care inspectorate

Alcohol and Drug Partnerships

A report on the use and impact of the Quality Principles through validated self-assessment

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Foreword

There is widespread recognition that problematic alcohol and drug use in Scotland blights lives. Its consequences are felt far beyond the individual. Alcohol and drug addiction costs us all dearly, not only through costs associated with ill-health and crime but also in the misery and pain caused to families and communities, sometimes for generations, and the squandering of potential. Problem alcohol and drug use stops people from being the very best that they can be and leading healthy, fulfilling lives. We recognise that many of those most affected have experienced adversity, loss and trauma in their lives. If they are to recover, they need skilled, consistent and responsive intervention which recognises and tackles the complex issues underpinning addiction. Services need to be available at the right time, in the right way and for as long as needed.

The Care Inspectorate's vision is that every person in Scotland should receive high quality, safe and compassionate care that reflects their rights, choices and individual needs. That is why I have so warmly welcomed the opportunity for the Care Inspectorate to work alongside the 29 alcohol and drug partnerships across the country to provide support and challenge to their self-evaluation as they continue in their journey of continuous improvement.

It was pleasing to be able to report a clear shift to a recovery focused philosophy in the planning, commissioning and delivery of services across the country. Overall, the Quality Principles are being embedded and beginning to show some impact in more person-centred treatment, care and support. However, we also heard clearly from people using alcohol and drug services about their experience of unhelpful attitudes from staff when using some services, including some health, welfare and housing services. Such attitudes serve only to further marginalise people who need our help and make recovery less achievable. We would encourage organisations with a role in supporting professional development across these services to consider how they might support the necessary culture change.

The success of the third sector in innovating and developing person-centred approaches comes through strongly in this report. Those responsible for strategic planning and commissioning can learn from areas where there is strong collaboration between statutory services and the third sector.

We have greatly valued the collaboration between inspectors and practitioners who have each brought their own experience and perspectives to bear in completing this validated self-evaluation. Our aim has been to build capacity for continuous improvement and we hope that this legacy will be of use in supporting self-evaluation and quality assurance going forward. Particularly, we would encourage alcohol and drug partnerships to now focus on the development of impact measures to seek assurance that the strengthening of processes supported by the use of the Quality Principles is translating into better experiences and more positive outcomes for people who use services, and for their families and communities.

Karen Reid

Karen Reid

Chief Executive, Care Inspectorate

Introduction

The 2014 Scottish Government document Quality Principles: Standard Expectation of Care and Support in Drug and Alcohol Services is central to the implementation of its improvement framework for services. The primary purpose of the Quality Principles is to ensure quality is embedded and evidenced across all services in Scotland.

Alcohol and drug partnerships (ADPs) are multi-agency strategic partnerships focused on alcohol and drugs misuse issues in their local areas. Members include those agencies with an interest in providing treatment and intervention for people experiencing problem alcohol and drug use, and other key stakeholders. ADPs are responsible for developing local strategies for tackling, reducing and preventing problem alcohol and drug use. They also have responsibility for planning and commissioning services to deliver improved core and local outcomes, taking into account local needs, circumstances and resources.

A year after issuing the principles, the Scottish Government commissioned the Care Inspectorate to lead a programme of validated self-assessment involving all 29 alcohol and drug partnerships in Scotland. The aim was to determine how well the Quality Principles[1] had been embedded and to assess their impact on supporting ADPs to achieve better outcomes for people who use alcohol and drug services. Key objectives were to provide:

- an evidence-informed assessment of how local services are implementing The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services, to help local ADPs identify their own strengths and prioritise areas for improvement
- a national picture of how the Quality Principles are being used to strengthen a culture of continuous improvement and quality assurance of performance, to support Scottish Government and other key stakeholders in designing any further national supports to services and ADPs.

Background to the development of alcohol and drug partnerships in Scotland

In 2009, the Scottish Government set out a framework for the delivery of alcohol and drug treatment and recovery services across the country. Key features of the framework included:

- a dedicated partnership on alcohol and drugs operating in each local authority area, firmly embedded within wider arrangements for community planning, to be called an alcohol and drugs partnership (ADP)
- an expert local team supporting the operation of every ADP
- where a particular health board area includes more than one local authority area, appropriate co-ordination arrangements at NHS board area level

[1] The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services have been developed to ensure anyone looking to address their problem drug and/or alcohol use receives high-quality treatment and support that assists long-term, sustained recovery and keeps them safe from harm.

- under the aegis of each ADP, the development and implementation of a comprehensive and evidence-based local alcohol and drugs strategy based on the identification, pursuit and achievement of agreed local outcomes, and supported by the development of a local outcomes framework
- a limited set of national core indicators, which each local partnership would be invited to include in its local outcomes framework
- individual bodies contributing fully and openly to the operation of their local partnership(s), including the development of the local strategy, and commissioning services in line with that local strategy
- the Scottish Government supporting local partners and the ADPs in achieving agreed local outcomes.

The reform of local delivery arrangements for drugs and alcohol services aimed to ensure that local delivery of alcohol and drugs services were effective, efficient, accountable and able to contribute to national and local outcomes. As part of this reform, the Scottish Government developed An Outcomes Toolkit for Alcohol and Drugs Partnerships (2009) to help ADPs identify local priority outcomes relating to alcohol and drugs. Scottish Government deployed national delivery advisers to support ADPs to establish and embed outcomes-based approaches.

The Scottish Government's Drug and Alcohol Quality Improvement Framework is the current phase of delivery of two national strategies, Road to Recovery and Changing Scotland's Relationship with Alcohol. Its purpose is to ensure quality is embedded and evidenced within all alcohol and drug services across Scotland.

The framework is intended to further instil the culture of self-assessment within ADPs that leads to improvement. Scottish Government provides national support to ADPs to assist local implementation, measurement and quality assurance of the Quality Improvement Framework. The recently published Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services is at the core of this framework.

Methodology for the validated self-assessment

The agreed aim of the programme was to support ADPs to undertake a robust self-assessment, looking critically at how well the Quality Principles were being used in practice by alcohol and drug services locally, and at the effectiveness of quality assurance policies and practice. The Quality Principles document invites ADPs to ask themselves questions about compliance with the Quality Principles and the experience of people who use alcohol and drug services. We discuss how well the Quality Principles are being embedded in chapter 3 of this report. We recognise that success in achieving any significant change and improvement requires effective collaborative working, strategic planning and leadership. To help ADPs explore how well they were doing in these areas, we developed a set of self-evaluation questions based on the excellence model developed by the European Framework for Quality Management. The excellence model has been used extensively over a number of years by local authorities and a wide range of organisations in the public, private and third sectors to support self-evaluation and continuous improvement. Its particular strength is to help those using it understand connections between results (or outcomes) and the processes that either support

positive results or act as a barrier. This helps ADPs to better understand areas of good performance and prioritise improvement actions. We discuss the factors contributing to, or hindering, successful embedding of the Quality Principles in chapter 4.

We decided that a small team of our strategic inspectors experienced in using the excellence model would work with local ADPs, providing support and challenge to ensure their self-assessment was thorough, rigorous and transparent. Using a standard self-assessment framework ensured consistency across the country and allowed comparison across ADPs. A key aim was to strengthen capacity for self-evaluation across ADPs and to invest in a resource for continuous improvement. The Scottish Drugs Forum also made an important contribution to the project through four members of its National Quality Development Team.

The validated self-evaluation commenced in January 2016 and included the following activities.

- Analysis of position statements – each ADP completed a position statement outlining an assessment of local progress in implementing the quality principles, which included services provided by the local authority and/or health board themselves, or commissioned by them from an independent provider. These provided a very helpful starting point to focus discussion with key people in the ADP.
- An e-survey of the views of 969 staff .
- An e-survey of the views of 1919 people using alcohol and drug treatment and recovery services (including family members).
- Review of case records for 344 people who received treatment and support from a range of alcohol and drug services.
- Interviews with ADP chairs and lead officers and other staff responsible for strategic planning of alcohol and drug services in all 29 ADP areas.

In September 2016, we provided each ADP with a feedback summary that identified key strengths and areas for improvement. We have encouraged ADPs to develop an improvement plan informed by their validated self-assessment.

We also invited ADPs to identify examples of good practice that they believed were having a positive impact on the lives of individuals, families and communities. These examples are listed in Appendix 2.

Acknowledgements

We would like to acknowledge and thank all the individuals and staff across the ADPs who participated and contributed to this work. This includes all staff working directly in services across the ADPs who supported our visits and activities. We are very grateful to everyone who took part in our surveys and came to our focus groups as part of this validated self-assessment.

In particular, we would like to thank the team of associate assessors who so willingly and enthusiastically contributed their knowledge and experience and the staff from the Scottish Drug Forum's National Quality Development Team who played such an important role in supporting the evidence-gathering process.

Key messages

The majority of alcohol and drug partnerships (ADPs) are actively embracing and working towards implementing the Quality Principles. While the degree to which they have been embedded is variable across the country, a positive shift towards a recovery philosophy has been made and it is clear that they are influencing strategic planning, commissioning, service delivery, workforce development, practice and organisational culture and change.

Most ADPs have appropriate governance structures and accountability arrangements in place to progress strategy and policy developments in relation to both national and local priorities. Most are linked to, or operating through, the health and social care scheme of integration and so to the integration joint boards (IJBs) and their strategic commissioning plans.

The majority of ADPs have a strategic commitment and strong aspiration to shift the balance of care from clinic-based provision to community provision that is holistic, person-centred and recovery-focused. There are examples of innovative user involvement at individual, service and partnership levels to proactively consult, engage and seek feedback. However, there is less evidence of how feedback is actually influencing service delivery models. Overall, the third sector is leading statutory services in innovation and person-centred service models. The way in which some NHS and social work services are delivered needs to modernise to maximise efficient use of resources and to also ensure a person centred approach.

