Forth Valley ADPs Strategy 2014 - 2016

The Road to Recovery in Forth Valley - Phase 2

Introduction

This updated strategy sets out the ADP's vision for reducing the harm caused by substance use within the communities of Forth Valley. Much has already been achieved through the work of Forth Valley Alcohol and Drugs Partnerships (FVADPs), but the time is right for a revision of our strategy, giving direction for the way forward.

Overview of the strategic context

At the time of writing the previous strategy (The Road to Recovery in Forth Valley), Alcohol and Drug Partnerships (ADPs) were in the process of being constituted. Now as integral parts of the Community Planning Partnerships of Forth Valley they are well established and functioning effectively. The signs are that Community Planning is here to stay and that partnership working will be increasingly valued and expected. Organisations will be working closer together and in the public sector this is being driven by legislation on health and social care integration. In addition there is a continuing move towards even more preventative work, which needs to be engaging and involving as described in the Christie Commission report on the future of public services. The content of this strategy is compatible with these themes.

Layout of this strategy

The paper is divided into the following sections:

Introduction

For each section in the strategy, we have considered:

What are the main issues?

- The reasons are discussed as to why the item in each section is an issue for Forth Valley ADPs and the communities they serve. There is a brief presentation of any relevant data and a discussion of inter-relationships with other parts of the whole picture.

What would a preventative approach look like?

- Prevention is important in terms of reducing the impact of alcohol, tobacco and drugs and related harms; and Forth Valley ADPs work to the principles of ideally stopping problems before they start, early detection, and minimising the need for treatment. Ultimately we aim to reduce substance use and therefore problem substance use in the population of Forth Valley.

What do FV ADPs want to achieve?

- We consider what the vision for the future is, and more specific goals and objectives where appropriate.

What are the key actions?

- This summarises the agreed actions in any given area, and specific plans for the future.

How will we know we have succeeded?

- This includes any measures of success there may be and how they are applied. Where there are no quantitative measures we will consider how to get a general feel for improvement.

1. The strategic basis for action

1.1 Needs assessment priorities

What are the main issues?

- The Forth Valley Substance Use (alcohol, drugs and tobacco) Healthcare Needs Assessment (FVSUNA), published in May 2012 indicated several priorities for focussing resources namely:
  - the most deprived communities, in particular families with children where the parents are known to be substance users,
  - pregnant women (see section 2.3.5)
  - prisoners (see section 4.1)
- In addition overall work should aim to reduce substance use across the whole population.

What would a preventative approach look like?

- As work in relation to Single Outcome Agreements (SOAs) and the Whole Population Approach (Sections 1.3 and 1.4) progresses this will reduce the needs identified in the FVSUNA.

What do FV ADPs want to achieve?

- Ensure that the priority areas in the current needs assessment are addressed.
- Review the needs assessment and carry out additional needs assessments on selected topics as required (see section 1.2).

What are the key actions?

- Review local ADP action plans, SOAs, maternal and child health service plans, and prison health plans to consider the potential impact in relation to these priorities, identify any gaps and consider how these gaps can be met.

How will we know we've succeeded?

- Review of datasets within the needs assessment after a suitable period of time.
- Review outputs of plans described above.

1.2 Recommendations from the evaluation of the 2011-14 strategy

What are the main issues?

- An independent review of Forth Valley ADP strategy was carried out by McMillan Rome.
- The review was positive and demonstrated that progress had been made in meeting the aims of the earlier strategy.
- In general targets are being met
- Work towards improvement through redesign and stakeholder (including client) engagement and involvement has been successful
- The Healthcare Substance Use Needs Assessment focused on issues relating to health care. The review commented that the SUNA produced by Forth Valley was limited in scope and approach.

What would a preventative approach look like?

- The review includes a consideration of prevention in relation to alcohol drugs and tobacco. It quotes Leavell and Clark's three 'levels' of prevention:

"Primary Prevention

Seeks to prevent a disease or condition at a pre-pathologic state; To stop something from ever happening, health promotion, health education, marriage counselling, genetic screening, good standard of nutrition, adjusted to developmental phase of life, specific, protection, use of specific immunization, attention to personal hygiene, use of environmental sanitation, protection against occupational hazards, protection from accidents, use of specific nutrients, protections from carcinogens, avoidance to allergens.

Secondary Prevention

Also known as 'Health Maintenance': seeks to identify specific illnesses or conditions at an early stage with, prompt intervention to prevent or limit disability; to prevent catastrophic effects that could occur if proper attention and treatment are not provided, early diagnosis and prompt treatment, case finding measures, individual and mass screening survey, prevent spread of communicable disease, prevent complication and sequelae, shorten period of disability, Disability Limitations, Adequate treatment to arrest disease process and prevent further complication and sequelae, Provision of facilities to limit disability and prevent death.

Tertiary Prevention

Occurs after a disease or disability has occurred and the recovery process has begun; Intent is to halt the disease or injury process and assist the person in obtaining an optimal health status. To establish a high-level wellness. 'To maximize use of remaining capacities', restoration and rehabilitation."

and concludes that,

"Prevention should therefore be seen, not as preventing substance use per se, but as the avoidance of harm to individuals, families and communities resulting from such use."

What do FV ADPs want to achieve?

- Ensure the findings of the review are sufficiently taken account of.

What are the key actions?

- Consider carefully whether a more comprehensive needs assessment exercise would be worthwhile
- Ensure our approach to Opioid Replacement Therapy (ORT) is up to date and consistently applied (based on six themes)
- Workforce development – alcohol and drug workforce, but also housing, JCP, social workers etc. (see section 1.5)

How will we know we've succeeded?

- Review against actions described above

1.3 Single Outcome Agreements (SOAs)

What are the main issues?

- The Community Planning Partnerships (CPPs) for each Council area have recently revised local Single Outcome Agreements (SOAs) with the Scottish Government.
- All three SOAs emphasise that substance use is intrinsic to society and is an issue of health inequality. Action points within the SOAs to address the determinants of health are therefore important for a whole population and preventative approach.
- The points specific to substance use which are included in each Local Authority SOA are presented in the following table:

Community Planning Partnerships (CPPs) Single Outcome Agreements (SOAs) 2013

Clackmannanshire Substance specific outcomes

Substance misuse and its effects are reduced; (one of nine priority areas)

- The cycle of substance misuse in families is broken (Long Term Outcome – 10 years)
- We will reduce the impact of substance misuse, particularly on children and young people (Short term Outcome - three years)

There is a specific target to reduce the number of Children referred to Child Reporter on Drug and Alcohol grounds.

Falkirk Substance specific outcomes

The following substance related actions are specified:

- Reduced levels of alcohol, drugs and substance misuse.
- Education framework for substance misuse for use across Forth Valley linked to Curriculum for Excellence;
- Improving our approach on tackling domestic abuse, particularly those involving drug and/or alcohol issues.

Harms to Health (including alcohol and drug use)

- Targeted training and delivery on Alcohol Brief Intervention;
- Roll out of social influencing project across secondary schools;
- Education framework for substance misuse for Falkirk (cont.) use across Forth Valley linked to Curriculum for Falkirk (cont.) Excellence;
- Support for families and friends of those affected by substance misuse;
- Support for children affected by parental substance misuse;
- Timely access to services for people with drug and alcohol problems; and
- Work with Domestic Abuse Forum to ensure services are sensitive and responsive to domestic abuse.
- Redesign and delivery of targeted Smoking Cessation Services to ensure increased support for areas of greatest need;
- Integrate learning from the Falkirk Smoking Cessation and Pregnancy pilot;
- Provision of community based support for smoking cessation and activity to reduce childhood exposure to second hand smoke (Smoke Free Homes);

Measures

- Drug related hospital admissions ;
- Alcohol related hospital admissions ;
- Maternities recording drug use;
- Alcohol Brief Intervention numbers (HEAT & non-HEAT); and

People in Treatment – new patients/clients.

Stirling Substance specific outcomes

The Stirling ADP has agreed five priorities which will be linked to the seven national outcomes for ADPs as well as the Stirling Single Outcome Agreement. The five priorities are:

1. Earlier intervention
2. Family Support
3. Ensure the treatment system is open and accessible
4. Access to employment and training opportunities
5. Children affected by parental substance misuse.

Stirling SOA

The Stirling Community Planning Partnership adopted an Outcomes for Stirling approach and developed a Community and Life Stage model for agreeing the SOA priorities.

The Stirling SOA has seven strategic outcomes based on the Outcomes for Stirling work. These are:

1. Improve the outcomes for children
2. Improve support for disadvantaged and vulnerable families and individuals with reduced risk to children from harm and neglect and from the effects of domestic violence and substance misuse.
3. Ensure neighbourhoods are well served and area safe and experience less anti-social behaviour particularly from the impact of alcohol misuse.
4. Improve the supply of affordable and appropriate housing
5. Reduce the risk factors that lead to health and other inequalities including a reduction in the effects of substance misuse
6. Improve the opportunities for learning, training and work
7. Develop a diverse economy that delivers good quality local jobs

Substance misuse is specifically mentioned an issue to be addressed within areas 2,3 and 5. however, successfully addressing the impact of substance misuse on individuals, families and communities, may also support the achievement of outcomes in the other areas as well.

Outcomes for Stirling work has also raised a number of possible intervention and prevention areas. These are:

- Early years, including learning
- Support for vulnerable individuals and families including early intervention to prevent neglect and harm
- Appropriate community support, care and housing for older people
- Alcohol misuse particularly in relation to anti-social behaviour and offending
- Business growth, enterprise investment and connectivity
- Accessibility of facilities and services
- Maintaining the quality of the environment and adapting to climate change
- Tackling inequalities in health, income and housing

The Stirling ADP will be required to play an active partnership role in addressing these action areas as substance misuse is likely to be central to a number of them.

What would a preventative approach look like?

- There are preventative elements inherent in the broader areas covered in the SOAs.
- The SOAs relate to an enhancement of individual and community assets.

What do FV ADPs want to achieve?

- The implementation of SOAs being successful in achieving their aims.

What are the key actions?

- Support CPPs in addressing the wider determinants of health
- Provide a Forth Valley overview for local ADPs in relation to substance use specific, including support and review of progress.
- Ensure there is a local overview for each Council area so that a Forth Valley wide overview is possible.
- Share learning across Forth Valley
- Cross reference SOA elements to other ADP activities and key strategic elements.

How will we know we've succeeded?

