UPDATED GUIDANCE FOR
ALCOHOL & DRUG PARTNERSHIPS (ADPs)
ON
PLANNING & REPORTING ARRANGEMENTS
2013-15
1. Introduction

Alcohol & Drug Partnerships (ADPs) are responsible for developing local strategies to deliver improved core and local outcomes on the basis of local need, and for making investment decisions to achieve these. They also have a key role in delivering the national policy initiatives, the Alcohol Framework and The Road to Recovery.

The Scottish Government’s 2012-13 and 2013-14 allocation letters for earmarked alcohol and drug funding identified nationally agreed core outcomes which all ADPs are expected to deliver against. These allocation letters indicated that ADPs should develop plans setting out how they will use the funding available to them (from both earmarked and additional resources) to deliver both improved core outcomes and local outcomes. Strengthening joint accountability for planning and delivering shared outcomes is essential to improving local delivery of alcohol and drug prevention, treatment and support services which support person-centred recovery.

This Guidance aims to support the embedding of outcomes based planning and reporting at local level, helping ADPs to self-assess their performance (including benchmarking against other ADPs) and to articulate their contribution to their local SOA, as well as contributing to a national picture of our overall progress in supporting alcohol and drug prevention, support and treatment. Improved information flows and visibility of ADPs will also help inform national strategies and decision-making by Scottish Government and CoSLA.

Scottish Government is grateful to members of the Short-Life Working Group on ADP Governance & Accountability for their work in developing and refining this guidance and to ADPs themselves for their feedback on the draft guidance and to the Short-Life Working Group which has helped to shape this revised documentation.

The key principles on which this guidance is based are to:
• strengthen local partnership working & joint accountability;
• reinforce outcomes based approaches;
• support ADPs to improve accountability to their CPP and demonstrate their contribution to their local SOAs by building on good practice;
• provide local flexibility but within a national framework to enable benchmarking;
• help build the national picture of delivery;
• minimise additional reporting requirements on ADPs.

The very nature of the outcomes which ADPs are seeking to deliver requires cross-cutting partnership working. The national outcomes and indicators for ADPs have therefore been developed to take account of, and be consistent with, other relevant national outcomes and indicators frameworks such as the National Performance Framework, the Quality Strategy, children affected by parental substance misuse (CAPSM), early years and community safety. The Scottish Government Drug & Alcohol Teams will continue to keep these under review as these frameworks develop.

It is recognised that the extensive reform of the public sector is likely to have implications for the operation of ADPs - including the review of Community Planning Partnerships and Single Outcome Agreements, the integration of health and social care, the review of Criminal Justice Authorities and the creation of single forces for
the Police and Fire services. For example, some local areas may choose to include alcohol and drugs within the remit of their Health and Social Care Partnership which would impact on ADP governance and accountability arrangements.

The Drug and Alcohol Teams agreed to keep these developments under review and consider any implications as part of continuous monitoring and review of these arrangements. We will keep colleagues informed of developments via the Drug and Alcohol e-Bulletin.

The Guidance to Community Planning Partnerships – Single Outcome Agreements¹ was issued December 2012. This guidance advises Community Planning Partnerships (CPPs) on the scope and content of new Single Outcome Agreements (SOAs) and on the timetable for agreement of these with the Scottish Government.

This guidance advises that new SOAs should continue to be developed and delivered within the context of the National Performance Framework. However, the National Community Planning Group has agreed that all CPPs should have a common and sharp focus on some key priorities where the aim should be to achieve transformational, not incremental, performance improvement. These key priorities are:

- Economic recovery and growth;
- Employment;
- Early years;
- Safer and stronger communities, and reducing offending;
- Health inequalities and physical activity; and
- Outcomes for older people.

The standard Reporting Templates being developed in consultation with ADPs [for ADP Delivery Planning (for Plans April 2015-March 2018) and ADP Reporting (from April 2012 - March 2013)], will be structured in such a way which allows ADPs to clearly link activities and outcomes to the new local SOAs.

While all ADPs will be developing plans and reports, the use of the standard templates will not be mandatory, they are intended to act as a tool to support your local processes if helpful.

2. Resource and Investment

One of the aims of this guidance is to reinforce the key role of ADPs in directing how earmarked and additional resources are utilised locally.

Scottish Government provides earmarked funding to ADPs to help them deliver against agreed outcomes. While this funding is routed for administrative purposes via NHS Boards, it is a partnership resource and, as such, investment decisions should be made on a partnership basis.

¹ www.scotland.gov.uk/Resource/0040/00409273.doc
It is also expected that this resource will be supplemented by investment from partners’ core funding and that the Partnership will be responsible for determining how all the available resource is invested. ADP Plans and Reports (2012) demonstrated that additional investment across Scotland was provided from partners’ core budgets to support alcohol and drugs interventions. Some ADPs also shared that resources in kind were often provided to supplement the SG funding. ADPs should seek to identify investment from both earmarked and core funds as part of their plans and reports.

The nature of problem alcohol and drug use means that the total resources used within localities are often greater than those provided to ADPs via the specific allocations from Scottish Government. ADPs should therefore over time aim to map out the total resource utilised in preventing, treating or dealing with the consequences of problem drug and alcohol use in their locality and seek to reflect this in their future delivery plans and annual reports. This mapping should seek to go beyond direct expenditure by the ADP to identify, where possible, the cost of problem drug and alcohol use in respect of, for example, criminal justice services, hospital admissions, sexual health and BBV interventions, and child protection services. This mapping will provide a fuller picture of the full costs of problem drug and alcohol use for local partners and will help inform long term strategic planning and service redesign to support early intervention and prevention.

Partners are jointly accountable for delivery of the ADP outcomes within this financial framework.