The majority of ADP strategies and delivery plans have been informed by a strategic needs assessment of both current and future local need. Further work is needed in some ADPs to make best use of shared resources to effectively plan local strategic priorities and develop better commissioning approaches.

ADPs face complex budget challenges in terms of planning, developing and delivering services. At the time of the validated self-evaluation, these were exacerbated by a lack of clarity about IJB budgets, creating uncertainty about the sustainability of a number of services. Nonetheless, all ADPs have in place financial planning and monitoring processes to support transparency and accountability in commissioning.

A wide range of innovative, early intervention approaches and initiatives are being used to build community engagement with the aim of increasing awareness and understanding of problematic substance use and recovery. However, most ADPs struggled to demonstrate the impact of their work on their local communities.

Further improvement is needed to develop strategic workforce planning. In particular, learning and development programmes need to extend to partners outwith alcohol and drug services, for example staff in housing services, in order to embed a recovery-oriented system of care (ROSC) across wider universal services.

Many people still experience stigma and prejudice when accessing a range of health, social care alcohol and drug treatment and recovery services. More work is needed to ensure people are treated with dignity and respect and supported by staff with appropriate attitudes and values.

There was a growing commitment towards a strengths-based approach in both assessment and intervention. The quality of assessment is highly variable within and across ADPs. Some ADPs need to use multi-agency meetings more effectively to ensure recovery plans are robust and progress is monitored effectively.

The majority of ADPs had procedures in place to identify and assess children affected by parental problematic substance use. Support needs to continue for joint working between staff in alcohol and drug services and staff in children's services to ensure children and young people affected by substance misuse are protected.

Quality improvement programmes need to fully reflect the Quality Principles. Many ADPs are trying hard to embed a culture of learning, to improve the quality of service delivery. Some ADPs need to give more attention to establishing mechanisms for a more coordinated, collaborative and systematic approach to self-assessment and quality improvement.

Implementing the Quality Principles

Quality Principle 1

You should be able to quickly access the right drug or alcohol service that keeps you safe and supports you throughout your recovery.

The majority of people should wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

Nobody should wait longer than six weeks to receive appropriate treatment and support.

"When you decide to get clean, six weeks seems an impossibly long time to wait."

The majority of ADPs across Scotland were meeting the Scottish Government's Local Delivery Plan (LDP) standard for alcohol and drug treatment waiting times. Some areas were consistently exceeding the standard. Most people were seen within the three-week target and the average waiting time to start their first treatment was actually much less. In some areas, this was as quickly as within one week from referral. Those ADPs that were constantly surpassing the waiting times standard had ambitiously set themselves targets to further reduce waiting times for people entering treatment.

A small number of partnership areas were not consistently meeting the LDP standard with the result that some people had to wait longer than three weeks to access any treatment. Our surveys and case file reading analysis showed around 10% of people waiting longer than six weeks from referral to treatment. Barriers to quickly getting a service included rural geography and lack of staff capacity due to vacancies, sickness and holidays. However, incorrectly recorded information on referral forms and poor administration created unnecessary delays. Delays in starting treatment also happened where people seeking treatment did not keep appointments.

Most ADPs had robust systems in place to effectively monitor and report on performance against the LDP standard in respect of waiting times. In a small number of partnership areas, staff would benefit from greater clarity on recording. This would support a more consistent approach to achieve more reliable data, on which the partnership could draw.

A range of innovative approaches was helping to improve waiting times for treatment and increase the proportion of people receiving early access. ADPs were creative, using social networking such as Skype and video conferencing to reach people in remote areas. Enhanced telephone contact, follow up letters about appointments, providing choice of appointment dates and holding clinics in GP surgeries were all helping to link people into services sooner. In some areas, strengthened joint working arrangements and co-location between commissioned and statutory services were also helping to

significantly improve waiting times and facilitate earlier access to appropriate treatment and recovery support.

Most ADPs had made efforts to identify and address barriers to achieving good performance on waiting times. The majority of ADPs had commissioned third sector organisations to either work alongside statutory services, provide a single point of access, or provide multi-agency hubs for people accessing services. These were improving access arrangements and providing effective pathways into services. Some ADPs had not made as much progress reviewing their care pathways in order to develop and implement a more integrative approach to their recovery-oriented system of care (ROSC).

Services are expected to evidence compliance with the alcohol and drug treatment waiting time standard as a part of commissioning processes. In a small number of ADPs, there was no clear or consistent way of addressing non-compliance in how SMR25 is recorded. Improving staff and service user understanding of the benefits of recording identifiable information on national data systems could better support compliance.

Services worked well together to improve outcomes for people accessing treatment and support. A range of outcomes tools were in place, including the Outcomes Star, the Recovery Outcome Tool and the Treatment Outcomes Profile. There was consensus among ADPs that these were very helpful in measuring improvements for individuals, but the diversity of the tools they were using made it challenging to bring data together to measure impact at a partnership level.

Most ADPs were preparing local systems to comply with the new Drug and Alcohol Information System (DAISy). To improve consistency and uniformity of reporting of outcomes data, some ADPs had phased their roll out across services of the recovery outcome tool as part of the national implementation pilot. While very supportive of the aims, most ADPs were cautious of a wholesale adoption until the Recovery Outcome Tool dataset was integrated with the new DAISy. The majority of ADPs noted real challenges in evidencing and fully tracking recovery journeys of people through their care pathways because existing information systems do not readily support data sharing.

Most people we spoke to were positive about the personal outcomes that they achieved as a result of the care, treatment and support they had received. The majority felt they had made considerable improvement in their recovery. Many spoke powerfully about the importance of getting early access to services and support that is sustained over time. There were helpful examples of ADPs celebrating individuals' personal achievements and outcomes as they progressed on their recovery journey. For example, Aberdeen ADP, in partnership with Aberdeen College and third sector partners, had developed City and Guilds Awards for people in recovery. They held an annual Recovery Star Award event to celebrate individuals moving on in their recovery.

While ADPs could confidently talk about the positive impact for people who got services, more work was needed to develop ways of helping ADPs evaluate services' impact in improving wellbeing and outcomes across their populations. While ADPs put forward anecdotal evidence, for example that 'did not attend' (DNA) rates were changing, this was not informed by robust data. The majority of ADPs recognised there was a need to gain feedback from people who did not engage or had disengaged

with services to reduce DNA levels following triage. A good practice example was Lanarkshire's proactive approach to understanding hidden populations. They had commissioned research to help them understand why people did not always engage with services. This had led to them implementing a rigorous approach to ensure engagement rates were maximised and DNA rates reduced through a patient reminder service.

Quality Principle 2

You should be offered high quality, evidence-informed treatment, care and support interventions which reduce harm and empower you in your recovery.

You should be treated fairly and equally, with respect and dignity, as a person able to make your own choices.

You should be able to easily access safe, secure and comfortable surrounding when engaging with the service.

The choice of interventions should be based on the best available evidence and agreed guidance.

You should have access to a range of recovery models and therapies which should help improve different areas of your life and move forward at your own pace.

You should have access to harm reduction advice which might include safer use, managed use and abstinence.

With your agreement, your information may be shared with other services and it should be made clear to you when this might happen without your consent.

"I think my worker chose the best intervention method for me as he listened to me very well. His intervention suited my needs to help me recover."

Many ADPs had developed leaflets providing information about services available in their local areas. Most made information available through dedicated ADP websites. However, some websites needed to be updated and refreshed. Greater attention could be given to promoting and signposting to recovery communities, peer support and mutual aid groups. Most people accessing treatment and support found out about services through word of mouth or through their GP. A significant number of people reported that they were not offered help until their drug or alcohol use had become particularly problematic. Greater promotion of information about who to contact and how to access services across local communities could better support and embed a culture of recovery as well as one of early intervention and prevention.

Many ADPs had redesigned their services to improve delivery, meet local need and be more recovery-focused. Single point of access models were being embedded in a number of partnership areas providing a prompt, streamlined approach to engaging individuals and families into services. Shared care approaches between statutory and third sector partners ensured prescribing and recovery services worked more effectively together. As a result, people accessing specialist or structured treatment experienced smoother transitions and were better linked in to recovery-oriented services.

Most ADPs had developed dedicated harm reduction teams or services that worked in an integrated way. Person-centred practice and co-production approaches were adopted in helping to decide treatment and support options. This ensured that a choice of harm reduction interventions and initiatives were available at the point of access and provided throughout a person's recovery.

In some areas, third sector and voluntary agencies offered flexible appointments outside usual office hours. There were also examples of 24/7 online advice and support, inclusive of weekend cover. Proactive and assertive outreach approaches to early support was helping to increase the number of people accessing alcohol and drug services. In Aberdeenshire, Angus and East Dunbartonshire early intervention workers followed up on individuals in cases of non-attendance and supported them to re-engage with services. Glasgow City ADP's Assertive Outreach pilot was engaging with traditionally hard to reach and vulnerable drug users who were sleeping rough.

Dundee, Aberdeenshire and Inverclyde ADPs had developed moving-on services that provided focused support to people beyond treatment to help them achieve their recovery goals and to reconnect with their local communities. The Prescribing for Recovery initiative by Aberdeen ADP was a good example of shifting the balance of care from primary care to community based services and social supports. MELDAP's Peer Support project had introduced peer support for substance misuse into general practice in Midlothian, delivered as a partnership between service users, general practitioners, secondary care and non-statutory agencies.

Most staff proactively engaged with individuals and families, supporting them into services. This helped ensure regular attendance at appointments and other wrap around services to address broader holistic needs beyond problematic alcohol and drug substance use, including housing, employment and relationships. We found examples of services that had strengthened their processes to intervene early and provide effective multi-agency, early intervention, support during pregnancy and to children affected by parental substance misuse.