- Via the measures defined in the SOAs and others as appropriate

1.4 Whole Population Approach

What are the main issues?

- Substance use has an impact across virtually the whole population, and is a problem of society
- Variations in the legal basis for the use of different substances is one factor in influencing acceptability across different parts of society
- Services tend to focus on the (relatively) immediate needs of individuals for whom substance use has caused problems
- There is an argument that shifting the population norms for substance use will have a large overall impact

What would a preventative approach look like?

- The whole population approach is inherently preventative.
- The whole population approach relates to increasing individual and community assets.

What do FV ADPs want to achieve?

- Reduce substance use across the whole population

What are the key actions?

- Support initiatives to address the wider determinants of health – such as those described in SOAs, general work on health improvement (especially mental wellbeing), health and employability work, etc.
- Take an overview of prevention and education work, including social influencing work
- Consider what the most suitable substance use messages for the population are, e.g. 'don't smoke', 'don't consume alcohol (but if you must then do so within recommended limits', and 'don't use illegal drugs (but if you must – consider safer methods)'. This within the context of social norms and an empathetic provision of help and support. ADPs will agree on key messages for various population groups.

How will we know we've succeeded?

- Changes in measures of population substance use over time

1.5 Workforce Development

What are the main issues?

- Substance use has an impact across the population and is a relevant issue for most public sector and third sector staff, to a varying extent.
- The appropriate knowledge, skills, attitudes and awareness vary according to the type of staff and role.
- Workforce development can be through education (for knowledge and awareness), training (for skills) and coaching and mentoring (for attitudes and application).
- A strategic approach to workforce development is required, linking to CPPs (and therefore SOAs), and all partner agencies. Organisations and partnerships need to understand and value their workforce.
- Other factors to consider are organisational structure and culture, policy and legislation, and work opportunities and conditions.

What would a preventative approach look like?

- As we develop the workforce we will begin to work further upstream, linking to pre-employment training and qualifications etc.
- Prioritisation of service areas for workforce development

What do FV ADPs want to achieve?

- Ensure strategic leadership in workforce development across all partners.
- Ensure consistency of workforce development with commissioning strategies, service design and delivery and the 'recovery' ethos (see section 1.7).
- A workforce fit for purpose to meet the other aims and thereby minimise harm and maximise 'recovery' in the population of Forth Valley, due to substance use.

What are the key actions?

- Considering the contribution, assets and activity of the workforce through scoping/ mapping.
- Needs analysis of education, training, coaching and mentoring (and other points mentioned above).
- Prioritisation of specific service delivery areas, e.g. drawing on work from STRADA on a strategic workforce development outcomes model.

How will we know we've succeeded?

- Repeat needs analysis after a suitable period

1.6 National Quality Improvement Framework (QIF)

What are the main issues?

- In April 2013 the Scottish Government, in conjunction with NHS Health Scotland and COSLA published 'Updated Guidance for Alcohol & Drug Partnerships (ADPs) on Planning and Reporting Arrangements 2013-15'
- This brings together existing guidance and some proposals for new arrangements covering:
  - Planning and Reporting Arrangements for 2012-2015
  - Overview of Proposed Planning and Reporting Arrangements for Alcohol and Drug Partnerships
  - ADP Funding, Planning and Reporting Cycle and (2) ADP Planning and Reporting Schedule
  - Core Outcomes for Alcohol and Drug Partnerships (ADPs)
  - Core Indicators and Core Outcomes and Core Indicators
  - Possible Local Indicators
- The ADP has seven core outcomes (below), each with several indicators, and the possibility for local indicators:
  - Health
  - Prevalence
  - Recovery
  - Families
  - Community Safety
  - Local Environment
  - Services
- It also specifies reporting requirements and provides a framework for integrating various planning and reporting mechanisms, including HEAT targets and SOAs

What would a preventative approach look like?

- A consideration of prevention across the seven ADP core outcome areas:
  - improving general mental wellbeing such that individuals are less likely to use substances
  - reducing the social acceptability of substance use – e.g. through social influencing work
  - considering the whole person in recovery, e.g. re-focussing on beliefs attitudes and skills in a positive way

- helping people to appreciate their relationships within a family and the inherent support that is within a family unit, and extended family
- encouraging asset-based approaches which increase community cohesion, inter-generational relationships and general positivity in a community
- help communities maximise the positive aspects of their physical environment, and thus the social environment
- encourage values-based services which demonstrate behaviour commensurate with these values.

What do FV ADPs want to achieve?

- To meet the updated guidance year on year with favourable feedback from Scottish Government.
- Provide a level of reassurance to commissioners and services users that Forth Valley services are of an acceptable quality and standard – remembering that this is strategy for communities.

What are the key actions?

- Work with the ADPs for each Council area to implement the guidance, using project management methods and the software such as Covalent, as appropriate

How will we know we've succeeded?

- Arrangements are in place and demonstrated through appropriate systems.

1.7 Develop a recovery orientated system of care

What are the main issues?

- People whose substance use has caused problems may seek help from services.
- Such services may be organised as 'mainstream' or 'specialist', but individuals with needs may not know of or understand this distinction.
- Service delivery tends to focus (necessarily) on immediate needs
- Longer term, problematic substance users need to be enabled to achieve a level of personal and social stability, usually accompanied by a reduction in substance use.
- Ultimately if staff are in the right place at the right time with the right skills, knowledge, experience and competencies support will be provided to give the best chance of 'recovery'.
- A recovery orientated system of care encompasses this goal from the outset – in tandem with workforce development (see section 1.5), and considering the contribution of non-staff
- 'Recovery' is the process of getting back something lost, such as health. The word 'recovery' may not the best term to use as many clients have no experience of being in a substance free lifestyle. They may not have been in a situation to which they would wish to return. Resilience may be an alternative term, and is more in line with the general person-centred care agenda.
- 'Recovery' (or resilience) – means considering the whole person. The following 'holistic model of wellbeing' provides a description of such a 'whole person':

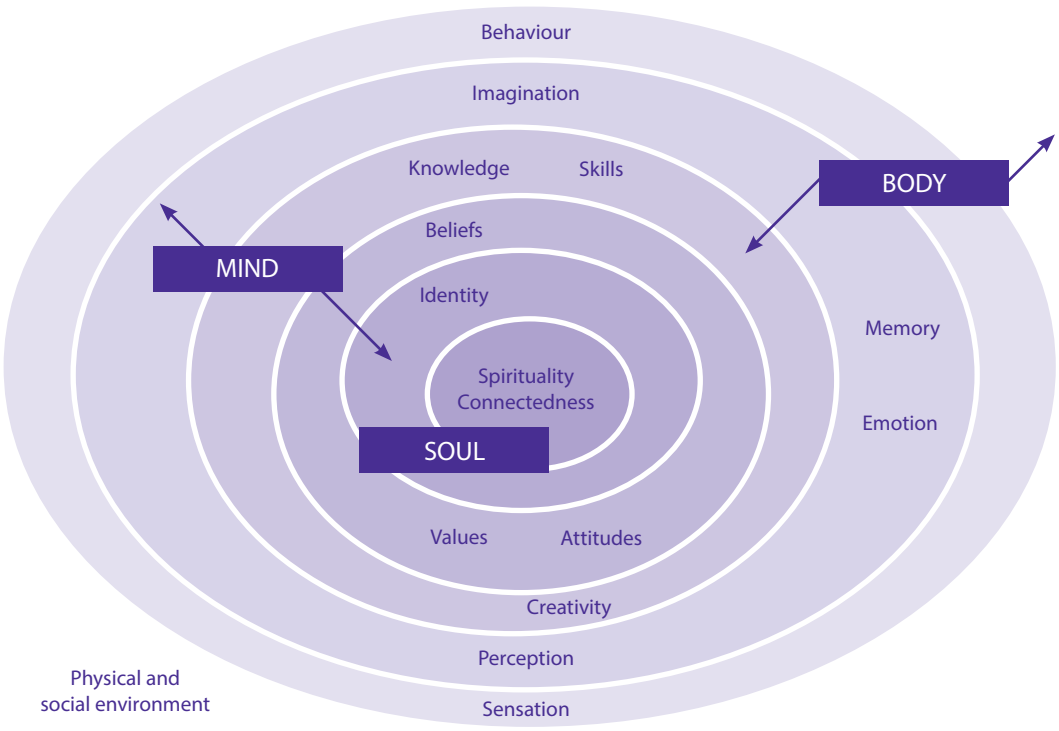
Holistic model of wellbeing – description of the 'whole person'

Figure 1 shows aspects of an individual person, at various 'levels', in a physical and social environment. The topic of substance use usually focuses firstly on behaviour – especially if this behaviour has led to a problem. This model suggests that it may be useful or necessary to look at other levels – which might underpin, or impact on behaviour

In terms of substance use each level is likely to have some relevance/ influence:

- Environment – the social and physical environment influence the availability of substances, and acceptability
- Behaviour – the key focus of substance use
- Perception, memory and imagination are aspects of the psychology of substance use behaviour, which might consist of causal links between sensations of withdrawal or mood and perceived need for a 'fix' Imagination is important for change – even to be able to imagine a future without substance use, and keep this vision in mind can be a significant first step for individuals.
- Knowledge, skills and creativity – can be positive or negative, e.g. skills may be in how to acquire and use substances. Developing alternative skills or creativity may be 'diversionary'. Also we tend to assume that knowledge has a direct link to behaviour. So, although education in substances is important in reducing substance use behaviour it is unlikely to be sufficient, especially where there is addiction. For example most smokers continue to smoke despite having knowledge of the harmful effects of doing so.
- Beliefs, values and attitudes – in the individual relate to the sense of personal morality in substance use. There may be conflict (cognitive dissonance) between such values and in relation to behaviour, and this can be used in motivational interviewing for example.
- Identity – people using substances may take on the associated identity (e.g. "I am a smoker"), which may be a hindrance to change.
- Connectedness and spirituality – for some people having a sense of place in the universe, meaning and purpose, may reduce the likelihood of substance use.

Figure 1 Holistic Model of Wellbeing



To make a difference to the whole person requires a process with a number of elements including, e.g.:

- Engagement
- Preparation
- Action
- Change
- Re-integration

(see Keep well Whole Person Engagement and Enablement ('WhoPEE) for staff)

What would a preventative approach look like?

- Recovery can be seen as (secondary) prevention in terms of reducing the risk of on-going or recurrent problems

What do FV ADPs want to achieve?