3. Guidance on Planning & Reporting and Core Indicators

The attached updated Guidance on ADP Planning & Reporting Arrangements for 2013-2015 outlines what each ADP should include a) in their ADP Delivery Plan, and b) in their ADP Annual Report on progress against that Plan. As requested by ADPs standard reporting templates for Plans and Reports are being developed for Reporting in September 2013. Use of these templates will not be mandatory, and are intended to act as a tool to support your local processes if helpful. ADPs can continue to adopt their own formats which can also meet local planning and reporting requirements and therefore reduce the need for separate and additional documentation.

In response to requests for examples of how information might be presented, we shared an example of one ADP Plan and other ADP report which linked well to the guidance.

It is anticipated that CPPs will be able to draw from the ADP Delivery Plan and Annual Report to populate their SOA submission.

As under previous Spending Reviews, Scottish Government has confirmed funding allocations for the (2013/14) and provided indicative allocations for the final year in the current spending review period (2014/15), to facilitate local planning. We recognise that ADP Planning is on a three yearly rolling programme. ADPs are therefore asked to provide a summary page when submitting Annual Reports, which identifies priorities including key milestones planned for the next 12 months. Annex C2 sets out the reporting schedule for both delivery plans and annual reports.
In response to feedback on timescales we have moved the date by which ADPs should share their Annual Report. The next Annual Report – which will cover the period April 2012 to March 2013 – should be shared with Scottish Government by 16 September 2013, and will include a summary page which identifies priorities including key milestones planned for the next 12 months.

As ADP accountability is via CPPs (and for HEAT targets/standards via Health Boards), rather than directly to Scottish Government, it is not anticipated that the Scottish Government will provide detailed feedback on the content of ADPs’ Plans and Annual Reports. The role of Scottish Government is to ensure that the contents meet the requirements set out in this Guidance and where it does not, agree with ADPs how this might be achieved. Scottish Government will also seek to disseminate good practice identified from the Plans and Reports through a range of methods, including the Alcohol and Drugs e-bulletin and facilitated events.

**National Support**

We would encourage ADPs to use the national support available to them as well as utilising local expertise.

A team of specialist ADP Delivery Advisors are in post to support capacity building and sharing of learning and good practice amongst ADPs. The team is in post until late 2014 with the aim of supporting ADPs around agreed priority areas including:

- improving skills to use data for evidencing progress against core outcomes
- delivering recovery-oriented systems of care through system redesign (including the transition from prison back to community and the importance of ensuring effective pathways are in place to support through-care arrangements)
- implementing a whole population approach to addressing problem alcohol use
- strengthen the Scottish Government’s engagement with the social work/care sector in relation to drug and alcohol policy objectives and drug and alcohol workforce development.

Scottish Government officials have been working with NHS Health Scotland and national drug and alcohol support organisations to develop a more cohesive approach to national support for ADPs. The National Drug and Alcohol Agencies (NADA) Network has been established to foster collaboration and plan jointly to effectively respond to national policy and strategy on alcohol and drugs and appropriately respond to the needs of ADPs.

In addition to seeking support from national agencies, ADPs are encouraged to exploit opportunities to access local expertise and resources, for example, in analysing and interpreting data and in building workforce capacity. Utilising wider networking partnerships, for example via the Joint Improvement Team’s supported activities, could provide valuable peer support to ADPs.

**Information Services Division**

Information Services Division (ISD) has a specific role in supporting ADPs, particularly in relation to reporting on core indicators and in benchmarking. For the Annual Report, due 16 September 2013, ISD will provide data on the core indicators in a spreadsheet to each ADP no later than the end of May 2013.
**Detailed Guidance**

Annex A sets out the **2012-15 Planning and Reporting Arrangements** which we expect ADPs to follow.

Annex B provides a **schematic** of how the Planning and Reporting process will work in practice.

Annexes C (1) & (2) outline the **planning and reporting cycle** and the **reporting schedule**.

Annex D contains the **Core Outcomes**, previously agreed and continuing for 2012/13.

Given the importance of providing evidence of progress towards outcomes, the **Core Indicators** are included at Annexes E (1) & (2). Their development has sought to ensure consistency of approach to outcomes and indicators with the revised National Performance Framework, the Healthcare Quality Strategy and other key policy frameworks such as early years and reducing offending and will keep changes under review. It is recognised that some of the indicators are proxy measures and that some data might not be available annually but these are intended to be both pragmatic and aspirational. Annual reports should set out this data in such a way that makes it clear what data is new and what is repeated from previous years (for example, italicised, bold text or box shading).

A list of possible **Local Indicators** is attached at Annex F. It should be noted that these are suggestions only. ADPs may identify others depending on their own local circumstances. Some ADPs are working together to develop joint local indicators (for example, the ADPs within the NHS Greater Glasgow and Clyde Board area). Some may wish to collaborate on joint data collection surveys. In addition, it may be that some of these local indicators could supplement national data and/or could be developed into national indicators. The latter will be kept under review as part of the continuing assessment of this process.

Annex G provides examples (previously shared with ADPs) of an ADP Plan and ADP Report which linked well to the guidance.

**Annexes**

- Annex A – Planning and Reporting Arrangements for 2012-2015
- Annex B – Overview of Proposed Planning and Reporting Arrangements for Alcohol and Drug Partnerships
- Annex C – (1) ADP Funding, Planning and Reporting Cycle and (2) ADP Planning and Reporting Schedule
- Annex D – Core Outcomes for Alcohol and Drug Partnerships (ADPs)
- Annex E – (1) Core Indicators and (2) Core Outcomes and Core Indicators
- Annex F – Possible Local Indicators
PLANNING & REPORTING ARRANGEMENTS FOR 2012-2015

These planning and reporting arrangements aim to:

- strengthen local partnership working & joint accountability;
- reinforce outcomes based approaches;
- support ADPs to improve accountability to their CPP and demonstrate their contribution to their local SOAs by building on good practice;
- provide local flexibility but with degree of consistency to enable benchmarking;
- help build the national picture of delivery;
- to minimise additional reporting requirements on ADPs.

