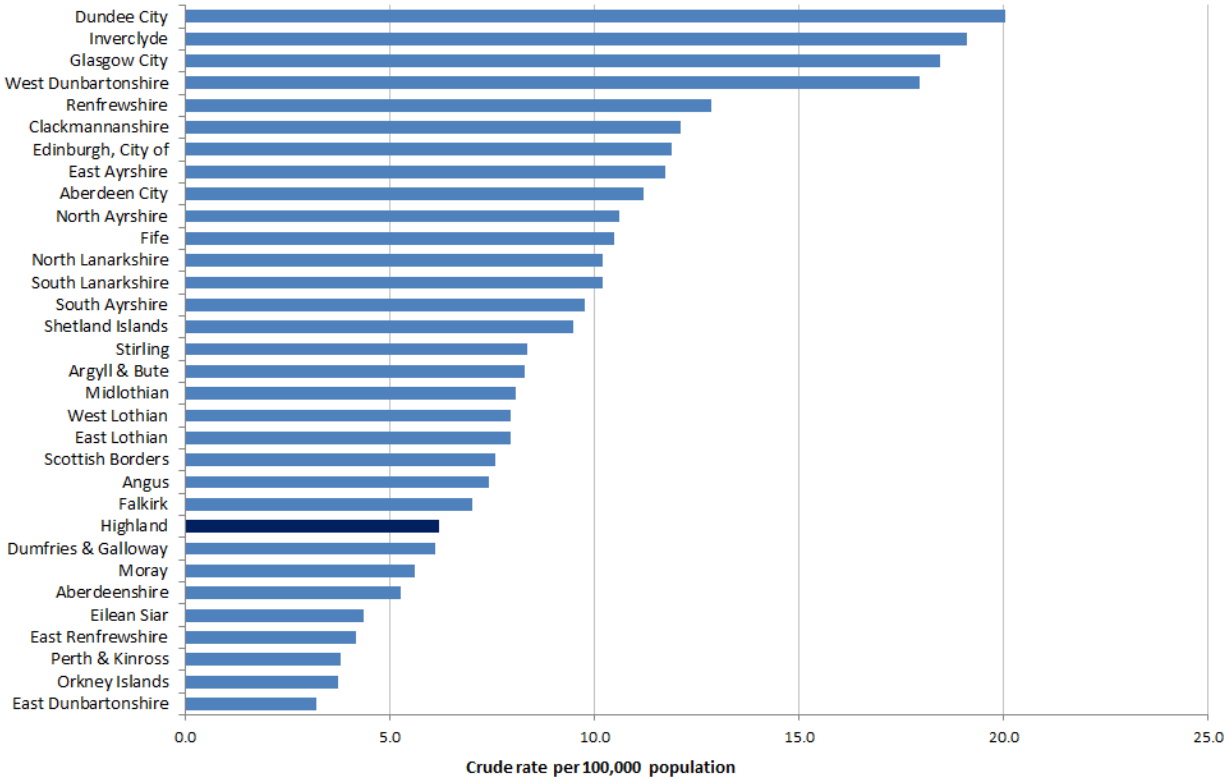
| ADP | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|
| **Highland** | 29 | 29 | 27 | 29 | 22 | 20 | 22 |
| **Scotland** | 29 | 29 | 26 | 26 | 25 | 21 | 21 |

Source: ScotPHO

## 4.2: Drug Related Mortality[xxxviii]

Compared to the rest of Scotland, the Highland ADP geographical area, is significantly lower than the Scottish average (based on a 5 year average) of 14 deaths.

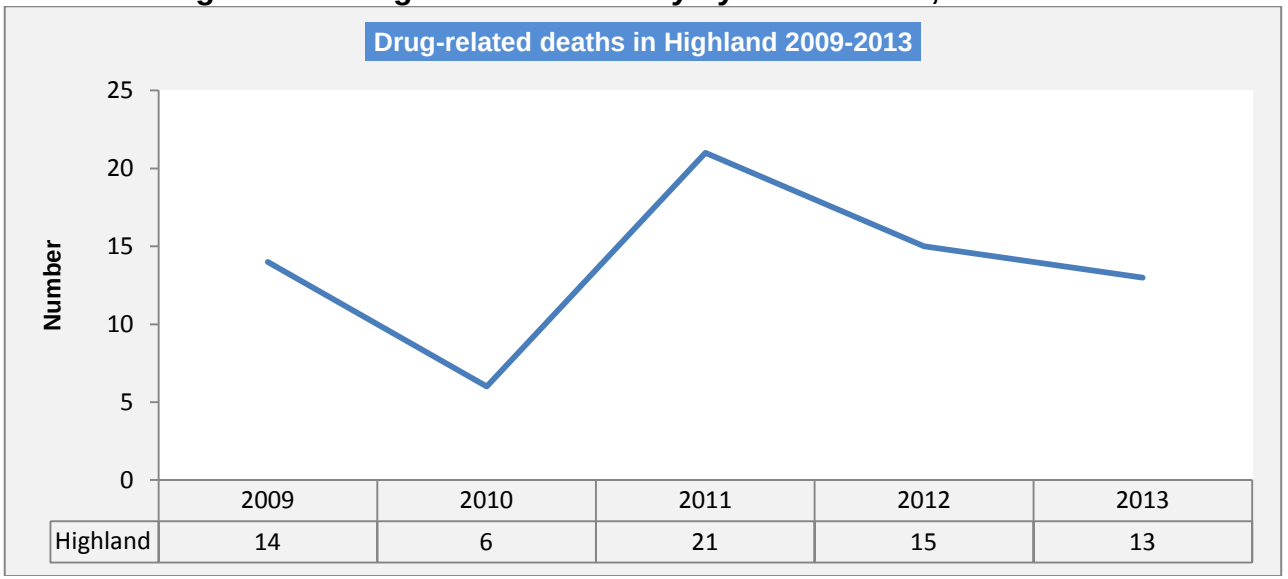
**Figure 14: Drug-related deaths by Local Authority 2010-2014 calendar years (5 year average), crude rate per 100,000 population.**




Source: National Records of Scotland

Based on the definition used for these statistics, 13 drug-related deaths were registered in the Highland ADP area in 2013. This has decreased from 15 in 2012 and 21 in 2011. There were 526 drug-related deaths in Scotland in 2013, 55 (99%) less than the previous year. The drug-related deaths per 1000 population from 2009-2013 in the Highland ADP area was 0.06. This is lower than the Scottish average (0.10).

**Figure 15: Drug– related mortality by council area, 2009 - 2013**




Source: National Records of Scotland

The average number of deaths has increased in both Highland and Scotland between 1999-2003 and 2009-2013. These are small numbers and therefore should be interpreted with caution.

**Table 26: Drug – related deaths by council area, averages for 1999-2003 and 2009-2013**

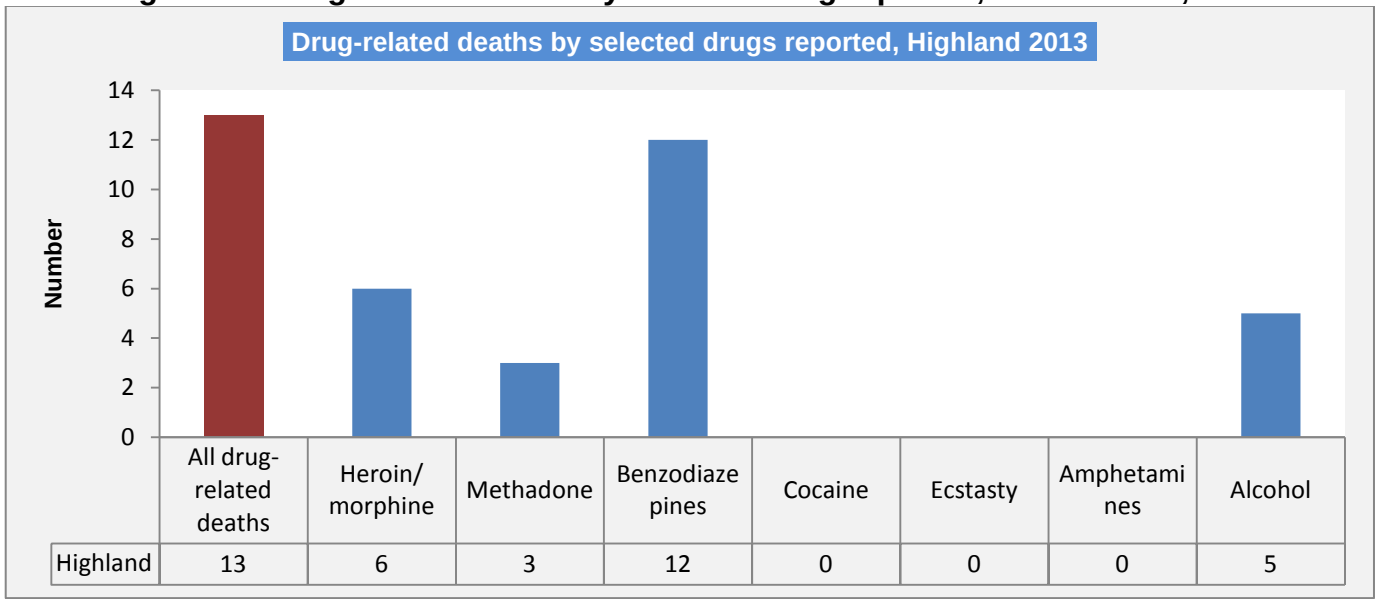
| Council Area | 1999-2003 | 2009-2013 |
|---|---|---|
| **Highland** | 6 | 14 |
| **Scotland** | 323 | 544 |

Source: National Records of Scotland

Of the 13 deaths in the Highland ADP area Methadone was implicated in, or potentially contributed to 3 deaths (23%). Benzodiazepines were implicated in, or potentially contributed to 12 of the 13 deaths (92%), and heroin 6 (46%). Numbers will add up to more than 13 as more than one drug may be reported per death.

Benzodiazepines were also the most common drug reported in Scotland. They were present in 49% of deaths, and methadone was implicated in, or potentially contributed to, 216 deaths (41%).

**Figure16: Drug-related deaths by selected drug reported, council area, 2013**




(More than one drug may be reported per death. These are mentions of each drug, and should not be added to give total deaths)
Source: National Records of Scotland

In both Highland and Scotland the 25-34 and 35-44 age groups had the highest average rate of drug-related deaths in 2009-2013. In most age groups Highland was below the national average; however it was above Scotland in 15-24 age group, and the same as Scotland in the 55-64 age group.

**Table 27: Drug-related deaths per 1000 population, Council area, annual averages for 2009 to 2013 – Age Group**

| Council Area | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | All Ages |
|---|---|---|---|---|---|---|
| **Highland** | 0.10 | 0.16 | 0.13 | 0.05 | 0.04 | 0.06 |
| **Scotland** | 0.08 | 0.25 | 0.26 | 0.12 | 0.04 | 0.10 |

Source: National Records of Scotland

The Highland directly age-sex standardised rate per 100,000 population of drug related mortality has decreased since 2011. The national rate also decreased but to a lesser extent. The Highland rate is not statistically different from the national rate.

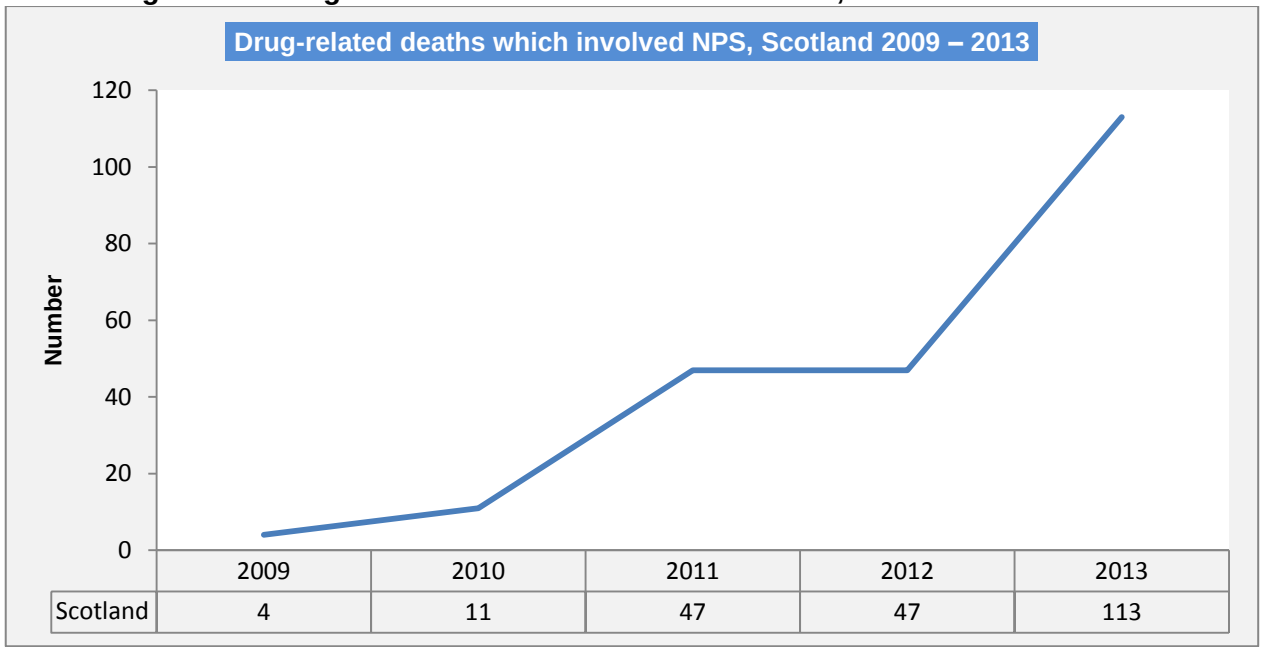
### 4.2.1 New Psychoactive Substances (NPS)[xxxix]

Over the past few years, there has been an increase in the prevalence of new psychoactive substances (NPS), also known as synthetic or 'legal' highs. NPS refers to substances that mimic the effect of illegal drugs, such as ecstasy or speed, but are not controlled under the Misuse of Drugs Act.

In 2013 there were 113 deaths in Scotland where **NPS were present**, compared with 47 in 2012; and 60 deaths where **NPS were implicated**, compared with 32 in 2012. In 55 of the 60 deaths, other substances were also implicated. This data is not broken down for local areas.

The NPS Phenazepam was most frequently found to be present and most often implicated in these deaths.

**Figure 17: Drug-related deaths which involved NPS, Scotland 2009 – 2013**




| | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Scotland | 4 | 11 | 47 | 47 | 113 |

Source: National Records of Scotland

## 5: Community safety outcomes of alcohol and drug misuse

### 5.1: Alcohol & crime[xl]

Alcohol misuse is a cross-cutting issue which impacts significantly on community safety in Highland. There were 101,191 incidents recorded during the period of 1st April 2013 to 31st March 2014. Of this total 9,878 were recorded with the alcohol marker. This equates to 9.8% of all incidents.

It is likely that further incidents also involved alcohol however this is not always known or recorded. The volume of incident types that are most likely to have an alcohol marker are incidents of; breach of the peace, drunk person, assault, and domestic abuse. Serious incidents such as domestic abuse, serious violent incidents, and sexual offence incidents, were more likely to involve alcohol.

**Table 28: Alcohol and drug related incidents recorded by the police in Highland**

| Incident type/Years | 2009/10 | 2011/12 | 2013/14 |
|---|---|---|---|
| Drunk and incapable | 2252 | 2202 | 1148 |
| Underage drinking | 552 | 325 | 130 |
| Offences from drunk driving | 395 | 305 | 349 |
| Offences from drug driving | NA | 29 | 22 |

Source: Police Scotland

It is encouraging to note downward trends in these recorded incidents except for offences relating to drunk driving. The latter is likely to relate to improvements in identification and recording.