- To build on the successes of re-design to area recovery services, and develop further, integrated multi-agency help for individuals to work towards recovery.
- Develop a common understanding of the principles of 'recovery' – which may be better termed 'resilience' – such that people recognise and appreciate their and others' contribution.
- Corporate, strategic and operational 'buy-in' to these principles and their application.
- Integration of this aspect within commissioning strategies and service development plans.
- Integration with community assets-based approaches.

What are the key actions?

- Continue review and development of re-designed services.
- Continue to develop treatment services such that clients' needs are assessed and met in a timely way – the client gets the right treatment at the right time in the right way, by appropriate contributors with sufficient competence.
- Ensure that treatment is reduced or ceased appropriately based on an objective and on-going assessment of need and consultation with service users.
- Develop 'SMART' Recovery.
- Develop a 'Recovery' 'Café'.
- Continue workforce development and user involvement to maximise the person-centred ethos (critical, realistic empathy) to encourage progression out of treatment and discharge from services.
- Engage with wider partners such as Job Centre Plus.
- Ensure links with the Health and Employability strategy.
- Ensure the 'recovery' ethos is demonstrable within all of the above.

How will we know we've succeeded?

- Measures of treatment duration
- Self reported outcomes from clients
- Increase awareness of 'recovery'
- A better understanding of services in the 'recovery' context, by all.

2. Topic Areas

2.1 Tobacco

What are the main issues?

- Tobacco is still used by a significant minority of the population, and causes significant morbidity and mortality to the population.
- According to the data (appendix 1), prevalence of smoking is broadly similar to the rest of Scotland. Smoking in pregnancy in Clackmannanshire seems to be a particular problem.
- The prevalence of tobacco use is decreasing, and changes in legislation have helped in reducing secondary exposure to smoke and the acceptability of smoking tobacco.
- For individuals with an established tobacco habit, quitting can be difficult due to the addictive nature of nicotine – the active substance within tobacco.
- Smoking cessation services are available to provide support for those wanting to quit. According to the data, we need to increase the number of quit attempts, and the success rate of quit attempts.
- Tobacco use is associated with deprivation, so addressing the determinants to health should help in reducing tobacco use.
- Tobacco use is a risk factor for using and developing problems in relation to other substances.

What would a preventative approach look like?

- Prevention of starting a tobacco habit, including work developing the assets and resilience of young people, and environmental approaches such as smoke free homes.

What do FV ADPs want to achieve?

- In line with Scottish Government policy a tobacco-free Forth Valley by 2034

What are the key actions?

- Recognise tobacco as the substance that has the greatest impact on the health of the population, in its own right and as a risk factor for the use of other drugs.
- Continue to support initiatives with a positive impact on the determinants of health.
- Continue initiatives for prevention and education.
- Support the re-design of smoking cessation services.

How will we know we've succeeded?

- A prevalence of smoking prevalence of less than 5% by 2034.

2.2 Alcohol

2.2.1 Alcohol Brief Intervention (ABI)

What are the main issues?

- The use of alcohol is a considerable source of harm to the population
- Alcohol also causes social problems. The data suggest common assault and breach of the peace are particular problems (see Appendix).
- Some drinkers consume alcohol at 'hazardous' or 'harmful' levels, and some of this group can be identified opportunistically and given 'brief intervention'.
- There is an established Alcohol Brief Intervention (ABI) programme in Forth Valley, which has been successful in terms of achieving targets. There is evidence that people receiving ABI benefit in terms of reduced alcohol consumption and reduced risk.

What would a preventative approach look like?

- Reducing population consumption and the determinants of high population consumption, coming under the whole population approach and SOAs (sections 1.3 and 1.4).

What do FV ADPs want to achieve?

- To continue to deliver the programme.

What are the key actions?

- Provide continued support for the programme, and embed this work into mainstream practice.

How will we know we've succeeded?

- Monitor success against established (HEAT) indicators as well as our own measures of success.

2.2.2. Alcohol Related Brain Damage (ARBD)

What are the main issues?

- A sustained period of alcohol consumption (especially with poor nutrition) can lead to brain damage, which can lead to permanently decreased mental and physical functioning.

What would a preventative approach look like?

- Early detection and treatment is effective.
- Reducing population alcohol consumption, especially the prevalence of hazardous drinking.

What do FV ADPs want to achieve?

- Reduced prevalence in the true rate of Alcohol Related Brain Damage (ARBD).
- Increased detection and treatment and collaborative management of cases.

What are the key actions?

- Commitment to this as an area of priority.
- Consider suitable structure for strategic planning in this area.

How will we know we've succeeded?

- Meeting of agreed objectives.

2.2.3 Licensing

What are the main issues?

- Population alcohol consumption is greater than recommended and there is associated harm to health.
- Availability and price are the most important factors in population consumption.
- Most alcohol consumed is made available through licensed outlets.
- Changes in licensing legislation have introduced a requirement to consider public health.
- It seems reasonable to assume that licensing provides an opportunity to limit availability to the population and therefore population consumption. The alcohol needs assessment for Forth Valley identifies licensing as priority for this reason.
- However the amount of alcohol going through a licensed outlet varies considerably, and people can travel so are not limited to outlets in the immediate vicinity. Despite the concept of 'overprovision' being introduced in the legislation this only applies to new applications – there is no provision for reducing the number of licences. In Forth Valley most of the population lives in areas where there are already a relatively large number of outlets to chose from within a relatively short distance.
- Stirling for example has a higher than average number of licences per head of population (see Appendix), but the consensus is that there is no overprovision (perhaps due to the low-volume nature of a relatively large proportion of licences).
- The main means by which Forth Valley ADP may have a positive influence are through the local ADPs and Licensing Forums, providing support for the local Licensing Board's licensing policy and over-provision statement, and supporting objections to specific licence applications.

What would a preventative approach look like?

- Influencing policy and legislation development such that the licensing system is robust.

What do FV ADPs want to achieve?

- An overall reduction in the population consumption of alcohol.

What are the key actions?

- Provide support to local ADPs, Licensing Boards and Forums and objectors.
- Establishing in more detail what this support looks like.

How will we know we've succeeded?

- Data on population consumption.

2.2.4 Fetal Alcohol Spectrum Disorders (FAS and FASD)

What are the main issues?

- Alcohol consumption during pregnancy is harmful to the unborn baby.
- Pregnant women may continue to consume alcohol, such behaviour being in part due to a lack of knowledge of the potential harm, or an inability to change behaviour despite knowledge.

What would a preventative approach look like?

- The approach is inherently preventative in terms of this condition, but work on the whole population approach, especially knowledge and attitudes in relation to alcohol is particularly important.

What do FV ADPs want to achieve?

- An overall reduction in people with FASD long term.
- A continued positive message of abstinence from alcohol when pregnant, trying to conceive or at risk of unintended pregnancy.
- Enable staff and others to provide positive messages information for women, and support for ceasing alcohol consumption.

What are the key actions?

- Review current provision, identify any gaps and meet them.

How will we know we've succeeded?

- Qualitative information from staff and women on self reported alcohol use.
- Reduction in prevalence from available data.

2.2.5 Alcohol - Treatment

What are the main issues?

- Alcohol is a legal drug and socially normal.
- Most people drink more than the recommended levels. This often has little or no long term effect.
- There is therefore a threshold for need for treatment, which relates to eligibility criteria and diagnostic tools.
- Alcohol Brief Intervention (ABI) helps in identifying the need for treatment (see section 2.2.1). It is in effect assessment and intervention combined.
- Dependence is a key diagnosis – those who are not dependent can be encouraged to stop drinking. Those who are dependent cannot, as uncontrolled detoxification can be dangerous to the point of being life-threatening.
- Specialist services are required for detoxification.
- Alcohol features prominently in individuals with problems relating to multiple substance use.
- 'Recovery' applies to alcohol treatment too.

What would a preventative approach look like?

- Reduce population consumption such that specialist services are not required.

What do FV ADPs want to achieve?

- Good quality treatment services for those who need them delivered in the right time at the right place by the right people, and a 'recovery' ethos.

What are the key actions?

- Continue to support redesign and service development, in line with 'recovery'.
- Consider proposals for treatment development as required.

How will we know we've succeeded?

- Quality monitoring will be used to monitor success.

2.3 Drugs / BBVs

2.3.1 Reducing drug related death

What are the main issues?

- Substances are toxic. Their use can have short term effects as well as long term effects. Acute intoxication can lead to death (i.e. this is a 'short term' effect with permanent consequences, which can occur at any point in a substance use career).
- It has been necessary to develop a strict definition of drug related deaths, but substances play a role in a much larger number of deaths (e.g. alcohol and tobacco related deaths, and mortality associated with self harm and violence).
- Drug related deaths are usually in individuals who have a fairly long history of substance use (i.e. it is the result of acute intoxication in people with a fairly long substance use history). They are often related to a wide range of substances simultaneously ('poly' – drug use). The individuals often have chaotic, unstable lifestyles, and are usually well known to services.
- The number of drug related deaths per month in Forth Valley can fluctuate. Occasionally there are spates of deaths which require investigation to identify any common cause.
- The use of opiates contributes largely to drug related deaths and reduced individual tolerance, and variations in purity are factors.
- Locally the widespread use of benzodiazepines may be a factor.
- The workforce and others need to be able to recognise multiple substance use issues and assess as appropriate.

What would a preventative approach look like?

- Reducing problem substance use so that deaths are less likely to occur.
- The purpose is to develop local intelligence, learning and early intervention to achieve this.
- Increased availability of naloxone for the reversal of acute opiate toxicity.
- Improved TAS support on liberation from prison.

What do FV ADPs want to achieve?

- A competent workforce who can recognise, support and/ or refer on, individuals who are at an increased risk of drug related death.
- A reduction in drug related deaths, ideally to zero.

What are the key actions?

- Continue to implement established processes of review, investigation of spates of deaths, and continued workforce development.

How will we know we've succeeded?

- Through the available data on drug related deaths.

2.3.2 Blood Borne Viruses (BBVs)

What are the main issues?

- Blood borne viruses such as HIV and Hepatitis B and C constitute a risk to injecting drug users.
- The rate of new infection of Hepatitis C in injecting drug users is not decreasing.
- Treatment options and effectiveness have improved considerably over recent decades.
- Prevention of injection related transmission is through clean equipment (e.g. provision of such), and safer injecting practices – which requires improved knowledge and behaviour in at-risk individuals.
- There is need to explore in-depth injecting behaviour in a holistic way – see section1.7).

