Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

New Strategic Direction for Alcohol and Drugs

Phase 2

2011-2016

A Framework for Reducing Alcohol and Drug Related Harm in Northern Ireland

December 2011

Contents

1 Introduction

1.1 Alcohol and drug misuse, and their related harms, cost our society hundreds of millions of pounds every year. However, this financial burden can never fully describe the full impact that substance misuse has on many vulnerable individuals, including children and young people, families, and communities in Northern Ireland. Alcohol and drug misuse have therefore been identified as significant public health and social issues in Northern Ireland over many years, and they continue to be a key priority.

1.2 In 2005 the Department of Health, Social Services, and Public Safety (DHSSPS) led the development of a cross-sectoral strategy that sought to reduce the harm related to both alcohol and drug misuse in Northern Ireland. DHSSPS launched this strategy, entitled the *New Strategic Direction for Alcohol and Drugs* (NSD), in 2006.

1.3 Originally, the NSD had a five-year life span. However, following discussion at the NSD Steering Group (the group which oversees the ongoing policy development and delivery of the Strategy), it was agreed that despite significant progress, five years allowed a limited amount of time for a public health strategy to be embedded and, particularly, to change culture and behaviours.

1.4 It was agreed that, rather than undertaking a full new strategic development process, the existing NSD would be reviewed, revised, and extended until 2016. This decision was taken to ensure a consistent approach on the issue

over a ten-year period, and to ensure that resources continue to be directed at front-line services, programmes, and interventions. It also allowed the NSD to reflect new trends, and re-direct effort to where it is most needed or to where new issues/concerns are emerging.

1.5 This document is the outcome of that work, and sets the policy direction for reducing the harm related to alcohol and drug misuse across Northern Ireland for the period October 2011 – October 2016.

2 Background to the Development and Delivery of the NSD

NSD Development

2.1 Since 1986, there have been a number of Government initiatives to develop and implement a strategic response to alcohol and drug misuse. Initially there were separate strategies for Alcohol (2000) and Drug (1999) misuse, however in May 2001 the Model for the Joint Implementation of the Drug and Alcohol Strategies (JIM) was launched.

2.2 In 2004 following a review of the two strategies and of the JIM, there was agreement that a *New Strategic Direction for Alcohol and Drugs* (NSD) needed to be developed to tackle the harm related to these issues in Northern Ireland. DHSSPS began work to develop the NSD in April 2005 and followed a six-stage approach to produce a fully integrated, inclusive and co-ordinated strategic direction for addressing alcohol and drug misuse in Northern Ireland over the period 2006-2011. The intention was to combine a clear regional vision with local and community aspirations.

2.3 There was a comprehensive and inclusive engagement and consultation element to the original NSD's development. DHSSPS established ten special interest groups to look at specific issues such as workforce development, young people, and service users. In addition, a range of bi-lateral discussions, seminars, workshops and meetings was held to give key stakeholders the opportunity to shape the development of the NSD.

2.4 Following a formal public consultation during February/March 2006, DHSSPS published the original NSD in May 2006, and its implementation began in October 2006.

NSD Implementation

2.5 The Health Minister established the overarching NSD Steering Group in 2006. The Chief Medical Officer chairs this group and the Health Minister attends meetings as appropriate. The primary role of the Steering Group is to oversee and drive forward work to achieve the outcomes contained in the NSD. It also considers and makes recommendations in respect of policy and action on relevant issues raised by members, and those teams and groups who report to it.

2.6 Membership of the Steering Group includes relevant professionals, statutory bodies and agencies, Government Departments, and voluntary/community sector representatives.

Advisory Groups

2.7 The Department established four advisory groups to provide advice and policy guidance on specific priorities contained within the NSD, and to inform the work of the NSD Steering Group. These groups were:

- Children, Young People and Families;
- Treatment and Support
- Binge Drinking (*now* referred to as the Alcohol Advisory Group); and
- Law and Criminal Justice.

2.8 The function of each group is to provide advice that draws on expertise in relation to the individual groups' strategic priorities and needs of specific strategic areas. Each group advises, commends and provides informative feedback on the NSD and its outcomes, and on relevant issues related to its own specific remit.

2.9 As part of the changes to the Health and Social Care system, and the taking forward of the Bamford Review, it was agreed that the work of the previous Treatment and Support Advisory Group would be carried out by the Substance Misuse Group established as part implementation of the Bamford Review. This group reports to the NSD Steering Group through its Chair.

2.10 DHSSPS also established a Liaison Group consisting of the Chairs of each advisory group along with the senior co-ordinators from the Public Health Agency (PHA), plus representatives from the Public Health Information and Research Branch and the Health Development Policy Branch within the DHSSPS. This group meets on a regular basis and helps to monitor overall progress against the NSD's targets and outcomes, and integrates and co-ordinates relevant issues.

Local Delivery

2.11 The NSD clearly recognised that local assessment of need, and the development and delivery of services, programmes and initiatives to meet these needs, is paramount to address this issue effectively. In support of this the local Drug and Alcohol Co-Ordination Teams (DACTs), which operated in each of the legacy Health and Social Service Board areas, developed local action plans. These action plans match and reflect NSD priorities, and support the implementation of the NSD at the local level. In order to deliver on these Local Action Plans, the PHA tendered for the services they require in their respective areas, enabling all organisations to bid to provide these services.

2.12 The PHA has established local delivery structures to oversee the implementation of their local action plans.

Community Involvement

2.13 From the very outset, the development of the NSD has benefited from the input and expertise of the voluntary and community sector. This was facilitated through focus group discussions, the Independent Sector Forums, and representation on the NSD Steering Group and the related Advisory Groups.

Links to Other Government Strategies

2.14 The NSD also contributes to, and is supported by, a wide range of other Government Strategies, such as the forthcoming Community Safety Strategy, Neighbourhood Renewal, Investing for Health, Accident Prevention, etc. This integration of strategies is supported by reciprocal involvement in relevant steering groups, and though the overarching lead given by Ministerial Group on Public Health. This enables more effective use of resources and a range of strategies to work together to achieve Government's overarching targets.