## 5.2: Crime figures[xli]

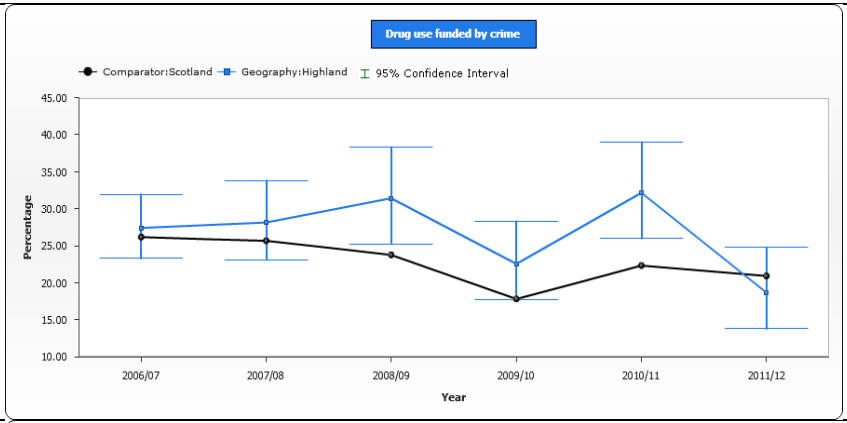
The following figures all show downward trends (in recent years) for different crime related data.

- **Offenders given a DTTO who are reconvicted within a year**
- **Attempted murder and serious assault**
- **Common assault**
- **Vandalism**
- **Breach of the peace**

**Figure 18: Community safety key issues**

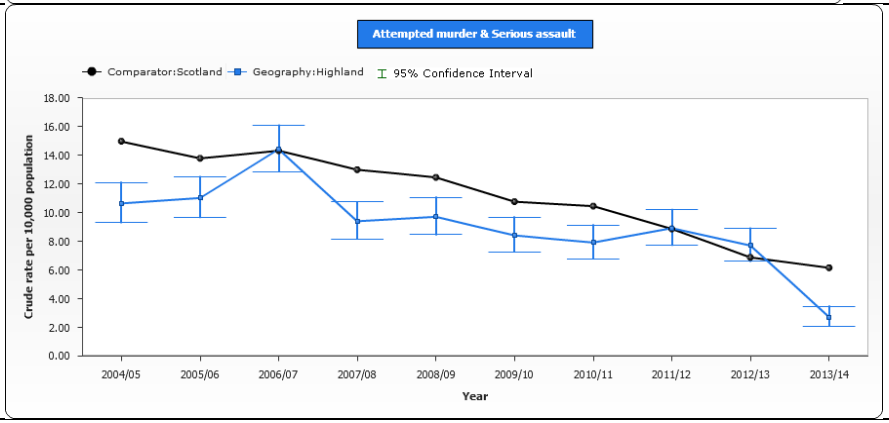
**Percentage of new clients at specialist drug treatment services who report funding their drug use through crime.**

In 2011/12 those clients at specialist drug treatment services who report funding their drugs through crime reached its lowest level in 2011/12 falling below the national average.
Highland is not significantly different to the national average.

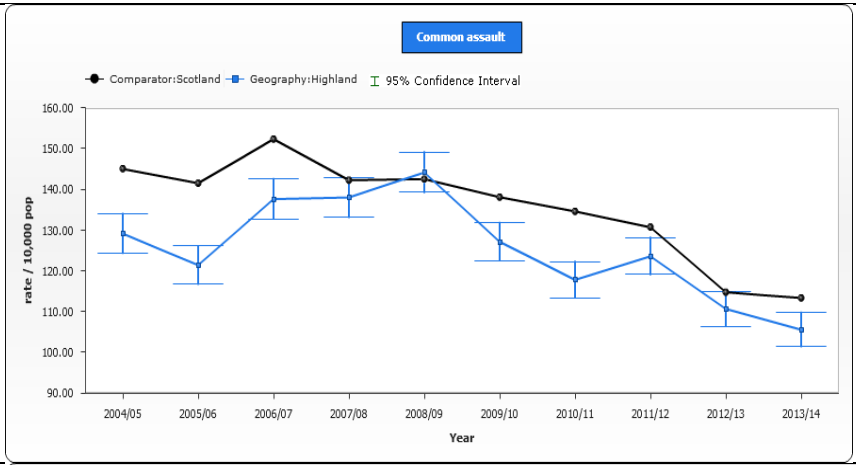



**Attempted murder and serious assault.**

Figures (crude rate per 10,000 population) have continued to fall for attempted murder and serious assault. Highland is statistically 'better' than the national average.
Note from 2013/14 the definition has changed from 'serious assault' to 'attempted murder and serious assault'.

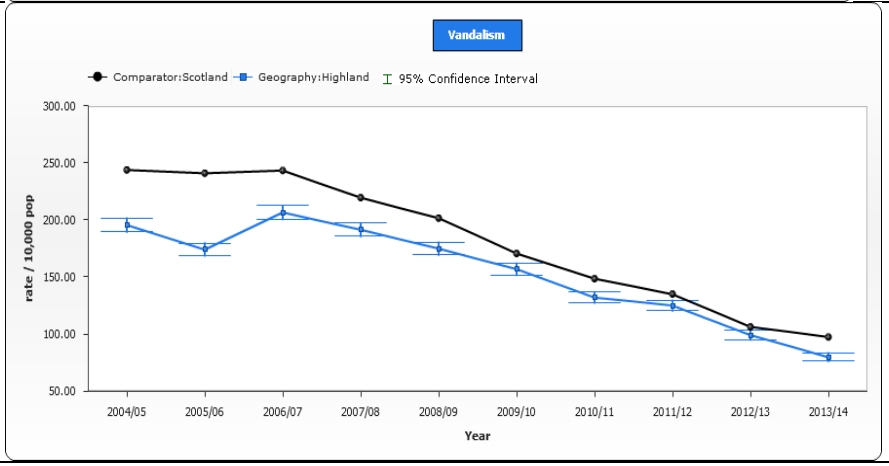


**Common assault.**
The Highland rate per 10,000 population has consistently been below the national rate since 2009/10.




**Vandalism**

The Highland rate per 10,000 population has decreased since 2006/7 and is statistically 'better' than the national average. The national figures have also decreased each year.




Source: ScotPho

## 5.3 Drug Treatment and Testing Orders[xlii]

Drug Treatment and Testing Orders (DTTOs) were introduced as a new community sentence under the Crime and Disorder Act 1998. They were designed as a response to the growing evidence of links between problem drug use and persistent acquisitive offending.

The Highland rate per 10, 000 population has not varied significantly between 2006/07 to 2013/14. The national figure has followed a similar pattern.

**Table 29: Drug Treatment and Testing Orders by Community Justice Authority. Number per 10,000 Population**

| Community Justice Area | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|---|---|
| Highland | 0.9 | 1.5 | 1.2 | 0.7 | 1.3 | 0.7 | 1.0 | 0.7 |
| Scotland | 1.8 | 1.6 | 2.0 | 2.0 | 1.8 | 1.5 | 1.7 | 1.6 |

Source: Highland Council Criminal Justice Services

## 5.4 Drug Seizures[xliii]

The number of seizures of controlled drugs has decreased by 4% in the Northern Police Force Area between 2011-12 and 2012-13. During the same period controlled drug seizures decreased by 3% in Scotland.

**Table 30: The no. of seizures of controlled drugs by police force area, 2010-11 to 2012-13**

| Police Force Area | 2010-11 | 2011-12 | 2012-13 | % change from 2011-12 to 2012-13 |
|---|---|---|---|---|
| Northern | 1872 | 2462 | 2362 | -4 |
| Scotland | 26693 | 29734 | 28968 | -3 |

Source: Scottish Government

In 2011-12 out of all Class A drugs Cocaine was seized most often in the Northern Police Force Area (172), followed by Heroin (116), then Ecstasy type substances (110). In Scotland in the same period Heroin was the most seized Class A drug (2793),

followed by Cocaine. There were 441 Ecstasy type substance seizures in 2011-12 in Scotland, Northern accounted for a quarter of these.

In 2012-13 Heroin was the most seized Class A drug in both the Northern Police Force Area (161) and Scotland (2329). Cocaine was second in both Northern (152) and Scotland (2140). Ecstasy type substances were seized 110 times in Northern Police Force Area, accounting for 20% of all seizures in Scotland (553).
In total, Class A drug seizures rose by 6% in Northern Police Force area between 2011-12 and 2012-13, and decreased by 9% in Scotland.

**Table 31: The number of seizures of class A drugs made by Northern Police Force by drug type, 2011-12 to 2012-13**

| Drug Type | 2011-12 | 2012-13 |
|---|---|---|
| Cocaine | 172 | 152 |
| Crack | 5 | - |
| Ecstasy type substances | 110 | 110 |
| Heroin | 116 | 161 |
| LSD | 1 | - |
| Methadone | 17 | 8 |
| Methylamphetamine | 3 | 1 |
| Morphine | 1 | 4 |
| Other Class A | 7 | 20 |
| *Total* | *432* | *456* |

Source: Scottish Government

In 2011-12 Cannabis resin was the most common form of Cannabis seized in the Northern Police Force Area (598) and Scotland (9864). Amphetamines were the second most common Class B drug seized in Northern Police Force Area (160) and Scotland (996). Mephedrone seizures in Northern (53) accounted for over quarter (27%) of all seizures of Mephedrone in Scotland (195) in 2011-12. In 2012-13 Herbal Cannabis was the most common type of cannabis to be seized in Northern (679), and in Scotland (12934). Of other Class B drugs (not including cannabis) Amphetamines was highest in both Northern (183) and Scotland (692).

**Table 32: The number of seizures of class B drugs made by Northern Police Force by drug type, 2011-12 to 2012-13**

| Drug Type | 2011-12 | 2012-13 |
|---|---|---|
| Herbal Cannabis | 598 | 678 |
| Cannabis Resin | 788 | 626 |
| Cannabis Plants | 42 | 34 |
| *Total Cannabis* | *1428* | *1338* |
| Amphetamines | 160 | 183 |
| Barbituates | - | - |
| Mephedrone | 53 | 12 |
| Other Class B | 22 | 102 |
| *Total* | *1663* | *1635* |

Source: Scottish Government

In 2011-12 Diazepam was the most common Class C drug seized in Northern Police Force Area (267) and Scotland (4294).

In 2012-13 Diazepam was again the most common Class C drug seized in Northern Police Force Area (153) and Scotland (3277).

Other Benzodiazepines followed in Northern (65) accounting for 74% of all Other Benzodiazepine seizures in Scotland (88).

Overall, Class C drug seizure fell by 26% in Northern, and by 25% in Scotland.

**Table 33: The number of seizures of class C drugs made by Northern Police Force by drug type, 2011-12 to 2012-13**

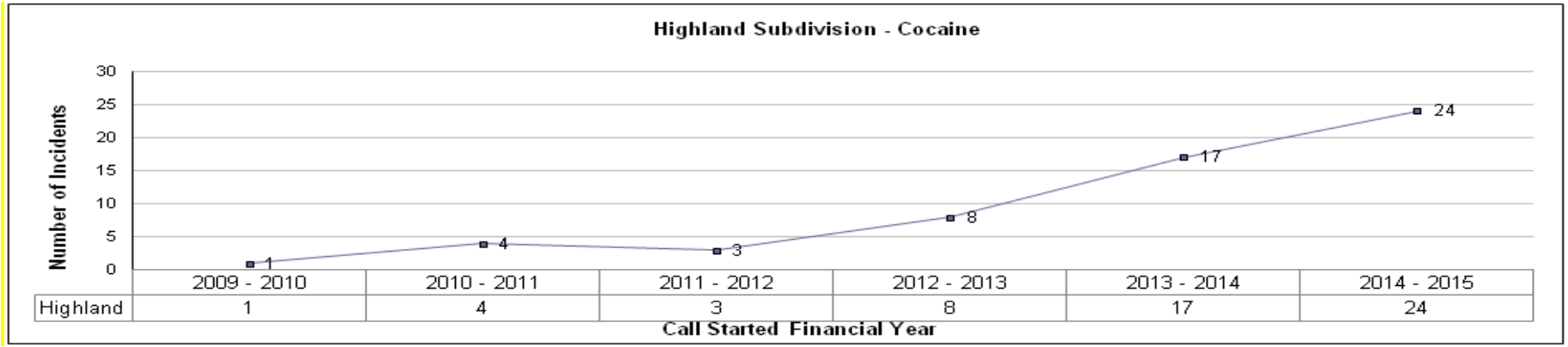
| Drug Type | 2011-12 | 2012-13 |
|---|---|---|
| Anabolic Steroids | - | 9 |
| Diazepam | 267 | 153 |
| GHB | - | - |
| Ketamine | 13 | 6 |
| Other Benzos | - | 65 |
| Temazepam | 8 | 3 |
| Other Class C | 79 | 35 |
| *Total* | *367* | *271* |

Source: Scottish Government

## 5.5 Number of incidents for Diagnostic Code Overdose with Cocaine or Heroin in Highland 2013 -14

The following figures show the number of Incidents for Diagnostic Code Overdose with Cocaine and Heroin in Highland. A similar pattern is also seen nationally. Overall there has been an increase between 2009-10 and 2014-15.

**Figure 19: Highland subdivision - Diagnostic Code Overdose Cocaine**




Source: Scottish Ambulance Service

**Figure 20: Highland subdivision - Diagnostic Code Overdose Heroin**


Source: Scottish Ambulance Service

## 5.6 Fire[xliv]

### Fire statistics

The Scottish Fire and Rescue Service (SFRS) can record instances where they suspect that a person being impaired due to alcohol and/or drugs was a contributory factor to a fire. It should be noted that if alcohol and/or drugs are suspected to have been a contributory factor in a fire, this does not necessarily mean that casualties were under the influence of alcohol and/or drugs.

The following table details the number and percentage of dwelling fires in which impairment due to suspected alcohol/drugs use was a contributory factor. In Scotland impairment due to suspected alcohol and/or drugs use was reported to be a contributory factor in 15 per cent of accidental dwelling fires (716) in 2013-14. The rate of non-fatal casualties per 1,000 accidental dwelling fires was three times higher where alcohol/drugs were believed to be a contributory factor (475 per 1,000 fires), compared to where alcohol/drugs were ruled out (151 per 1,000 fires).

In Highland 13% (18) of the total dwelling fires were due to suspected alcohol/drug impairment. This is a slightly lower percentage than nationally. In the previous year (2012-13) the figures were categorised by Fire and Rescue Service, not local authority, so cannot be compared.

The 2012-13 figure for Highland & Islands for dwelling fires in which alcohol/drugs was a contributory factor was 13.7% (24) of total dwelling fires.

Also, there were no fatalities from alcohol related dwelling fires in 2013/14 or 2014/15 to date, this is down from 1 fatality in 2012/13. There was a slight increase in causalities from alcohol related dwelling fires from 2012/13 (26) to 2013/14 (27). There have been 15 casulties in 2014/15 to date.

**Table 34: Accidental dwelling fires where impairment due to suspected alcohol/drugs use was a contributory factor, 2013-14 provisional**

| | Yes | No | Not Known | Total accidental dwelling fires |
|---|---|---|---|---|
| Highland ADP | 18 (13%) | 112 (78%) | 14 (10%) | 144 |
| Scotland | 716 (15%) | 3370 (72%) | 595 (13%) | 4681 |

Source: Fire and Rescue Statistics, Scotland, 2013-14

These figures were further broken down to localised areas in Highland (see below table).