What would a preventative approach look like?

- Improvements in the resilience of the population to reduce risk (see Whole population approach (WPA) section 1.4).
- Dry blood spot (DBS) testing, harm reduction approaches etc.

What do FV ADPs want to achieve?

- Reduction in injection-associated new cases of BBV, ideally to zero.
- Early identification and treatment of injection-related BBV cases.

What are the key actions?

- Continue to develop prevention and education initiatives, by working with clients themselves in a whole person approach.
- Continue to work with harm reduction services, BBV MCN and other treatment services to improve further, awareness, and service quality.

How will we know we've succeeded?

- Data on injection-related BBV incidence and prevalence.
- Measures against service quality targets.

2.3.3 Sexual health

What are the main issues?

- Substance use is a factor in poor sexual health through two possible mechanisms. Sexual behaviour whilst under the influence of substances may be different to normal. A lack of self-esteem and self-efficacy may impact negatively on both substance use and sexual behaviour.
- Sexual exploitation and child sexual exploitation.

What would a preventative approach look like?

- Improvements in the resilience of the population to reduce risk (see Whole Population Approach, section 1.4).

What do FV ADPs want to achieve?

- Good sexual health in those whose substance use is problematic.
- Good prevention and management of sexual exploitation.

What are the key actions?

- Ensure ADP structures have appropriate links with sexual health structures.
- Consider reductions in substance use and improved sexual health as (possibly) secondary outcomes to improving the determinants of health, e.g. self-esteem/ self-efficacy/ emotional intelligence/ mental wellbeing/ resilience of young people.
- Continue to work in partnership through the two Child Protection Committees in Forth Valley which are working with Scottish Government to pilot work around child sexual exploitation including co-ordinating a multi-agency approach, recognising child sexual exploitation, supporting young people and their families, identifying, investigating, disrupting and prosecuting abusers and collecting and managing data.
- Continue to work through the Child Protection Committees, Violence Against Women Partnerships, and Adult Support and Protection Committees across Forth Valley to raise awareness of sexual exploitation, not only of children and young people (as in relation to the Child Sexual Exploitation pilot), but also of vulnerable adults. These Committees in Forth Valley are looking to pilot an approach which will utilise and build the knowledge, skills and experience of local practitioners. Local "champions" from across the statutory and third sector have been recruited to help tackle some of the issues of sexual exploitation and be a key force in raising awareness, with events planned across the region that will include information-sharing and simply talking to young people, parents/carers, local community groups and colleagues.

How will we know we've succeeded?

- Improved sexual health indicators, especially in those with substance use issues.

2.3.4 New Psychoactive Substances

What are the main issues?

- In modern society there is a desire on the part of the population to take mood altering substances.
- Legislation has designated some substances as legal and others illegal (in various classes).
- Use of legal substances such as alcohol and tobacco has a huge negative impact on the population.
- New psychoactive substances, not currently designated as illegal, are continually being developed. These create and lead to demand in the population.
- The effects of these substances are poorly understood and can be extremely harmful in the short term – to the extent of being life-threatening in the short-term and can lead to long-term irreversible health consequences. This means there may be a lack of knowledge, competence and confidence in the workforce in dealing with the effects of these substances.
- The message is abstinence.

What would a preventative approach look like?

- Reducing the desire for substance use in general in the population.

What do FV ADPs want to achieve?

- A competent and confident workforce who can provide the best support for individuals using these substances.
- Total abstinence from new substances in the Forth Valley population.

What are the key actions?

- Some sort of mechanism for sharing information and learning across Forth Valley.

How will we know we've succeeded?

- Agree success criteria and monitor against these.

2.3.5 General Practitioner (GP) involvement

What are the main issues?

- For illegal drugs, treatment has become a specialised area of medicine.
- There is a system for General Practitioner (GP) prescribing, as part of the overall treatment service, which is by agreement rather than compulsory or expected.
- There is a risk that GPs may lose their overview of the general health and needs of their patients who happen to be undergoing treatment for problems with illegal drugs (i.e. perhaps to a greater extent than for secondary care issues in general).

What would a preventative approach look like?

- GPs and partners take a preventative approach to substance use issues.

What do FV ADPs want to achieve?

- A general consideration of the issue and discussion options for a way forward.

What are the key actions?

- Dialogue with clinical leads.

How will we know we've succeeded?

- Agree success criteria and monitor against these.

2.3.6 Drugs - treatment

What are the main issues?

- Illegal drug use can lead to dependence, which can be managed through the use of prescribed medicines.
- Treatment is generally through secondary care services, in partnership with primary care and general services.
- The consensus on best practice regarding treatment may change over time depending on evidence. Different stakeholders may have different views on the aims and means of treatment.
- The outcomes of treatment can be considered to be more 'social' than 'clinical' - -e.g. reduced criminal behaviour, greater stability in home-life.
- In terms of policy there is an increased move towards a general principle of aiming for the client being off drugs and off treatment; and away from any idea of indefinite maintenance on treatment.
- A person-centred, holistic, recovery based approach (see section 1.7) must take account of the client's views – beliefs, values, attitudes – and readiness to change etc. Treatment goals and timescales should be agreed with the client, and should be realistic.

What would a preventative approach look like?

- Prevention of problem use of illegal drugs (see above).

What do FV ADPs want to achieve?

- Consensus on the principles of treatment in Forth Valley – agreed and stated.

What are the key actions?

- Beginnings of dialogue on this at relevant groups.
- Clarity that FV ADPs will decide local principles, policy and practice.

How will we know we've succeeded?

- Agree success criteria and monitor against this.

3. Demographic and Other Groups

3.1 Children

What are the main issues?

- Children may be potential substance users, current substance users, in families with substance misusing adults or otherwise exposed to harm or risk associated with substance use.
- Children in families where there are substance use problems in the parents or guardians may constitute a child protection issue. The data suggest this is a particular problem in Clackmannanshire (see Appendix).

What would a preventative approach look like?

- Helping people with substance use problems make good family planning decisions.
- Reduce general substance use and related problems in Forth Valley.
- Adult and child services working together to support the whole family.

What do FV ADPs want to achieve?

- Children adequately protected in Forth Valley.
- Adult services understand the needs of children and child services understand the impact of alcohol and drugs on the adult.

What are the key actions?

- Continued involvement with Child Protection structures.

How will we know we've succeeded?

- Success criteria agreed at CPC ADP groups, and applied.

3.2 Older people

What are the main issues?

- Older people can be more likely to experience loneliness and isolation
- This can increase the use of substances – e.g. alcohol consumption may increase in older age.
- Illegal substance use tends to decline into older age. But overall the population using illegal drugs is aging. The number of people using illegal drugs into old age is small but increasing.

What would a preventative approach look like?

- Addressing loneliness and isolation by more positive means than substance use.
- Increased inter-generational work.
- Getting people off drugs before they get to old age.

What do FV ADPs want to achieve?

- Improved health for older people.
- Workforce development in the field of substance use in older people.

What are the key actions?

- Begin dialogue

How will we know we've succeeded?

- Agree and monitor success criteria.

3.3 Ethnicity / Language

What are the main issues?

- Ethnicity is factor in substance use – type and prevalence.
- Ethnicity may be a factor in terms of access to services for reasons of culture, religion and language.

What would a preventative approach look like?

- Language appropriate services to be available.

What do FV ADPs want to achieve?

- Ensure needs relating to ethnicity are understood and accounted for.
- Ensure that services are equally accessible to people of all ethnicities.

What are the key actions?

- Awareness raising sessions for staff.
- Ensure EQIA processes are up to date, plans implemented and review dates set.

How will we know we've succeeded?

- Instigate client feedback, including a consideration of ethnicity.

4. Criminal Justice System

4.1 Crime and non-custodial approaches

What are the main issues?

- Crime and substance use are inherently linked. Most crimes of property are drug related. Most crimes of violence are alcohol related. Anti-social behaviour of all types is related to substance use.
- It seems reasonable to assume that reducing substance use especially that leading to acute intoxication will improve behaviour and reduce crime.
- The criminal justice system can be complex, with a range of agencies (including police, courts, criminal justice social work), policies and procedures to be considered. Partnership working is key.

What would a preventative approach look like?

- Improving the social and physical environment, reducing deprivation and inequalities will reduce substance use and therefore crime.

What do FV ADPs want to achieve?

- A significant input to addressing substance use behaviour and related problems at all stages of progression through the criminal justice system.
- A suitable structure for strategic planning – linked to Community Planning Partnership structures and considering how to make best use of resources, processes, ideas, ethos etc. across all relevant agencies.
- Staff development and partnership working with police, courts, criminal justice social work departments etc.

What are the key actions?

- Strategic commitment and planning.
- Consider several discrete projects.
- Target certain population groups, e.g. SMART.

How will we know we've succeeded?

- Develop and apply success criteria.

4.2 Prison

What are the main issues?

- There is a higher prevalence of past and current substance use in the prison population than the general population.
- When in prison there is greater opportunity for substance use problems in an individual to be addressed.
- The prison health service is now part of the NHS, however the transition into and out of prison remains challenging in terms of ensuring continuity of care.

What would a preventative approach look like?

- Crime reduction and reduced custodial sentences.

What do FV ADPs want to achieve?

- Substance use issues in prisoners are identified and met.

What are the key actions?

- Process mapping, pathway development and standard operating procedures for treatment and care in prison and transitions in and out.

How will we know we've succeeded?

- Data from prisons, client feedback.

Summary

This strategic document sets out the key issues and actions for Forth Valley ADP for the next 2 years.

Statistical Appendix

The following charts summarise the readily available information from Clackmannanshire, Falkirk and Stirling to provide an alcohol and drugs profile.