Nevertheless, more work was needed to implement and embed a recovery-oriented system of care across mainstream services, for example housing. Some ADPs had more work to do to ensure staff understood the contribution they could and should be making to ensure people benefited from seamless interventions throughout all stages of their recovery.

Overall, most people felt services were responsive to their needs. However, some felt strongly that NHS treatment services took too long to assess, screen, test and treat them for opioid replacement therapies. People were limited in the services they could access and how long they had to wait for treatment and intervention, where GPs had a policy of not prescribing opioid replacement therapies. In a few partnership areas this was resulting in substantial waiting times.

The majority of people benefitted from a range of harm reduction interventions and initiatives that were well-matched to their needs and offered throughout their recovery. However, there was sometimes significant delay in accessing specific detoxification and residential rehabilitation interventions. Often, this appeared to be largely due to lengthy and complicated referral processes. Fife partnership's Residential Rehabilitation pilot was an example of an integrated approach linking the treatment service with a rehabilitation service, achieving more efficient access to rehabilitation services.

A number of ADPs had developed innovative approaches to overcome challenges in providing equitable and prompt access to services, including making best use of local community facilities as access points for services, and using digital technology. There were good examples in Scottish Borders, Dumfries and Galloway and Forth Valley of overcoming barriers caused by limited public transport or reaching otherwise hard to engage communities. Nonetheless, some people living in remote and rural areas were notably disadvantaged by costly or limited transport options. This was a significant barrier to them attending appointments and accessing community supports.

There was a range of treatment options available, including psychosocial and psychological support. However, some people, particularly those with more complex problems and some vulnerable young people who had experience trauma, reported difficulties in accessing specialised psychological therapies. The requirement to attain some degree of stability or reduce alcohol or illicit drug use before being considered for psychological therapies meant that some people were unable to get the help they required quickly. Self-medicating while waiting for medical and psychological interventions was common. We found very few ADPs had embedded specialist alcohol and drug workers in community mental health teams or vice versa. Those who had were finding benefits in stronger joint working around assessment and planning. We found good examples in Orkney and in Lanarkshire, where people presenting in distress were offered an appropriate intervention without any delay.

There were encouraging examples where investment in developing and refurbishing premises had resulted in accessible accommodation that people found safe and welcoming and conducive to their recovery. However, some people expressed dissatisfaction with the physical environment of some dispensing rooms, clinics and waiting rooms. Receiving treatment and support in poor quality surroundings made them feel undervalued and not respected. In some partnership areas, access to rooms and meeting spaces was a significant challenge, particularly for people with disabilities.

Quality Principle 3

You should be supported by workers that have the right attitudes, values training and supervision throughout your recovery journey.

Workers should be welcoming, work in a person-centred way and believe in your ability to change and recover.

Workers should provide timely, evidence-informed treatment and support that is right for you.

Workers should provide support that is trauma-informed and recognise any current or previous trauma you are dealing with.

Workers should provide you with harm reduction advice, this may include safer use, managed use or abstinence.

Workers should support you to set your own recovery goals and to manage your own care and support.

Workers should talk to you about plans and arrangements for you moving through the service and/or reducing/ending your current contact with the service.

Workers should encourage and help you to connect with a recovery community or mutual aid group.

> "There remains a significant stigma and prejudice for clients with substance misuse issues which is sometimes obscenely displayed by individuals in non-substance misuse services. There is the need for more education and awareness and in particular around the behaviours that sometimes accompanies someone who has substance misuse issues."

The Quality Principles state that people experiencing problematic alcohol or drug use should be supported by staff who have the right attitudes and values, ensuring all are treated with dignity and respect. There was consensus from people that most of the staff who were trying to help them were welcoming, worked in a person-centred way and believed in their ability to change and recover. They benefitted from regular, meaningful contact. Nevertheless, a significant number of people reported that they felt judged and stigmatised in their interactions with professionals that included GPs,

consultants and staff working in non-specialist services such as housing and employment support. It was clear that workforce development is vital to ensuring staff have the appropriate values and high professional standards, reinforcing respect and dignity as fundamental principles.

Some staff we spoke to felt that a focus on targets and processes impacted on their ability to work in a person-centred way and impacted on the quality of service they provided. It is clear that staff worked extremely hard to ensure most people were seen within waiting time targets while being responsive to the needs of individuals.

ADPs had worked hard to take on board the need to ensure services were appropriately trauma-informed. Services ranged from low-intensity trauma support being delivered by frontline practitioners and keyworkers to more intensive psychological interventions by community mental health workers, psychologists, therapists and councillors. The majority of staff who contributed to this validated self-evaluation reported that the training they had received had increased their knowledge and understanding of the impact of trauma and managing disclosure. However, a quarter said they would benefit from specific awareness training in this area. This included how to manage disclosure as well as trauma-specific interventions.

"I felt able to share past trauma with my worker who was very supportive and understanding."

While the majority of staff had access to specialist clinical advice and support from specialist services, in some areas staff reported a lack of expert provision to support people in need of more specialist services. This included access to specialist psychology and counselling services. Many staff felt constrained and frustrated in their ability to deliver and use psychological interventions due to both time and capacity restraints. In some areas, although generic workers were providing psychosocial support, they did not always feel appropriately or sufficiently well trained to deliver such interventions. In positive contrast, a few services ensured practitioners had protected time to apply psychological techniques such as motivational interviewing. A few ADPs had implemented coaching groups for staff to consolidate and improve their practice in motivational interviewing and other psychosocial interventions.

There was strong evidence that services were taking a harm reduction approach, providing advice such as safer use, managed use and abstinence. Staff were providing appropriate harm reduction minimisation and other interventions which were well-matched to the needs of individuals and were offered throughout a person's recovery.

Most staff encouraged people to manage their own recovery. Our review of records indicated that people had control over the kind of support they received in 81% of cases.

Staff actively encouraged and helped people to connect with recovery communities or mutual aid partnerships where these were available. Most people told us that staff prepared them for the end of contact. Some ADPs were using self-directed support to enable people to purchase or take part in activities and courses to help them achieve their personal outcomes set out in their recovery plan.

Some ADPs had developed specific posts that encouraged and supported people to re-connect with their local community. Good practice examples included the growth of peer mentors, SMART recovery groups and recovery cafés. However, in some ADPs, recovery communities were still at an early stage of development. This was particularly evident in more rural and remote ADPs.

> "I have been involved in recovery group activities such as guitar group and map meetings and other activities and college courses. My personal development and recovery is a positive and ongoing path."

Overall, it was clear that much work had been done to embed a recovery approach across the country. Work had been done in staff recruitment and workforce development, policy and practice development, and commissioning. Staff were being supported to promote and embed a recovery philosophy within their practice using recovery concepts, outcome tools and evidence-based practice. Nonetheless, a recovery philosophy was not yet embedded across wider mainstream services or fully promoted within communities. Further work was needed to strengthen and embed a greater understanding and application of a recovery philosophy and the Quality Principles into workforce practices and culture. This would ensure people are made fully aware of what they should expect from services in terms of the quality of care, treatment and recovery support provided.

Quality Principle 4

You should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on your needs and aspirations.

Your assessment should be based on your strengths, taking account of your recovery capital.

Your assessment should be done in a sensitive and supportive way.

Your assessment should identify any traumatic events in your life which may have affected you.

You should be told about the range of options available to you.

Your views should be listened to and used to develop your personal recovery plan.

Assessment is part of an ongoing process and could be carried out over more than one session. This should not be a barrier to accessing services quickly.

You should be told about the reasons for, and benefits of, your worker recording information about your recovery journey on local and national data systems. With your consent, your information may be shared with other services and it should be made clear to you when this might be done without your permission.

"I was never offered or given an assessment so I was never able to have a choice of recovery or therapy."

While it was clear that, for most people, their recovery plan was underpinned by an assessment of their needs, this was not the case for nearly one in ten people. Assessments varied significantly in quality. While there was a growing commitment towards a strengths-based approach, there were still opportunities to improve the quality of assessments through greater focus and identification of the individual's recovery capital and strengths.

Risk assessments could be further improved by ensuring people are fully involved in their risk assessment. Regular review of risk management plans to review progress would ensure that they fully reflect current circumstances.

There was strong commitment to ensuring people had control over the kind of support they received. We could see from reviewing case records that people were meaningfully included and fully supported to set their own goals and self-manage their recovery in 88% of cases. In nearly three-quarters, we could see that assessments had taken into account past and current trauma experienced by the person so that appropriate supports could be put in place.

The majority of people who responded to our service user survey reported that they were told about the range of treatment options available to them. The overwhelming majority of staff also felt that services gave people information about all treatment options available. However, a significant minority of people we spoke with in the course of our visits to partnership areas around the country felt they were provided with little or no recovery-focused treatments, other than harm reduction. For example, detoxification or residential rehabilitation interventions had not been offered as a treatment choice. Not all ADPs offered specialist psychological services. A number of people experienced barriers to accessing statutory mental health services to address trauma, while some staff felt funding restrictions were leading to treatment options becoming more limited.

The use of recovery outcome tools helped to support a positive focus towards strength-based, person-centred, holistic assessments that identified and addressed wider needs. However, there was a considerable variety of different outcome tools being used. In some cases, multiple outcome tools were used simultaneously when receiving support from more than one service. There were also instances of duplication of assessments when accessing or transferring between services. People told us that they did not want to be asked the same questions or retell their story to different staff working with them.

"There is no joined up assessment process so every service, no matter how small, does its own assessment on the person - waste of valuable time and a barrier in the use of resources."

Many staff expressed frustration at the level of duplication and expectations placed on them to use particular assessments and outcome tools. This included inputting into multiple recording systems, including local and national databases. It was a particular frustration to third sector services, where dual reporting and recording processes were in use in order to comply with both the expectations of commissioners and their own organisation. It was noticeable that, in ADPs where there was a shared-care approach between statutory services and third sector partners, as part of a recovery-oriented system of care (ROSC) there was greater cohesiveness and improved coordination of services. For example, Forth Valley, Aberdeenshire and Aberdeen City ADPs worked within an integrated care pathway and supported a single-shared-assessment approach, which had clear benefits for the person using services.