**Table 35: Accidental dwelling fires – Highland alcohol related**

| Area | 2012/13 | 2013/14 | 2014/15 (YTD) | Total |
|---|---|---|---|---|
| Caithness and Sutherland Area Committee | 1 | 2 | 1 | 4 |
| City of Inverness Area Committee | 8 | 9 | 5 | 22 |
| Lochaber Area Committee | 3 | 2 | 1 | 6 |
| Nairn and Badenoch and Strathspey Area Committee | 3 | 1 | 0 | 4 |
| Skye, Ross and Cromarty Area Committee | 5 | 4 | 2 | 11 |
| Grand Total | 20 | 18 | 9 | 47 |

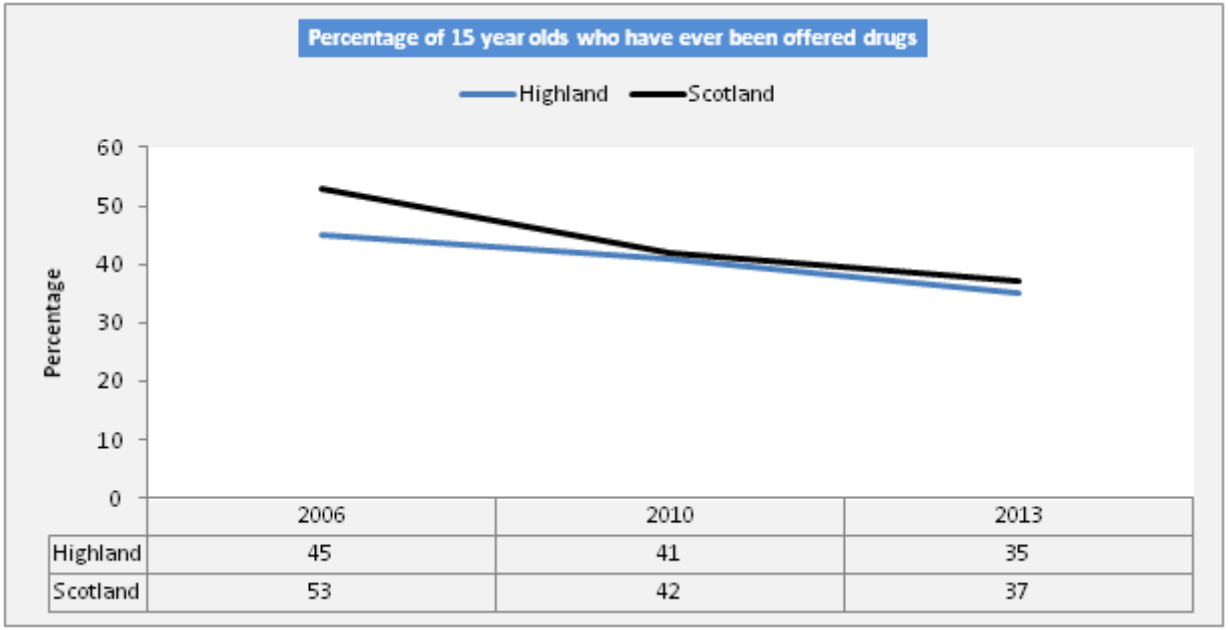
Source: Fire and Rescue Statistics, Scotland

## 6. Local Environment

### 6.1: Percentage of 15 year olds who have been offered drugs in the last year[xlv]

Between 2006 and 2013 the Highland ADP area prevalence rate for young people who had been offered drugs continued to be lower than the national average, but did not reduced at a similar rate. The target for 2015 is to sustain the decreasing trend by the same percentage rate of reduction.

**Figure 21: Percentage of 15 year olds who have ever been offered drugs**



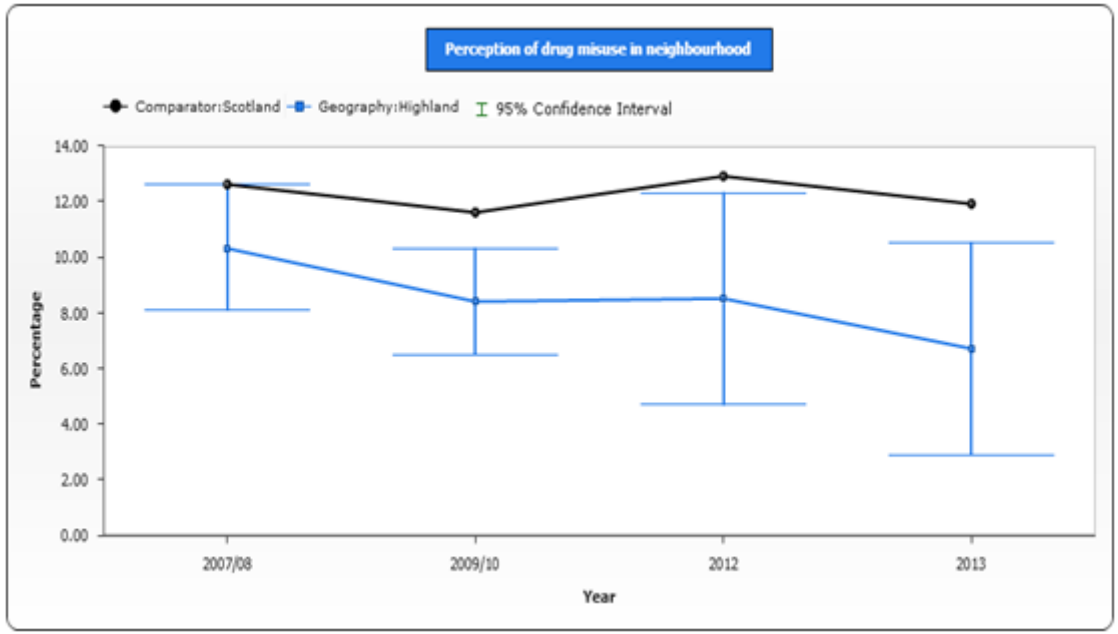

| | 2006 | 2010 | 2013 |
|---|---|---|---|
| Highland | 45 | 41 | 35 |
| Scotland | 53 | 42 | 37 |

Source: SALSUS

## 6.2: Percentage of people perceiving drug misuse or dealing to be common or very common in their neighbourhood[xlvi]

The percentage of people who perceive drug use and dealing as common in their area reduced both locally and nationally from 2007/08 to 2013. Over the same period the national percentage also decreased but at a lower rate. Highland is statistically significantly 'better' than National average. It is also perceived as less common in Highland ADP area than in Scotland as a whole.

**Figure 22: Perception of drug misuse in neighbourhood**




Source: ScotPHO

**Table 36: Percentage of people perceiving drug misuse or dealing to be very or fairly common in their neighbourhood. Financial years 2007/08, 2009/10**.

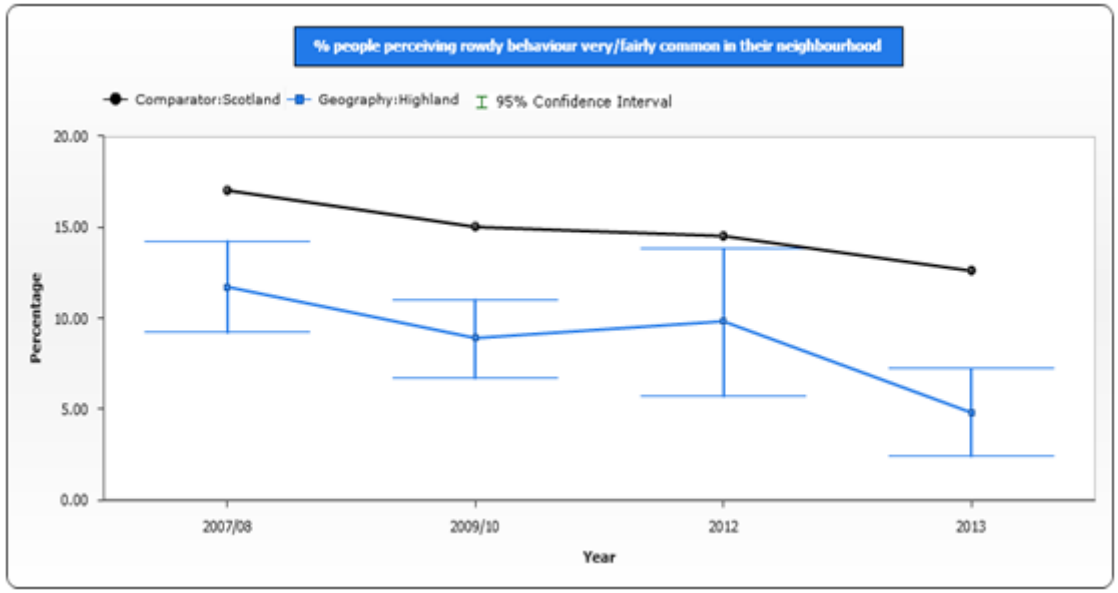
| Alcohol & Drugs Partnership area | 2007/08 | 2009/10 | 2012 | 2013 |
|---|---|---|---|---|
| **Highland** | 10.3% | 8.4% | 8.5% | 6.7% |
| **Scotland** | 12.5% | 11.6% | 12.9% | 11.9% |

Source: ScotPHO

### 6.3: Percentage of people perceiving rowdy behaviour (e.g. drunkenness, hooliganism or loutish behaviour) to be very or fairly common in their neighbourhood

The national percentage of people perceiving rowdy behaviour to be very or fairly common in their neighbourhood has decreased continuously from 2007/08 to 2013. In Highland there was a very slight increase in percentage between 2009/10 and 2012, falling again by 2013. However, Highland is statistically significantly 'better' than National average.

**Figure 23: Percentage of people perceiving rowdy behaviour very/likely in their neighbourhood**




Source: Scotpho

**Table 37: Percentage of people perceiving rowdy behaviour (e.g. drunkenness, hooliganism or loutish behaviour) to be very or fairly common in their neighbourhood. Financial years 2007/08, 2009/10, 2012/13**

| Alcohol & Drugs Partnership area | 2007/08 | 2009/10 | 2012 | 2013 |
|---|---|---|---|---|
| **Highland** | 11.7 | 8.9 | 9.8 | 4.8 |
| **Scotland** | 17 | 15 | 14.5 | 12.6 |

Source: Scotpho

## 6.4: Living Circumstances

### 6.4.1: Homelessness[xlvii]

In 2013 there were a total of 713 homeless approaches in Highland. 614 were assessed as homeless; of this 614, the Highland Council had a duty to accommodate 573 permanently. Homelessness occurs in Inverness most often, followed by Dingwall. Although these figures are not directly related to drugs and/or alcohol they are useful as there are links between substance misuse and homeless.

**Table 38: Homelessness**

| 2013 | Number of homeless approaches | Number assessed as homeless | No. of homeless applicants we have a duty to accommodate permanently |
|---|---|---|---|
| **Alness** | 50 | 47 | 46 |
| **Bad & Strat** | 27 | 21 | 21 |
| **Dingwall** | 94 | 81 | 78 |
| **Inverness** | 337 | 307 | 283 |
| **Lochaber** | 81 | 52 | 48 |
| **Nairn** | 25 | 19 | 17 |
| **Portree** | 57 | 51 | 50 |
| **Sutherland** | 3 | 3 | 3 |
| **Thurso** | 19 | 16 | 12 |
| **Wick** | 20 | 17 | 15 |
| **Total** | **713** | **614** | **573** |

**Source: Highland local records**

### 6.4.2: Living Situation

The SDMD[xlviii] records the living situation of drug and alcohol treatment clients. A client may identify more than one living situation, therefore the total of all living situations may not add up to the total information available. 217 clients gave information for this indicator. In Highland, in the majority of years (with the exception 2008/09) most clients lived alone. This was followed by living with a spouse/partner. The percentage of clients who live with other drug users has fluctuated between 2008/09 and 2012/13; however overall there has been an increase.

**Table 39: Living Situation: years ending 31 March 2009 to 2013**

| | | Individuals | Information on Individuals Living Situation | | Living with Spouse/ Partner | | Living with Parents | | Living Alone | | Living with Friends/Other Family | | Living with others - other | | Living with other drug users | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | Yes | | No | | No Answer | | Other | |
| | | n | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| Highland | 2008/09 | 224 | 217 | 97% | 73 | 34% | 44 | 20% | 67 | 31% | 22 | 10% | * | * | 41 | 19% | 106 | 49% | * | * | - | - |
| | 2009/10 | 290 | 281 | 97% | 74 | 26% | 71 | 25% | 98 | 35% | 26 | 9% | * | * | 61 | 22% | 131 | 47% | 43 | 15% | - | - |
| | 2010/11 | 295 | 293 | 99% | 49 | 17% | 35 | 12% | 69 | 24% | 12 | 4% | 22 | 8% | 53 | 18% | 28 | 10% | 204 | 70% | 10 | 3% |
| | 2011/12 | 318 | 317 | 100% | 59 | 19% | 38 | 12% | 85 | 27% | 18 | 6% | 17 | 5% | 85 | 27% | 27 | 9% | 201 | 63% | * | * |
| | 2012/13 | 306 | 306 | 100% | 55 | 18% | 44 | 14% | 90 | 29% | 26 | 8% | 14 | 5% | 75 | 25% | 33 | 11% | 194 | 63% | * | * |

Source: Scottish Drug Misuse Database – ADP breakdown

# 7: Vulnerable groups

## 7.1: Prisoners, inequalities and HMP Inverness health needs assessment[xlix]

The reviews of evidence on individual health promotion topics as described in *Better Health Leading to Better Lives for Prisoners* (2012)[l] suggest prisoners' health is at greater risk from excess alcohol consumption, drug use, blood-borne virus (BBV) infection, smoking, social deprivation, mental ill health, unsafe sex, unhealthy diet, bad dental hygiene, and low physical activity.

A prisoner survey[li] identifies evidence of individual risk factors affecting health, which present key health improvement opportunities within this community. For example:

- 50% of prisoners surveyed stated that they were drunk at the time of their offence and 38% report that their drinking affected their relationship with their family. This is in contrast to 14% of men and 9% of women in the Scottish population saying they had an alcohol problem

- 76% of Scottish prisoners report being smokers compared to the national average of approximately 24%. However, 56% of those surveyed stated that they wished to give up.

- Prisoners surveyed reported 'feeling interested in people', 'feeling loved' and 'feeling close to other people' (57%, 43%, 56%) only 'some of the time' or 'rarely'.

- 44% of surveyed prisoners reported being under the influence of illicit drugs at the time of their offence and 39% reported that drug use was a problem for them on the outside.

Responsibility and accountability for prisoner health care services transferred from SPS to NHS in 2011. Health Boards provide a range of health and substance misuse services, broadly comparable to that available in the community. The emphasis is on recovery focused treatment options, including naloxone provision and improved through care services.

NHS Standards and targets for health and addiction services now apply within a custodial setting, including the National Drug and Alcohol Treatment Waiting Times (HEAT Targets). There is an opportunity to develop joint health and justice outcomes in partnership with NHS as we move forward to introduce Recovery Orientated Systems of Care (ROSC) in collaboration with Alcohol and Drug Partnerships (ADPs) across Scotland.

The changing picture for offenders in custody reflects the wider national profile, including the emerging issue of New Psychoactive Substances (NPS) and misuse of prescription drugs. Challenges are cross cutting, requiring action to tackle supply, prevention activity to address demand, and work with health and addiction services. SPS continues to work with the National Prisoner

Healthcare Network Advisory Board (NPHNAB) and associated work streams to respond to the assessed needs of prisoners with problematic drug use with the aim of improving health, and reducing inequalities and re-offending.
Patterns and trends from recent years continue. Illicit use of prescribed drugs in custody, also identified through intelligence, is an area of concern that is continually monitored by local establishments and at a national level.

**Health inequalities of prisoners in Scotland**

Since 1999, life expectancy in males living in the poorest 15% of areas in Scotland has increased by 1.4 years while life expectancy for males living in the rest of Scotland has increased by 2.1 years. The corresponding figures for females are 1.2 years for those living in the poorest areas and 1.6 years for the rest of Scotland. In general, prisoners, both before and on liberation from prison, live in these poorest areas of Scotland. Their health inequalities are further exacerbated by the even higher rates of premature death that ex-prisoners experience, related to violence, accidents, substance misuse and suicide.

### 7.2 HMP Inverness Needs Assessment[lii]

A needs assessment was carried out in HMP Inverness. Data was gathered around drug and alcohol use of both prisoners and staff, and also about mental health & wellbeing. Recommendations were made for each section.

| **Key** | |
|---|---|
| P | Prisoners |
| Pc | Perception by agency or staff member |
| S | Staff |

### 7.2.1 Mental Health & Wellbeing

The health and wellbeing of NHS and Prison staff, and Prisoners is mostly improved by either working or living within the Prison setting. This was evidenced by the WEMWBS scores; Prisoners scored 49 and staff scored 54 and the Scottish average is 50.
(P&Pc) Prisoners, particularly those who were untried, cited stress and anxiety when asked about mental health and wellbeing issues.
(S) A number of senior staff reported stress as a mental health and wellbeing issue and related it to work load and capacity. The issue of nursing responsibility and prison staff duty of care responsibility was raised should be discussed by management.