Please note the following:

- The comparator is Scotland as a whole. (Do we want to be just 'average' for Scotland?)
- The charts combine the most up to date data for different parameters, which may therefore relate to different years
- The indicators may not reflect the complexity of causation – e.g. breach of the peace may generally be alcohol related, but there are other factors too; COPD and lung cancer are strongly related to tobacco use, but again there may be other factors involved; the number of licences alone does not necessarily relate to the volume of alcohol entering the population
- The data relate to fairly small areas and may vary quite a lot year on year in a random fashion

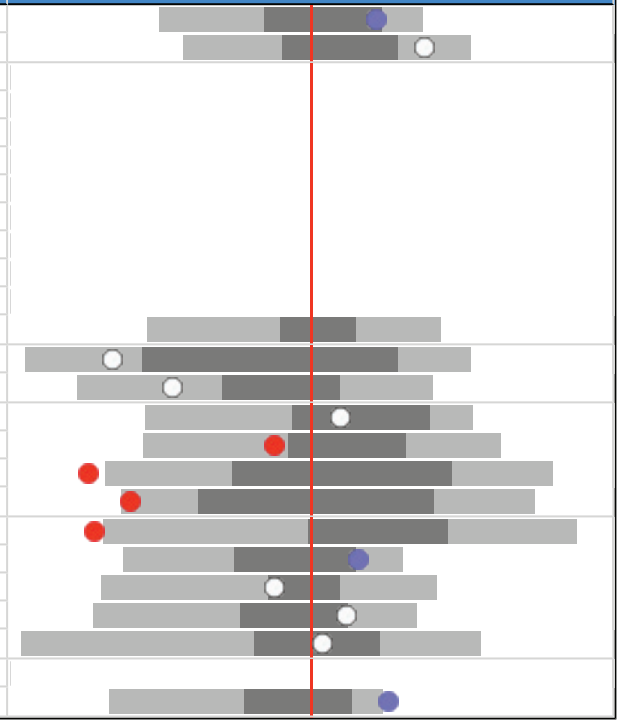
For more information and updates see:
http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

ScotPHO
Period: 2013

Alcohol Profile (Clackmannanshire)

Printed Date: 30-JUL-2014 13:22

Domain		Indicator	Period	Number	Measure	Type	National Average
Health	1	Alcohol-related hospital discharges	2012	260	502.4	sr3	693.3
	2	Alcohol-related mortality	2012	7	13.2	sr3	21.2
Prevalence	3	Males exceeding daily/weekly drinking limits [13]	2011	n/a		%	48.7
	4	Females exceeding daily/weekly drinking limits [13]	2011	n/a		%	38.6
	5	Individuals exceeding daily/weekly drinking limits [13]	2011	n/a		%	43.4
	6	Males binge drinking [13]	2011	n/a		%	26.0
	7	Females binge drinking [13]	2011	n/a		%	16.7
	8	Individuals binge drinking [13]	2011	n/a		%	21.1
	9	Males problem drinking [13]	2011	n/a		%	13.9
	10	Females problem drinking [13]	2011	n/a		%	9.5
	11	Individuals problem drinking [13]	2011	n/a		%	11.7
	12	Weekly drinkers (pupils age 15) [13]	2010	n/a		%	20.4
CAPSM/Families	13	Child protection with parental alcohol/drug misuse	2013	17	16.2	rt3	9.6
	14	Child protection with parental alcohol misuse	2013	10	9.5	rt3	5.1
Community safety	15	Serious assault [4]	2012	28	5.5	rt1	6.1
	16	Common assault [4]	2012	572	111.5	rt1	102.5
	17	Vandalism [4]	2012	711	138.7	rt1	100.3
	18	Breach of the Peace [4]	2012	380	74.1	rt1	46.8
Environment	19	% people perceiving rowdy behaviour very/fairly common in their neighbourhood	2012	59	22.6	%	14.5
	20	Premise licences in force - On trade	2013	82	20.1	rt2	26.6
	21	Premise licences in force - Off trade	2013	52	12.7	rt2	11.4
	22	Premise licences in force - Total	2013	134	32.8	rt2	38.0
	23	Personal licences in force	2013	491	120.3	rt2	123.5
Services	24	ABIs delivered [13]	2012	n/a		%	155.4
	25	Alcohol treatment waiting times	2012	0	0.0	%	7.9



Notes:
4. Data available at ADP (Alcohol & Drug Partnership) level only.
13. Indicator based on HB boundaries prior to April 2014.

Spine Chart Key:
% =percent
rt1 =Crude rate per 10,000 population
rt2 =Crude rate per 10,000 population aged 18+
rt3 =Crude rate / 10,000 population aged less than 18 years
sr3= age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

Spine Chart Key:
- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- No significance can be calculated

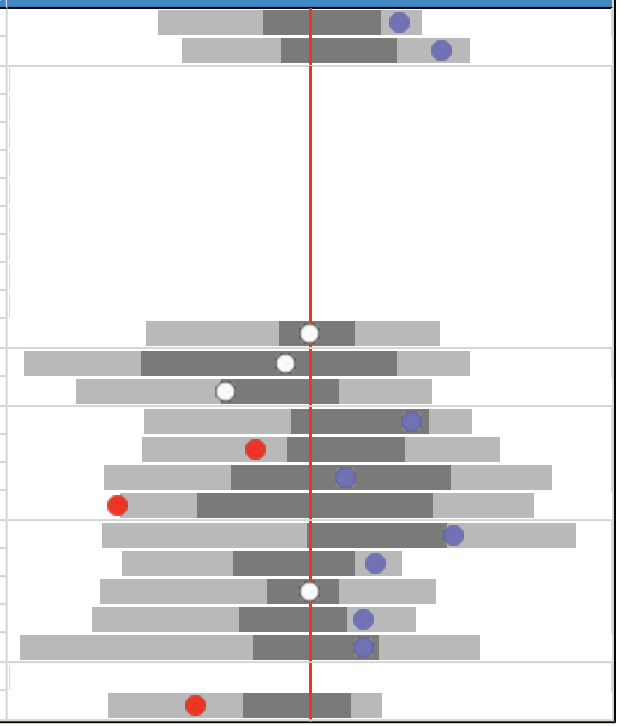
See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

ScotPHO
Period: 2013

Alcohol Profile (Falkirk)

Printed Date: 30-JUL-2014 13:23

Domain		Indicator	Period	Number	Measure	Type	National Average
Health	1	Alcohol-related hospital discharges	2012	682	442.0	sr3	693.3
	2	Alcohol-related mortality	2012	18	11.9	sr3	21.2
Prevalence	3	Males exceeding daily/weekly drinking limits [13]	2011	n/a		%	48.7
	4	Females exceeding daily/weekly drinking limits [13]	2011	n/a		%	38.6
	5	Individuals exceeding daily/weekly drinking limits [13]	2011	n/a		%	43.4
	6	Males binge drinking [13]	2011	n/a		%	26.0
	7	Females binge drinking [13]	2011	n/a		%	16.7
	8	Individuals binge drinking [13]	2011	n/a		%	21.1
	9	Males problem drinking [13]	2011	n/a		%	13.9
	10	Females problem drinking [13]	2011	n/a		%	9.5
	11	Individuals problem drinking [13]	2011	n/a		%	11.7
	12	Weekly drinkers (pupils age 15) [13]	2010	68	20.4	%	20.4
CAPSM/Families	13	Child protection with parental alcohol/drug misuse	2013	33	10.3	rt3	9.6
	14	Child protection with parental alcohol misuse	2013	25	7.8	rt3	5.1
Community safety	15	Serious assault [4]	2012	59	3.8	rt1	6.1
	16	Common assault [4]	2012	1,822	116.2	rt1	102.5
	17	Vandalism [4]	2012	1,480	94.4	rt1	100.3
	18	Breach of the Peace [4]	2012	1,198	76.4	rt1	46.8
Environment	19	% people perceiving rowdy behaviour very/fairly common in their neighbourhood	2012	22	9.2	%	14.5
	20	Premise licences in force - On trade	2013	222	17.8	rt2	26.6
	21	Premise licences in force - Off trade	2013	143	11.5	rt2	11.4
	22	Premise licences in force - Total	2013	365	29.3	rt2	38.0
	23	Personal licences in force	2013	1,333	106.9	rt2	123.5
Services	24	ABIs delivered [13]	2012	n/a		%	155.4
	25	Alcohol treatment waiting times	2012	43	18.9	%	7.9



Notes:
4. Data available at ADP (Alcohol & Drug Partnership) level only.
13. Indicator based on HB boundaries prior to April 2014.

Spine Chart Key:
% =percent
rt1 =Crude rate per 10,000 population
rt2 =Crude rate per 10,000 population aged 18+
rt3 =Crude rate / 10,000 population aged less than 18 years
sr3=age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

Spine Chart Key:
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- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- No significance can be calculated

See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

ScotPHO
Period: 2013

Alcohol Profile (Stirling ADP)

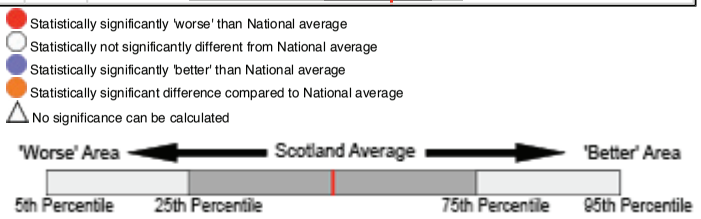
Printed Date: 30-JUL-2014 13:24

Domain		Indicator	Period	Number	Measure	Type	National Average	'Worst' Scotland Comparator 'Best'
Health	1	Alcohol-related hospital discharges	2012	357	407.8	sr3	693.3	
	2	Alcohol-related mortality	2012	15	18.2	sr3	21.2	
Prevalence	3	Males exceeding daily/weekly drinking limits [13]	2011	n/a		%	48.7	
	4	Females exceeding daily/weekly drinking limits [13]	2011	n/a		%	38.6	
	5	Individuals exceeding daily/weekly drinking limits [13]	2011	n/a		%	43.4	
	6	Males binge drinking [13]	2011	n/a		%	26.0	
	7	Females binge drinking [13]	2011	n/a		%	16.7	
	8	Individuals binge drinking [13]	2011	n/a		%	21.1	
	9	Males problem drinking [13]	2011	n/a		%	13.9	
	10	Females problem drinking [13]	2011	n/a		%	9.5	
	11	Individuals problem drinking [13]	2011	n/a		%	11.7	
	12	Weekly drinkers (pupils age 15) [13]	2010	42	16.7	%	20.4	
CAPSM/Families	13	Child protection with parental alcohol/drug misuse	2013	22	12.0	rt3	9.6	
	14	Child protection with parental alcohol misuse	2013	11	6.0	rt3	5.1	
Community safety	15	Serious assault [4]	2012	39	4.3	rt1	6.1	
	16	Common assault [4]	2012	917	100.7	rt1	102.5	
	17	Vandalism [4]	2012	853	93.7	rt1	100.3	
	18	Breach of the Peace [4]	2012	601	66.0	rt1	46.8	
Environment	19	% people perceiving rowdy behaviour very/fairly common in their neighbourhood	2012	31	12.5	%	14.5	
	20	Premise licences in force - On trade	2013	287	39.5	rt2	26.6	
	21	Premise licences in force - Off trade	2013	112	15.4	rt2	11.4	
	22	Premise licences in force - Total	2013	399	54.9	rt2	38.0	
	23	Personal licences in force	2013	1,135	156.1	rt2	123.5	
Services	24	ABIs delivered [13]	2012	n/a		%	155.4	
	25	Alcohol treatment waiting times	2012	47	37.6	%	7.9	

Notes:
4. Data available at ADP (Alcohol & Drug Partnership) level only.
13. Indicator based on HB boundaries prior to April 2014.