This Guidance is split into two sections:

a) **ADP Delivery Plan:** The next ADP Delivery Plan is due by **31 March 2015** and should cover the period April 2015 to March 2018;
b) **ADP Annual Report:** This should be submitted by **16 September 2013, 15 September 2014 and 14 September 2015.** ADP Annual Reports should contain a summary page which identifies priorities including key milestones ADPs are planning to achieve over the next 12 months (i.e. April 2013 – March 2014).

Both your Plan and Report should be agreed by all your ADP partners. It is anticipated that both Plans and Reports will contain a combination of quantitative and qualitative information and are likely to be around 10-20 pages in length. You may have existing plans or reports which you currently produce for your ADP and/or CPP that contain the elements outlined below, and which will cover the required planning or reporting time periods. In that instance, those documents will suffice and there is no need to produce bespoke documents.

Standard reporting templates will be developed in consultation with ADPs for ADP Delivery Planning and ADP Reporting. These templates will be included in the updated guidance which will be issued at end of July 2013. *Use of these templates will not be mandatory but are intended to act as a tool to support your local processes if helpful.*
a) **ADP Delivery Plan**

Your ADP Delivery Plan should reflect the goals of your local ADP Strategy and be agreed by all ADP partners. ADPs are no longer required to share annual updates on ADP Delivery Plans by 31 March 2013 and March 2014. The next ADP Delivery Plan is due by **31 March 2015** and should cover the period April 2015 to March 2018.

The format of your Plan is for your ADP to determine in light of local management and reporting requirements but it should include:

- **ADP Partner Organisations**

  *Note: Plans should be agreed by all your partner organisations. These would normally include at a minimum: the local NHS Board, local authority, police and the Third Sector. Additional partners may reflect local priorities. The names of the organisations directly engaged in preparing the Plan should be listed.*

- **A high-level summary of key changes to be achieved over the duration of the Plan**

  *Note: This summary should identify a small number of strategic changes which your ADP intends to achieve during the three years of the plan period which will help deliver the Alcohol Framework\(^2\) and The Road to Recovery\(^3\), and how these will contribute to your SOA. These could be outcomes or outputs but will contribute to preventing alcohol and drug harm and/or improving person-centred recovery services and support. The summary should also identify key milestones for the coming year.*

- **Core & Local Outcomes to be achieved**

  *Note: Core Outcomes for 2012/13 are attached at Annex D. These remain the same as the Core Outcomes for 2011/12. Your ADP may have local outcomes in addition to these (including any contained in your Single Outcome Agreement). These should also be outlined in your Plan.*

- **Financial Investment (including earmarked Scottish Government funding and partners’ core funding)**

  *Note: Your plan should identify both the designated drug and alcohol funding from Scottish Government which the ADP receives (via their NHS Board) to enable you to deliver your local Plan. Where appropriate, you should also separately identify any other resource (e.g. financial, staffing as well as in kind) which impacts on alcohol and/or drug prevention, treatment and support activities locally – the source of this resource should also be specified.*

---


\(^3\) The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, May 2008: [http://www.scotland.gov.uk/Publications/2008/05/22161610/0](http://www.scotland.gov.uk/Publications/2008/05/22161610/0)
• **Priority Actions & Interventions to Improve Outcomes**

*Note: This section of your Plan should outline priority actions for investment including the increasing emphasis on preventative spend as well as on ensuring treatment and support services are person-centred and recovery-oriented. The Alcohol Logic Model (and supporting evidence)*[^4], *the Quality Alcohol Treatment & Support Services report[^5] and the Alcohol & Drugs Workforce Statement[^6] should be helpful in identifying your priorities. You should indicate arrangements for strengthening service user engagement. The distribution of resources between acute or specialist services, support services (typically Tier 1 and 2) and community-based support for Recovery should be clear and transparent. (The Audit Scotland Self-Assessment Checklist will be helpful in this regard, see “Drug & Alcohol Services in Scotland”, pp37-41, Appendix 4, [http://www.audit-scotland.gov.uk/docs/health/2009/nr_090326_drugs_alcohol.pdf](http://www.audit-scotland.gov.uk/docs/health/2009/nr_090326_drugs_alcohol.pdf))

All actions and interventions identified should clearly link to delivery of improved national core and local outcomes.

• **Core & Local Indicators to enable progress to be measured**

*Note: This section should outline how you are monitoring performance and can demonstrate that the investment in alcohol and drugs delivery is making a direct impact in your area. Core indicators, as set out at Annex E (1) & (2), should be included in Delivery Plans and Reports. In addition, your ADP may have local indicators of progress towards core and local outcomes which should also be outlined in your Plan. Examples of possible local indicators are attached at Annex F.*

For all indicators, you should include baseline figures (for the start of the reporting period, or the most up-to-date available figures), as well as your targets for the end of the three year planning period. However, wherever possible, ADPs should present trends as far back as possible to enable more robust assessments of the longer-term direction of travel. This will also help you to consider appropriate targets for the 3 year planning period.