People we spoke with placed a high priority on services' management of confidentiality, so that trust could develop. We saw appropriate attention to gaining consent to share personal information between services but more work was needed to ensure it was made clear to people when information may be shared without their permission, for example to keep children safe.

"I was told my information could be shared without my consent if I were a risk to myself or others."

Quality Principle 5

You should have a recovery plan that is person-centred and addresses your broader health, care and social needs, and maintains a focus on your safety throughout your recovery journey.

Your recovery plan belongs to you; the actions laid out in it are achieved in partnership between you and services.

Your recovery plan should be reviewed regularly, at a time agreed between you and your worker. Your recovery plan should include information on reducing harm.

Recovery plans should aim for stable recovery beyond treatment into aftercare.

Recovery plans should detail further services you may need to access as part of your aspirations, at a time agreed by you and your case worker. Support for this should include relapse prevention advice and assertive engagement with a local mutual aid group or recovery community.

If you relapse you should be treated with the dignity and respect that welcomes your continued effort to achieve your recovery goals.

You should be offered a copy of your recovery plan.

"My counsellor has linked me in with different groups and has also helped me to join in with a local walking group."

Most people had a recovery plan in place that was person-centred, relevant and up to date. Most people we heard from told us that they felt their recovery plan was personal to them, their needs and wishes. We heard a lot of positive comments about people feeling they were truly working together with staff on actions in their plan. The majority reported that if they relapsed, they were treated with dignity and respect, which encouraged their continued effort to achieve their recovery goals.

The majority of people said that their recovery plan included information on reducing harm and aimed for stable recovery beyond treatment into aftercare. Most recovery plans identified community-based services to support people's progress and address other areas in their life. This included relapse prevention and assertive engagement with local mutual aid and community recovery groups. However, one in ten people who responded to the service user survey felt they lacked information about community-based services they may need to access as part of their progress through treatment. A few told us they were discharged from treatment services with no aftercare or support.

"I had to access a lot of meetings off my own back for my recovery. No aftercare was in place whatsoever."

There was significant variance in the quality of recovery plans. While the majority of recovery plans set out the desired outcomes, just under half of plans were specific, measurable, achievable, realistic and timeous (SMART) in design. More work was needed to support staff to improve the quality, uniformity and consistency of plans. This would also support ADPs to accurately measure individual and service outcomes more effectively.

In the majority of cases, there was no evidence that people had been offered a copy of their recovery plan or that staff had recorded that it had been offered. Recovery plans were not routinely signed by both the keyworker and the individual.

There was significant variation in the different recovery plans that were in use across services and even within an ADP area. Some people experienced having more than one plan when receiving support from more than one service. Improving both the efficiency and integration of recovery planning processes, would bring greater coherence and consistency of approach, both for people using services and service providers.

There was an appropriate level of collaborative working in implementing the plan for the individual. Despite this, recovery plans were not routinely shared with services that were actively supporting people in their recovery progress, even though they played an important role within the plan.

Quality Principle 6

You should be involved in regular reviews of your recovery plan to ensure it continues to meet your needs and aspirations.

Your review should include an assessment of your strengths and recovery capital.

Your review should include an assessment of the effectiveness of your current treatment to help you achieve your recovery goals.

As you progress on your recovery journey, your personal plan should be reviewed to reflect changes in your situation.

Improving your situation should involve discussing areas in your life such as your aspirations for the future, wider health needs, family, children, finances, education, employment and housing, and the services or supports which could help you achieve these.

If you need to, you should be supported to access wraparound services such as housing, volunteering, employment etc. providers of these services should treat you with dignity and in a non-discriminatory way.

"From my first meeting, a recovery plan was mentioned and I feel that I have been working through it at each visit looking at different things and how they have or may affect me in the future. I found the thing I did with the cycle of change very helpful."

Most people were meaningfully involved in assessment and the review of their recovery plan. There were very few cases where there had been undue delay or difficulty implementing key actions in the person's recovery plan.

Over half of reviews included an evaluation of the effectiveness of current treatment or interventions towards achieving the individual's recovery goals. This did not mean that no evaluation had been undertaken in the remainder – it was unclear or there was limited evidence.

There were examples of effective use of multi-agency meetings to review progress, for example shared-care reviews helpfully included joint reviews with the individual and multi-agency staff team coming together to review and update progress. However, this was not standard practice across all ADPs and services.

In two-thirds of cases, recovery plans were regularly reviewed. Some staff and individuals were unclear of expectations about the frequency of reviewing recovery plans. It would be helpful for ADPs to give greater clarity and guidelines for reviews to ensure progress is always appropriately monitored and measured.

"I have never seen my plan, never mind getting it reviewed."

The majority of reviews helpfully supported people to address other areas of their life identified from their assessment and recovery plan. However, there was still a significant number where the holistic needs to promote recovery were not adequately addressed within recovery plans.

"I was helped to sort out housing, debt payments and benefits, which I would never have been able to do myself at the time. I was supported in any area where I needed help. I have been supported in helping my children so that we can rebuild our family life."

Quality Principle 7

You should have the opportunity to be involved in an on-going evaluation of the delivery of services at each stage of your recovery.

You should have the opportunity to have your say in how services are delivered.

You should be told about your responsibilities and what you can expect from the service (supported by the Recovery Philosophy).

You should be told about how to complain if you are unhappy with the service.

You should be told about independent advocacy services that can help you be heard.

"We need to be better at involving service users in the ongoing evaluation of delivery of services during all aspects of their recovery."

Over two-thirds of cases were rated good or above at involving and taking account of individuals', families' and carers' views. This included seeking their views about how services were delivered. The

majority of people who completed the service user survey agreed that they had the opportunity to have their say in how services were delivered. Mechanisms for capturing views included one-to-one meetings, questionnaires, consultations and suggestion boxes. However, an important minority felt their views were not taken into account throughout their recovery or were unsure about the extent to which their views were considered. Robust mechanisms to formally capture, and evaluate, the views of people on the impact of service delivery and quality were absent in some areas. Most ADPs identified this as an area for improvement.

In one-third of the records we read, practice was either weak or unsatisfactory in evidencing how well people were supported to understand and exercise their rights or how to make a complaint. Nonetheless, three-quarters of people who completed the service user survey agreed that they had been told how to complain if they were unhappy with the service.

There was very little evidence that staff were giving people with whom they were working information about independent advocacy. This too, was in contrast to the surveys, in which three-quarters said they told people about independent advocacy services and just over half of people said that they had been given such information. Some staff seemed unsure about advocacy services available in their area. Strengthening understanding of the role of independent advocacy would promote greater awareness and maximise opportunities for people who may need help to express their views and wishes.

Quality Principle 8

Services should be family inclusive as part of their practice.

Family can mean those people who play a significant role in your life.

Family members can only be involved in your recovery if you want them to be.

You may want to involve other people who can support your recovery. The service should encourage and help you to do this.

The service should help you minimise the impact that your drug or alcohol use may have on those around you.

If you have children, their needs and wellbeing will be a primary concern.

The service should be aware of the needs of members of your family and those you live with and, if needed, seek support for them.

"My family are involved in my care - my partner supports me along to appointments."

Most staff we spoke with clearly recognised the importance of involving family and significant others in an individual's recovery. There was a variety of approaches across ADPs in how they promoted and delivered family inclusive practices. There were many positive examples of people being actively helped and encouraged to involve their families and others in their recovery. These included harm reduction information and advice, including Take Home Naloxone kits and training for family members, carers and significant others.

A significant number of ADPs had delivered Community Reinforcement and Family Training (CRAFT). This is a structured family intervention programme of workshops in conjunction with Scottish Families Affected by Alcohol and Drugs (SFAD) on family inclusive practice for staff. Some residential rehabilitation programmes considered families/carers as pivotal to the person's long-term recovery and actively encouraged their involvement to re-establish and strengthen these links. The Recovery Outcome Tool and Outcomes Star were helpfully focusing staff and individuals to consider personal and social relationships, including identifying support for family members and significant others, and a carers' assessment.

Some staff highlighted barriers to involving families, which included clinical pressures, time constraints and lack of staff capacity. Most ADPs acknowledged that family-inclusive practice could be more actively promoted, to support and strengthen involvement, especially within the prison population. The family hub linked to HMP Grampian was a positive example of strengthening family involvement.

> "In the past when I've been released, I don't think enough has been done to integrate me back into family life."

In 66% of case files there was evidence that staff had helped the person to minimise the impact their drug or alcohol use may have had on those around them. Some services included the person's support network at initial assessment meetings and recovery plan reviews. A number of ADPs had embedded a whole-family approach within their key processes, to support parents, children, carers and other family members within a person's recovery. Examples include Inverclyde ADP's Intensive Family Response Service, the Strengthening Families programmes that were being delivered in North Lanarkshire and Angus, and Highland ADP's Catalyst Project.

> "I was made aware of the impact my problems were having on my family and that support was available from other services to also support them."

Where there were dependent children, there was evidence that the majority of people had been told that the needs and wellbeing of their children was the primary concern. The responsiveness of services to the needs and wellbeing of dependent children was good overall. However, in a small number of cases the needs and wellbeing of the children were not fully considered in the assessment. The National Risk Framework to Support Assessment of Children and Young People[2] could help staff to assess risk to children impacted by the person's risk management plan in a more informed way. The majority of ADPs had robust processes and procedures in place to enable the identification and assessment of children of substance misusing parents. However, in a few ADPs, staff did not always draw on guidance or sources of information from elsewhere to fully inform the risk assessment process.