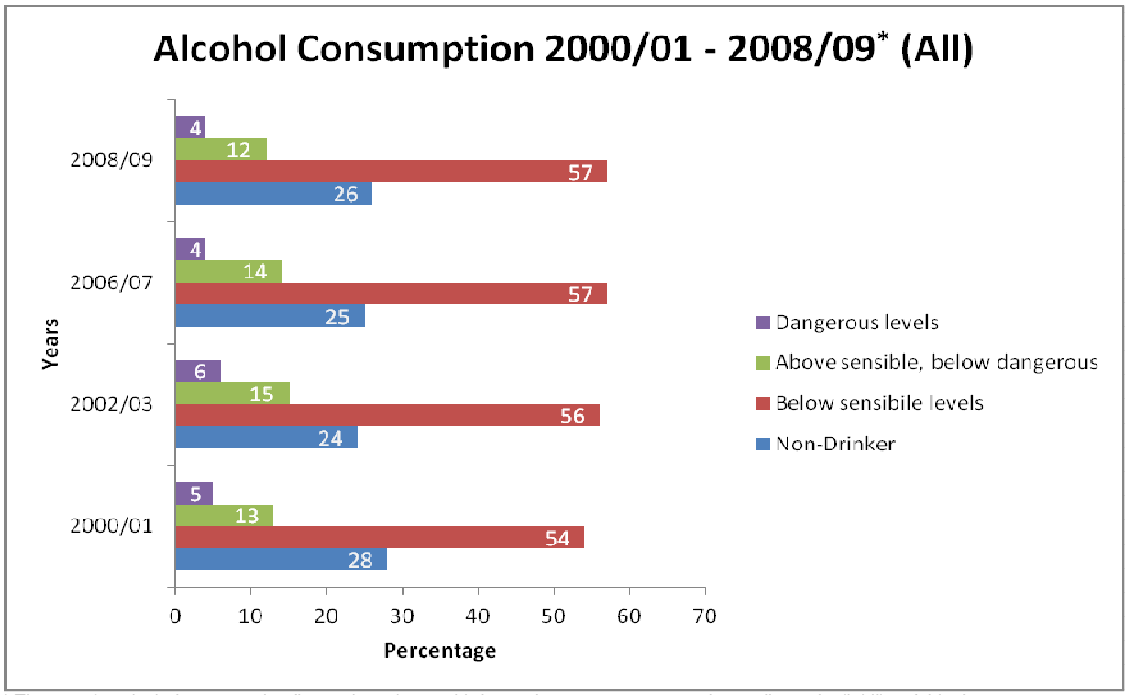
3 Current Position

3.1 The following Chapter sets out the current overarching position in relation to the prevalence of alcohol and drug misuse in Northern Ireland. This is only the outline position, and much more detailed information is available on prevalence and other related indicators (such as treatment, crime, etc.) in the detailed NSD Update Report which is available at: http://www.dhsspsni.gov.uk/nsd_update_report_-_april_2010.pdf

Alcohol

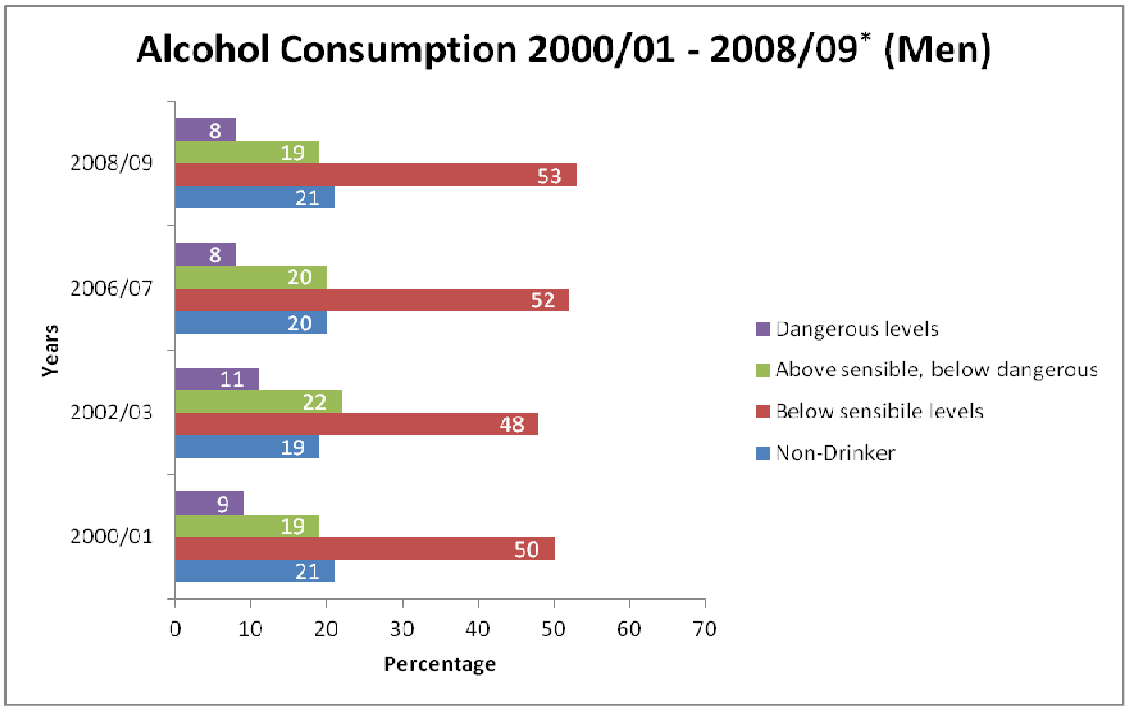
3.2 An estimate undertaken in 1998 placed the social cost of alcohol related harm in Northern Ireland at £770m. A further piece of work published by the Department in 2010 (available online at: http://www.dhsspsni.gov.uk/social_costs_of_alcohol_misuse_200809.pdf) estimated that the cost of alcohol misuse could be as much as £900 million each year. It should be noted that the more recent figures cannot be directly compared to the 1998 figures as the methodology has changed over time.