(P & Pc) Many of the Prisoners cited mental health problems such as Obsessive Compulsive Disorder/Attention Deficit Disorder/Post traumatic Disorder/self harm/ anxiety and depression. A number of issues arose relating to the continuity of mental health services after liberation.
*Recommendations*

- (P) Continuous and early assessment for mental health issues
- (P) Refresh health improvement plan (in particular mental health promotion and suicide prevention for all staff not just NHS staff). Develop an assets based approach to prisoner health and wellbeing
- (P) Pilot of a patient/client activation tool to assess willingness to engage
- (P) Ensure all Prisoners with a military/army background are provided information and practical help to contact organisations such as Veterans Scotland
- (P) Revisit mental health as part of a through care pathway
- (S) Management to address NHS and Prison staff work force issues regarding nursing care and duty of care
- (S) Re-engagement with the healthy working lives agenda and use the WEMWBS[liii] as an indicator
- Develop motivational interviewing skills for all parties

### 7.2.2 Alcohol

The misuse of alcohol remains a key driver for offending behaviour and has an impact on the prisoner's health and wellbeing. A range of services are available provided by, for example, the Medical Centre, Education and partner agencies such as Alcoholics Anonymous[liv] and SMART[lv] recovery. From a medical perspective once the initial detoxification programme is complete a Prisoner will have other medical priorities. The high level of alcohol misuse was reported consistently by those staff and agencies interviewed as well as the Prisoners themselves. It was also frequently reported that many Prisoners become repeat offenders because upon liberation they return to exactly the same environment making it difficult to change behaviour.

(P &Pc). It was reported that the consumption of alcohol leads onto other risky behaviours such as drug misuse or unprotected sex.

Hooch (home brew) was known to be brewed within the Prison particularly around Christmas.

(S) Alcohol misuse by staff, was not reported as an issue but a minority of staff alluded to a past culture of drinking. Given population trends in alcohol consumption this position is likely to be untrue and the level of alcohol consumption similar to that of the wider community.

***Recommendations***

- (P) Continuous assessment of a Prisoner's drinking to assess level of risk to the individual
- (P) Provide a choice of support options for Prisoners to address their drinking behaviour, for example, structured support such as Alcohol Anonymous or through SMART recovery
- (P) Refresh health improvement plan (in particular the misuse of alcohol and drugs, gambling and smoking). Develop an assets based approach to prisoner health and wellbeing
- Develop motivational interviewing skills for all parties
- (P) Pilot of a patient/client activation tool to assess willingness to engage
- (P) Revisit alcohol (and other addictions) as part of a through care pathway
- (S) Re-engage with the Healthy Working Lives agenda (in particular addressing alcohol misuse)

### 7.2.3 Drug use (past or present)

The misuse of illegal drugs remains a key driver for offending behaviour and has an impact on the prisoner's health and wellbeing. A range of services are available provided by, for example, the Medical Centre, Education and partner agencies such as Osprey House and SMART recovery. From a medical perspective a Prisoner priority, after incarceration, is to have a consultation with a doctor frequently with the objective of gaining a prescription. The high level of drug misuse was reported consistently by those staff and agencies interviewed as well as the Prisoners themselves. It was also reported that many Prisoners become repeat offenders because they return to the same environment making it difficult to change behaviour.
The impact of 'legal highs' is now an issue within the Prison. The impact is often resource intensive for the medical and nursing teams. Numbers are increasing but future trends are unknown.

(P&Pc) Tobacco/smoking was frequently cited as a crook and an aid to keep off drugs.
(S&Pc) It was reported that prescription drugs become 'currency' within the Prison and to stop this happening it requires continuous vigilance by staff.
(S) No staff member reported any drug misuse. Given population trends in drug misuse this position is likely to be untrue and the level of drug misuse will be similar to that of the wider community.

***Recommendations***

- (P) Continuous assessment of a Prisoner's drug related behaviours to assess level of risk to the individual
- (P) Provide a choice of support options for Prisoners to address their drug related behaviour, for example, structured support through Osprey House or though SMART recovery
- (P) Refresh health improvement plan (in particular the misuse of alcohol and drugs, gambling and smoking). Develop an assets based approach to prisoner health and wellbeing
- (P) Pilot of a patient/client activation tool to assess willingness to engage

- (P) Revisit drugs (and other addictions) as part of a through care pathway
- (S) Re-engage with the Healthy Working Lives agenda (in particular addressing drugs misuse)
- Develop motivational interviewing skills for all parties

.

### 7.2.4 Addiction Prevalence Testing (APT) – KPI performance data 2014 – 2015[lvi]

APT was carried out across all prisons to evidence progress and towards the *'reduced or stabilised substance misuse'* offender outcome. Addiction testing of receptions and liberations was conducted during November 2014.

Polmont achieved the greatest reduction in samples testing positive for illegal drugs. Cornton Vale and Inverness also achieved significant reductions between admission and liberation in samples testing positives for illegal drugs:

- Polmont **79 %** to **5%** (n=107 to 2) sample sizes 135 admission, 38 liberation.
- Cornton Vale **79%** to **19%** (n=63 to 7) sample sizes 80 admission, 36 liberation.
- Inverness **73%** to **13%** (n=38 to 2) sample sizes 52 admission, 16 liberation.

The SPS Substance Misuse Strategy[lvii] published in 2010 reflects the aims and objectives of the Scottish Government's National Drug Strategy. Over the past decade policy on managing prisoners with problematic substance misuse has moved from a punitive response to a therapeutic approach; offering a comprehensive integrated treatment service to support recovery and community integration and to reduce reoffending.

### 7.3 Domestic Abuse

Preventing domestic abuse or intimate partner violence has been identified as a priority for Scotland, with *Equally Safe: Scotland's strategy for preventing the causes and consequences of violence against women and girls* aiming to tackle the root causes of violence using a public health approach. Reviews of evidence on violence prevention suggest there is a strong link between alcohol and domestic abuse, with alcohol appearing to increase its occurrence and severity.[1] Domestic abuse is a factor in health and social inequalities, with 79% of incidents recorded by Police Scotland in 2014-15 having a female victim and a male perpetrator.[1]

In 2014-15 there were 2,247 incidents of domestic abuse recorded by the police in Highland, an increase of 200 (10%) from 2,047 incidents in 2013-14. Whilst data for the last two years is not directly comparable to previous data, the overall trend is still increasing, with a marked rise in recorded incidents since 2009-10. These figures are likely to be underestimates as data from the Scottish Crime and Justice Survey suggests one fifth (19.5%) of incidences are not known about by the police.[1]

**Figure 1: Incidents of domestic abuse recorded by the police; Highland, 2005-06 to 2014-15**

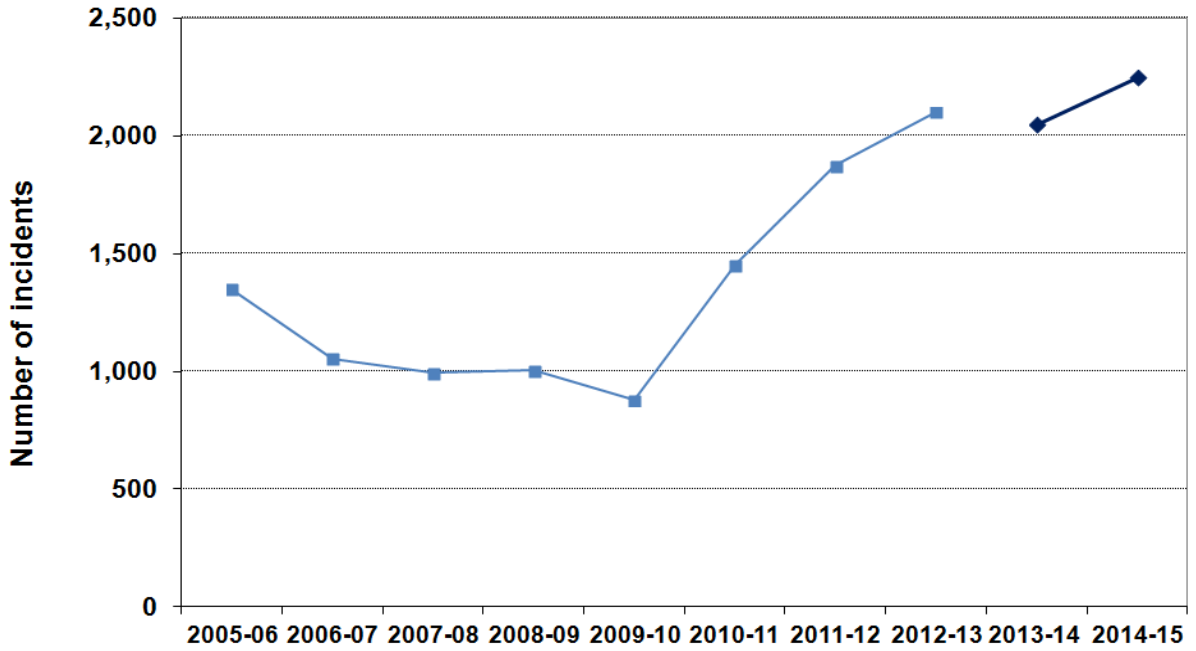
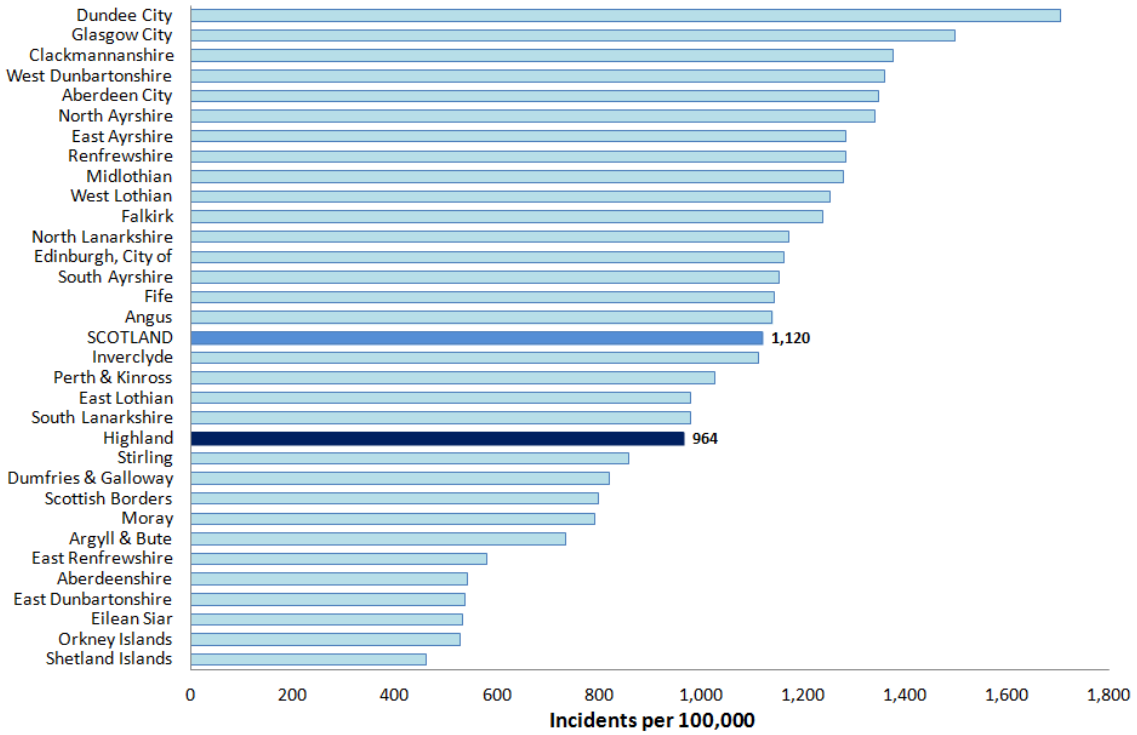



Chart has been displayed with gaps in the time series to highlight changes in methods of data collection introduced in 2013-14

Source: Scottish Government

In 2014-15 Highland had a lower reported rate of domestic abuse incidents of 964 per 100,000 population compared to the Scottish rate of 1,120 per 100,000 population. This is higher when compared to other more rural local authorities like Aberdeenshire, Moray and the south of Scotland.

**Figure 2: Incidents of domestic abuse recorded by the police per 100,000 population, by local authority, 2014-15**




Source: Scottish Government

## 8: Recovery

Recovery is a process through which a person addresses their problem drug and/or alcohol use to become an active and contributing member of society. This concept of recovery and a belief that people can and do recover from drug problem and/or alcohol use and dependency are at the heart of the HADP and Scottish Government's strategies on drugs and alcohol.

There is no single path to recovery, however the road, the journey will be far easier to travel when people are treated with dignity and respect. In practice, people can best be empowered to recover through the establishment of a recovery-oriented system of care (ROSC)[lviii]. The underlying philosophy of a ROSC is that treatment, review and aftercare are integrated and priority is given to empowering people to sustain their recovery.

### 8.1 Recovery Orientated Systems of Care

Distinguishing features of a ROSC include:

- being person-centred
- being inclusive of family and significant others
- keeping people safe and free from harm
- the provision of individualised and comprehensive services - such as housing, employability and education
- services that are connected to the community
- services that are trauma-informed

At its centre it has strength-based assessments, which take account of individuals' recovery capital, and integrated interventions and services that are responsive to a person's needs and beliefs. There is a commitment to peer recovery support services, and most importantly, it is inclusive of the voices and experiences of people, and their families, in recovery.

ROSC also provides for system-wide education and training, ongoing monitoring and outreach, is outcomes driven and evidence informed. A ROSC is an effective drug and alcohol system empowering service users to progress at their own pace through a care pathway from first entering drug, alcohol and other services to returning to the wider community and universal public services and activities.

### 8.2 Mutual Aid

Reviews of recovery from dependence on drugs and or alcohol often emphasise the positive outcomes associated with mutual aid and have found that the best predictor of sustained recovery is the extent of recovery capital; including personal and psychological resources, social supports and quality of life (a safe place to live, meaningful activities and a role in their community).

Mutual aid and peer support have potential benefits for service providers as they offer a level of aftercare, particularly in remote and rural areas that statutory and Third Sector services may not have the resources to provide.

**Table 40: Mutual Aid**

| No of Mutual Aid Meetings | 2016 |
|---|---|
| SMART | 4 |
| Al-Anon | 9 |
| AA | 56 |
| Families Anonymous | 1 |
| Other Family Support | 1 |

Source: HADP

## 9: Substance Misuse Services

### 9.1 Quality Principles

The *Quality Principles: Standard Expectation of Care and Support in Drug and Alcohol Services*[lix] are central to the implementation of the Scottish Government's Quality Improvement Framework for drug and alcohol treatment and support services. The Quality Improvement Framework is the focus of the next phase of delivery of the national drugs and alcohol strategies – its purpose is to ensure:

- quality is embedded and evidenced across all services in Scotland
- quality in the provision of care, treatment and recovery services and
- quality in the data that will evidence the medium and long-term outcomes of people in recovery.

Highland drug and alcohol Substance Misuse Services are currently undertaking self-evaluation to gauge progress with implementing the Quality Principles as part of a national validation exercise supported by the Care Inspectorate.