• **Governance & financial accountability arrangements**

*Note: Your Plan should briefly outline the local governance arrangements for developing and overseeing delivery of the plan, including how decisions are made on investment of the available financial resources (both earmarked and from partners’ core funding). It should also indicate through what route and with what frequency your ADP reports to your CPP.*

[^4]: Health Scotland Alcohol Logic Model: [http://www.healthscotland.com/OFHI/alcohol/logicmodels/lm_01.html](http://www.healthscotland.com/OFHI/alcohol/logicmodels/lm_01.html)
[^6]: Supporting the development of Scotland’s Alcohol and Drug Workforce, December 2010: [http://www.scotland.gov.uk/Publications/2010/12/AandD](http://www.scotland.gov.uk/Publications/2010/12/AandD)
• Request for National Support

Note: Scottish Government seeks to support ADPs to deliver high quality person-centred prevention, treatment and support services through the work of the Alcohol and Drugs Delivery Units as well as through our funding of the commissioned organisations (Health Scotland, Information Services Division, Alcohol Focus Scotland, Scottish Training for Drugs and Alcohol (STRADA), Scottish Drugs Recovery Consortium, Scottish Drugs Forum, Scottish Families Against Alcohol and Drugs).

Set out any issues/areas of support required to help deliver your Plan.
b) ADP Annual Report

As with your Delivery Plan, your ADP Annual Report should be agreed by all ADP partners. It should be published by 16 September 2013, 15 September 2014 and 14 September 2015, with a copy forwarded to Scottish Government. For the report prepared for 16 September 2013, this should cover financial year 2012/13. ADP Annual Reports should contain a summary page which identifies Priorities including key milestones ADPs are planning to achieve over the next 12 months (i.e. April 2013 – March 2014).

The format of your Annual Report is for your ADP to determine in light of local management and reporting requirements but it should include:

- **General overview**
  
  *Note: A concise summary of your ADP’s key achievements and issues over the previous year, linking back to the priorities identified in your Plan, should be included. This should highlight any significant progress towards core or local outcomes and how these link to your SOA. This section is likely to contain both qualitative and quantitative elements*

- **Expenditure (including earmarked Scottish Government funding and additional funding sourced from partners and others)**
  
  *Note: Your Report should identify both the earmarked drug and the earmarked alcohol funding from Scottish Government which the ADP has received (via your local NHS Board) and spent in order to deliver your local plan. It should separately identify any other expenditure/support in kind on drugs and/or alcohol prevention, treatment or support which each ADP partner has contributed from their core budgets to deliver the Plan. It should also highlight the main actions and activities in which you have invested. You should also highlight any underspend and proposals on future use of any such monies.*

- **Actions/activities to achieve targets and deliver improved outcomes**
  
  *Note: Highlight the key actions and activities which, as a result of ADP investment and leadership, have contributed to progress towards your core and local outcomes over the previous year. It would be helpful if you could include case studies/learning examples which help demonstrate the impacts of ADPs on people’s lives and which other ADPs may find useful for example around service user engagement or CAPSM.*

- **Core and Local Indicators**
  
  *Note: Your report should include an assessment of performance against the targets you identified for each indicator in your Plan, including the core indicators attached at Annexes E. This should include a combination of narrative and quantitative data. On the core indicators you should, where possible, consider how your ADP performance benchmarks against other ADPs.*
• Governance and financial accountability arrangements

Note: Your report should demonstrate how effectively the partnership is working. It should also outline how decisions on investment of the available funding are made. It should also outline how links with your CPP, in particular reporting arrangements and feedback, have worked in practice.

It would be helpful if you could also include feedback on how these ADP planning and reporting arrangements have operated in practice.

• National Support

Note: Your feedback on the National Support provided by Scottish Government and the commissioned organisations (Health Scotland, Information Services Division, Alcohol Focus Scotland, Scottish Training for Drugs and Alcohol (STRADA), Scottish Drugs Recovery Consortium, Scottish Drugs Forum, Scottish Families Against Drugs), over the previous year would be welcome.
OVERVIEW OF PROPOSED PLANNING & REPORTING ARRANGEMENTS FOR ALCOHOL & DRUG PARTNERSHIPS

Alcohol & Drug Partnership

Local data collection

Local indicators

SDMD

Core indicators

HEAT Data

Information Services Division

Plan/Report on deployment of funding to deliver improved core & local outcomes, plus contextual information

Community Planning Partnership

SOA

Scottish Government

National Performance Framework

NHS Board

LDP & Quality Strategy

Public
ADP FUNDING, PLANNING & REPORTING CYCLE

**MARCH**
Allocation letters sent out confirming requirements for:
a) reporting for previous year’s allocation &
b) plans for investing future allocation

**BY 31 MARCH**
Every three years ADPs share agreed local delivery plans for how investment will be utilised to deliver specified core/local outcomes

**SEPTEMBER**
ADP share with SG previous financial year’s investment & core/local outcomes delivered and Summary Page which identifies priorities & key milestones for the next 12 months

**WINTER**
Ministers & COSLA receive update on national progress

*Subject to Parliament’s approval of overall budget & Ministerial agreement of allocations

**Next plan is due 31 March 2016 for April 2015 – March 2016**
## ADP Planning and Reporting Schedule

### Deadlines

<table>
<thead>
<tr>
<th>Period</th>
<th>3 year Delivery Plan</th>
<th>Annual Report and Summary Page identifying priorities &amp; key milestones for next 12 months</th>
<th>ISD Indicators &amp; Benchmarking Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>16 September 2013 (on 2012/13 activities)</td>
<td>End May 2013</td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>15 September 2014 (on 2013/14 activities)</td>
<td>End May 2014</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX D

CORE OUTCOMES FOR ALCOHOL & DRUG PARTNERSHIPS (ADPs)

1. **HEALTH**: People are healthier and experience fewer risks as a result of alcohol and drug use: a range of improvements to physical and mental health, as well wider well-being, should be experienced by individuals and communities where harmful drug and alcohol use is being reduced, including fewer acute and long-term risks to physical and mental health, and a reduced risk of drug or alcohol-related mortality.

2. **PREVALENCE**: Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others: a reduction in the prevalence of harmful levels of drug and alcohol use as a result of prevention, changing social attitudes, and recovery is a vital intermediate outcome in delivering improved long-term health, social and economic outcomes. Reducing the number of young people misusing alcohol and drugs will also reduce health risks, improve life-chances and may reduce the likelihood of individuals developing problematic use in the future.