3.3 According to the Continuous Household Survey, alcohol consumption has remained relatively constant since 2000/01, although, in recent years, we have seen a slight decrease in the proportion of people drinking above sensible levels and at dangerous levels.



* The 2004/05 alcohol consumption figures have been withdrawn due to concerns over the quality and reliability of this data.

3.4 There are differences in the level of consumption between men and women, as shown by the graphs below, with men more likely to consume higher levels of alcohol than women.



* The 2004/05 alcohol consumption figures have been withdrawn due to concerns over the quality and reliability of this data.

* The 2004/05 alcohol consumption figures have been withdrawn due to concerns over the quality and reliability of this data.

3.5 Further information on the Continuous Household Survey is available on the following website: http://www.csu.nisra.gov.uk/survey.asp141.htm. From 2010/11 onwards, the Health Survey Northern Ireland will be the source of statistics on alcohol consumption.

3.6 The results from the Adult Drinking Patterns Survey showed that almost three quarters of survey respondents in both 2008 (72%) and 2005 (73%) reported drinking alcohol. A larger proportion of males than females in 2005 and in 2008 reported that they drank alcohol (74% compared to 70% in 2008 and 77% compared to 70% in 2005).

3.7 In addition, just over four fifths of respondents who had consumed alcohol in the week prior to the survey exceeded the recommended daily limits in both 2008 (81%) and 2005 (82%). The current recommended daily limits of alcohol are four or more units for males and three of more units for females. Similar results were found in both years of the survey, with there being no

statistically significant difference in the proportion of males and females exceeding the recommended daily limits in the week prior to the survey (79% of males and 83% of females in 2008 and 81% of males and 83% of females in 2005).

3.8 Levels of alcohol consumption in Northern Ireland are banded into weekly guidelines for sensible drinking. On a weekly basis, males drinking 21 units or less are considered to be within sensible limits, those drinking between 22 and 50 units are considered to be above sensible but below dangerous and those drinking 51 units and above are drinking at dangerous levels. The sensible limit for females is 14 units per week, the above sensible and below dangerous level is between 15 and 35 units and dangerous are 36 units and above. There was a statistically significant increase in the proportion of respondents who had drank alcohol in the week prior to the survey drinking within the sensible weekly guidelines from 71% in 2005 to 76% in 2008. While, there was a significant decrease in the percentage of respondents drinking above sensible and below dangerous levels from 23% in 2005 to 19% in 2008. Similar proportions of respondents were drinking at dangerous levels in both 2005 and 2008 (6% and 5%, respectively).

3.9 One feature often ascribed to Northern Ireland drinking is that of 'binge drinking'. This is a colloquial expression describing the consumption of several drinks/units in a single or prolonged session. It is also true that the bulk of drinking takes place on Fridays, Saturdays and Sundays. According to the Adult Drinking Patterns Survey (2008) almost one-third (32%) of respondents who had drank in the week prior to the survey had engaged in at least one binge drinking session in that week – this is a statistically significant decrease from 38% in 2005.

3.10 In 2005, males (43%) were more likely than females (33%) to be classified as binge drinkers. By 2008, these figures show 35% of males and 29% of

females. The percentage of male binge drinkers therefore show a pronounced decrease between 2005 and 2008, whereas there was no significant difference in the proportions of female binge drinkers.

3.11 This survey has been repeated in 2011, with the fieldwork undertaken from the beginning of May to the beginning of July 2011 – the results will be published by January 2012.

3.12 There also remains a concern about the high proportion of young people who have drunk alcohol and in particular the proportion of young people reporting having been drunk. The Young Persons' Behaviour and Attitudes Survey found the proportion of respondents aged 11-16 who said that they had ever taken an alcoholic drink (not just a taste or a sip) significantly decreased from 60% in 2003 to 55% in 2007.

3.13 The Young Persons' Behaviour and Attitudes Survey also reports a statistically significant decrease in the proportion of young people (aged 11-16) who reported getting drunk from 33% in 2003 to 30% in 2007.

3.14 The Secondary Analysis of the 2010 Young Persons' Behaviour and Attitudes Survey (Drugs, Solvents, Alcohol and Smoking) is due to be published by January 2012.

Drug Misuse

3.15 Drug misuse, compared to alcohol, can vary in respect of scale, pattern and intensity. Drug misuse in Northern Ireland over the last 20 years has reflected the changing nature of illicit drug use. The other point about drug misuse, as with alcohol misuse, is that people inevitably make comparisons with other countries and regions. In Northern Ireland, this has been particularly the case with opiate misuse, and more recently with cocaine use. In fact, Northern Ireland's pattern of drug misuse has probably mirrored that in Great Britain and the Republic of Ireland in terms of recreational use,

but has not seen the same intensity of problem drug misuse, especially in respect of heroin and crack cocaine.

3.16 Figures provided by prevalence surveys show that cannabis remains the main illegal drug of choice, and the most commonly reported on by treatment services. In the early 1990s, an emerging 'rave' or club scene was observed and commented on, and ecstasy, LSD and speed became drugs that were of some concern, especially among young people. At the same time, there was a growing acknowledgement of localised heroin use in certain parts of Northern Ireland, and public concern about such use in these areas was noticeable. Particular note should also be taken of the prevalence of blood borne viruses among the injecting drug user population.

3.17 This Northern Ireland trend seemed to grow slowly into the early 21st century. Since then the rise in drug misuse among young people seems to have slowed, and there has not been an explosion in opiate use as was seen in Dublin and parts of Great Britain at the end of the 1990s. However cannabis use is still of some concern and it would also appear that there has been an increase in the use of cocaine as exemplified by increased seizures, treatment referral figures and anecdotal evidence.