### 9.2 Drug and Alcohol Information System (DAISy)[lx]

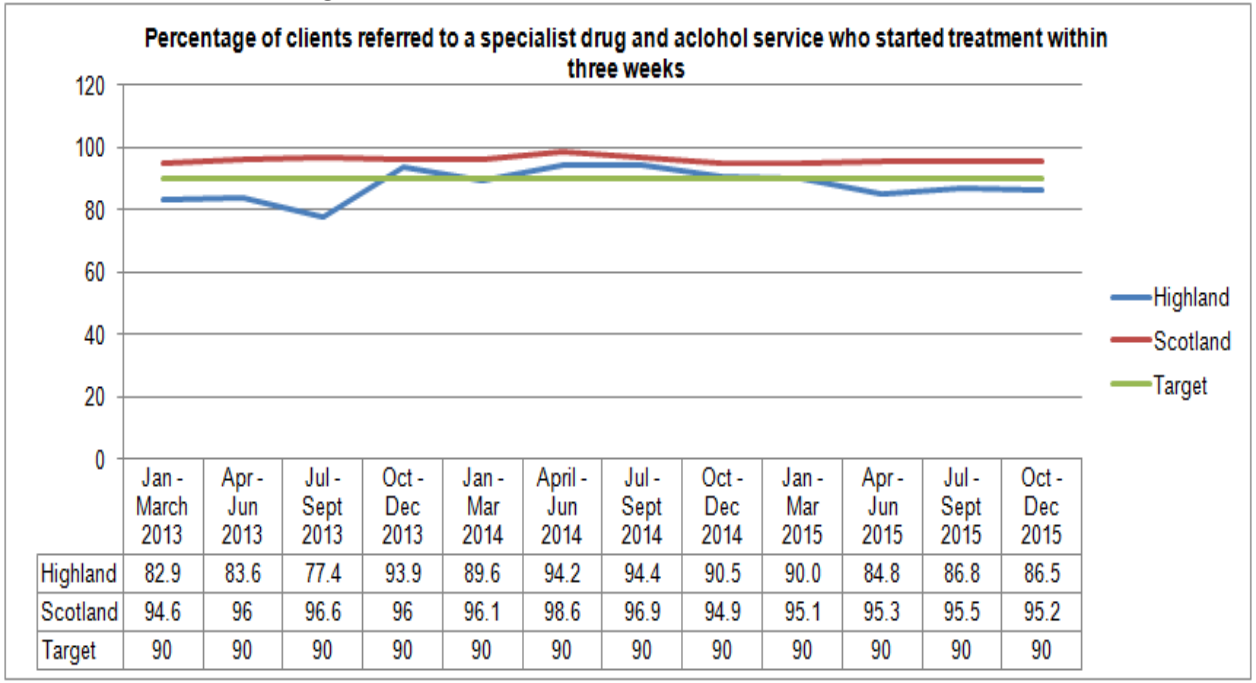
Alongside implementation and self-evaluation of the Quality Principles, services are in the development phase of establishing Recovery Orientated Systems of Care (ROSC). The national Drug and Alcohol Information System (DAISy) which is due for implementation in 2017, will provide an electronic performance management system for evidencing treatment outcomes. The associated Recovery Outcomes Web (ROW)[lxi] Tool will be implemented in Highland in 2016 prior to national roll and will provide a system for evidencing recovery orientated outcomes.

### 9.3 Service Provision[lxii]

Highland wide drug and alcohol treatment provision is delivered by; Osprey House (specialist service), Harm Reduction Service, Drug Testing & Treatment Orders, Beechwood House (Crossreach residential rehabilitation and community outreach service), New Craigs Hospital (in-patient detox beds), HMP Inverness Addiction Service and the Mental Health Liaison Team. Inverness based provision consists of; CPN(A) Substance Misuse Team, Dual Diagnosis Service, Homeless Healthcare and Addictions Counselling Inverness. Community Substance Misuse Teams across Highland consist mainly of CPN(A)'s and cover; Badenoch & Strathspey, Nairn & Ardersier, Mid Ross, East Ross,Caithness, Sutherland, Lochaber, Skye, Lochalsh and Wester Ross. Third Sector councils on alcohol also cover Skye and Lochalsh, Lochaber and Ross and Sutherland.
Substance Misuse Services are responsible for delivery of the Scottish Government's HEAT standard for drug and alcohol treatment, which states that 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. The following graph shows in the last three quarterly reporting periods the target of 90% has not been achieved.

Substance Misuse Services currently offer a broad range of person-centred interventions with examples including; motivational interviewing/ health behaviour change, solution focused therapy, relapse prevention, mindfulness, CBT (depression, anxiety, stress management and guided self-help), sleep management, harm reduction, naloxone, overdose awareness, behavioural activation therapy, family therapy, cognitive analytic therapy, contingency management, mapping techniques (link node mapping), trauma work, BBV testing and advice and ORT. This list is not exhaustive and individualised recovery plans are developed following comprehensive assessment. In addition to statutory and Third Sector services, there are a range of other providers with a secondary substance misuse focus that include; APEX, Criminal Justice Service, Action for Children and the Youth Action Service.

**Figure 24: Percentage of clients waiting more than 3 weeks between referral to a specialist drug and alcohol service and commencement of treatment**




| | Jan - March 2013 | Apr - Jun 2013 | Jul - Sept 2013 | Oct - Dec 2013 | Jan - Mar 2014 | April - Jun 2014 | Jul - Sept 2014 | Oct - Dec 2014 | Jan - Mar 2015 | Apr - Jun 2015 | Jul - Sept 2015 | Oct - Dec 2015 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Highland | 82.9 | 83.6 | 77.4 | 93.9 | 89.6 | 94.2 | 94.4 | 90.5 | 90.0 | 84.8 | 86.8 | 86.5 |
| Scotland | 94.6 | 96 | 96.6 | 96 | 96.1 | 98.6 | 96.9 | 94.9 | 95.1 | 95.3 | 95.5 | 95.2 |
| Target | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 | 90 |

Source: ISD

# 10: Whole Population Approaches

## 10.1: Alcohol Brief Interventions

### Number of ABIs delivered in accordance with the HEAT Standard guidance

National guidance defines an alcohol brief intervention as "a short, evidence-based, structured conversation about alcohol consumption with a patient/ service user that seeks in a non-confrontational way to motivate and support the individual to think about and/ or plan a change in their drinking behaviours in order to reduce their consumption and/ or their risk of harm."

Highland and Scotland have displayed a similar trend since 2009/10 in the percentage of ABIs delivered. Both remain above the HEAT standard requirement. In 2014/15 the national percentage had fallen whereas locally there was a increase. No significance can be calculated for this indicator.

Work is ongoing to embed ABI's and extend delivery in wider settings.

**Table 41: Percentage of ABIs delivered (% of target)**

| | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|---|---|
| NHS Highland | 75.9 | 74.2 | 150.5 | 148.8 | 153.8 | 140.9 | 218 |
| Scotland | 60.8 | 111.9 | 176.9 | 158.9 | 155.4 | 170.8 | 145 |

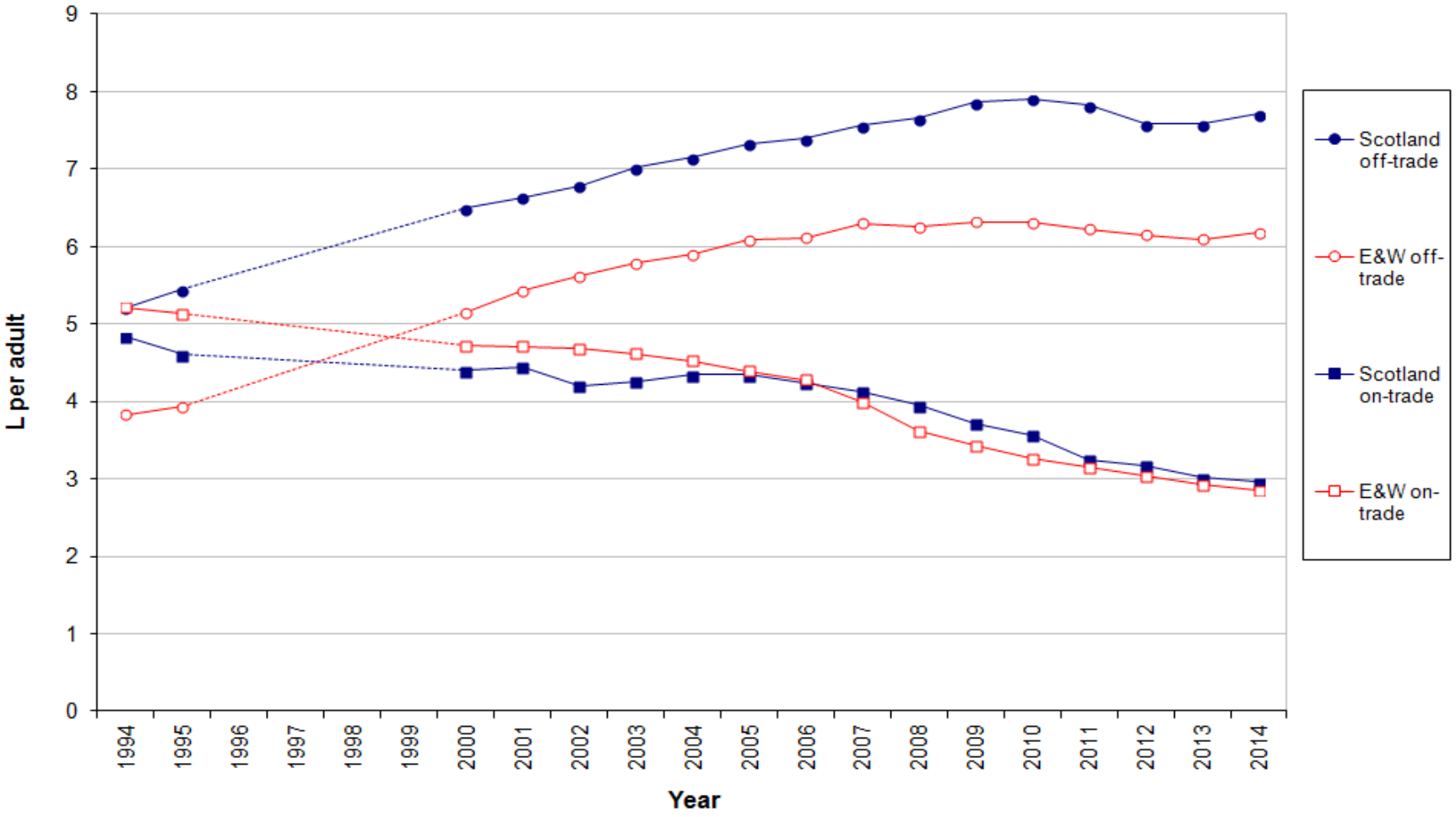
**Source: ScotPHO**

## 10.2: Licensing

In Scotland, the volume of pure alcohol sold per adult through the on-trade decreased by 39% from 4.8L in 1994 to 3.0L in 2014, whereas off-trade sales increased by 48% over the same time period, from 5.2L in 1994 to 7.7L in 2014. It is estimated that 72% of all pure alcohol sold in Scotland in 2014 was sold through the off-trade, the highest market share observed over the time period analysed (MESAS[lxiii]).

The downward trend in off-trade sales in Scotland between 2010 and 2012 has not continued with the most recent data providing an early indication that off-trade sales may be returning to an upward trend (MESAS).

**Figure 25: Litres of pure alcohol sold per adult (aged ≥16 years) in Scotland and England & Wales, by market sector, 1994-2014**



Source: MESAS

The rate per 10,000 population of on trade premises in Highland and Scotland have both remained constant from 2012/13 to 2013/14. However, Highland is statistically significantly 'worse' than National average which is likely to reflect the tourism trade.

**Figure 26: On-trade premise license per 10,000 population**

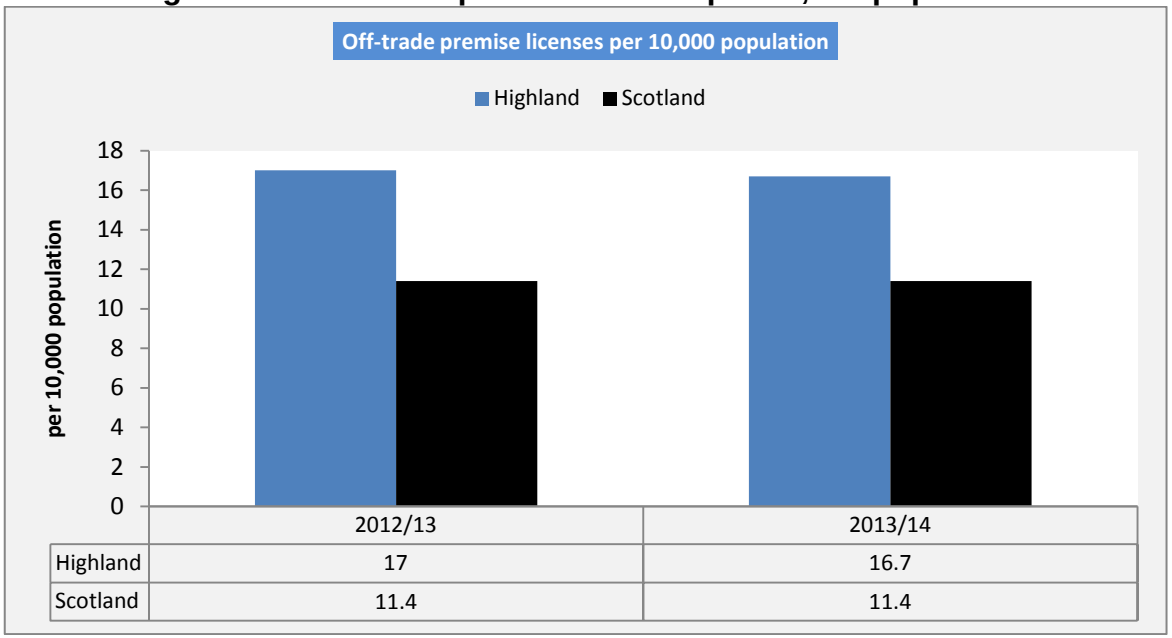

| | 2012/13 | 2013/14 |
|---|---|---|
| Highland | 48.3 | 48.3 |
| Scotland | 27 | 26.6 |

Source: ScotPHO

The rate per 10,000 population of off trade premises in Highland and Scotland have both remained constant from 2012/13 to 2013/14. However, Highland is statistically significantly 'worse' than National average. In Nov 2013, the Licensing Board agreed an alcohol overprovision statement as part of the Highland alcohol policy. The agreement targets large retail establishments and

covers off- sales where capacity is over 40 square metres and does not include small businesses and on-sales. Licensing applications continue to be monitored and responded to appropriately.

**Figure 27: Off-trade premise license per 10,000 population**




| | 2012/13 | 2013/14 |
|---|---|---|
| Highland | 17 | 16.7 |
| Scotland | 11.4 | 11.4 |

Source: ScotPHO

**Number of new applications for premise or occasional licenses, and proportion refused on the grounds of OP**

There were no premise license refused under Section 23 of the 2005 Licensing Act in Highland in 2012/13 and this changed to 5 refusals in 2014 relating to Lidl applications. Scotland refused 21 licenses under section 23 of the 2005 licensing act in 2011/12, increasing to 12 in 2012/13.

## 11. Consultations

Two types of consultation were carried out; one involved meeting with six of the locality based alcohol and drug forums (see 11.1) and the other was through a public survey using survey monkey (see 11.2).

### 11.1 Consultation with the locality based alcohol and drug forums

HADP consulted in local areas with the help of the alcohol and drug forums to gain a local perspective on what issues and concerns there are around substance misuse, and also what outcomes they would like to see. Sixty people in total were involved in the consultation. The areas involved were: Inverness, Skye & Lochalsh, Lochaber, Ross & Cromarty, Sutherland and Caithness. Individual responses will not be identified in this report.

Three questions were asked in relation to both alcohol and drug misuse issues.

Responses were grouped into 4 headings which mirror the HADP strategy; Recovery, Maximising Health, Protecting Communities, and Children & Families.