Joint working between alcohol and drug services and children's services could be improved by strengthening Getting it Right for Every Child (GIRFEC)[3] processes. Good practice would include sharing the individual's and child's assessments and plans between all services supporting the family. This practice was not consistent or routine across adult and children services in most ADP areas.

Although staff across all ADPs had a very clear understanding of their responsibilities for child protection, they needed better guidance in relation to information sharing and the named person role. Local arrangements should aim for consistency of response across recovery-oriented system of care (ROSC) partners.

Obtaining the views of families, carers and significant others involved in people's recoveries would enhance family inclusive practice, particularly in the assessment and review process. This included seeking the views of children and young people affected by the individual's substance misuse.

While we found services were moving towards or delivering family inclusive approaches, there was still further scope in strengthening proactive engagement, in order to support people to involve others who can aid their recovery. Greater awareness of the needs of family members and the role support services outside treatment services can offer was identified as a specific area for improvement by most partnership areas.

"The family worker had helped me a lot but I wish I had been told about her much earlier in the process."

[2] The document is a national risk assessment 'toolkit' for child protection to support practioners in identifying and acting on child protection risks in children and young people.

[3] GIRFEC is the national approach in Scotland to improving outcomes and supporting the wellbeing of our children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them.

Embedding the Quality Principles – contributing factors

How effective was policy, service development and planning?

Most ADPs had reviewed, or were reviewing, their models of service delivery to facilitate progress in supporting the development of local recovery-oriented systems of care (ROSC). Further work was needed in a significant number of ADPs to extend the integration of their ROSC beyond core alcohol and drug treatment services. This included improving coordinated care pathways that progressed seamlessly through treatment services into ROSCs that were well connected to the community.

Some ADPs, as part of ROSC development, had undertaken substantial work to improve staff understanding of recovery through a range of consultation events and learning and development sessions. However, there was still a limited understanding by staff in wider services of the ROSC principles and their own role in contributing to successful implementation.

Most ADPs had a mix of statutory and commissioned third sector services as part of a ROSC, with the third sector providing the majority of recovery-oriented services. In ADPs where statutory services provided the bulk of services, there were fewer choices in respect of early intervention and prevention. Modernising strategic commissioning could support a widening of the range of services and providers and a proportionate shift in the balance of care away from NHS-dominated provision.

The majority of ADPs had commissioning plans in place, with clear accountability and governance, and robust performance reporting processes. These were coherent with the vision and priorities set out in local delivery plans and most had been informed by evidence-based, needs assessments. Nonetheless, a significant minority of commissioning plans were not up to date and around a fifth of ADPs had no strategic commissioning plan in place.

Where commissioning plans were in place, most were appropriately linked to, or operated through, health and social care plans or integration joint board (IJB) strategic commissioning plans. In all ADPs, commissioning plans should be aligned to the IJB's strategic plan.

All commissioned services were monitored through performance management reporting. Some ADPs had strengthened, or were already in the process of strengthening, their approach to more outcome-based commissioning and to achieve full implementation of the Quality Principles. However, this was not yet consistent across all ADPs.

Most ADPs recognised they needed to improve outcome-based reporting to increase the quality of the outcomes data they collected at both a service and partnership level.

Some ADPs had undertaken significant work towards implementing and embedding the Quality Principles within service delivery and practice. However, a systematic approach was needed across ADPs to evaluate how effectively the Quality Principles were being implemented and embedded in practice across all services. This included both statutory and third sector services. Most services were undertaking aspects of self-assessment activity, but a number of ADPs had no systematic or meaningful approach to continuous improvement.

Despite a range of innovative early intervention approaches being in place, there was a lack of systematic, formal evaluation being undertaken by ADPs to demonstrate their effectiveness and efficiency. This included demonstrating the success of implementing whole-population approaches and interventions using the New Psychoactive Substances resource pack.

The majority of ADPs acknowledged they needed to establish more coordinated, systematic and effective stakeholder engagement. There were some encouraging examples of positive engagement and involvement of people in service development but only a few ADPs had in place a user involvement or stakeholder strategy to formalise and structure their approach.

How well were ADPs contributing to effective management and support of staff?

Some ADPs had implemented robust and structured workforce development. Others had no overarching workforce development strategy in place to support effective coordination of ROSC implementation and delivery. The majority of ADPs recognised they needed to improve their workforce development planning, particularly in relation to recovery-oriented system of care (ROSC) implementation.

In some ADPs there were limited learning or development programmes to fulfil staff roles and responsibilities within a ROSC. In a few ADP areas, organisational development and human resource processes had not kept pace with development needs and skill gaps. It would be helpful for learning and development programmes to extend to partners outwith alcohol and drug services, for example, housing and other mainstream services, given the important contribution that these services may make to an individual's recovery. ADPs could also usefully broker shadowing and job swap opportunities to support greater understanding and joint working. The effectiveness of training and development programmes was not always evaluated within ADPs to evidence their impact.

As described earlier in this report, there was a high level of familiarity with the Quality Principles among staff. Only a small minority of staff had little knowledge of them but some staff had received no information or training to support them to embed a recovery ethos into practice. There would be benefit in ADPs coordinating their efforts to ensure success at embedding a recovery-oriented ethos and person-centred approach.

Some staff did not receive regular feedback on the quality of their work. There was limited evidence in case records of discussions with managers or of manager oversight of work. Although the majority of staff reported that they received effective support and challenge from their line manager, not all were positive about the quality of supervision and support provided. ADPs could usefully support development of guidance on expectations of supervision and quality assurance.

How effective was partnership working?

The majority of operational staff were very positive and confident in demonstrating that they worked well together to improve outcomes for individuals, families and communities. Many attributed this to well embedded historic arrangements in local areas.

While there were many examples across ADPs of proactive participation and engagement with communities, many people still experienced stigma and prejudice when accessing services in the community or in hospital. ADPs should consider what more could be done to help reduce the stigma through greater awareness and education to create the necessary conditions to successfully embed a recovery philosophy.

At the time of this validated self-evaluation, service commissioners lacked complete knowledge of the resource allocation available to them because of delays in agreeing overall budgets and spending plans in some integration joint boards. Interim funding arrangements were being offered, many of which were short-term. As a result, many third sector services had experienced significant challenges in recruitment, planning and delivering continuity of service. This was leading to unhelpful tensions between third sector and statutory services in the context of otherwise constructive and respectful working relationships.

There was a lack of innovation in NHS treatment services and, to a slightly lesser extent, social work services compared to those provided by the third sector. While there were a few examples of NHS and local authority staff being embedded into hubs, the majority of NHS and local authority services were delivered on a very traditional basis and were service-led rather than needs-led. People using services spoke consistently about having to travel to hospital clinics to receive treatment and difficulties in getting services outside of normal office hours or in other flexible ways. This was particularly the case for people living in remote and rural areas.

Formal structures and governance arrangements to support effective partnership working at a strategic level were being strengthened and streamlined. The majority of ADPs had formal arrangements in place between child and adult protection committees and other strategic groupings. In a few partnership areas these connections could be reinforced and made clearer. ADPs should take every opportunity to support alcohol and drug services to strengthen their links with services for children and young people in order to embed a family-inclusive approach and help reduce harm to children.

Approximately half of the staff who responded to our survey felt that they were adequately consulted or that their views were fully taken into account when planning services at a strategic level, including how resources were distributed. However, a quarter of staff disagreed.

Greater cohesion of operational procedures and delivery processes could increase joined-up working and reduce duplication experienced by staff and individuals. Services could work together better to develop joint processes for shared, universal, strength-based assessments, joint recovery plans and reviews.

How good was the leadership and direction shown by ADPs?

Most ADPs demonstrated clear strategic leadership and direction. Effective governance structures and accountability arrangements were in place within most ADPs. This provided robust mechanisms for progressing strategy and policy developments in relation to national and local priorities. However, a significant minority of ADPs needed clear strategic direction and governance to effectively drive forward local delivery plan priorities. In these areas there tended to be an absence of strategic commissioning planning and insufficient progress in recovery-oriented systems of care (ROSC) development and workforce planning.

Many ADPs had initiated and led the successful development of a comprehensive redesign of service delivery that had strengthened joint approaches to support improved access to services. This had notably contributed to success rates in meeting waiting time targets in some ADPs as well as ROSC progression.

The majority of ADPs communicated their vision and aims in line with national priorities and local delivery plans well. Most ADPs had made progress to underpin a recovery culture within practice through holistic, person-centred approaches that reflect the needs of people.

There could be benefit in senior managers communicating changes more effectively with staff. Strengthening opportunities to meaningfully consult, involve and communicate with staff on changes and decisions that impact on services would improve and increase transparency in decision-making processes.

Staff were benefiting from a culture where they felt largely motivated and inspired in their work. This was widely supported by the majority of ADPs where a strong commitment to innovation and ongoing improvement was encouraged. This was evidenced in the wide range of successful developments, initiatives and examples of good practice that were taking place across ADPs.

A range of multi- and inter-agency events, forums and activities supported staff across services to come together to foster a culture of collaborative working, shared aims and learning. In some ADPs, these were unplanned and infrequent.