3.18 The Drug Prevalence Survey highlighted that in Northern Ireland, lifetime use of any illegal drugs increased from 20% in 2002/03 to 28% in 2006/07 among all adults aged 15-64 years. The lifetime prevalence rate for any illegal drug increased for both males (from 27% to 34%) and females (from 13% to 22%). Last year use of any illegal drugs increased from 6% in 2002/03 to 9% in 2006/07 among all adults aged 15-64 years, this increased for both males (from 10% to 14%) and females (from 3% to 5%).

3.19 There was no significant difference in the last month use of any illegal drugs between 2002/03 (3%) and 2006/07 (4%) among all adults aged 15-64

years. Although, there was a significant increase in females reporting they had used any illegal drugs in the last month from 1% in 2002/03 to 2% in 2006/07.

3.20 The most recent prevalence figures (2006/07) over a range of drugs are set out in the tables below:

Table 2.1: Northern Ireland – Lifetime Prevalence (%) 2006/7

Drug	All Adults 15-64	Males	Females	Young Adults 15-34	Older Adults 35-64	15-24	25-34	35-44	45-54	55-64
Any illegal drugs*	28.0	33.9	22.1	40.2	19.3	38.4	42.1	28.1	19.6	6.4
Cannabis	24.7	30.1	19.3	35.0	17.3	33.0	37.3	24.7	17.9	6.2
Heroin	0.5	0.6	0.4	0.6	0.4	0.6	0.5	0.2	0.9	0.2
Methadone	0.1	0.1	0.1	0.1	0.1	0.0	0.2	0.2	0.0	0.0
Other Opiates**	20.2	17.4	23.0	14.4	24.7	8.4	21.1	26.9	23.8	22.6
Cocaine (total including crack)	5.2	7.4	2.9	9.1	2.3	7.7	10.8	4.3	1.4	0.5
Crack	0.4	0.4	0.4	0.6	0.3	0.6	0.5	0.6	0.0	0.0
Cocaine Powder	5.1	7.3	2.9	9.1	2.2	7.7	10.8	4.1	1.4	0.5
Amphetamines	5.8	7.3	4.4	9.1	3.4	5.7	12.9	6.2	2.1	1.2
Ecstasy	7.7	9.9	5.5	14.3	2.9	12.0	16.9	6.2	0.8	0.5
LSD	6.6	9.7	3.5	9.4	4.5	4.6	14.9	7.9	2.9	1.8
Magic mushrooms	6.7	11.2	2.4	8.3	5.6	4.4	12.6	11.3	3.7	0.0
Solvents	3.5	5.1	2.0	5.5	2.1	4.0	7.1	4.0	1.2	0.7
Poppers***	7.8	10.9	4.9	14.0	3.4	11.6	16.7	6.8	1.7	0.6
Sedatives & Tranquillisers	20.2	18.1	22.3	11.7	26.5	10.1	13.6	22.9	30.5	26.7
Anti-depressants	21.0	13.4	28.4	13.6	26.6	9.8	17.8	26.0	28.8	24.8

Table 2.2: Northern Ireland – Last Year Prevalence (%) 2006/7

Drug	All Adults 15-64	Males	Females	Young Adults 15-34	Older Adults 35-64	15-24	25-34	35-44	45-54	55-64
Any illegal drugs*	9.4	13.7	5.2	17.3	3.7	19.0	15.5	5.8	3.1	1.4
Cannabis	7.2	10.3	4.1	12.4	3.3	13.7	11.0	5.5	2.5	1.3
Heroin	0.1	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.4	0.0
Methadone	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Opiates**	8.4	8.0	8.7	7.1	9.3	4.6	9.9	9.2	9.4	9.4
Cocaine (total including crack)	1.9	2.8	0.9	3.5	0.7	2.3	5.0	1.2	0.5	0.0
Crack	0.0	0.1	0.0	0.0	0.1	0.0	0.0	0.2	0.0	0.0
Cocaine Powder	1.9	2.8	0.9	3.5	0.7	2.3	5.0	1.2	0.5	0.0
Amphetamines	1.0	1.1	0.9	1.7	0.4	1.9	1.5	1.2	0.0	0.0
Ecstasy	1.8	2.4	1.2	3.4	0.6	3.7	3.1	0.9	0.2	0.5
LSD	0.2	0.2	0.2	0.0	0.3	0.0	0.0	0.9	0.0	0.0
Magic mushrooms	0.2	0.1	0.3	0.5	0.0	0.6	0.4	0.0	0.0	0.0
Solvents	0.2	0.3	0.1	0.4	0.1	0.3	0.4	0.2	0.0	0.0
Poppers***	1.3	2.3	0.3	2.7	0.2	3.6	1.7	0.0	0.0	0.6
Sedatives & Tranquillisers	9.2	8.2	10.2	4.6	12.6	3.4	6.0	9.2	16.5	12.8
Anti-depressants	9.1	5.8	12.4	5.8	11.7	4.1	7.7	9.6	16.3	9.0