**Maximising Health (Prevention)**

| **Question 1: Which alcohol issues or concerns should be a priority and why?**<br>The main issues raised by the forum members were as follows: | | | |
|---|---|---|---|
| **Recovery (Treatment)** | **Maximising Health** | **Protecting Communities** | **Children & Families. *(Children Affected by Parental Substance Misuse).*** |

| | | | |
|---|---|---|---|
| Better links between the different treatment services and more awareness of dual diagnosis (alcohol only)<br><br>A need for more treatment options, e.g. counselling services and detox places, support groups and relapse support<br><br>Aftercare for service users also seemed to be lacking, e.g. housing options for those in recovery and for people in recovery to gain a new identity<br><br>A need for more data sharing between treatment services regarding specific clients<br><br>There was still stigma surrounding alcohol misuse and accessing treatment services | Accessibility and availability of alcohol<br>Alcohol has been normalised and is part of the culture<br><br>Stigma attached to non drinkers<br><br>Increase in drinking at home and practice of pre-loading<br><br>Hidden drinking and drinking to mask other problems such as pain relief or disturbed sleep<br><br>Lack of awareness of safe limits<br><br>Positive images portrayed by the media through advertising and promotions<br><br>Need for diversionary activities (for young people) and understanding of impact of inequalities | A need for localised knowledge of alcohol problems<br><br>Concerns that new drink driving laws may encourage people to drink more at home.<br><br>The rise in the use of breathalysers is an issue as young people tend to compete to see who is most over the limit.<br><br>The lack of a designated place for drunk people. Police have to make health decisions on where drunk and incapable people should go e.g. police cells or hospital.<br><br>Domestic violence. | Young people model the drinking habits of their parents.<br><br>Concerns that parents purchase alcohol for young people.<br><br>Belief by parents that this leads to a safer practice by young people.<br><br>A lot of children have problems that are not flagged up as they are unknown to services.<br><br>Children may feel neglected due to their parent's alcohol abuse.<br><br>Children may have an inappropriate level of responsibility to deal as a consequence of parental alcohol<br><br>A need for support systems for the whole family and more prevention strategies to stop cases escalating to a social work level. |

**Quotes**

*Supermarkets donate too much space to alcohol and advertising. It shouldn't be allowed on TV and shops should advertise mocktails. Always see people drinking on TV and soaps are all set in pubs*

*Parents are taking more of a harm reduction role. But how far does 'permission' go?*

*Parents need to grasp the severity of the problem*

**Q2: Which drug issues or concerns should be a priority and why?**

The main issues raised by the forum members were as follows:

| **Recovery (Treatment)** | **Maximising Health,** | **Protecting Communities,** | **Children & Families. *(Children Affected by Parental Substance Misuse).*** |
|---|---|---|---|
| Lack of service user involvement<br><br>Concern over stigma attached to those using treatment Services<br><br>Concern over stigma being attached to those using methadone<br><br>A call for harm reduction messages given drug users are still sharing equipment | Education for young people/teachers/staff about:<br><br>-negative mental/physical health effects of drugs<br><br>-content of drugs<br><br>- harm and risk reduction advice<br><br>Concern raised about the impact of poly drug use (including alcohol) | Concern over the availability of drugs on the internet and impact on populations rural/urban<br><br>Increased availability of NPS and perception it was taking over cannabis<br><br>Change in name from 'legal highs' to NPS makes no difference to how the drugs are viewed and they are still perceived to be a safe alternative | If concerned about a young person using drugs parents do not know which services to access<br><br>Perception that drug misuse is more common than alcohol misuse<br><br>Perception by young people that they are informed about drugs but due to the information source may be misinformed<br><br>Prevention should be for all age groups not just young people |

| | | | |
|---|---|---|---|
| A call for a variety of treatment options e.g. Community/residential rehabilitation<br><br>More NPS training for front line staff<br><br>More training in how drug misuse affects general health and behaviour, interaction with prescription medications and mental health | Concern raised about prescription drugs such as Gabapentin and Pregabalin<br><br>Concern raised about the internet as a source of drug misuse information and the need to provide reliable alternative websites.<br><br>Media has a role in showing how people can overcome drug addcition<br><br>Terminology used to describe drug users can be detrimental<br><br>Target prevention in areas of known deprivation | Concern over the ease of supply of cannabis, effects on mental health and effects of passive smoking<br><br>A drug habit is easier to hide than an alcohol habit<br><br>Death due to drug misuse does not appear to be a deterrent | Families can enable drug/alcohol misuse without realising |
| **Quotes**<br><br>*Services leave people until they are ready to stop. More needs done in terms of prevention* | | | |

| | | | |
|---|---|---|---|
| **Q3: What results do you want to see achieved?**<br><br>The main issues raised by the forum members were as follows: | | | |
| **Recovery (Treatment)** | **Maximising Health,** | **Protecting Communities,** | **Children & Families. *(Children Affected by Parental Substance Misuse).*** |

| | | | |
|---|---|---|---|
| Accessible peer support and mutual aid<br><br>To enhance understanding of services available service providers should attend an AA meeting<br><br>More locally based services including drop in centres/harm reduction services.<br><br>Variety of local services including the third sector to include counselling, community support, motivational interviewing, psychosocial therapies.<br><br>Increase in the resources for effective interventions and services<br><br>After care provision increased for those in recovery for example peer support and suitable accommodation<br><br>Address stigma associated with treatment and recovery<br><br>Faster access to treatment/rehab services | Education – minimum standard for all schools. More structure in curriculum and be integrated into other subjects<br><br>Cultural change:<br><br>-Use straightforward messages about harms<br><br>-regulation on sales and advertising and introduce minimal pricing<br><br>-continuous educational messages such as sending letters to those with drug/alcohol problems about treatment options, improved messages for families including how behaviours affect children, information in leisure centres<br><br>Improved information sharing between services<br><br>Training for staff in generic services as a prevention strategy<br><br>Aspirations for improved environments including | Improved information to communities about ongoing issues and successes<br><br>Increased range of diversionary activities<br><br>Licensing:<br>-improved staff training<br>-decrease in underage drinking<br>-maintaining safe premises<br>-better use of pubwatch<br><br>Intranasal naloxone programme rolled out to range of services | Structured support for family counselling<br><br>Amalgamate all services so they can work together<br><br>Improved sharing of information between children and adult services<br><br>Work with parents and communicate with children<br><br>Provide a safe space for young people and young carers<br><br>Gap in services between 16-18 year olds for example employment<br><br>Reduce stigma by emphasising role of family and community |

| | | | |
|---|---|---|---|
| Provision of crèche facilities<br><br>Improved assessment process by GP, CMHT, SW; more staff | more places for young people<br><br>Focus forthcoming strategy where there is greatest need to address inequalities<br><br>Avoid responding to media rather than priorities being set in response to the media<br><br>How to capture hidden harm – use of ABIs | | |
| **Quotes**<br><br>*Some services are too focussed on people with addiction problems, but need to do more for people who are drinking hazardously or harmfully but aren't necessarily addicted*<br><br>*Need to record the journey that people go through. Measure people's wellbeing/quality of life along the way. Need to ask people what they find helpful*<br><br>*In supermarkets alcohol should be in a separate part of the shop completely. This would reduce shop lifting, reduce underage sales and make people more aware of how much they are spending* | | | |

### 11.2 Public Strategy Consultation Survey

The HADP developed a public survey monkey to ask what the priorities were in communities, and also what differences or changes would show that drug and alcohol related harms are being reduced. This was sent out through existing address and email lists such as NHS Highland, Highland Council and Police Scotland.

In total **843** people responded to the survey, however, every person did not answer each question.

**The respondents**

**Table 42: Demographic information about the public survey respondents**

| **Demographic information** | | | | | |
|---|---|---|---|---|---|
| **Age** | Under 16 | 16 - 25 | 26 - 35 | 36-45 | Over 45 |
| **Total: 840** | 25 (3%) | 52 (6.2%) | 120 (14.4%) | 184 (21.9%) | 458 (54.5%) |
| **Status** | Pupil | Student | Employed | Unemployed | Retired |
| **Total: 839** | 45 (5.4%) | | 717 (85.5%) | 31 (3.7%) | 46 (5.5%) |
| **Postcode Total 824** | 233 of respondents reported they lived in Inverness and 99 respondents were from out with the Highlands. Respondents were from across the Highlands. | | | | |

Source: HADP

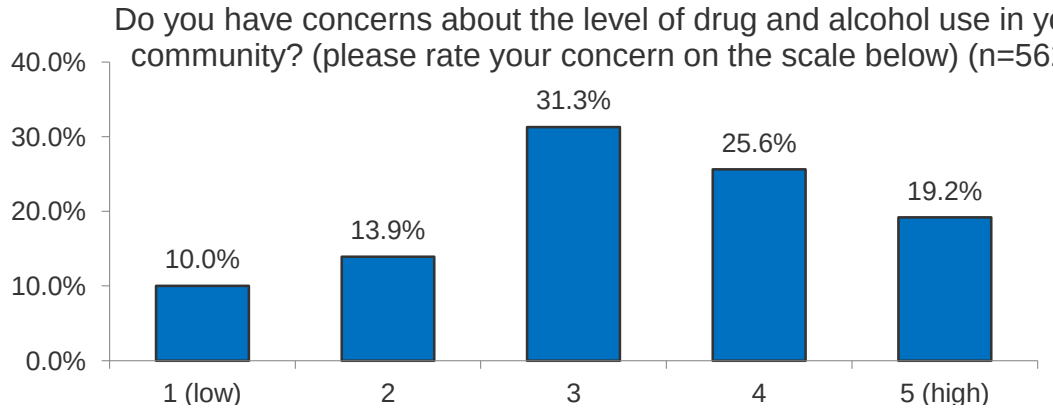
**The survey asked seven questions in total.**

**Q1: Do you have concerns about the level of drug and alcohol use in your community?**

Respondents were asked to rate whether they have concerns about the level of drug and alcohol use in their community from 1 (low concern) to 5(high concern). 562 people responded to this question.

The majority of people had concerns which were rated as 3 or above (76%, n=428). 19.2% (n=108) had very high concerns about drug and alcohol use in their community.

**Figure** 28: **Do you have concerns about the level of drug and alcohol use in your community?**

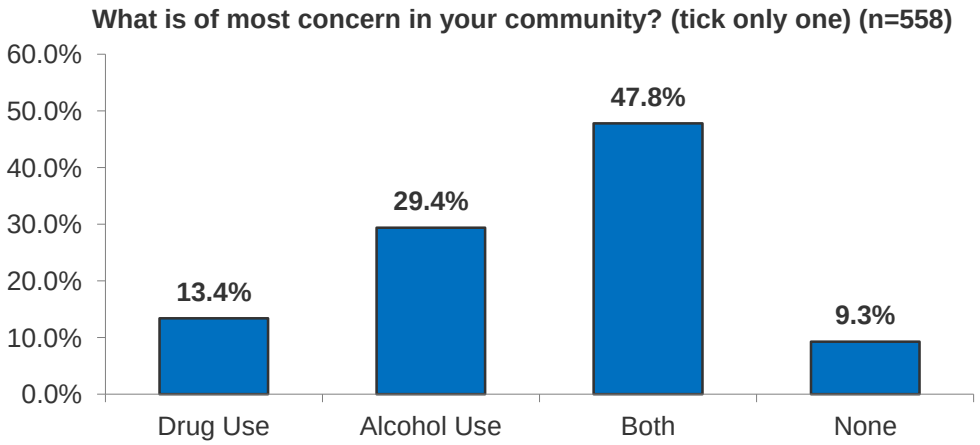



Source: HADP

**Q2: What is of most concern in your community?**

Respondents were asked what was of most concern in their community, alcohol, drugs, both or none. 558 people responded to this question. The majority felt that both alcohol and drugs were a concern in their community (47.8%, n=267). Individually there was more concern for alcohol (29.4%, n=164) than drugs (13.4%, n=75).

**Figure 29: What is of most concern in your community?**




Source: HADP

**Comments (information from the public survey)**

In responding to the preceding two questions comments were made in relation to the impact of alcohol and drug misuse on people's lives. Alcohol being part of Highland culture was raised.

*Violence, unwanted pregnancy, loss of job and relationships, loss of potential, death by misadventure all common in theses contexts and in this area*

*It is acceptable as part of the cultural beliefs in this area to drink heavily and often, a belief which can/does influence younger, underage drinkers.*

*Damaging cultural acceptance and limited alternative activities other than 'social' norm of both.*

A number of comments related to a perceived increase in alcohol and drug use.

*There is an increase in the problems with drugs and alcohol and a desperate need for rehab facilities. I know many people who deliberately offend to get some respite from their problems*

*I work part time in a bar and frequently encounter people of all ages who appear to be under the influence of drugs.*

*Talk about drugs is much more frequent than I had noticed in years previously and Class A drugs seem to be fairly commonplace from my perspective.*

A number of respondents acknowledged concern over both alcohol and drug misuse but recognised that the prevalence of alcohol misuse was far greater.

*Whilst drug use is problematic for those affected by it, I believe the numbers to be comparatively low, whereas alcohol use is often seen as acceptable even when it has become problematic, so the problem is widespread and often unchallenged.*

Inevitably there were comments made about treatment services relating to a perceived need for a full range of services including independent charities/organisations.

*Continued support for individuals with alcohol and drug problems is crucial from the statutory sector with support from the third sector. At times drug issues are minimised as "not there", this leads to a hidden population that finds it harder to seek help when they get in to difficulties/wish to make a change to their use.*

*NA, AA and Al-anon who do give fantastic support and ongoing support are the only recovery in my profession that i see is working long term at present.*

The impact of drug and alcohol misuse in a family setting was also highlighted.

*As a parent I am concerned about the amount of alcohol young people are consuming even though, they are regularly educated about the safe use of alcohol in schools. The amount of 12 year old young people who regularly binge drink most weekends is alarming. I feel the age of consumption is getting younger and the amount more. It is getting to be the norm.*

*There are high numbers of people using legal highs, heroin, cocaine, ecstasy in conjunction with alcohol as a regular weekend occurrence. This is applicable to not just young people but older people who have families, jobs etc who would never come forward as using drugs, how do you get the message out to this group that this type of activity is very damaging to their families, themselves and their communities as well as being a drain on the health budget etc.*

One response related to access to alcohol in particular the role of supermarkets in supplying cheaper products and also suggested that on-sales were unjustly penalised.

*Cheap drink from supermarkets is a problem for people with drink problems not the pubs which are penalised time and time again.*

New Psychoactive Substances were mentioned more than any other issue from the perspective of availability and public protection.

*There are a lot of legal highs being used by young adults. This seems to have spread to age range of 30 year olds as well. It is a well known fact that a shop in Nairn sells them over the counter. This has left one of my sons with epilepsy.*

*Legal Highs and alcohol appear to be very assessable and wonder if there is more that we could all do to help those who are struggling with addiction, such as offering small self contained flats rather than B&Bs.*

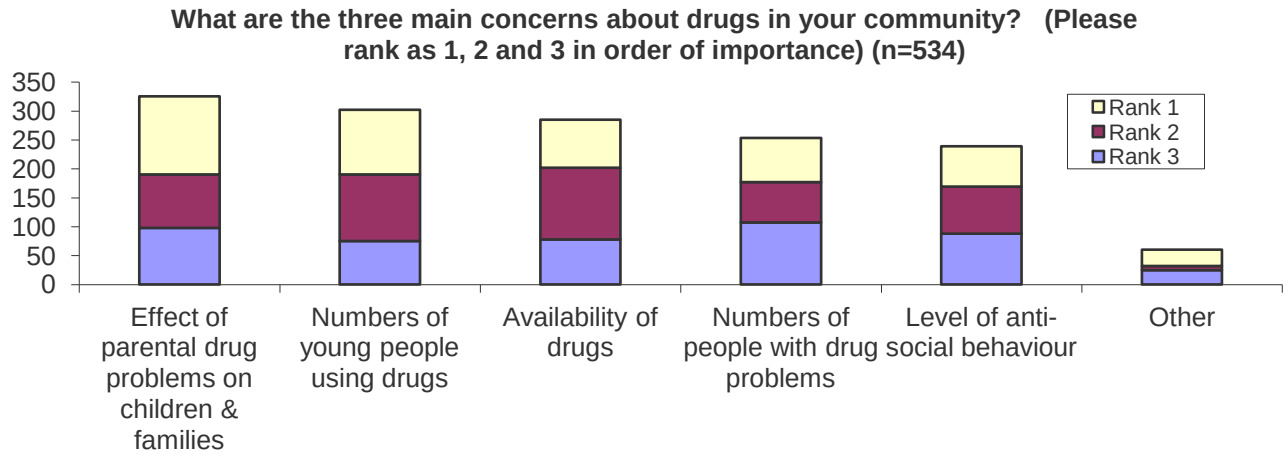
*There are lots of youngsters in our village using both drugs and alcohol. I have been informed it is also ready available through school. Allegedly there are a lot of legal highs being used by these folks with little or no knowledge of the real dangers of the drugs*

**Q3: What are the main concerns about drugs in your community?**

Respondents were asked to rank their top three priorities for drugs in their community. 534 people answered this question.

- Effect of parental drug problems on children and families (60.9%, n=325)
- Numbers of young people using drugs (56.6%, n=302),
- Availability of drugs' (53.4%, n=285)

**Figure 30: What are the main concerns about drugs in your community?**




Source: ScotPHO

**Comments (information from the public survey)**

The issue of availability of drugs was highlighted particularly in relation to cannabis use and NPS.

*Most anti social behaviour that we experience is 'fuelled' from either drug or alcohol misuse or both. The 'availability' of drugs on the street is always a concern.*

*Particularly concerned for young people using very strong strains of cannabis and related substances as they underestimate the potential effect on longer term health. Also concerned about availability of legal highs and ecstasy as young people have no idea what they are taking, and this can be very dangerous, even life threatening.*

The acceptability of drug use within the Highland culture was also raised.