3. **RECOVERY**: Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use: a range of health, psychological, social and economic improvements in well-being should be experienced by individuals who are recovering from problematic drug and alcohol use, including reduced consumption, fewer co-occurring health issues, improved family relationships and parenting skills, stable housing; participation in education and employment, and involvement in social and community activities.

4. **FAMILIES**: Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances: this will include reducing the risks and impact of drug and alcohol misuse on users’ children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.

5. **COMMUNITY SAFETY**: Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour: reducing alcohol and drug-related offending, re-offending and anti-social behaviour, including violence, acquisitive crime, drug-dealing and driving while intoxicated, will make a positive contribution in ensuring safer, stronger, happier and more resilient communities.

6. **LOCAL ENVIRONMENT**: People live in positive, health-promoting local environments where alcohol and drugs are less readily available: alcohol and drug misuse is less likely to develop and recovery from problematic use is more likely to be successful in strong, resilient communities where healthy lifestyles and wider well-being are promoted, where there are opportunities to participate in meaningful activities, and where alcohol and drugs are less readily available. Recovery will not be stigmatised, but supported and championed in the community.

7. **SERVICES**: Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery: services should offer timely, sensitive and appropriate support, which meets the needs of different local groups (including those with particular needs according to their age, gender, disability, health, race, ethnicity and sexual orientation) and facilitates their recovery. Services should use local data and evidence to make decisions about service improvement and re-design.
CORE INDICATORS

1. As shown in Figure 1, the core indicators are intended to be one type of a range of information that can help indicate progress towards both the core outcomes and locally specific outcomes. They sit alongside indicators which are specific to individual ADPs and their local needs and priorities, indicators contained in single outcome agreements, and a range of contextual and qualitative information. The latter can add much more depth and meaning (e.g. through case-studies and individuals’ recovery stories) and help to explain – or even challenge – the picture shown by quantitative indicators.

Figure 1

2. There are limitations to what can be considered as core indicators. Some good potential indicators may only be collected in a few ADPs, but core indicators need to be available consistently for every ADP. The core indicators will evolve and change over time as new data becomes available. There are some outcomes, such as Community Safety, where, for historical reasons, more core indicators are available. For others - notably Recovery - there is clearly room for further development. The selection of these initial core indicators therefore focuses on what data is currently available, but the clear aspiration is to improve these indicators going forward. We have also sought to ensure consistency of approach to outcomes and indicators with the revised National Performance Framework, the Quality Strategy and other key policy frameworks such as early years and reducing offending and will continue to do so. For these reasons, the core indicators provided here should be seen as a starting point.
3. It is recognised that indicators are just that – they are intended to be indicative of progress towards outcomes, but inevitably provide a partial picture of that progress. All indicators are proxy measures of real outcomes, but some will be more direct than others. In the short-term it may be necessary to use less ideal proxies and even output data to indicate progress towards outcomes. These indicators, while efficient to use, may not always get to the heart of an outcome or an ADP’s contribution. Locally specific indicators and contextual and qualitative information will also be vital in interpreting indicators and outcomes and in providing a credible account of the contribution of local partners to observed outcomes (examples of possible local indicators are provided at Annex F).

4. A number of these indicators are only currently available at national or Health Board level and cannot be broken down by ADP. For some indicators, particularly those based on survey data, it is unlikely that samples can be expanded in the current financial climate in order to obtain ADP level data.

5. It will be for ADPs to determine locally for each indicator what direction of travel represents a positive outcome. This may require agreement with local partners. For instance, an increase in the “Number of Child Protection Case Conferences where parental drug and/or alcohol abuse has been identified” may be due to an increase in prevalence in an area and/or an increase in detection rates due to the efforts of local services and professionals. In this case, the ADP will need to discuss and agree both the actions to be taken and the expectations around the impact of these on the indicator with the local Child Protection Committees.
## ANNEX E (2): CORE OUTCOMES AND CORE INDICATORS

<table>
<thead>
<tr>
<th>Outcome</th>
<th>National Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| People are healthier and experience fewer risks as a result of alcohol and drug use | Rate of drug-related hospital discharges (three year rolling average over last 5 years) | Overdoses and other acute drug-related health problems are key risks of drug use. The reduction in health risks due to the prevention of drug use, the recovery of drug users, and the reduction of health risks for those continuing to take drugs, should be reflected in fewer hospital admissions in an area. | Source: ISD Scotland – SMR-01  
Frequency: Annual  
- Last: May 2012  
- Next: May 2013  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
- Other: gender, age group, SIMD |
| | Rate of alcohol-related hospital discharges (three year rolling average over last 5 years) | The reduction in health risks due to the prevention of alcohol misuse and the recovery of people with problematic use should be reflected in fewer hospital admissions in an area. | Source: ISD Scotland – SMR-01  
Frequency: Annual  
- Last: May 2012  
- Next: May 2013  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
- Other: gender, age group, SIMD |
| | Rate of alcohol-related mortality (three year rolling average over last 5 years) | Direct measure of the level of alcohol-related harm in a given area. The reduction in health risks due to the prevention of alcohol misuse and the recovery of people with problematic use should be reflected in fewer alcohol related deaths in an area. | Source: NRS (ISD analysis)  
Frequency: Annual  
- Last: Aug 2012 (2011 data)  
- Next: Aug 2013 (2012 data)  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
- Other: gender, age group, SIMD |
| | Prevalence of hepatitis C among people who inject drugs | A decrease in this indicator will reflect a lower risk from injecting drugs and mean fewer injecting drug users are infected with hepatitis C | Source: HPS  
Frequency: 2 years  
- Last: 2011 |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>National Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Next: April 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Breakdowns available:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• National ☑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• NHS Board ☑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Local Authority ☑</td>
</tr>
</tbody>
</table>
### 2. PREVALENCE

Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others

A reduction in the prevalence of harmful levels of drug and alcohol use as a result of prevention, changing social attitudes, and recovery is a vital intermediate outcome in delivering improved long-term health, social and economic outcomes. Reducing the number of young people misusing alcohol and drugs will also reduce health risks, improve life-chances and may reduce the likelihood of individuals developing problematic use in the future.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
| Estimated prevalence of Problem Drug Use Amongst 15-64 year olds in Scotland, by age group. | The reduction in the prevalence of problematic drug use as a result of both prevention and recovery should be directly reflected in reduced estimates of adult problem drug use and injecting drug use. | Source: ISD study *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland.* Frequency: 3 yrs approx  
- Last: Nov 2011 (2009-10 prevalence)  
- Next: mid 2014 (2012/13 data, TBC) | Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
- Other: Community Justice Authority Area, Police Board |
| Estimated prevalence of injecting drug use amongst 15-64 year olds in Scotland. |  |  |  |
| Percentage of 15 year old pupils who usually take illicit drugs at least once a month (areas with larger prevalence). | Reducing the number of young people misusing alcohol and drugs will be reflected in a reduction in both frequent use and any use amongst 15 year old school pupils. | Source: ISD Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)  
Frequency: 2 years  
- Last: December 2011 (2010 data)  
- Next: October 2014 (2013 data)  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
- Other: ADP  
* Local authority and ADP level data being collected in 2013, a year earlier than originally planned |  |
<p>| Percentage of 15 year old pupils who have taken an illicit drug in the last year (areas with lower prevalence). |  |  |  |</p>
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
| The proportion of individuals drinking above daily and/or weekly        | • Drinking above recommended limits is associated with an increased risk of | A reduction in population consumption is a prerequisite to delivering many of the core outcomes.                                                                                                                                                                                | **Source**: Scottish Health Survey  
**Frequency**:  
• *Last*: Sept 2012  
• *Next*: Sept 2013  
**Breakdowns available**:  
• National ✗  
• NHS Board ✗*  
• Local Authority ✗  
• Other: Gender, age, SIMD  

* Health Board level data available for all Boards every 4 years; every 2 years for larger Boards.                                                                                                              |
<p>| recommended limits                                                      | limits                                                                     |                                                                                                                                                                                                                       |                                                                                                                                                                                                                         |
| The proportion of individuals drinking above twice daily (&quot;binge&quot;      | “Binge” drinking is associated with increased risk of acute harm and is    |                                                                                                                                                                                                                       |                                                                                                                                                                                                                         |
| drinking) recommended limits                                            | linked to a range of anti-social behaviours.                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                                         |
|                                                                         |                                                                          |                                                                                                                                                                                                                       |                                                                                                                                                                                                                         |</p>
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
| The proportion of individuals who are alcohol dependent | Reducing the number of individuals who are alcohol dependent will lead to a range of positive individual and societal outcomes | **Source:** Scottish Health Survey CAGE questionnaire (screening tool used to identify potential alcohol dependence)  
**Frequency:**  
- Last: Sept 2012  
- Next: Sept 2013  
**Breakdowns available:**  
- National  
- NHS Board  
- Local Authority  
- Other: Gender, age, SIMD  
* Health Board level data available every 4 years (every 2 years for larger Health Boards). |
| Proportion of 15 year olds drinking on a weekly basis (and their mean weekly level of consumption) | Drinking in childhood is associated with increased risk of a range of potential harms (as evidenced by SALSUS). There is also some evidence that drinking patterns learnt early in life stay with the individual into later life. | **Source:** Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)  
**Frequency:** 2 years*  
- Last: December 2011 (2010 data)  
- Next: October 2014 (2013 data)  
**Breakdowns available:**  
- National  
- NHS Board  
- Local Authority  
- Other:  
* Local authority and ADP level data being collected in 2013, a year earlier than originally planned |
### 3. RECOVERY

**Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use**

A range of health, psychological, social and economic improvements in well-being should be experienced by individuals who are recovering from problematic drug and alcohol use, including reduced consumption, fewer co-occurring health issues, improved family relationships and parenting skills, stable housing; participation in education and employment, and involvement in social and community activities.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
| Percentage reduction in daily drugs spend during treatment | People who are recovering from problematic drug use are likely to show reductions in the level of drug use and, for those who inject, a reduction in injecting. While this indicator is restricted to those in treatment it provides a robust indicator of treatment assisted recovery in an area. | Source: Service submissions to ISD Scottish Drug Misuse Database (SMR-25b)  
Frequency: Annual  
- Last: Dec 2012  
- Next: Dec 2013  
Breakdowns available:  
- National ☐  
- NHS Board ☐  
- Local Authority ☐  
- Other:  
  * No data available this year due to low levels of data completeness |
<p>| Reduction in the percentage of clients injecting in the last month during treatment |  |
| Proportion of clients who abstain from illicit drugs between initial assessment and 12 week follow-up |  |
| Proportion of clients receiving drugs treatment experiencing improvements in employment/ education profile during treatment | People who are recovering from problematic drug use are likely to show improvements in their wider well-being, including their social profile. While this indicator is restricted to those in treatment it provides a robust indication of treatment assisted recovery in an area. |  |</p>
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. CAPSM/FAMILIES</td>
<td><strong>Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances</strong>&lt;br&gt;This will include reducing the risks and impact of drugs misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.</td>
<td><strong>Rate of maternities recording drug use (three year rolling average)</strong>&lt;br&gt;A reduction in the number of maternities recording drug use means that fewer children are likely to be born into households where the mother is a drug user which, in turn, makes it less likely they will be affected by parental substance misuse.</td>
<td><strong>Source</strong>: ISD, SMR-02&lt;br&gt;<strong>Frequency</strong>:&lt;br&gt;• Last: April 2012 (data for 2004/05-2006/07 to 2007/08-2009/10)&lt;br&gt;• Next: April 2013 (data for 2010/11, 2011/12, 2012/13)&lt;br&gt;<strong>Breakdowns available</strong>:&lt;br&gt;• National ✗&lt;br&gt;• NHS Board ✓&lt;br&gt;• Local Authority ✗</td>
</tr>
<tr>
<td></td>
<td><strong>Rate of maternities recording alcohol use (three year rolling average)</strong>&lt;br&gt;A reduction in the number of maternities recording alcohol use means that fewer children are likely to be born into households where the mother misuses alcohol. Heavy alcohol use during pregnancy increases the risk of Foetal Alcohol Spectrum Disorder (FASD).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Number of Child Protection Case Conference where parental drug and alcohol abuse has been identified as a concern/risk</strong>&lt;br&gt;To provide an indication of number of children identified by local authorities as at significant risk due to parental drug and alcohol abuse.</td>
<td></td>
<td><strong>Source</strong>: Scottish Government Child Protection statistics&lt;br&gt;<strong>Frequency</strong>: Annual&lt;br&gt;• Last: March 2013 (2011/2 data)&lt;br&gt;• Next: March 2014&lt;br&gt;<strong>Breakdowns available</strong>:&lt;br&gt;• National ✗&lt;br&gt;• NHS Board ✓&lt;br&gt;• Local Authority ✗</td>
</tr>
<tr>
<td>Outcome</td>
<td>Indicators</td>
<td>Rationale for indicator</td>
<td>Source and availability</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
|         | Proportion of positive ABI screenings in ante-natal setting | Highlights the number of pregnant women where problematic drinking has been identified. Possible risks to baby and existing children. | **Source:** NHS Board  
**Frequency:** Annual  
- Last: Local data collection  
- Next: Local data collection  
**Breakdowns available:**  
- National  
- NHS Board  
- Local Authority |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
| 5. COMMUNITY SAFETY | Percentage of new clients at specialist drug treatment services who report funding their drug use through crime | Communities will be safer where there is less drug-related acquisitive crime and this should be reflected in fewer reports of crime-funded drug use by clients entering drugs treatment | Source: Service submissions to ISD Scottish Drug Misuse Database (SMR-25a)  
Frequency: Annual  
- Last: March 2013 (2011-12)  
- Next: March 2014 (2012-13)  
Breakdowns available:  
- National ☑  
- NHS Board ☐  
- Local Authority ☑ |
| | One year reconviction frequencies rate (per 100 offenders), for offenders given a Drug Treatment and Testing Order | Communities will be safer where drug-related reoffending is being successfully tackled. | Source: Scottish Government Reconviction Rates in Scotland  
Frequency: Annual  
- Last: 2012 (2009-10 cohort)  
- Next: Summer 2013 (2010-11 cohort)  
Breakdowns available:  
- National ☑  
- NHS Board ☐  
- Local Authority ☑ |
| | Number of cases of vandalism (or malicious mischief), breach of the peace, assault or anti-social behaviour per 1,000 population | Strong link between alcohol misuse and crime. Individuals, families and communities will benefit for a reduction in offences where alcohol is likely to be a contributory factor. | Source: Police data (Crimefile recording system and the STORM command and control system)  
Frequency:  
- Last: March 2012  
- Next: April 2013  
Breakdowns available:  
- National ☑  
- NHS Board ☐ |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Local Authority ✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other: Locus of offence is recorded so potential to identify other geographies. * Data may need to be derived at the local level</td>
</tr>
<tr>
<td></td>
<td>Number of Community Payback Orders issued where alcohol and drug treatment is required, and proportion that are successfully completed</td>
<td>Low level offenders are required to carry out their punishment in the community where they committed the crime. Ensures that offenders receive effective treatment for alcohol and drugs, the community also receives reparation for the offender's crimes. Proportion of Orders completed potentially more of an outcome measure.</td>
<td>Source: Scottish Court Service data&lt;br&gt;Frequency: Annual&lt;br&gt;  - Last: December 2012&lt;br&gt;  - Next: December 2013&lt;br&gt;Breakdowns available: National ✓&lt;br&gt;  - NHS Board □&lt;br&gt;  - Local Authority ✓</td>
</tr>
<tr>
<td></td>
<td>Proportion of victims of a crime who reported that the offender was under the influence of alcohol / drugs</td>
<td>Indication of how alcohol and drug related crimes are impacting on communities, and also whether communities are becoming safer.</td>
<td>Source: Scottish Crime and Justice Survey&lt;br&gt;Frequency: Bi annual&lt;br&gt;  - Last: October 2013&lt;br&gt;  - Next: October 2014&lt;br&gt;Breakdowns available: National ✓&lt;br&gt;  - NHS Board □&lt;br&gt;  - Local Authority ✓</td>
</tr>
</tbody>
</table>
### Outcome

6. **LOCAL ENVIRONMENT**

People live in positive, health-promoting local environments where alcohol and drugs are less readily available.

- Alcohol and drug misuse is less likely to develop and recovery from problematic use is more likely to be successful in strong, resilient communities where healthy lifestyles and wider well-being are promoted, where there are opportunities to participate in meaningful activities, and where alcohol and drugs are less readily available. Recovery will not be stigmatised, but supported and championed in the community.

### Indicators

- **Percentage of young people who have been offered drugs in the last year**
- **Percentage of people perceiving drug misuse or dealing to be very or fairly common in their neighbourhood**

### Rationale for indicator

- Young people are less likely to become involved in drug use when drugs are less readily available and this is likely to be reflected in reductions in the number of school pupils aged 13 and 15 who are offered drugs.
- Communities which are safer as a result of reductions in drug related offending and anti-social behaviour are likely to exhibit fewer signs of drug use and dealing which should be reflected in reductions in both experienced and perceived levels of drug misuse and dealing.