Table 2.3: Northern Ireland – Last Month Prevalence (%) 2006/7

Drug	All Adults 15-64	Males	Females	Young Adults 15-34	Older Adults 35-64	15-24	25-34	35-44	45-54	55-64
Any illegal drugs*	3.6	4.9	2.4	5.9	2.0	6.3	5.5	3.0	1.8	0.7
Cannabis	2.6	3.7	1.6	3.7	1.8	3.5	4.0	3.0	1.4	0.7
Heroin	0.1	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.4	0.0
Methadone	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Opiates**	4.9	5.1	4.7	3.6	5.8	1.7	5.7	5.1	6.4	6.3
Cocaine (total including crack)	0.3	0.7	0.0	0.6	0.2	0.0	1.2	0.0	0.5	0.0
Crack	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine Powder	0.3	0.7	0.0	0.6	0.2	0.0	1.2	0.0	0.5	0.0
Amphetamines	0.3	0.4	0.2	0.3	0.3	0.3	0.4	0.7	0.0	0.0
Ecstasy	0.8	0.8	0.7	1.4	0.3	2.2	0.5	0.3	0.0	0.5
LSD	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.2	0.0	0.0
Magic mushrooms	0.0	0.1	0.0	0.1	0.0	0.0	0.2	0.0	0.0	0.0
Solvents	0.1	0.2	0.0	0.2	0.0	0.0	0.4	0.0	0.0	0.0
Poppers***	0.3	0.6	0.0	0.7	0.0	0.9	0.6	0.0	0.0	0.0
Sedatives & Tranquillisers	7.1	5.7	8.4	2.3	10.7	1.1	3.6	7.8	13.0	12.0
Anti-depressants	7.5	4.2	10.7	4.2	10.0	1.5	7.1	8.0	13.9	8.2

Note: All figures are rounded to the nearest decimal place

* For this study, "any illegal drugs" refers to amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

** A change in the measurement of 'other opiates' occurred in the 2006/7 survey. Please see Methodology section for further details.

*** Poppers ie amyl or butyl nitrite.

3.21 Another aspect or feature of drug use in Northern Ireland is the misuse of 'over-the-counter' (OTC) medicines and prescribed drugs, often, but not solely, by older people. In addition, volatile substance misuse remains a perennial issue, especially among young people.

3.22 The Drug Prevalence Survey 2006/07 showed that about one-fifth of adults (aged 15-64 years) in Northern Ireland had used sedatives and tranquillisers (20%) and anti-depressants (21%) at some point in their lifetime. Nearly one in ten respondents had used them in the last year; sedatives and tranquillisers (9%) and anti-depressants (9%), and in the last month 7% of respondents had used sedative and tranquillisers and 8% had used anti-depressants. Females reported higher prevalence rates than males for lifetime and last month use of sedative and tranquillisers and had higher prevalence across all three-time periods for anti-depressants.

3.23 Comparative figures for Ireland are as follows: lifetime prevalence of 11% for sedatives and tranquillisers and 9% for anti-depressants; last year prevalence of 5% and 4% respectively; and last month prevalence 3% and 3% respectively.

3.24 In 2006/07, nearly one in twenty respondents (4%) reported having ever used solvents, with 0.2% of respondents having used them in the last year and 0.1% in the last month. The lifetime prevalence rate for solvents was 5% for males and 2% for females, 5% for young adults (aged 15-34) and 2% for older adults (aged 35-64). Similar results were found in both the 2002/03 and the 2006/07 surveys for solvent use, although there was an increase in lifetime use among older adults (aged 35-64) and more specifically those aged 35 to 44.

3.25 More information is available on the Drug Prevalence Survey via the following link: http://www.dhsspsni.gov.uk/drug_prevalence_survey_2006-07__bulletin_6.pdf. First results from the 2010/11 Drug Prevalence Survey were published on 22 November 2011.

Young People's Behaviour and Attitude Survey

3.26 The Young Persons' Behaviour and Attitudes Survey collects information on drug misuse among 11-16 year olds in Northern Ireland. Among all respondents, lifetime use of any drugs or solvents decreased from 23% in 2003 to 19% in 2007. Since 2003, lifetime use of any drugs or solvents decreased among male pupils (from 26% to 19%), with no significant difference in lifetime prevalence among female pupils (20% in 2003 and 19% in 2007).

3.27 Similarly, there was a decrease in last year use of any drugs or solvents from 18% in 2003 to 13% in 2007. Since 2003, last year use of any drugs or

solvents decreased among male pupils (from 20% to 14%) and among female pupils (from 16% to 13%).

3.28 Among all respondents, last month use of any drugs or solvents decreased from 12% in 2003 to 7% in 2007. Since 2003, last month use of any drugs or solvents decreased among male pupils (from 13% to 8%) and among female pupils (from 10% to 7%).

Treatment

3.29 The Drug Misuse Database (DMD) collects information on problem drug users presenting to treatment services for the first time, or for the first time in six months or more, that gave consent for their information to be included on the database. In 2010/11, 2,593 individuals presented for treatment, in which 72% were males and 28% were female. The most frequently reported main drugs of misuse (the drug that was causing the individual the most problems when they presented to the treatment service) were cannabis (42%), benzodiazepines (23%), mephedrone/methedrone (8%), and heroin (7%).

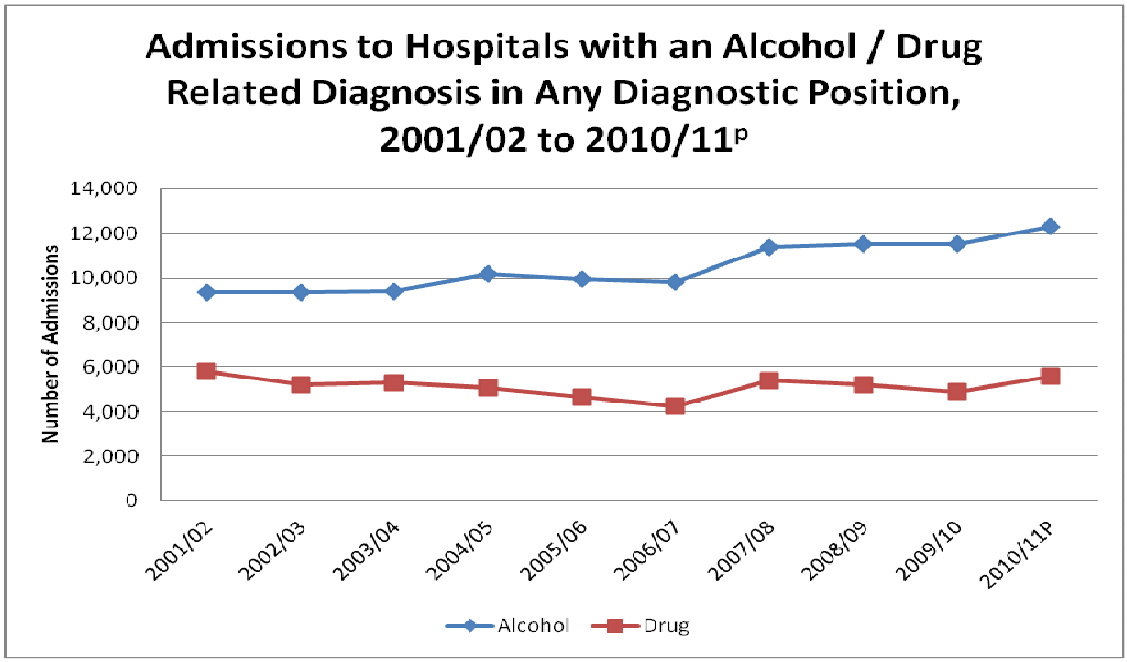
3.30 There was considerable variation between male and female clients and the main drug of misuse reported. Just under a half (49%) of male clients reported cannabis as their main problem drug, compared to approximately one fifth (19%) of female clients. In addition, a larger proportion of male clients (8%) than female clients (3%) reported cocaine (including crack cocaine) as their main problem drug. In contrast, a larger proportion of female clients (37%) than male clients (12%) reported benzodiazepines as their main problem drug.