*The effect of parental use of drugs has to be addressed if we are to break the cycle of drug dependency*
*We have generations now growing up and thinking this addiction culture is the normal way to live sadly.*

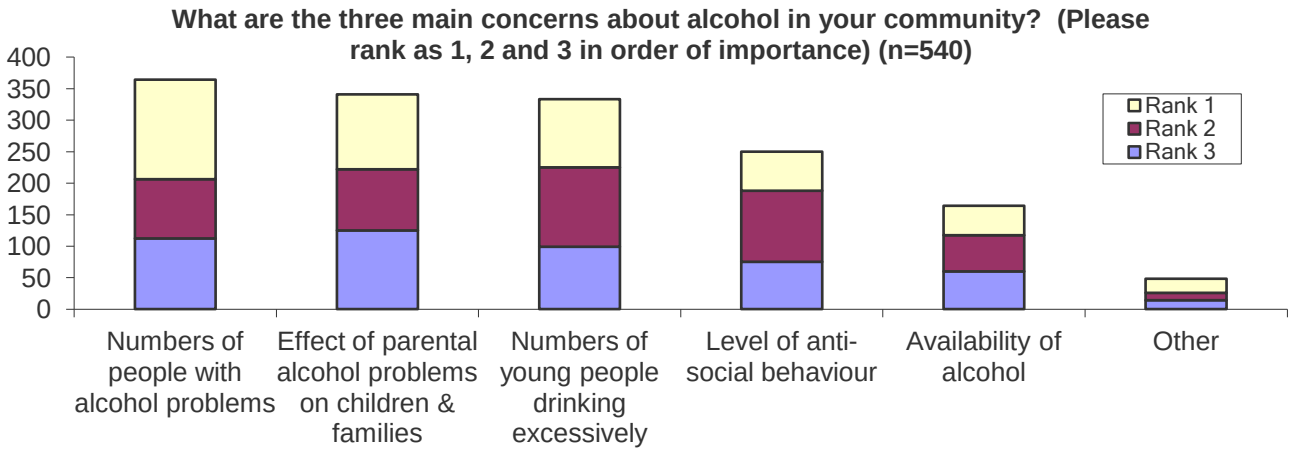
Parental responsibility was mentioned most often.

*It is my opinion that we need to be educating our young people more on the effects of addiction.*

*I think that there is often a relationship between parental drug/alcohol use and child drug/alcohol use.*

## Figure 31: What are your main concerns about alcohol in your community?

**What are the three main concerns about alcohol in your community?**




Source: HADP

Respondents were asked to rank their top three priorities for alcohol in their community. 540 people answered this question.

- Numbers of people with alcohol problems (67.4%, n=36),
- Effects of parental alcohol problems on children and families (63.1%, n=341)
- Numbers of young people drinking excessively (61.7%, n=333)

**Comments (information from the public survey)**

Respondents were concerned about the availability and accessibility of alcohol.

*Alcohol is easily available, and can be obtained in general stores, pubs etc, proof of age not always asked for, peer pressure from 'mates', In a smaller community may be hidden again as someone will nearly always get people home, more alcohol drunk in home setting as cheaper*

*Alcohol is far too widely available and should not be sold in supermarkets or advertised - make it less readily available. Putting the prices up may also help this.*

The Highland drinking culture and the normalisation of alcohol was commented on and how this will impact on future generations.

*There seems to be more tolerance/acceptance of alcohol problems in Highland than elsewhere. There is definitely a drinking culture which affects children and young people both within the family and in supporting them to make informed, healthy choices for their own futures.*

*Alcohol use and "getting drunk" are seen as natural, and we are bombarded with images of drunken people on TV and social media. The scale of long term damage, particularly to people who drink from a young age, is only just being seen. This will continue to get worse, with increased personal, social and healthcare costs.*

*If we can educate and support the young and children affected by Alcohol misuse we may be able to minimize the damage in the future.*

*I think many people underestimate the amount they drink on a regular basis, especially as wine and some beers have increased in % of alcohol over the years and alcohol use all through the week has become normalised within the home*

Parental use of alcohol and family support was frequently mentioned.

*Parents setting a bad example to children are a concern. Obviously anti-social behaviour is also creating problems such as domestic violence, and abuse which is a serious problem no matter how common.*

*.*

*I feel a very deep sorrow for children who are neglected or abused through the alcohol problems of parents as their life chances are very much reduced.*

*I think that there is often a relationship between parental drug/alcohol use and child drug/alcohol use*

Concern was expressed about older people and those who hide their drinking.

*I am not as concerned about the 18-21's as I am about the older generations. There are a lot of people with alcohol problems that are unaware of the serious risks that are associated with excessive drinking.*

*My other is not concern for young people but for older people who hide the level of their drinking and dependency. In this community every family has someone who drinks too much and it is mostly not the younger generation.*

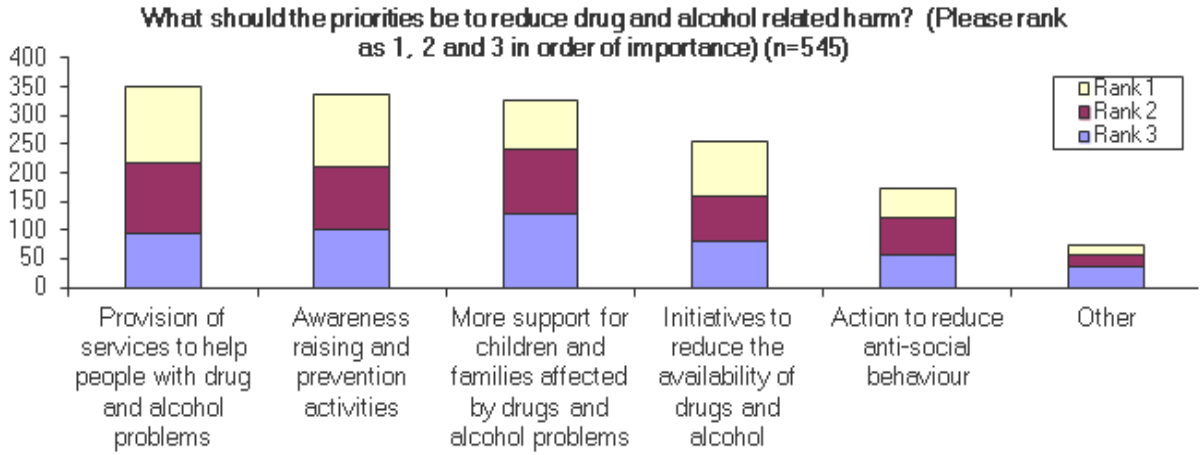
*. I think women are very susceptible to this. I feel a very deep sorrow for children who are neglected or abused through the alcohol problems of parents as their life chances are very much reduced.*

**Q5: What should the priorities be to reduce drug and alcohol related harm?**

Respondents were asked to rank their top three priorities to reduce drug and alcohol related harm in their area. 545 people answered this question.

- Provision of services to help people with drug and alcohol problems (64%, n=349),
- Awareness raising and prevention activities (61.7%, n=336),
- More support for children and families affected by drugs and alcohol problems (59.6%, n=325)

**Figure 31: What should the priorities be to reduce alcohol harm?**




Source: HADP

Comments:

One of the respondents commented on the complexity of the issues and the importance of being able to work at different levels

*The problems are so entrenched and multi-factorial that they need tackled simultaneously and on a grand scale.*

A number of comments related to the increased provision of local services including those provided by the 3rd sector and voluntary organisations. This included comments about the challenges of providing services in rural locations.

*Money should be put into local services that already provide help and support to people with substance misuse issues. These are mostly 3rd sector / voluntary organisations that have to 'fundraise' continually to be able to continue to provide these much needed services. I believe that if there was more financial support, more could be provided - not just to combat substance misuse but to provide alternative measures*

*Directing users and families to Alcoholics anonymous and Al-anon should be encouraged by SW and NHS.*

*In a rural area such as Caithness, detox/retox facilities are provided in Inverness - would it really be realistic to expect an alcoholic or drug abuser to travel to Inverness to receive in-patient treatment. Also I would advocate the roll out of a brief intervention approach so that primary services would take the role of first diagnosticians rather than patients who may be unstable in their substance misuse having to be on waiting lists for treatments.*

Respondents acknowledged the importance of services such as detox, rehabilitation and psychiatric nursing provision a number of comments related to lack of support for people dependant on alcohol and their support networks such as partners and family.

*Although detox, rehab and psychiatric nursing provision are excellent in Highland, there is little or no support for alcoholics or their kin in the community so the problem just goes round in circles. The only support for spouses/partners/children of alcoholics in my community (other than Social Work) is Al-Anon which receives no funding.*

A number of comments related to the importance of family support and this included preparing children and young people for their future.

*Families and teenagers need more person centred education on the effects of alcohol and drug consumption both short and long term effects. Families need to be aware that their children will copy these behaviours (i.e. drinking huge volumes of alcohol) if they see the parents doing this.*

*It is important that families are supported so that they can be ideal role models for their children thus giving the children a better start and a hope for a brighter future.*

*There needs to be a change in message to promote zero tolerance of excessive alcohol and drug use, especially amongst young people. This is not a task that can be solely devolved to schools. Parents and families have a huge part to play in raising kids in supportive, loving homes without neglect & abuse, where the use of drugs & alcohol are not seen as core parts of normal life.*

A number of gaps in services were highlighted for example the transition of young people into adult hood.

*There is a big gap between older adolescent misuse and adult misuse services particularly for age/developmentally appropriate assessment of risk need and harm. Attendance at ED does not guarantee referral onto service.*

Respondents highlighted the importance of prevention in particular diversionary activities for young people.

*My priority would be prevention, but this needs to be effective enough to impact on reducing numbers of people with problems.*

*I think the lack of youth clubs/youth cafes where the youngsters can hang out and socialise until later at night is biggest gap in services. 14-18 year olds have nowhere to gather or socialise so they drink and take drugs in 'hangouts' in the cold.*

*People should be able to get help with behaviour before their heavy drinking turns into a problem. Clubs where people can talk about this and get structured help as well as introducing them to other pastimes (fitness, outdoors, dancing, sport etc.) would be good. A kind of light level AA with a social side but without labelling people as alcoholics who can never be trusted to drink again and where any slip up is seen as a massive failure.*

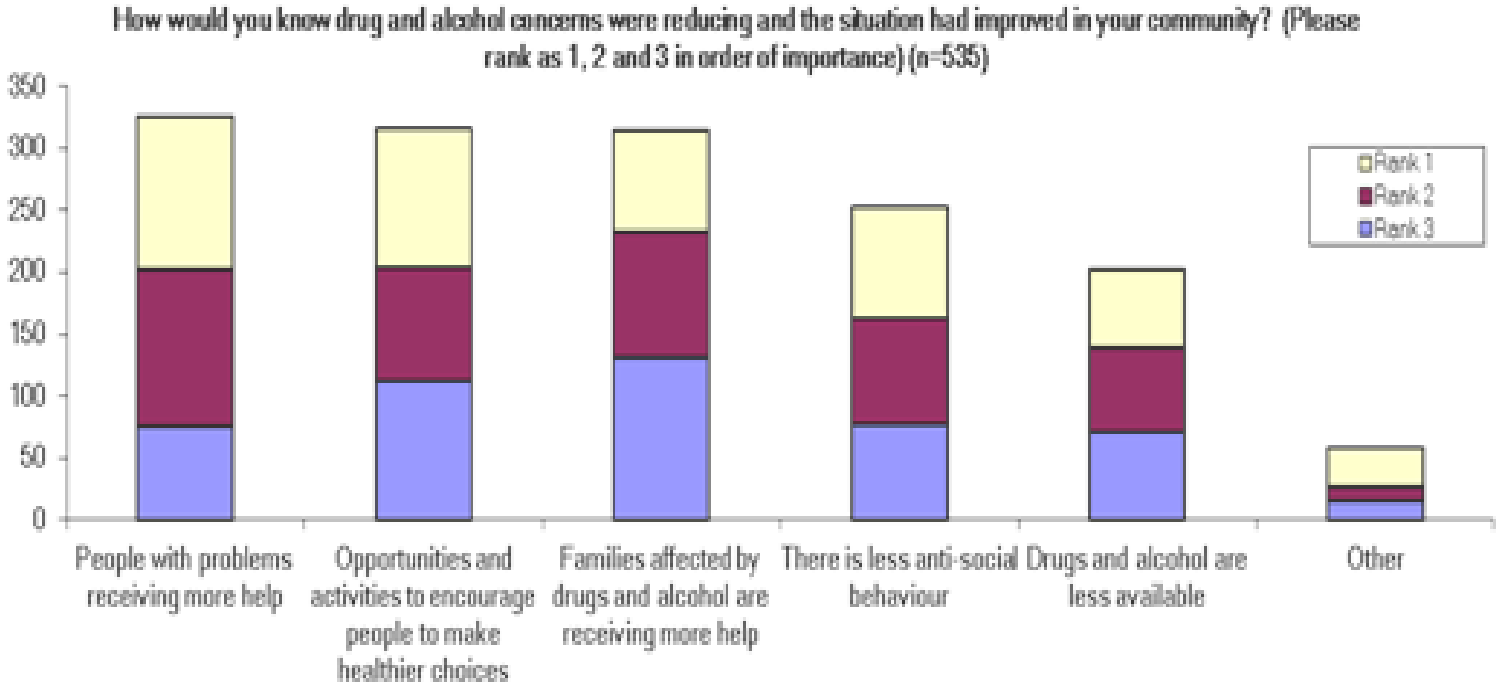
Population based prevention legislative interventions such as minimum alcohol pricing and the role of research were highlighted.

*Minimum alcohol pricing has been shown to be effective in reducing harm from alcohol, and the most effective legislation that would reduce alcohol related Morbidity and mortality. In raising awareness and prevention I think that culture regarding alcohol can, and is already, changing. I think more can be done in this direction. People need to know the risks of heavy drinking-I think most people don't. We need more research into effective abstinence systems*

*Efforts should be made to direct funds where research indicates it will be cost effective in reducing harm. Where research is lacking, research should be funded. There is no great advantage to swinging aimlessly at the problem or creating policy from general opinion on what might perhaps work.*

**Q6: How would you know drug and alcohol concerns were reducing and the situation had improved in our community?**

**Figure 32: How would you know drug and alcohol concerns were reducing and the situation had improved in our community?**




Source: HADP

Respondents were asked to rank how they would know that drug and alcohol concerns were reducing and the situation had improved in their community in order of importance.

- People with problems receiving more help' (60.9%, n=326)
- Opportunities and activities to encourage people to make healthier choices (59%, n=316)
- Families affected by drugs and alcohol are receiving more help (58.9%, 315) were most often ranked within the top 3. 22.9% (n=123) ranked

Comments:

A number of comments related a change in the pressures put on services such as the emergency services, education and the NHS.

*Levels of use decrease, reports of law breaking reduced.*

*A reduction in antisocial behaviour would make the community feel safer. There are many un-tapped opportunities and activities within the region which are not necessarily promoted by healthcare professionals or to specific groups such as substance abusers.*

*Less instances on Police and Emergency Services being visible in the area, and more action on providing services to help people with addictions whether this be through more visible media in Chemists, GP Practices, Community Hall etc. If they could self refer for advice or help or attend drop in sessions, then this may improve numbers of people accessing help. Through this same way, people could also access help for families affected or through raising awareness as part of the curriculum for excellence to show children at school how to access help for them and their families*

A change in culture was also mentioned.

*When young people are no longer talking about getting drunk like it is the coolest thing to do and people do not set off for the pub to get "leathered". When this sort of language starts to disappear things will be heading in the right direction. People will always be able to get drink and drugs so making it less available will not make much difference. Anyone trying to break away from a culture of drink or drugs will need attractive alternative activities, perhaps support of a coach etc.*

Q7: Any other comments

Respondents were invited to make any other comments. A number of comments related to longer term strategies about tacking the issues of drug and alcohol misuse including the commissioning of services, prevention and research.