Appendix1: Glossary

ABI	**Alcohol Brief Interventions** is a key element of the Scottish Government's Alcohol Strategy. They are short, evidence based, structured conversations about alcohol consumption with a patient or service user, in a non-confrontational way, to motivate and support them to think about or plan a change in their drinking behaviour in order to reduce their alcohol consumption and/or their risk of harm.
ADP	**Alcohol and drugs partnerships** are multi-agency partnerships in each local authority area that bring together health boards, local authorities, police, the Scottish Prison Service, community justice authorities and third sector organisations to deliver action on alcohol and drugs at local level.
DAISy	**Drug and Alcohol Information System** is a database being developed to collect Scottish drug and alcohol treatment, outcomes and waiting times data from staff delivering specialist drug and alcohol interventions.
GIRFEC	**Getting It Right For Every Child** is the national approach in Scotland to improving outcomes and supporting the wellbeing of children and young people by offering the right help at the right time from the right people. It supports children and young people and their parent(s) to work in partnership with the services that can help them. www.scotland.gov.uk/gettingitright
GP	A **general practitioner** is a doctor based in the community and providing routine healthcare.
HMP	**Her Majesty's Prison.**
HSCP	**Health and social care partnerships** are the organisations formed as part of the integration of services provided by health boards and councils in Scotland.
HEAT Targets	These targets are set by NHS Scotland and the Scottish Government's health directorates, to ensure our services are constantly monitored and improved. There are **four groups of targets, collectively known as HEAT: H – Health Improvement; E – Efficiency; A – Access to treatment; T - Targets**.
IJB	**Integration joint boards** are responsible for the strategic planning and delivery of their delegated functions. The IJB has an operational role as described in their integration scheme.
LDP	The Scottish Government's **Local Delivery Plan** sets out the standard for drug and alcohol treatment. It 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.
MELDAP	**Mid and East Lothian Drug and Alcohol Partnership.**

Named Person	Children and young people from birth to 18, or beyond if still in school, and their parents will have access to a named person to help them get the support they need. A named person will be a clear point of contact if a child, young person or their parents want information or advice, or if they want to talk about any worries and seek support. A named person will normally be the health visitor for a pre-school child and a promoted teacher, such as a head teacher, guidance teacher or other promoted member of staff, for a school age child. They will also be a point of contact for other services if they have any concerns about a child's or young person's wellbeing. **www.gov.scot/Topics/People/Young-People/gettingitright/named-person**
NHS	**The National Health Service.**
NPS	**New psychoactive substances** are a range of drugs that have been designed to mimic established illicit drugs, such as cannabis, cocaine, ecstasy and LSD.
ORT	**Opioid replacement therapy** involves replacing an illegal opioid, such as heroin, with a longer acting but less euphoric opioid. Methadone or buprenorphine are typically used and the drug is taken under medical supervision.
Outcomes Star	Outcomes Star™ is an evidence-based, unique suite of tools for supporting and measuring change when working with people.
Person-centred	Person-centred is a way of thinking and doing things that sees people using health and social care services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.
Recovery	A process through which a person is enabled to address their problem drug and/or alcohol use to achieve improved benefits to their physical, mental and social health, becoming an active and contributing member of society.
Recovery capital	The depth and breadth, quality and quantity of resources that can be used and built upon for a person to achieve and maintain recovery from substance misuse as well as make behavioural changes.
Relapse prevention	Relapse prevention is a cognitive-behavioural approach with the goal of identifying and preventing high risk situations. It is aimed at improving overall coping skills and promoting health and wellbeing.
Recovery Outcome Tool	Recovery Outcomes Tool is a validated tool which has been developed by Scottish Government for use by services with people who misuse drugs and alcohol. The aim of the tool is to measure changes in a person's life as a result of intervention by specialist drug and alcohol services.
ROSC	A **recovery-orientated system of care** is a coordinated network of community-based services and supports that is person-centred and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SDS	**Self-directed support** allows people, their carers and their families to make informed choices about what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes.
SFAD	**Scottish Families Affected by Drugs** is an organisation that aims to support families that are affected by someone else's alcohol and/or drug misuse and raise awareness of the issues that affect them.
SMART	When setting objectives, they should be: **Specific; measurable; Achievable; Realistic; Time bound.**
SMART	**Self-management for addiction recovery.**
Recovery plan	A recovery plan is a record of the individuals needs and sets out the supports available and agreed actions to be taken.
SMR25	An assessment report sent to SDMD when someone enters treatment.
Strength-based assessment	A process to identify a person's needs, aspirations and strengths that can be used to aid their recovery.
THN	Naloxone is a drug that can temporarily reverse the effects of a potentially fatal overdose with opioid drugs such as heroin or morphine. Following suitable training, **Take Home Naloxone** kits are issued to people at risk of opiate overdose in order to prevent overdose deaths.
TOP	**Treatment Outcomes Profile** is a national outcome monitoring tool that measures change and progress in key areas of the lives of people being treated in drug and alcohol services.
Trauma-informed	An approach to engaging people with a history of trauma in a way that demonstrates an understanding and responsiveness to the impact of the trauma and that emphasises physical, psychological and emotional safety for both providers and survivors. It helps identify opportunities for survivors of trauma to rebuild a sense of control and empowerment.
Whole-population approach	Policies or strategies that focus on the whole population to significantly reduce alcohol consumption to improve everyone's health and wellbeing.
Whole-family approach	The aim of the whole-family approach is to improve outcomes for vulnerable children, young people and adults through better co-ordination of the support they receive from services for children and adults.

Appendix 2: Good practice examples

Aberdeen City

The Prescribing for Recovery initiative within primary care settings had freed up appointment capacity within practices where Aberdeen Recovery Community (ARC) workers took over as primary workers for care and distribution of prescriptions, supporting people to progress and move on in their recovery. The impact of the programme has been positive, with GPs, ARC workers and individuals reporting more positive recovery outcomes than if individuals had just stayed with a GP prescriber alone. This included a higher level of attendance at appointments and more holistic interventions and psycho-social supports.

City and Guilds awards for people in recovery is a successful initiative run in partnership with Alcohol and Drugs Action (ADA), Aberdeen Foyer and Aberdeen College that offers a suite of qualifications in skills and personal development. People undertaking a range of recovery activity can receive educational credits for their recovery work. This initiative had led to 67 people engaging in the programme during 2015-16 and achieving academic attainment through a range of credits and awards, thereby increasing self-empowerment and employment opportunities. ADA acquired accreditation as a delivery centre and delivers a self-coaching course, which is SCQF level 5 rated, and a stage 2 recovery coach course. Fifty-three people completed the self-coaching course and had this certified. Many of those people have become ADA volunteers and actively joined their local community, contributing to organisations such as SMART and Mutual Aid groups.

Aberdeenshire

Turning Point Scotland – service development. Aberdeenshire ADP had reviewed service processes and identified the need to make it easier for people to access services. Following a service re-design, a single point of access (SPOA) model was developed and implemented. This model had made alcohol and drug treatment in North Aberdeenshire more accessible and effective, increasing the number of people receiving treatment and support, and had reduced waiting times. SPOAs were the main hub connecting people to services for treatment and support, and connecting them to their community, including employability, housing and education.

Moving on and engagement. As part of Aberdeenshire's ROSC, moving-on services were commissioned to provide focused support to people to help them achieve their recovery goals beyond treatment. Moving-on workers encouraged and supported people to reconnect with their local community through volunteering, employment or training to move them positively on from services in a planned way.

Angus

The whole-family approach. Angus ADP had implemented a sound and integrated whole-family approach across its ROSC following a rapid improvement event. A programme manager oversaw the well-structured deployment of this pilot approach that aimed to promote recognition of co-existing mental health and physical health issues for the individual and their significant others. A coherent set of outcomes demonstrated the effectiveness of the work across all the 12 families it had involved thus far.

Dumfries and Galloway

Motivational interviewing practice-based coach groups. The ADP established 'coach groups' for staff to consolidate and improve their practice in motivational interviewing. This included all local agencies involved in the local ROSC including social work and third sector. This initiative was a valid attempt to improve the quality of service delivery in the form of good-quality counselling in the area. It also boosted feelings of professional efficacy and competence among the workforce and led to better outcomes for clients.

Recovery Over and Around the Machars (ROAM) is a weekly partnership group to facilitate people to get out and about around the Machars (a rural peninsula in Galloway) to interact with their community and make positive connections with other local groups. Run in partnership with Addaction and ADS, a driver and minibus helps people who live in isolated and rural areas to attend. The group had also set up and developed their own service-user led Recovery Café with a start-up fund from The Scottish Recovery Consortium. ROAM has had a positive impact on people and improved outcomes in a range of ways including them being trained as peer mentors and volunteer mentors to support others in recovery.

East Dunbartonshire

Alcohol screening and brief intervention approaches. As part of a whole-population approach, the alcohol screening and brief intervention strategy for East Dunbartonshire focused on the development of alcohol brief interventions (ABI) within a wider range of community settings. There was evidence of a strong partnership approach to supporting staff practice and development in delivering ABIs, which was aided by third sector employment of an ABI worker.

East Dunbartonshire Recovery Life Café. This model of co-production was developed following service user consultation where people in recovery struggled with relapse out with traditional service hours. The café offered a peer support network and provided people with the opportunity to build on their experiences of recovery in a safe place. The café was initially set up and funded by the ADP and had developed into a fully constituted group with a management committee. Local evaluation had demonstrated positive outcomes for the wellbeing of people in recovery. The success of the Recovery Life Café was recognised in 2015, when it received an award in the Strengthening Community Engagement and Resilience category of the Safer Communities Awards run by the Scottish Community Safety Network.

East Renfrewshire

Improving outcomes for recovery through service redesign and improvement. East Renfrewshire ADP identified a need to improve the quality and breadth of service provision, particularly in relation to recovery focused community services. The ADP considered a whole-system approach to redesigning services for treatment, care and recovery to ensure that people's needs were fully met. A redesign steering group oversaw the redesign process, which followed the Scottish Government's adopted improvement model. Improved outcomes for individuals and families, which were a result of person-centred, holistic approaches, were articulated through the ADP performance framework. The ADP commissioned an independent evaluation of the recovery service, which highlighted positive improvements. This service redesign work was recognised nationally as a good practice template for ROSC and was published on the Social Services Knowledge Scotland (SSKS) website.

Fife

Prescribing and Rehabilitation Glenrothes (PARG). This integrated project between FIRST and NHS Fife Addiction Services was well implemented and structured to support people in to treatment, including access to prescriptions in less than a week. There was measurement of some very effective outcomes including a reduction in drug related deaths in this traditionally hard to reach area.
Fife residential rehabilitation pilot. This integrated approach between FIRST and Fife Council was well implemented, based on needs assessment work and sound cost-benefit analysis work. This offered a successful alternative to community rehabilitation to people with complex or specific needs.