### Source and availability

| Source: Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) |
| Frequency: 2 years* |
| **Last**: Dec 2011 (2010 data) |
| **Next**: Oct 2014 (2013 data) |
| **Breakdowns available:** |
| National ☑ |
| NHS Board ☑ |
| Local Authority ☑* |

* Local authority and ADP level data being collected in 2013, a year earlier than originally planned.

| Source: Scottish Household Survey |
| Frequency: Annual |
| **Last**: Aug 2012 (for years 2009/10 – every LA reported every second year) |
| **Next**: Aug 2013 |
| **Breakdowns available:** |
| National ☑ |
| NHS Board ☑ |
| Local Authority ☑* |

* Larger local authorities each year, and every local authority over a two-year period.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
|         | Percentage of people spontaneously reporting 'alcohol abuse' as a negative aspect of their neighbourhood | Surveys demonstrate that alcohol is seen as the drug impacting most on Scotland, impacting on too many communities. A positive shift in this indicator is likely to improve individual quality of life and community cohesion. | Source: Scottish Household Survey Frequency: Annual  
- Last: October 2012  
- Next: August 2013  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
* Larger local authorities each year, and every local authority over a two-year period. |
|         | Number of premise and occasional licences in force per annum and the overall capacity of premise licences  
Number of new applications for premise or occasional licences, and proportion refused on the grounds of overprovision | Strong evidence that reducing the availability of alcohol is a key component of an effective alcohol strategy. | Source: Licensing Boards; routine returns of some data to the Scottish Government Frequency:  
- Last: April 2013/Local data collection  
- Next: April 2014/Local data collection  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority  
- Other:  
* Licensing statistics being collected (published April 2013) by the Scottish Government but some data will (e.g. capacity) need to be derived at the local level. |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
</table>
| 7. SERVICES | Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery | The number of screenings (using a validated screening tool) for alcohol use disorders delivered and the percentage screening positive with the breakdown of i) % eligible for ABI and ii) % eligible for referral to treatment services | Source: Health Boards  
Frequency: Annual  
- Last: Local data collection  
- Next: Local data collection  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority |
| | Services should offer timely, sensitive and appropriate support, which meets the needs of different local groups (including those with particular needs according to their age, gender, disability, health, race, ethnicity and sexual orientation) and facilitates their recovery. Services should use local data and evidence to make decisions about service improvement and redesign. | The number of alcohol brief interventions delivered in accordance with the HEAT Standard guidance | Source: Health Boards  
Frequency: Quarterly (to ISD); published annually (by ISD)  
- Last: June 2012  
- Next: June 2013  
Breakdowns available:  
- National  
- NHS Board  
- Local Authority (ADP delivery to be collected from 2012/13) |
| | Percentage of clients waiting more than three weeks between referral to a specialist drug and alcohol service and commencement of treatment | Offering person-centred support for recovery from drug and alcohol misuse requires that people are able to access support when they require it. This will be reflected in the reduction in the time people have to wait for this support. | Source: Service submissions to ISD  
Drug and Alcohol Treatment Waiting Times Database  
Frequency: Quarterly  
- Last: Mar 2013 (Oct-Dec 2012 data)  
- Next: June 2013 Jan – Mar 2013 data  
Breakdowns available:  
- National  
- NHS Board |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Rationale for indicator</th>
<th>Source and availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of treatments drug service clients receive at 3 month and 12 month follow-up (and annually after that)</td>
<td>Highlights the range of services available to client in each ADP at key stages of recovery.</td>
<td><strong>Source:</strong> Service submissions to <em>ISD Scottish Drug Misuse Database</em> (SMR-25b)&lt;br&gt;<strong>Frequency:</strong> Annual&lt;br&gt;- <em>Last:</em> Dec 2012&lt;br&gt;- <em>Next:</em> Dec 2013&lt;br&gt;<strong>Breakdowns available:</strong>&lt;br&gt;- National *&lt;br&gt;- NHS Board <em>&lt;br&gt;- Local Authority ⚫&lt;br&gt;</em> No data available this year due to low levels of data completeness</td>
</tr>
</tbody>
</table>
Possible Local Indicators

Local indicators are those which are specific to a particular ADP and their local needs and priorities, and are not at the moment robustly collected at a national level. These local indicators could be supplemented by a range of contextual and qualitative information. They are measures of local practice, particularly in regards to local licensing and policing policy. It would be helpful for ADPs to share any locally-specific indicators that could potentially be worked-up into consistent, nationally-available indicators in the future.

Examples of local indicators include:

**Health**
- Number of times naloxone has been used by ambulance staff and A&E

**Recovery**
- Proportion of clients who reported increase in STAR/ARC (or other recovery outcomes tool) score after attending service for 3 months

**Families**
- Number of contacts with Scottish Families Affected By Drugs helpline, and reasons for contact
- Number of cases of domestic violence

**Community Safety**
- Rates of drink, driving, drunkenness and drinking in a designated place
- Accidental dwelling fires where impairment due to suspected alcohol/drugs use was a contributory factor
- Number of test purchasing visits and the proportion failed

**Services**
- Proportion of alcohol and drug services with Investors in People Award (or equivalent)
- Proportion of services where an EQIA had been carried out in the last 3 years
- Proportion of services where an assessment for the National Quality Standards for Substance Misuse Services has been carried out in the last 12 months
- Demographic breakdown of users of services (by gender, age, race, disability and sexual orientation)
- Pathways of different drug services client groups (age, gender, health and type of drug use) as they progress through treatment
- Number of naloxone awareness sessions carried out in the last 12 months in ADP area