Spine Chart Key:
% =percent
rt1 =Crude rate per 10,000 population
rt2 =Crude rate per 10,000 population aged 18+
rt3 =Crude rate / 10,000 population aged less than 18 years
sr3= age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

Spine Chart Key:



See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

FV ADPs Performance

Statistics from ScotPHO profiles

http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

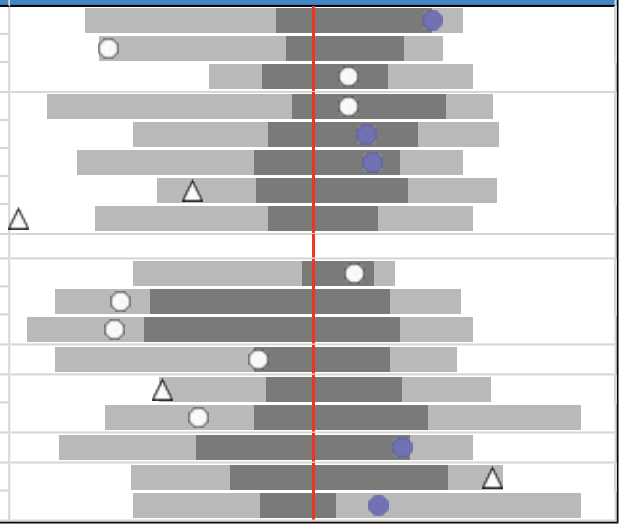
Alcohol	Clackmannanshire		Falkirk		Stirling	
Alcohol-related hospital discharges	260	better	649	better	410	better
Alcohol-related mortality	12	av	35	av	14	av
Weekly drinkers (pupils age 15)	18%	-	20%	av	42	av
Child protection with parental alcohol/drug misuse	21	worse	16	better	20	av
Child protection with parental alcohol misuse	7	av	n/a		11	av
Serious assault	28	av	59	better	39	better
Common assault	572	worse	1822	worse	917	av
Vandalism	711	worse	1480	better	853	better
Breach of the Peace	380	worse	1198	worse	601	worse
Alcohol abuse in neighbourhood	7	av	18	av	14	av
Premise licences in force - On trade	107	av	228	better	255	worse
Premise licences in force - Off trade	27	better	138	av	137	worse
Premise licences in force - Total	134	av	366	better	392	worse
Personal licences in force	471	av	1188	better	999	worse
Alcohol treatment waiting times	0	better	43	worse	47	worse

ScotPHO
Period: 2013

Drugs Profile (Clackmannanshire)

Printed Date: 30-JUL-2014 13:25

Domain		Indicator	Period	Number	Measure	Type	National Average
Health	1	Drug-related hospital discharges [11]	2012	28	54.9	sr3	107.2
	2	Drug-related mortality	2012	11	21.3	CR7	11.0
	3	Hepatitis-C positives among PWID	2011	8	47.1	%	53.0
Prevalence	4	Population prevalence of problem drug use	2009	480	1.5	%	1.7
	5	Male prevalence of problem drug use	2009	350	2.1	%	2.5
	6	Female prevalence of problem drug use	2009	130	0.8	%	1.0
	7	Drug use last month (pupils age 15)	2010	n/a	15.0	%	11.4
	8	Drug use last year (pupils age 15)	2010	n/a	30.8	%	18.5
Recovery	9	Drugs spend reduction		n/a		%	
CAPSM/Families	10	Maternities with drug use [2]	2010	22	12.5	Mats	18.8
	11	Child protection with parental drug misuse	2013	12	11.5	rt3	6.4
	12	Child protection with parental alcohol/drug misuse	2013	17	16.2	rt3	9.6
Community safety	13	Drug use funded by crime [13]	2011	19	24.1	%	20.9
Environment	14	Children being offered drugs (pupils age 15) [13]	2010	n/a	50.6	%	42.5
	15	Drug misuse in neighbourhood	2012	44	17.1	%	12.9
Services	16	Drug treatment waiting times [13]	2012	20	4.0	%	8.3
Data Quality	17	SDMD initial completeness [13]	2012	399	100.5	%	62.9
	18	SDMD follow-up completeness [13]	2012	72	19.0	%	14.6



Notes:

2. Three-year combined number, and 3-year average annual measure.
11. The ESP2013 has been used to calculate the rate for this indicator. Please see Appendix I of the technical report for further details.
13. Indicator based on HB boundaries prior to April 2014.

Spine Chart Key:

% =percent
CR7 =Crude Rate per 100,000 population
Mats=Crude rate per 1,000 maternities
rt3 =Crude rate / 10,000 population aged less than 18 years
sr3 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

Spine Chart Key:

- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- No significance can be calculated

See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

ScotPHO
Period: 2013

Drugs Profile (Falkirk)

Printed Date: 30-JUL-2014 13:26

Domain		Indicator	Period	Number	Measure	Type	National Average	'Worst' Scotland Comparator 'Best'
Health	1	Drug-related hospital discharges [11]	2012	69	44.3	sr3	107.2	
	2	Drug-related mortality	2012	14	9.1	CR7	11.0	
	3	Hepatitis-C positives among PWID	2011	32	66.7	%	53.0	
Prevalence	4	Population prevalence of problem drug use	2009	1,000	1.0	%	1.7	
	5	Male prevalence of problem drug use	2009	780	1.6	%	2.5	
	6	Female prevalence of problem drug use	2009	240	0.5	%	1.0	
	7	Drug use last month (pupils age 15)	2010	48	14.6	%	11.4	
	8	Drug use last year (pupils age 15)	2010	66	20.3	%	18.5	
Recovery	9	Drugs spend reduction		n/a		%		
CAPSM/Families	10	Maternities with drug use [2]	2010	50	9.4	Mats	18.8	
	11	Child protection with parental drug misuse	2013	21	6.5	rt3	6.4	
	12	Child protection with parental alcohol/drug misuse	2013	33	10.3	rt3	9.6	
Community safety	13	Drug use funded by crime [13]	2011	41	21.7	%	20.9	
Environment	14	Children being offered drugs (pupils age 15) [13]	2010	140	44.8	%	42.5	
	15	Drug misuse in neighbourhood	2012	12	5.2	%	12.9	
Services	16	Drug treatment waiting times [13]	2012	8	8.3	%	8.3	
Data Quality	17	SDMD initial completeness [13]	2012	48	48.5	%	62.9	
	18	SDMD follow-up completeness [13]	2012	7	13.7	%	14.6	

Notes:
2. Three-year combined number, and 3-year average annual measure.
11. The ESP2013 has been used to calculate the rate for this indicator. Please see Appendix I of the technical report for further details.
13. Indicator based on HB boundaries prior to April 2014.

Spine Chart Key:
% =percent
CR7 =Crude Rate per 100,000 population
Mats=Crude rate per 1,000 maternities
rt3 =Crude rate / 10,000 population aged less than 18 years
sr3 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

Spine Chart Key:
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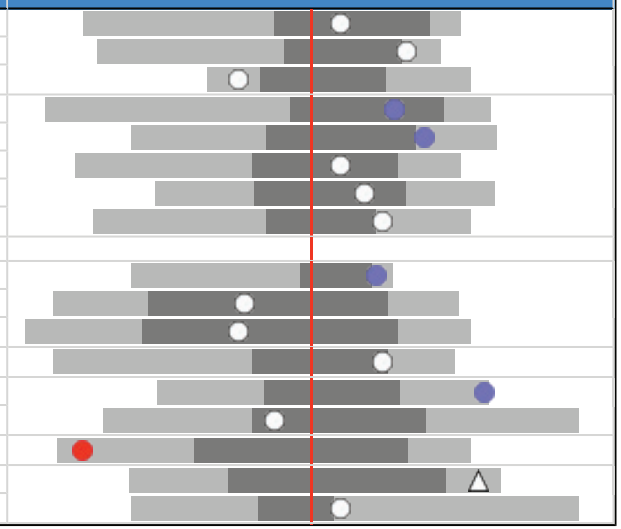
See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

ScotPHO
Period: 2013

Drugs Profile (Stirling ADP)

Printed Date: 30-JUL-2014 13:27

Domain		Indicator	Period	Number	Measure	Type	National Average
Health	1	Drug-related hospital discharges [11]	2012	80	92.9	sr3	107.2
	2	Drug-related mortality	2012	6	6.1	CR7	11.0
	3	Hepatitis-C positives among PWID	2011	34	64.2	%	53.0
Prevalence	4	Population prevalence of problem drug use	2009	710	1.2	%	1.7
	5	Male prevalence of problem drug use	2009	440	1.6	%	2.5
	6	Female prevalence of problem drug use	2009	270	0.9	%	1.0
	7	Drug use last month (pupils age 15)	2010	24	9.8	%	11.4
	8	Drug use last year (pupils age 15)	2010	39	15.6	%	18.5
Recovery	9	Drugs spend reduction		n/a		%	
CAPSM/Families	10	Maternities with drug use [2]	2010	22	8.7	Mats	18.8
	11	Child protection with parental drug misuse	2013	15	8.2	rt3	6.4
	12	Child protection with parental alcohol/drug misuse	2013	22	12.0	rt3	9.6
Community safety	13	Drug use funded by crime [13]	2011	19	17.0	%	20.9
Environment	14	Children being offered drugs (pupils age 15) [13]	2010	79	33.2	%	42.5
	15	Drug misuse in neighbourhood	2012	36	14.3	%	12.9
Services	16	Drug treatment waiting times [13]	2012	21	19.3	%	8.3
Data Quality	17	SDMD initial completeness [13]	2012	101	98.1	%	62.9
	18	SDMD follow-up completeness [13]	2012	17	16.5	%	14.6



Notes:
2. Three-year combined number, and 3-year average annual measure.
11. The ESP2013 has been used to calculate the rate for this indicator. Please see Appendix I of the technical report for further details.
13. Indicator based on HB boundaries prior to April 2014.