3.31 In 2010, the third Census was conducted of statutory and non-statutory drug and alcohol treatment services in Northern Ireland. The results showed that on 01 March 2010 there were 5,846 individuals in treatment for drug and/or

alcohol misuse. Of these 57% were in treatment for alcohol only misuse, 22% were in treatment for drug only misuse and 21% were in treatment for both alcohol and drug misuse. The majority of individuals in treatment were males (73%), with just over one quarter being female (27%). The next Census of treatment services in Northern Ireland is due to take place on 01 March 2012.

Hospital Admissions

3.32 During the last ten years, the number of admissions to hospital with an alcohol relating diagnosis has increased by 31.1% from 9,375 admissions in 2001/02 to 12,291 in 2010/11[P]. In contrast the number of drug related admissions to hospital have decreased by 3.9% over the ten year period 2001/02 to 2010/11[P] from 5,813 to 5,587. However, it should be noted that when comparing the last five years the number of drug related admissions increased from 4,257 in 2006/07 to 5,587 in 2010/11[P] representing an increase of 31.2%.

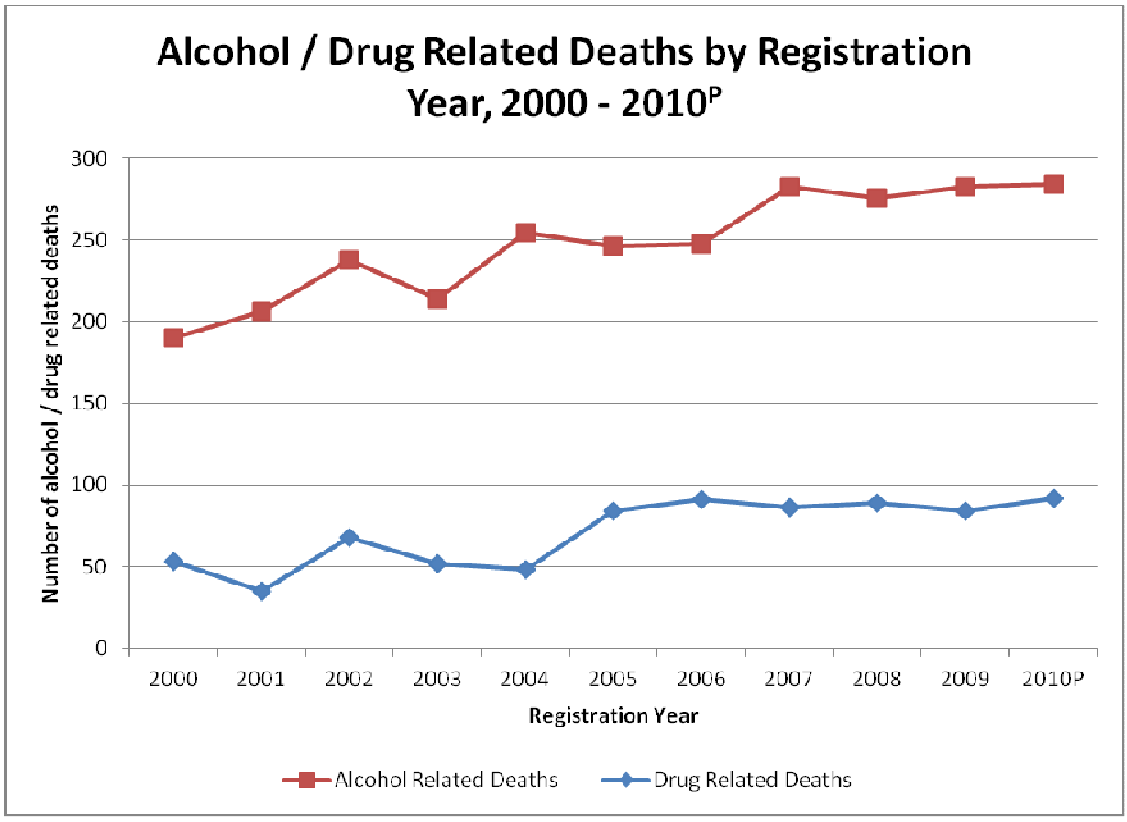


Source: Hospital Inpatient System, Hospital Information Branch (DHSSPS)
[P] Data relating to the 2010/11 year is provisional and maybe subject to changes, see Annex C for notes.

Deaths

3.33 In 2010[P], there were 284 alcohol related deaths this is similar to the number registered in 2009 when 283 alcohol related deaths were registered. The number of alcohol related deaths has risen by around 50% over the last decade and 2010 saw the highest number of alcohol related deaths on record.