Forth Valley (Stirling/Clackmannanshire/Falkirk)

CAB Advice Project. This two-year pilot had been effectively structured and deployed across a number of community settings to maximise access opportunities for service users. The ADP had scoped the project well and there were a number of measurements in place demonstrating outcomes in areas of people's lives, such as financial gain and improving mental health. The project had carefully evaluated its performance including the amount of ADP practitioner time being saved by using the CAB advisor.

Glasgow City

Assertive Outreach Pilot. This pilot was initiated following concerns relating to discarded drug paraphernalia, spread of blood-borne viruses (BBV's) public injecting by people who were rough sleepers, associated crime and anti-social behaviour. Using an assertive outreach approach to engage with a traditionally hard to reach and very vulnerable group had led to improved understanding about their wellbeing and culture. Health needs were identified and the team facilitated engagement in treatment and care for many street drug users. Other benefits included decreased drug paraphernalia in the city centre, contribution towards the public health agenda regarding the spread of HIV infection in the city and identifying emerging trends in drug use. Strong partnership and inter-agency working was evident and pivotal to the success of the pilot, which had been evaluated and continued to be monitored by a steering group of ADP partners.

Best Bar None Glasgow. Glasgow ADP was the first area to launch this innovative initiative in 2005, which is now national practice. A range of partners closely collaborated with the local Nite Zone initiative as they sought similar outcomes. The team had developed innovative bespoke resources and had developed a social media presence and materials that could be shared with other areas. The initiative had demonstrated reductions in violent crime and anti-social behaviour over and above relative drops in other comparable areas.

Highland

Harm reduction service. Highland ADP supported NHS Highland as a partner to develop their Overdose Awareness and Naloxone programme. This was an innovative and creative approach providing both intramuscular and intranasal versions of Naloxone. This had resulted in much wider engagement across key partners including families, users, carers, service providers, prison staff and police.

The Catalyst Project. This pilot project was informing the development of a model of practice to effectively support children and families throughout recovery from problem drug and alcohol use. This 18-month consultation project was investigating the types of whole family interventions and services that would best support the needs of local children and families who resided in Alness and surrounding communities. A two-staged approach had been adopted with community asset building applied in the first phase to engage and consult with local children, young people and their families through hosting innovative community events. The second phase involved raising awareness of young people's stories and priorities with local service providers and working with them to improve integrated practice to support whole-family recovery processes.

Inverclyde

Persistent Offenders Partnership (POP). This assertive partnership approach engaged with and addressed the needs of people with problems relating to addiction, which impacted on offending behaviour, health and social functioning. Several practice examples indicated improvements in the wellbeing of individuals, family relationships and reduced offending behaviour in the community. Intensive Family Response Service. This service was developed in response to carers' needs and aspirations over a period of time and to address an identified gap in service. The service was restricted to people accessing integrated drug services. The service example demonstrated a partnership approach to supporting individuals and family members in identifying and managing their needs while caring for a person using drug services through a range of interventions and support.

Lanarkshire

Strengthening Families Programme (North Lanarkshire) was a targeted intervention aimed at those families experiencing the impact of drug and alcohol use. This service was developed following the emergence of ROSC within North Lanarkshire which had increased understanding that people sustained their recovery journey within family and community life, and that providing opportunities to enhance and support whole-family recovery was essential. Significant benefits from the programme

were evident for both young people and families including those completing the programme returning to subsequent programmes as peer mentors.

Patient Reminder Service. This service was implemented to address high rates of did-not-attends (DNAs) and increase engagement rates within South Lanarkshire alcohol and drug services. A multivariate model was used; the intervention that a person received was determined by the risk of them not attending the service. Monitoring of the model had demonstrated that more people were engaging with treatment.

Mid and East Lothian (MELDAP)

Peer Support Project was an integrated approach delivered in partnership between service users, GPs, secondary care and non-statutory agencies who introduced peer support for substance misuse into a general practice in Midlothian. The pilot demonstrated some very positive outcomes and there was strong evidence that the learning and innovation potential was acknowledged in the recommendations to expand the pilot more widely.

Moray

Quarriers: Arrows Direct Access drug and alcohol service. Moray ADP had re-designed services to make access easier and provide services that were recovery-focused and met local need. Arrows Direct Access provided people with early help through their single access pathway to services and robust, pro-active follow up for non-attendance and support to re-establish contact. Arrows supported the development of a ROSC to promote positive outcomes for the service user and wider family. While Arrows was still in the early stages of implementation, recovery support to people experiencing substance issues and their families was demonstrating positive outcomes in wellbeing.

North Ayrshire

Recovery as Work (RaW) – Café Solace. This initiative was developed in response to feedback from stakeholder consultation and engagement regarding opportunities for progressing recovery in North Ayrshire. Café Solace provided a supportive and informal community hub for people to access low cost, high-quality food and other support.

Self-management and Recovery Training (SMART). This service was developed in response to feedback from stakeholder consultation and engagement and resulted in the development of a network of peer-led mutual aid SMART meetings aimed at helping people overcome their addictive behaviour.

Perth and Kinross

The Social Prescribing Project was a sound and well integrated approach that featured an appointed lead officer who had collaborated closely with a large number of stakeholders and local communities to raise awareness of addiction issues and develop mutual aid and a range of sustainable support networks. The project had also developed an evaluation framework in order to measure the positive

impact the work had on communities and had demonstrated a range of positive results to date. There was good evidence that this project was strengthening community capacity across Perth and Kinross.

Renfrewshire

Addaction Intensive Family Support Group was established to provide an intensive family service, seven days a week, to bridge a gap in providing a responsive service to avoid crisis situations developing. There was a strong partnership ethos and approach to service planning and delivery. Service evaluation had determined that the service had achieved a number of short-term outcomes, including: fewer children on the child protection register or accommodated; parents had increased understanding of the impact of substance misuse on their families; parents prioritised the safety and wellbeing of their children; families had improved resilience and coping skills; and families accessed appropriate community resources.

Scottish Borders

The whole-population approach: licencing and communities. The ADP's relationship with the local licencing forum had been strengthened by this innovative work, which had a clear rationale and integrated approach underpinning it. There have been a number of impressive initiatives and results arising from the project aimed at increasing the communities understanding of addiction issues, particularly the early intervention work and underage drinking.

Take Home Naloxone provision (THN). THN is an evidence based programme to reduce drug related deaths from accidental opioid overdose. Borders Addiction Service developed a model whereby all service users at risk of opioid overdose were routinely supplied with THN as part of the assessment process. This resulted in Borders having the highest reach of first time supplies in Scotland in the first year of the programme and thereafter. THN is made available through Injecting Equipment Provision (IEP) pharmacies and through Addaction workers.

Shetland

Shetland Community Bike Project (SCBP) provided employment and volunteering opportunities for people facing barriers to work including mental health, drug or alcohol related issues to support them into training, volunteering or employment. People develop essential skills such as teamwork, time keeping and hands on experience in the workshop repairing and servicing bicycles for re-sale or rent. Many people have successfully progressed into paid employment, further education, training or volunteering as a result of the opportunities provided by the project. The Shetland Community Bike Project has been recognised across Scotland for its efforts in supporting youth employment.

South Ayrshire

ADP Volunteer Peer Worker Project (VPWP). The project was initiated following consultation with people who indicated that they would like to develop new skills, become involved with, and give back to, their local community. Following evaluation of the pilot, the project developed into a

comprehensive training and support programme for volunteer support workers (VPW) involving a 12-week college induction, volunteer work based placements and SVQ qualifications. The project was being supported by a newly developed ADP peer worker post.

Children and families social worker (addictions). This post was developed to progress joint working practice between adult services and children and families social work services. The main focus of the post was early intervention, support during pregnancy and workforce development. The post holder was co-located with NHS addiction services with outreach work to commissioned services. A range of benefits were demonstrated for people in terms of: early intervention and support; enhanced partnership working; communication between adults and children and family services; and the development and delivery of a range of workforce development opportunities for staff within adult and children and families services.

West Dunbartonshire

West Dunbartonshire Health and Social Care Partnership addictions blood-borne viruses (BBV) outreach team. This outreach team provided community-based treatment to people with the Hepatitis C virus to increase the numbers of people from the hard to reach population accessing and completing essential treatment and support. This initiative was unique within Greater Glasgow and Clyde health board area, being the only community outreach service actively treating chronic Hepatitis C patients out with the hospital setting. There was a strong partnership ethos and approach involving colleagues from the health and social care partnership, partner addiction services, GPs, other primary health, third sector, public health, consultant physicians and specialist pharmacists. The service had received two formal evaluations and improvement in wellbeing was evident, with a reduction in did-not-attend rates and 150 people successfully treated.

Appendix 3: The Quality Principles

These Quality Principles have been laid out as a journey, beginning with access to services leading on to assessment, recovery planning, review and beyond. No one Quality Principle is more important than another.

1. **You should be able to quickly access the right drug or alcohol service that keeps you safe and supports you throughout your recovery.**

   The majority of people should wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

   Nobody should wait longer than six weeks to receive appropriate treatment and support. If you are experiencing a wait that is approaching six weeks, contact your referring agency or local Alcohol and Drugs Partnership.

2. **You should be offered high-quality, evidence-informed treatment, care and support interventions which reduce harm and empower you in your recovery.**

   You should be treated fairly and equally, with respect and dignity, as a person able to make your own choices.

   You should be able to easily access safe, secure and comfortable surroundings when engaging with the service.

   The choice of interventions should be based on the best available evidence and agreed guidance.

   You should have access to a range of recovery models and therapies which should help improve different areas of your life and move forward at your own pace.

   You should have access to harm reduction advice which might include safer use, managed use and abstinence.