Spine Chart Key:
% =percent
CR7 =Crude Rate per 100,000 population
Mats=Crude rate per 1,000 maternities
rt3 =Crude rate / 10,000 population aged less than 18 years
sr3 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

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See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

FV ADPs Performance

Statistics from ScotPHO profiles

http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

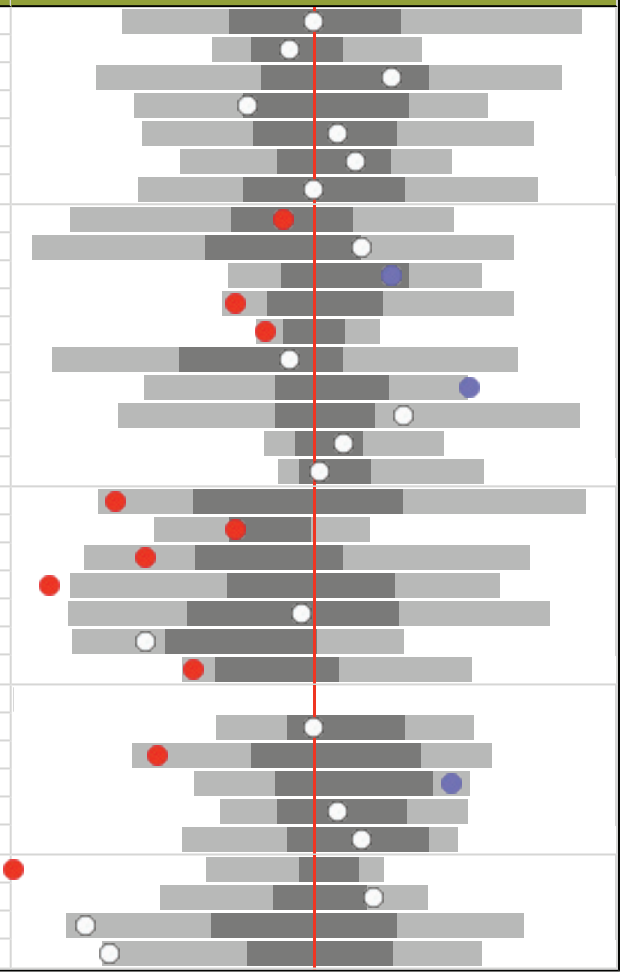
Drugs	Clackmannanshire		Falkirk		Stirling	
Drug-related hospital discharges	31	**better**	70	**better**	64	**better**
Drug-related mortality						
Hepatitis-C positives among PWID	13	av	21	av	34	av
Population prevalence of problem drug use	480	av	1020	**better**	710	**better**
Male prevalence of problem drug use	350	**better**	780	**better**	440	**better**
Female prevalence of problem drug use	130	**better**	240	**better**	270	av
Drug use last month (pupils age 15)	15%	-	15%	-	10%	av
Drug use last year (pupils age 15)	31%	-	20%	-	16%	av
Drugs spend reduction						
Maternities with drug use	22	**better**	50	**better**	22	**better**
Child protection with parental alcohol/drug misuse	21	**worse**	16	**better**	20	av
Child protection with parental drug misuse	16	**worse**	15	av	13	av
Drug use funded by crime	19	av	41	av	19	av
Children being offered drugs (pupils age 15)			140	**better**	79	**better**
Drug misuse in neighbourhood	44	**better**	40	**better**	51	av
Drug treatment waiting times	20	**better**	8	av	21	**worse**
SDMD initial completeness	399	-	48	-	101	-
SDMD follow-up completeness	72	**better**	7	av	17	av

ScotPHO
Period: 2012

Tobacco Control Profiles 2013 (Clackmannanshire CHP)

Printed Date: 30-JUL-2014 13:28

Domain		Indicator	Period	Number	Measure	Type	National Average
Adult prevalence	1	Smoking prevalence (adults 16+)	2010	n/a	24.0	%	24.0
	2	Smoking prevalence (adults 16-39)	2010	n/a	29.0	%	27.0
	3	Smoking prevalence (adults 40-64)	2010	n/a	23.0	%	26.0
	4	Smoking prevalence (adults 65+)	2010	n/a	16.0	%	14.0
	5	Smoking prevalence (adults 16-64)	2010	n/a	26.0	%	27.0
	6	Smoking prevalence (men aged 16+)	2010	n/a	24.0	%	26.0
	7	Smoking prevalence (women aged 16+)	2010	n/a	23.0	%	23.0
Cessation	8	Smokers making quit attempts	2012	1,008	10.3	%	11.0
	9	Smokers successfully quitting at 1 month follow-up	2012	441	4.5	%	4.2
	10	Quit rate at 1 month follow-up	2012	441	43.8	%	38.1
	11	Quit rate at 3 months follow-up	2012	50	5.0	%	10.3
	12	Quit rate at 12 months follow-up	2011	31	3.7	%	5.5
	13	Quit rate at 1 month follow-up in most deprived quintile (1)	2012	124	12.3	%	12.8
	14	Quit rate at 1 month follow-up in quintile 2	2012	132	13.1	%	9.8
	15	Quit rate at 1 month follow-up in quintile 3	2012	86	8.5	%	7.4
	16	Quit rate at 1 month follow-up in quintile 4	2012	63	6.3	%	5.4
	17	Quit rate at 1 month follow-up in least deprived quintile (5)	2012	36	3.6	%	3.5
Smoking during pregnancy	18	Women smoking during pregnancy [2]	2009	458	27.4	%	20.9
	19	Smoking during pregnancy in most deprived quintile (1) [2]	2009	208	39.9	%	34.7
	20	Smoking during pregnancy in quintile 2 [2]	2009	112	31.8	%	25.1
	21	Smoking during pregnancy in quintile 3 [2]	2009	80	25.2	%	17.8
	22	Smoking during pregnancy in quintile 4 [2]	2009	46	12.6	%	12.4
	23	Smoking during pregnancy in least deprived quintile (5) [2]	2009	12	10.6	%	6.8
	24	Quit attempts from pregnant smokers	2010	12	8.2	%	16.9
Smoking attributable deaths and diseases	25	Smoking attributable deaths [2]	2010	n/a		%	23.6
	26	Lung cancer deaths [2]	2010	113	54.7	sr3	55.0
	27	COPD deaths [2]	2010	86	42.2	sr3	33.0
	28	Smoking attributable admissions [2]	2011	1,048	690.9	sr3	970.3
	29	Lung cancer registrations [2]	2010	133	64.4	sr3	68.5
	30	COPD incidence [2]	2011	161	76.6	sr3	87.1
School children	31	Smoking prevalence in S2 pupils	2010	11	10.3	%	3.1
	32	Smoking prevalence in S4 pupils	2010	13	11.3	%	12.9
	33	Smoking prevalence in S2 and S4 boys	2010	11	9.3	%	7.0
	34	Smoking prevalence in S2 and S4 girls	2010	13	12.5	%	8.6



Notes: 2.Three-year combined number, and 3-year average annual measure.

Spine Chart Key: % =percent
sr3= age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.

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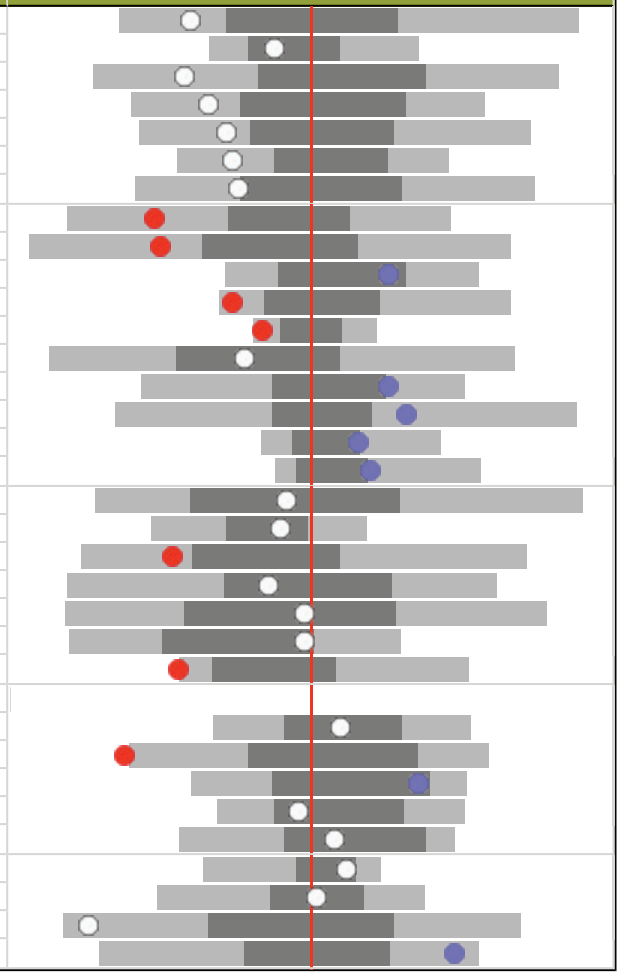
See the detailed Definitions and Sources table for indicator information and Technical Report for further guidance on interpreting the spine.