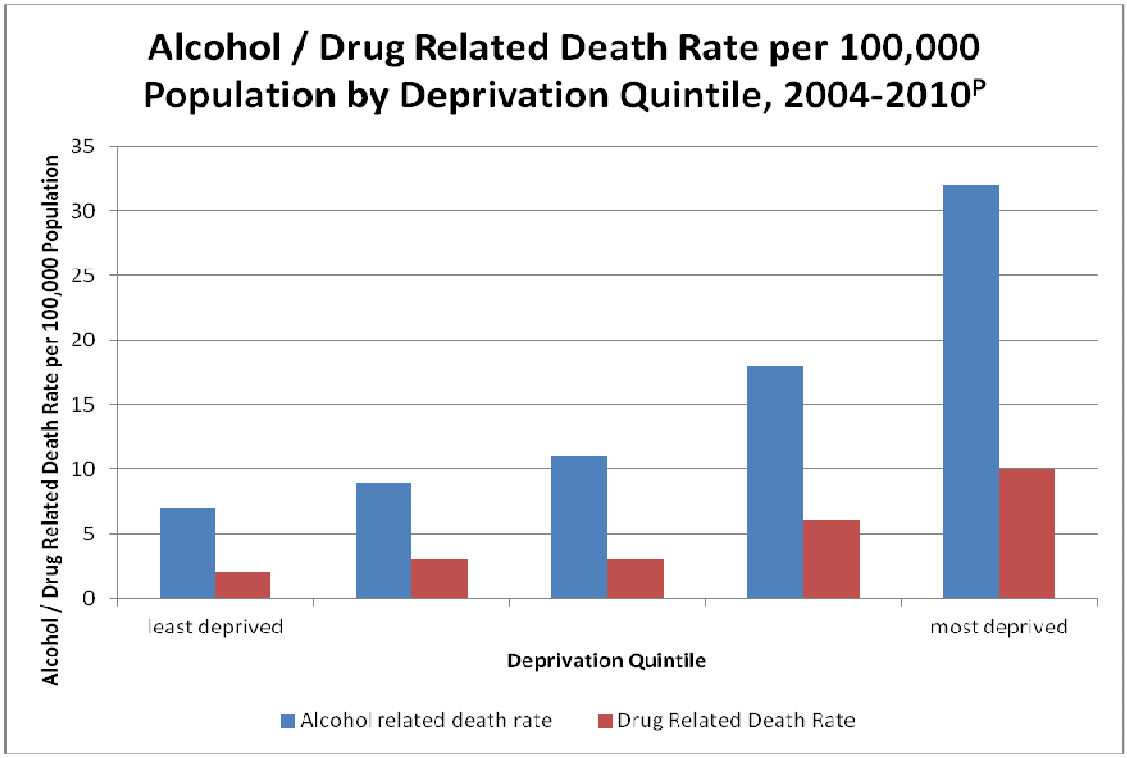
3.34 In 2010[P], there were 92 drug related deaths where the cause of death was due to either legal or illegal drugs. This is an increase on the 84 drug related deaths registered in 2008. The number of drug related deaths registered has doubled over the last decade.



Source: General Register Office, Demography and Methodology Branch (NISRA)
[P] 2010 statistics are provisional until the publication of the 2010 Annual Report of the Registrar General

3.35 There are significantly higher numbers of drug and alcohol related deaths in areas of deprivation across Northern Ireland. People living in the most

deprived areas are five times more likely to die from a drug related death and five times more likely to die from an alcohol related death than those in the least deprived areas. Further breakdown of information on alcohol and drug related deaths is available via the following link: http://www.nisra.gov.uk/demography/default.asp30.htm



Source: General Register Office, Demography and Methodology Branch (NISRA)
P 2010 statistics are provisional until the publication of the 2010 Annual Report of the Registrar General

Impact Measurement Tool

3.36 In 2005, DHSSPS commissioned Matrix Research & Consultancy and ASM Horwath to design and develop a tool to be used in Northern Ireland to assess the effectiveness of alcohol and drug service providers that received funding from the NSD. The consultants developed the Impact Measurement Tool (IMT) – there are seven different versions of the tool (typologies) depending on the type of service the project provides. A summary of the 2009/10 IMT results for each typology is presented below.

Adult Treatment

3.37 The results showed that 1,360 adults received treatment or aftercare for alcohol or drug misuse in 2009/10. In order to assess the outcomes of treatment an initial assessment and at least one review must have been completed, these were completed for under two-fifths (38%) of all individuals in treatment.

3.38 Of clients that had received both an initial assessment and at least one review, the majority experienced a positive change in their situation between their assessment and their latest review across the following domains: personal responsibility, social contact/network, managing physical health, mental and emotional health, daily lifestyle, relationships, alcohol consumption and drug use. The other two domains are crime/community safety and accommodation in which the majority of clients experienced no change in their situation.

Barnardo's (PHAROS Service)

3.39 In 2009/10, 58 families received treatment from Barnardo's Pharos service. Over four in five (84%) of these families had received an initial assessment and at least one review. Across all six domains, the majority received a positive impact in terms of their situation. The domains are parental responsibility, family lifestyle, family relationships, safeguarding, substance misuse, and family social contact/networks.

Education and Prevention

3.40 In Northern Ireland 981 drug and alcohol training events were carried out in 2009/10, in which 12,599 individuals attended. Some of these training events took places in school while other events were specifically targeted at vulnerable children. As baseline information was not completed for three-fifths (60%) of the training events no impact assessment can be carried out.

Enabling

3.41 In 2009/10, 23,863 individuals attended 1,210 community engagements.

Workforce

3.42 There were 156 workforce development courses in Northern Ireland in 2009/10 where 1,899 individuals attended. Due to the amount of missing information at the review stages, it has not been possible to comment on the overall impact of these courses.

Young Persons Treatment

3.43 The results on young people in treatment are presented in two sections, those who are directly affected and those who are indirectly affected by substance misuse.