*The commissioning of services for limited periods is a disaster for the provision of drug and alcohol services. It provides no continuity and does not develop best practice locally. It affects the quality of service provision and puts too much emphasis on 'results driven' outcomes which are not based in evidence. Dependency on drugs and alcohol is a lifelong condition. People can and do recover well but they need time and support and access to services when they need them. Employability is a major factor in recovery and lack of appropriate opportunities in deprived areas is a concern, along with the hardship and distress caused by punitive benefits strategy.*

*Raising awareness of the problems caused by excessive alcohol use or becoming drug dependant must be worth pursuing - the positive effects are evidenced by the success of the campaign to encourage people not to use tobacco.*

*In the Highlands we need more youth centres and sports facilities open to young people, at very little cost. So they can do something else instead of looking where they can get drugs or alcohol through boredom.*

*We need to fund new research on prevention and not provide more ineffective treatments. Social justice, wage justice, wealth redistribution and healthy and positive spiritual communities are likely to be more rewarding approaches.*

The issue of service user involvement was also raised.

*Having personal experience of alcoholic & drug users & the effect they caused within my close family I think that whilst these surveys are good from a professional point of view, it would be really good to involve drug users / alcoholics / ex drug users / ex alcoholics / children / families etc in discussions about reducing alcohol & drug concerns. It would be useful to hear what families have found useful coping strategies. It would be good to know how a current drug / alcohol user feels and if any health drives etc have any impact on how they feel about their current situation. It would be good to know the circumstances that make it easy for them to access drugs alcohol etc & from ex users it would be good to know what was useful / unhelpful in helping them to turn around their lives.*

Concern was expressed about how service users are treated and links to reoffending.

*More should be done to help those with addictions - it's far too widely available and there's not a great deal of help available locally. Treatment should be encouraged and if necessary imposed for their benefit and those around them to give them healthier and happier lives. I do think a lot more could be done regarding this matter, but instead they are often treated like criminals and don't get the help they need which is why reoffending is so common especially when alcohol and or drugs is concerned.*

Ensuring joined up services for example with mental health was raised particularly in relation to lack of services for children and young people.

*Addiction often goes hand-in-hand with some sort of mental health problem. This needs to be addressed if the problems are to be reduced. Mental health services are non-existent for children/young people in my community and minimal for adults. There are not enough CPNs.*

Finally, comments from two service users.

*We could do with easier access to services. Lot of what is on offer is 0900hrs-1700hrs Monday to Friday. Evenings and weekends although covered by NHS24 are the times most people need help.*

*I think the whole approach to drug use is wrong. Drugs have always been used. Drugs will always be used. We need clean supply and support for users.*

### 11.3 The Highland Council's annual survey of performance and attitudes Sept 2015

Two key questions about alcohol and drug misuse were included in the Community Safety section of the Highland Council annual survey of performance and attitudes published in September 2015[lxiv].

**Question 1: How much of a concern to you is each of the following in the area where you live?**

Respondents were then asked about their level of concern regarding thirteen different activities that might be taking place within their neighbourhoods. Of the 13 activities, 4 arouse concern of more than 1 in 2 of the respondents namely:

- road safety (78%) speeding, drink/drug driving;
- alcohol abuse (69%) under-age drinking/alcohol related disorder;
- drug misuse (58%);

**Question 2: What do you think would help most to reduce drug and alcohol related harm in your community?**

The respondent was offered four proposals and were invited to tack all that apply:

- People with problems receive more help (63%)
- Opportunities and activities to encourage people to make healthier choices (62%)
- More support for families who are affected by alcohol and drug problems (49%)
- Drugs and alcohol are less available (43%)

### 11.4 Key Messages

The following key messages have been summarised from the public consultation (focus groups 10.1 and public survey 10.2).

#### 11.4.1 Recovery (treatment)

The provision of high quality services for people with drug and alcohol problems remains a public priority.

Flexible local services including those provided by the 3rd and independent sector were valued with recommendations for increasing availability. This should cover the full range of service models that are joined up ranging from treatment, recovery/relapse through to social support such as accommodation (after care). There should be more awareness of dual diagnosis. Mental health services were seen vital to treatment and recovery. Crèche faculties will help some service users access services.

Peer support and mutual aid to be readily available.

Partnership working and data sharing should be improved across the whole range of service providers.

NHS treatment services to increase the number of service users involved; this also applies to all services.

Service providers should consider and provide family support.

Training in alcohol and drug awareness to include impact on wellbeing, prescription medications and interaction with prescription medications, poly drug use and mental health.

New Psychoactive Substances were perceived to be an increasing issue in local communities and internet purchases seen as a problem in increasing availability particularly in rural communities. Furthermore knowledge amongst service providers and service users was limited.

The evidence about the health impacts and risks form cannabis use to be communicated to service providers and to service users.
Stigma remains a barrier for people wishing to access services.
Low level of awareness that alcohol and drug misuse can affect all age groups and not just an issue for young people.

### 11.4.2 Maximising Health

There is an acceptance that alcohol remains part of the Highland culture and that drinking patterns have changed with more alcohol being consumed within the home and the practice of pre-loading.

The application of law or policy was seen as important for reducing alcohol availability, for example advertising standards, licensing and a minimal unit price for alcohol.

Schools and the curriculum for excellence are viewed as an important source of education for young people.

The media is influential in how people consume alcohol for example through the portrayal of positive and glamorous images. The media can also show positive messages about people who have recovered from alcohol or drug addiction.

Support for whole population approaches such as alcohol brief intervention.

Counteracting the internet as a source of information and supply of drugs.

Variations within population approaches need to be addressed for example older people's drinking habits as well as young people. Variations arise because of inequalities.

Harm and risk reduction social marketing campaigns need to be appropriately targeted and sustained. Cannabis and effects on mental health should become a priority.

### 11.4.3 Protecting Communities

A need for local accurate data to help inform local decision making.
A lack of knowledge about drink driving laws continues to be of concern.
Lack of designated places for drunken people.
Domestic violence and how it impacts on families and children.
The need to increase the number of diversionary activities for young people.
Concern about the availability of drugs over the internet and seemingly few controls in place.
Intranasal naloxone programme rolled out to front line staff regardless of organisation.
Increased use of NPS and how this impacts on local communities.
Better use of 'pub watch'.
Health improvement interventions to focus across the whole population and not solely on young people.

### 11.4.4 Children and Young People

All services should consider providing family support such as family counselling.
Families and young people have limited knowledge about where to access services and different types of support.
Concern over children affected particularly by alcohol and the need for family supports.

Transition into adult services for 16-18 year olds remains a challenge and a poor experience for young people.

Increase awareness about how children and young people model the drinking habits of their parents.

Tackle the perception that provision of alcohol by parents to underage young people leads to longer term responsible drinking and is acceptable. Families can become an enabler of alcohol/drug use without realising it.

Concerns that young people access information from the internet and this might not be evidence based and can be misleading.

## 12. Identified gaps and possible areas for future work

The following gaps and possible areas for future work have been identified from the information collected from the needs assessment and have been categorised under the headings of 'recovery', 'maximising health', community safely' and 'children and young people'.

**Gaps identified or work to be progressed:**
**Strategic**

- develop an inequalities focused strategic framework based on the needs assessment
- progress service user involvement in the full range of alcohol and drugs work
- continue to develop the partnership between HADP and the Child and Adolescent Protection Committee and implement local responses to national guidance
- development of a commissioning intention strategy with a view to increase the range of third sector recovery service providers
- establish an effective multi-agency data sharing group to review and develop effective mechanisms across agencies for data sharing and data analysis

**Maximising Health**

- Shift the volume of activity and resource towards prevention and ‘up stream’ services, projects and programmes (for example licensing)
- Consolidate and review the communications and media plans to improve joined up working across agencies and to tackle stigma and discrimination (for example targeted social marketing)

**Recovery**

- Continue to refocus all services to being recovery orientated rather than treatment
- Development of an outcomes based integrated recovery pathway
- Extend the range of services, through a commissioning process, to third and independent sector partners

**Community Safely**

- Support criminal justice services and partners to develop integrated recovery pathways
- Support HMP Inverness in developing a health improvement plan
- Develop a process with partners for managing drunk and incapable persons

**Children and Young People**

- Continue to develop family support interventions for those families affected by alcohol and drug misuse
- All services consider and/or refocus family support interventions for those families affected by alcohol and drug misuse
- Prioritise the ongoing development of ‘Women, *Pregnancy and Substance Misuse Guidance’*

## 13. Recommendations

The recommendations have been categorised under the headings of 'recovery', 'maximising health', community safely' and 'children and young people'. They have been developed by bringing together qualitative and quantitative data and the views and opinions collected from the consultations. Furthermore they have been cross referenced with the Scottish Government's *Quality Principles*[lxv].

| **Recommendations** | |
|---|---|
| **Recovery**<br>Treatment services are continually under pressure because of increased service user demand covering a large rural geographical area. Future demographic changes in relation to an aging population will add to these pressures. New ways of working across a range of services are required to meet changing demand. | |
| **Services** | **Lead(s)** |
| Appraisal of the evidence for different service treatment models and how this might fit with current localised services | HADP/Head of substance misuse treatment services |
| Increase the range of service providers to include the third and independent sector; to include family support, mutual aid, SMART recovery, and peer support | HADP/ Head of substance misuse treatment services /service providers |
| Recovery orientated systems of care, where appropriate, to be part of service level agreements | HADP/ Head of substance misuse treatment services /service providers |
| Strengthen outreach capability and capacity for enabling vulnerable and chaotic drug users to engage with harm reduction and treatment services | Head of substance misuse treatment services |
| Delivery and support for world cafe recovery events in partnership with people in recovery | HADP/ Head of substance misuse treatment services /service providers |
| Continue to deliver the opioid replacement therapy programme and develop a ORT action plan | HADP/ Head of substance misuse treatment services |
| To continue assessing and supporting poly drug and NPS users through substance misuse services where use is problematic | HADP/ Head of substance misuse treatment services |
| **Training** | |
| Develop, in consultation with HADP partners, a training needs analysis to improve the knowledge of the impact of alcohol and drugs on wellbeing | HADP |
| Deliver specific training in the following topics: interaction with prescription medications, poly drug use and mental health, cannabis use and mental health | HADP/ Head of substance misuse treatment services |

| | |
|---|---|
| A proportionate and co-ordinated response to providing training on New Psychoactive Substances | HAPD/Head of substance misuse treatment services |
| Information and or training about the prevalence and incidence of alcohol and drugs throughout Highland to enable service providers to understand issues of equity and the appropriate targeting of resources | HADP |
| **Service user involvement** | |
| Increase the involvement of service users in the planning, evaluation and delivery of services | HADP/ Head of substance misuse treatment services |
| Ensure mandatory and specific training programmes that specifically address issues of discrimination and tackling stigma (equality and diversity) are delivered to all staff and volunteers | HADP / learning and development |
| To establish mechanisms for service users, families and mutual aid groups to inform the decision making processes for developing and commissioning of services | HADP/ Head of substance misuse treatment services |
| **Data** | |
| Review of data sharing protocols for individual cases | HADP/ Head of substance misuse treatment services |
| Establish an agreed mechanism across partners to ensure a seamless transition of, for example, DAISy system and support for recovery orientation systems of care | HADP/ Head of substance misuse treatment services |
| | |
| **Maximising Health**<br>Health is maximised and communities and communities feel engaged and empowered to make healthier choices regarding alcohol and drugs. | |
| **Licensing** | |
| Introduction of the licensing tool kit to enable local communities to be involved in local licensing decisions. | HADP/ Health Improvement. |
| Evaluation of the current alcohol overprovision statement and the review of the evidence available in developing a refreshed or new statement based on affordability, accessibility and availability | HADP/ Public Health |
| **Media and Social marketing** | |
| Communication teams and those with responsibility to work with the media to review and to develop guidance about working with the media, for example, using positive messages about people in recovery and not reinforcing positive and glamorous images of individuals drinking alcohol or using drugs | HADP/Communication teams |
| Development of social marketing campaigns targeted at groups (for example families/elderly) and issues (for example harm and risk reduction/challenging stigma). | HADP/Health Improvement |
| Development of social marketing campaigns to counteract the internet as a source of information and supply of drugs | HADP/Health Improvement |
| Co-operation of partners in the development of the effective use of social media (for example facebook, on line chat and twitter). | HADP/Health Improvement |
| **Population based approaches** | |
| To work with HADP stakeholders in developing the capacity and delivery of presentations to raise awareness of whole population based approaches and the benefits of reducing availability. | HADP/Health Improvement |
| Continuation of the delivery and monitoring of ABIs expanding to a range of community setting | Health Improvement |

| | |
|---|---|
| Review evidence and develop targeted programmes for communities and individuals living in deprived circumstances such as the elderly | HADP/Health Improvement |
| | |
| **Community Safety**<br>Individuals and communities are protected against drug and alcohol related harm | |
| **Individual/ community level** | |
| Review current provision of safe places for drunken people with a view to increase capacity if there is an identify need | Police Scotland |
| Identify a clear mechanism for monitoring the availability of illegal drugs over the internet and ensure this is shared amongst partner | Police Scotland |
| Continuation of the roll out of the intranasal naloxone programme to multi-agency front line staff | HADP/Head of substance misuse treatment services |
| Develop a research framework for the purpose of increasing knowledge and understanding about NPS in Highland | HADP |
| Continue to work with festival organisers throughout Highland to ensure harm and risk reduction messages/campaigns are available before and during the events | HADP/Health Improvement Festival organisers |
| Encourage the uptake and maintenance of 'pub watch' schemes amongst publicans | Licensees, Alcohol Licensing Forums and Police |
| Deliver an awareness campaign targeting the public about the changes in the drink driving law to highlight the lower 50 mg limit | Police Scotland |
| Deliver an awareness campaign about home fire safety including referrals for home fire safety visits | Fire and Rescue |
| Explore and develop an action plan with partners how women experiencing domestic violence might be better supported | HADP/Violence Against Women Partnership |
| **Prison** | |
| Enhance prisoner through care and strengthen links with community supports and services | HMP Prison Inverness/ HAPD Health Improvement/ Criminal Justice |
| Develop a health improvement plan to include alcohol and drugs | HADP/ HMP Inverness/Health Improvement |
| To progress the peer training programme for prisoners within HMP Inverness | HMP Inverness/ Health Improvement |
| | |
| **Children and Young People**<br>Children and young people affected by alcohol and drugs either as a result of societal factors or by parental substance misuse are protected and build resilience through the joint working of adult and children's services | |
| **Diversionary activities** | |
| Continuation of divisionary activities for young people such as Rock Challenge and ensure an increase in | HADP/Education; Highlife |

| | |
|---|---|
| the numbers of children/young people living in deprived circumstances | Highland/Health Improvement |
| **Education and prevention** | |
| Promotion of the substance misuse tool kit in prevention and education initiatives including the development of teaching plans, for example in NPS | HADP/Education; Highlife Highland/Health Improvement |
| Ensure adherence with the *Highland Getting Our Priorities Right* guidance in relation to the training of practitioners | Education/Health Improvement |
| **Media and Social Marketing** | |
| Targeted campaigns about the types of services available | HADP/CAMHS/Children's Commissioner/Education; Highlife Highland |
| Targeted social media campaigns, for example, how children and young people model their behaviour on parental drinking habits, the impact of parental attitudes about the acceptable age for young people to start drinking, NPS use and the internet as a source of information and supply | HADP/CAMHS/Children's Commissioner/ Education; Highlife Highland |
| Progress the pathways for the transitioning of children and young people into adult services | HADP/CAMHS/Children's Commissioner/ Education; Highlife Highland |
| Identify mechanisms and monitoring to enable understanding about the impact of alcohol and drugs on children and families and ensure this information is shared appropriately amongst partners | HADP/CAMHS/Children's Commissioner/ Education; Highlife Highland |
| **Services** | |
| Appraisal of the evidence for different service treatment models and how this might fit with current localised services | HADP/CAMHS/Children's Commissioner |
| Strengthen the capacity of generic and specialised services, where appropriate, to provide a service model that includes family support (i.e counselling) | HADP/CAMHS/Children's Commissioner |
| To establish early intervention responses for young people aged 16-18 attending emergency departments due to intoxication | A&E/ Children's' Commissioner/HADP |
| Prioritise data analysis to understand inequalities and variations across a range of health and non health data sets and disseminate findings | HADP/service analysts |
| To update the content and include reference to emerging and ongoing drug and alcohol trends in the Women Pregnancy and Substance Misuse Guidelines from 2015-2018 | HADP/CAMHS/Children's Commissioner |
| | |
| **General - data** | |
| Establish a multi-agency data sharing group to review and develop an improvement plan for the data used in the HADP domains of recovery, community safety, maximising health and, children and young people. | HAPD/analysts/Health Intelligence |
| | |

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