ScotPHO
Period: 2012

Tobacco Control Profiles 2013 (Falkirk CHP)

Printed Date: 30-JUL-2014 13:30

Domain		Indicator	Period	Number	Measure	Type	National Average
Adult prevalence	1	Smoking prevalence (adults 16+)	2010	n/a	28.0	%	24.0
	2	Smoking prevalence (adults 16-39)	2010	n/a	30.0	%	27.0
	3	Smoking prevalence (adults 40-64)	2010	n/a	31.0	%	26.0
	4	Smoking prevalence (adults 65+)	2010	n/a	17.0	%	14.0
	5	Smoking prevalence (adults 16-64)	2010	n/a	31.0	%	27.0
	6	Smoking prevalence (men aged 16+)	2010	n/a	30.0	%	26.0
	7	Smoking prevalence (women aged 16+)	2010	n/a	26.0	%	23.0
Cessation	8	Smokers making quit attempts	2012	2,657	7.5	%	11.0
	9	Smokers successfully quitting at 1 month follow-up	2012	1,153	3.3	%	4.2
	10	Quit rate at 1 month follow-up	2012	1,153	43.4	%	38.1
	11	Quit rate at 3 months follow-up	2012	131	4.9	%	10.3
	12	Quit rate at 12 months follow-up	2011	73	3.5	%	5.5
	13	Quit rate at 1 month follow-up in most deprived quintile (1)	2012	307	11.6	%	12.8
	14	Quit rate at 1 month follow-up in quintile 2	2012	306	11.5	%	9.8
	15	Quit rate at 1 month follow-up in quintile 3	2012	229	8.6	%	7.4
	16	Quit rate at 1 month follow-up in quintile 4	2012	180	6.8	%	5.4
	17	Quit rate at 1 month follow-up in least deprived quintile (5)	2012	131	4.9	%	3.5
Smoking during pregnancy	18	Women smoking during pregnancy [2]	2009	1,063	21.7	%	20.9
	19	Smoking during pregnancy in most deprived quintile (1) [2]	2009	308	36.8	%	34.7
	20	Smoking during pregnancy in quintile 2 [2]	2009	405	30.6	%	25.1
	21	Smoking during pregnancy in quintile 3 [2]	2009	173	18.9	%	17.8
	22	Smoking during pregnancy in quintile 4 [2]	2009	114	12.5	%	12.4
	23	Smoking during pregnancy in least deprived quintile (5) [2]	2009	63	7.0	%	6.8
	24	Quit attempts from pregnant smokers	2010	27	7.5	%	16.9
Smoking attributable deaths and diseases	25	Smoking attributable deaths [2]	2010	n/a		%	23.6
	26	Lung cancer deaths [2]	2010	329	51.5	sr3	55.0
	27	COPD deaths [2]	2010	311	44.2	sr3	33.0
	28	Smoking attributable admissions [2]	2011	3,527	754.4	sr3	970.3
	29	Lung cancer registrations [2]	2010	450	70.5	sr3	68.5
	30	COPD incidence [2]	2011	524	81.6	sr3	87.1
School children	31	Smoking prevalence in S2 pupils	2010	7	2.3	%	3.1
	32	Smoking prevalence in S4 pupils	2010	42	12.7	%	12.9
	33	Smoking prevalence in S2 and S4 boys	2010	30	9.2	%	7.0
	34	Smoking prevalence in S2 and S4 girls	2010	18	5.8	%	8.6



Notes: 2.Three-year combined number, and 3-year average annual measure.

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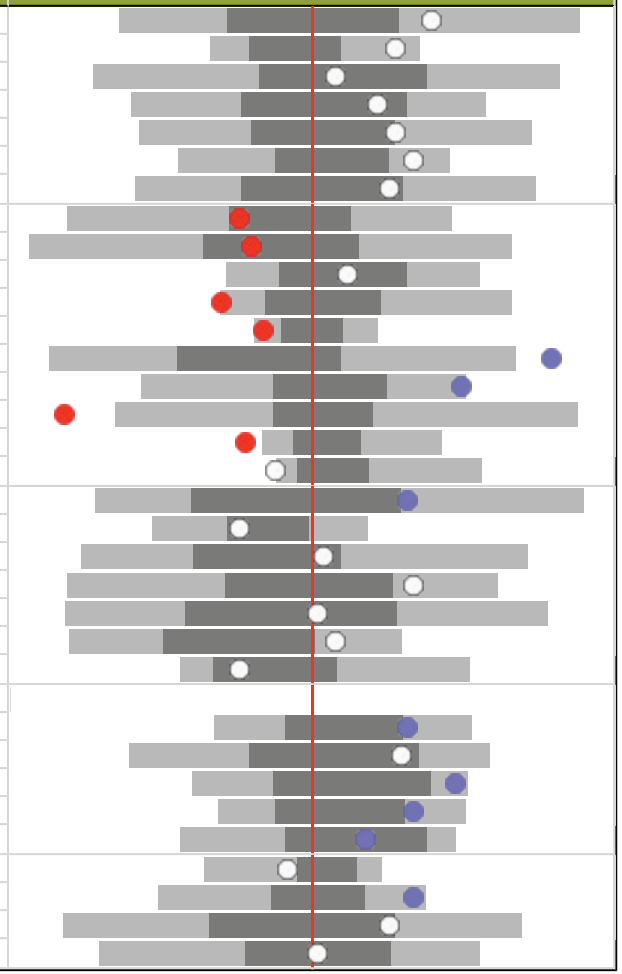
ScotPHO
Period: 2012

Tobacco Control Profiles 2013 (Stirling CHP)

Printed Date: 30-JUL-2014 13:31

Domain		Indicator	Period	Number	Measure	Type	National Average
Adult prevalence	1	Smoking prevalence (adults 16+)	2010	n/a	20.0	%	24.0
	2	Smoking prevalence (adults 16-39)	2010	n/a	20.0	%	27.0
	3	Smoking prevalence (adults 40-64)	2010	n/a	25.0	%	26.0
	4	Smoking prevalence (adults 65+)	2010	n/a	12.0	%	14.0
	5	Smoking prevalence (adults 16-64)	2010	n/a	23.0	%	27.0
	6	Smoking prevalence (men aged 16+)	2010	n/a	21.0	%	26.0
	7	Smoking prevalence (women aged 16+)	2010	n/a	20.0	%	23.0
Cessation	8	Smokers making quit attempts	2012	1,423	9.4	%	11.0
	9	Smokers successfully quitting at 1 month follow-up	2012	577	3.8	%	4.2
	10	Quit rate at 1 month follow-up	2012	577	40.6	%	38.1
	11	Quit rate at 3 months follow-up	2012	61	4.3	%	10.3
	12	Quit rate at 12 months follow-up	2011	44	3.6	%	5.5
	13	Quit rate at 1 month follow-up in most deprived quintile (1)	2012	242	17.0	%	12.8
	14	Quit rate at 1 month follow-up in quintile 2	2012	184	12.9	%	9.8
	15	Quit rate at 1 month follow-up in quintile 3	2012	63	4.4	%	7.4
	16	Quit rate at 1 month follow-up in quintile 4	2012	51	3.6	%	5.4
	17	Quit rate at 1 month follow-up in least deprived quintile (5)	2012	37	2.6	%	3.5
Smoking during pregnancy	18	Women smoking during pregnancy [2]	2009	415	17.7	%	20.9
	19	Smoking during pregnancy in most deprived quintile (1) [2]	2009	94	39.3	%	34.7
	20	Smoking during pregnancy in quintile 2 [2]	2009	156	24.6	%	25.1
	21	Smoking during pregnancy in quintile 3 [2]	2009	55	15.0	%	17.8
	22	Smoking during pregnancy in quintile 4 [2]	2009	80	12.3	%	12.4
	23	Smoking during pregnancy in least deprived quintile (5) [2]	2009	29	6.3	%	6.8
	24	Quit attempts from pregnant smokers	2010	17	11.5	%	16.9
Smoking attributable deaths and diseases	25	Smoking attributable deaths [2]	2010	n/a		%	23.6
	26	Lung cancer deaths [2]	2010	173	43.3	sr3	55.0
	27	COPD deaths [2]	2010	121	27.5	sr3	33.0
	28	Smoking attributable admissions [2]	2011	1,903	675.1	sr3	970.3
	29	Lung cancer registrations [2]	2010	207	53.1	sr3	68.5
	30	COPD incidence [2]	2011	288	74.3	sr3	87.1
School children	31	Smoking prevalence in S2 pupils	2010	7	3.7	%	3.1
	32	Smoking prevalence in S4 pupils	2010	25	10.0	%	12.9
	33	Smoking prevalence in S2 and S4 boys	2010	14	6.2	%	7.0
	34	Smoking prevalence in S2 and S4 girls	2010	18	8.5	%	8.6



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FV ADPs Performance

Statistics from ScotPHO profiles

http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Tobacco - 1	Clackmannanshire		Falkirk		Stirling	
Smoking prevalence (adults 16+)	24%	av	28%	av	20%	av
Smoking prevalence (adults 16-39)	29%	av	30%	av	20%	av
Smoking prevalence (adults 40-64)	23%	av	31%	av	25%	av
Smoking prevalence (adults 16-64)	26%	av	31%	av	23%	av
Smoking prevalence (adults 65+)	16%	av	17%	av	12%	av
Smoking prevalence (men aged 16+)	24%	av	30%	av	21%	av
Smoking prevalence (women aged 16+)	23%	av	26%	av	20%	av
Smokers making quit attempts	1008	worse	2657	worse	1423	worse
Smokers successfully quitting at 1 month follow-up	441	av	1153	worse	577	worse
Quit rate at 1 month follow-up	441	better	1153	better	577	av
Quit rate at 3 months follow-up	50	worse	131	worse	61	worse
Quit rate at 12 months follow-up	31	worse	73	worse	44	worse
Quit rate at 1 month follow-up in most deprived quintile (1)	124	av	307	av	242	better
Quit rate at 1 month follow-up in quintile (2)	132	better	306	better	184	better
Quit rate at 1 month follow-up in quintile (3)	86	av	229	better	63	worse
Quit rate at 1 month follow-up in quintile (4)	63	av	180	better	51	worse
Quit rate at 1 month follow-up in least deprived quintile (5)	36	av	131	better	37	av

FV ADPs Performance

Statistics from ScotPHO profiles

http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Tobacco - 1	Clackmannanshire		Falkirk		Stirling	
Women smoking during pregnancy	458	worse	1063	av	415	better
Smoking during pregnancy in most deprived quintile (1)	208	worse	308	av	94	av
Smoking during pregnancy in quintile (2)	112	worse	405	worse	156	av
Smoking during pregnancy in quintile (3)	80	worse	173	av	55	av
Smoking during pregnancy in quintile (4)	46	av	114	av	80	av
Smoking during pregnancy in least deprived quintile (5)	12	av	63	av	29	av
Quit attempts from pregnant smokers	12	worse	27	worse	17	av
Smoking attributable deaths	n/a		n/a		n/a	
Lung cancer deaths	113	av	329	av	173	better
COPD deaths	86	worse	311	worse	121	av
Smoking attributable admissions	1048	better	3527	better	1903	better
Lung cancer registrations	133	av	450	av	207	better
COPD incidence	161	av	524	av	288	better
Smoking prevalence in S2 pupils	10%	worse	2%	av	4	av
Smoking prevalence in S4 pupils	11%	av	13%	av	10	better
Smoking prevalence in S2 and S4 boys	9%	av	9%	av	6	av
Smoking prevalence in S2 and S4 girls	13%	av	6%	better	9	av