   With your agreement, your information may be shared with other services and it should be made clear to you when this might happen without your agreement.

3. **You should be supported by workers who have the right attitudes, values, training and supervision throughout your recovery journey.**

   Workers should be welcoming, work in a person-centred way and believe in your ability to change and recover.

Workers should provide timely, evidence-informed treatment and support that is right for you.

Workers should provide support that is trauma-informed and recognise any current or previous trauma you are dealing with.

Workers should provide you with harm reduction advice, this may include safer use, managed use and abstinence.

Workers should support you to set your own recovery goals and to manage your own care and support.

Workers should talk to you about plans and arrangements for you moving through the service and/or reducing/ending your current contact with the service.

Workers should encourage and help you to connect with a recovery community or mutual aid group.

4. **You should be involved in a full, strength-based assessment that ensures the choice of recovery model and therapy is based on your needs and aspirations.**

Your assessment should be based on your strengths, taking account of your recovery capital.

Your assessment should be done in a sensitive and supportive way.

Your assessment should identify any traumatic events in your life which may have affected you.

You should be told about the range of treatment options available to you.

Your views should be listened to and used to develop your personal recovery plan.

Assessment is part of an on-going process and could be carried out over more than one session. This should not be a barrier to accessing services quickly.

You should be told about the reasons for, and benefits of, your worker recording information about your recovery journey on local and national data systems. With your consent, your information may be shared with other services and it should be made clear to you when this might be done without your permission.

5 **You should have a recovery plan that is person-centred and addresses your broader health, care and social needs, and maintains a focus on your safety throughout your recovery journey.**

Your recovery plan belongs to you; the actions laid out in it are achieved in partnership between you and services.

Your recovery plan should be reviewed regularly, at a time agreed between you and your worker.

Your recovery plan should include information on reducing harm.

Recovery plans should aim for stable recovery beyond treatment into aftercare.

Recovery plans should detail further services you may need to access as part of your progression through treatment and care back to the wider community.

Recovery plans should look towards you moving on from the service, in line with your aspirations, at a time agreed by you and your case worker. Support for this should include relapse prevention advice and assertive engagement with a local mutual aid group or recovery community.

If you relapse you should be treated with the dignity and respect that welcomes your continued effort to achieve your recovery goals.

You should be offered a copy of your recovery plan.

6. **You should be involved in regular reviews of your recovery plan to ensure it continues to meet your needs and aspirations.**

Your review should include an assessment of your strengths and recovery capital.

Your review should include an assessment of the effectiveness of your current treatment to help you achieve your recovery goals.

As you progress on your recovery journey, your personal plan should be reviewed to reflect the changes in your situation.

Improving your situation should involve discussing areas in your life such as your aspirations for the future, wider health needs, family, children, finances, education, employment and housing, and the services or supports which could help you achieve these.

If you need to, you should be supported to access wraparound services such as housing, volunteering, employment etc. Providers of these services should treat you with dignity and in a non-discriminatory way.

7. **You should have the opportunity to be involved in an ongoing evaluation of the delivery of services at each stage of your recovery.**

You should have the opportunity to have your say in how services are delivered.

You should be told about your responsibilities and what you can expect from the service (supported by the Recovery Philosophy).

You should be told about how to complain if you are unhappy with the service.

You should be told about independent advocacy services that can help you be heard.

8. **Services should be family inclusive as part of their practice.**

   Family can mean those people who play a significant role in your life.

   Family members can only be involved in your recovery journey if you want them to be.

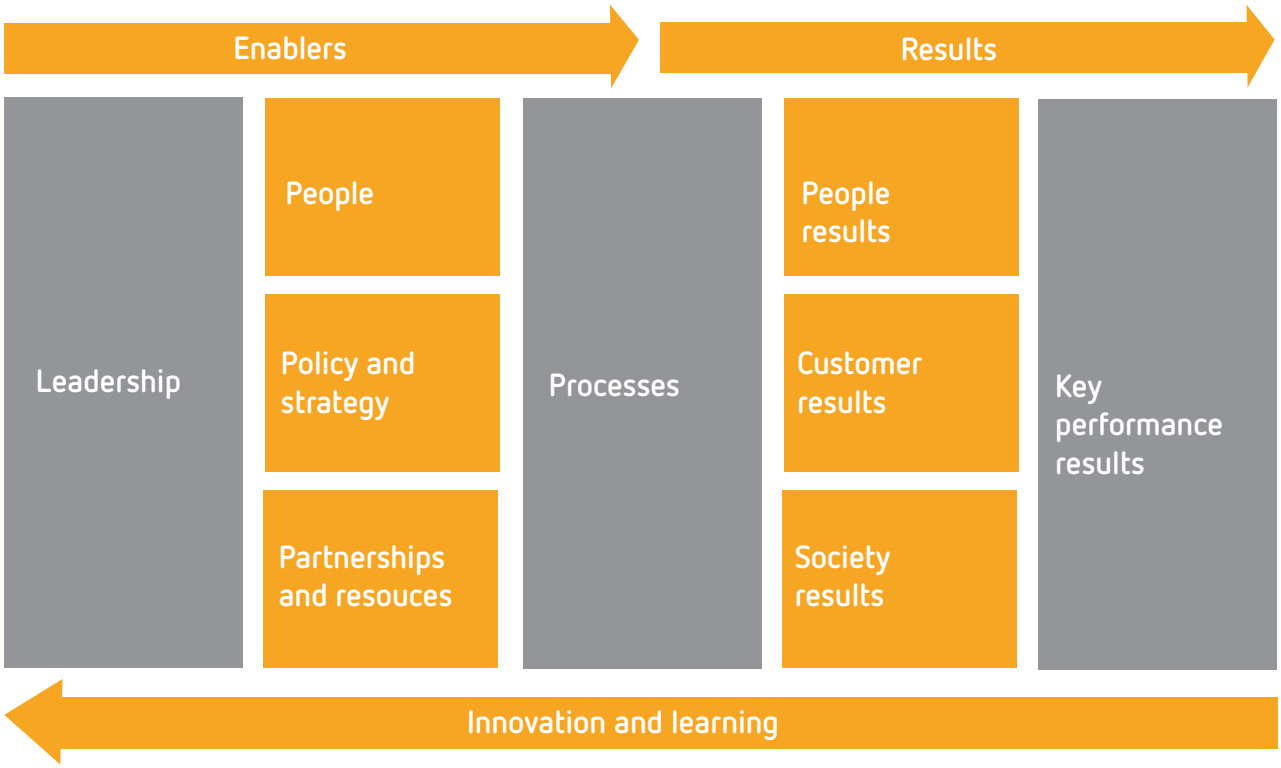
   You may want to involve other people who can support your recovery. The service should encourage and help you to do this.

   The service should help you minimise the impact that your drug or alcohol use may have on those around you.

   If you have children, their needs and wellbeing will be a primary concern.

   The service should be aware of the needs of members of your family and those you live with and, if needed, seek support for them.

Appendix 4: The Excellence Model



Appendix 5

Project team

Sharon Robertson, project lead, strategic inspector, Care Inspectorate
Mike Harkin, depute lead, strategic inspector, Care Inspectorate
Maureen Johnston, team member, strategic inspector, Care Inspectorate
Chelsea Bell, business support,Care Inspectorate

Acknowledgements

The project team would like to acknowledge the valuable contributions made by the people listed below.

Scottish Drugs Forum
Neil Stewart, head of quality and workforce development
Bruce Thomson, manager, national quality development
Jen Upson, senior officer, national quality development
Janet Hamill, senior officer, national quality development

Associate Assessors
Fiona Bennie, community addictions nurse, Borders Addiction Service

Lisa Bowlerwell, team leader, Alcohol and Drugs Action

Elaine Brown, ADP lead officer, Clackmannanshire / Stirling Alcohol and Drug Partnership

John Burns, evaluation officer, North Ayrshire Health and Social Care Partnership

Susan Cassidy, senior practitioner, Drug and Alcohol Team, Perth and Kinross

Dionne Chamberlain, community addictions nurse, Borders Addictions Service

David Dempster, service manager, Fife Alcohol Support Service / Fife Community Drug Team

Soraya Ria Din, team leader (strategy) substance misuse, Substance Misuse Team,
South Lanarkshire Council

Fiona Doig, ADP strategic co-ordinator, Borders Alcohol and Drug Partnership

Anne Fleming, clinical lead nursing, Tayside Substance Misuse Service

Luan Grugeon, chief executive officer , Alcohol and Drugs Action

Ingrid Hainey, service manager, CAIR Scotland

Sarah Harwood, senior nurse practitioner, NHS Highland, Osprey House

Beverly Horton, service lead/advanced practitioner, NHS Highland, Caithness Drug and Alcohol Service

Lesley Johnston, team leader, Positive Steps

Deirdre MacLean, training and practice development officer, Highland Alcohol and Drug Partnership/ Substance Misuse Service

Tafadzwa Madziva, senior addiction nurse, NHS Greater Glasgow and Clyde

Neil Morrison, inspector, adults services, Care Inspectorate

Faye Murfet, ADP co-ordinator, South Ayrshire Alcohol and Drug Partnership

Laura Ogilvie, development officer, Angus Alcohol and Drug Partnership

Claire Purdie, project worker, Addaction South Ayrshire Recovery Service

Helen Reid, service manager, Alcohol and Drugs Support South West Scotland

Kim Ross, inspector, adults services, Care Inspectorate

Deborah Stewart, co-ordinator, Highland Alcohol and Drug Partnership

David Williams, commissioning manager, Edinburgh ADP, Edinburgh Alcohol and Drug Partnership

Russell Wood, clinical team manager, NHS Tayside, Substance Misuse Service

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

Website: www.careinspectorate.com
Email: enquiries@careinspectorate.com
Care Inspectorate Enquiries: 0345 600 9527

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