3.44 In 2009/10 there were 706 young people in treatment for their substance misuse and just under half (46%-47%) received both an initial assessment and at least one review. The results showed that the majority of these young people had a positive experience across four of the six domains: mental and emotional health, affect on work and studies, family relationships, and progress on problems.

3.45 There were fewer young people (144) in treatment for indirect substance misuse (hidden harm). The majority of these clients had a positive experience in the same four domains as those above.

Source and next available updates of data

3.46 Updates will be available soon for the majority of the statistics in this section - please see list below as to when the updates are available (all will be available at http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm)

- Alcohol consumption will be available from the First Results of the Health Survey Northern Ireland - *October 2011*
- All Ireland Drug Prevalence Survey (Bulletin 1) – *22 November 2011*
- Adult Drinking Patterns Survey (2010) - *December 2011*
- Secondary Analysis of the Young Persons' Behaviour and Attitudes Survey (2010) - *January 2012*
- Census of Drug and Alcohol Treatment Services in Northern Ireland: 1st March 2012 – *June 2012*

4 The NSD Review, Emerging Issues of Concern, and the NSD Phase 2 Consultation

4.1 As set out in Chapter 1, the original NSD had a five-year life span (covering the period 2006 to 2011). During 2009 and 2010, discussions were undertaken by the NSD Steering Group, the Advisory Groups, the Health and Social Care sector, and other key stakeholders on how these issues could be taken forward once the NSD ended.

4.2 It was initially agreed that an update document be developed to see how effective the NSD was in terms of delivering on its aims and objectives. This document (published in 2010 and available online at http://www.dhsspsni.gov.uk/nsd_update_report_-_april_2010.pdf) looked particularly at the progress against the NSD's key priorities, completion of the NSD outcomes, and progress against its indicators.

4.3 Overall, the update was very positive, and it highlighted much progress in key areas. It also raised a number of areas where not as much progress had been made as originally anticipated and which would require further work. It also highlighted that a number of the strategic drivers had changed during the period 2006-2011, and that a number of new issues had emerged that were not originally a high priority within the NSD.

4.4 The NSD Steering Group acknowledged that significant progress had been made, but it also recognises that the time span for the original NSD allowed a limited amount of time for a public health strategy to be embedded and, particularly, to change culture and behaviours.

4.5 Accordingly it was agreed that, rather than undertaking a full new strategic development process, the existing NSD (in light of the update document) would be reviewed, revised, and extended until 2016. This decision was taken to ensure a consistent approach on the issue over a ten-year period, and to ensure that resources continue to be directed at front-line services, programmes, and interventions.

4.6 This process would also allow the NSD Phase 2 to reflect new trends, and re-direct effort to where it is most needed or to where new issues/concerns are emerging.

Emerging Issues

4.7 As highlighted above, since the publication of the original NSD a number of issues had emerged – and these issues now have a greater prominence in the NSD Phase 2. These emerging issues were identified, noted and considered by the NSD Steering Group and the relevant Advisory Groups. This process was also informed by the Independent Sector Forums, the Advisory Council on the Misuse of Drugs, the British-Irish Council Drug Misuse Sectoral Group, and recent research. These issues were also acknowledged in the NSD Update Report.

4.8 These emerging issues include:

Issue	Rationale
Prescription or Over-The-Counter Drugs	Information sources, prevalence surveys, and discussions at both the regional and local level have continued to demonstrate the high levels of prescription and over-the-counter drug use in Northern Ireland. There appear to be issues around the level of prescribing in Northern Ireland, as well as the illicit use of prescription and over-the-counter drugs. The buying of prescription drugs on the internet has also emerged as a problem. A group is therefore being established to develop range of key outcomes in relation to raising awareness of this issue, preventing further misuse, and providing appropriate advice, professional training, treatment and support.

Emerging Drugs of Concern / "Legal Highs"	There has been increased awareness of the issue and availability of so-called "legal high" products in Northern Ireland. In some cases, "legal highs" are sold to people trying to buy illicit drugs; in other cases, these products are being actively promoted and sold across Northern Ireland. A range of key outcomes has been developed in relation to uncovering the scale of the issue, raising awareness of the dangers of these products, preventing misuse, and providing appropriate advice, professional training, treatment and support. We will also work with colleagues across the UK jurisdictions in relation to the legal status of these products – in order to prevent harm.
Families and Hidden Harm	In the first phase of the NSD's implementation, there was a significant emphasis on prevention and education work with children and young people, and progress has been made in this area. However, effectively engaging with families and parents/carers is a much more difficult task, and we acknowledge that this has not been tackled with the same consistency or focused approach. The revised NSD therefore contains a greater emphasis on engaging with parents and carers, both in terms of prevention and education, and treatment and support. In addition, there needs to be a continued focus on preventing and addressing Hidden Harm – through the implementation of the PHA's Hidden Harm Action Plan. Therefore, Hidden Harm will be a key priority throughout the NSD Phase 2.
Recovery	Across the UK there has been an increased emphasis placed on helping those affected by alcohol and drug misuse to work towards recovery. Scotland recently defined recovery as "a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society. Furthermore, it incorporates the principle that recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment." In practice, recovery will mean different things at different times to each individual person with problem drug use. For an individual, 'the process of recovery' might mean developing the skills to prevent relapse into further illegal drug taking, rebuilding broken relationships, or actively engaging in meaningful activities. Milestones could be as simple as gaining weight, re-establishing relationships with friends, or building self-esteem. It is critical that recovery is sustained.

Mental Health, Suicide, and Drugs and Alcohol Misuse, Sexual Violence and Abuse, and Domestic Violence	There has been increasing recognition of the association between poor mental health, suicide and self-harm, and alcohol and drug misuse. Indeed, many of the risk and protective factors for these issues are the same. Therefore, through the NSD Phase 2 we are seeking to improve further the co-ordination of work on these issues at both a strategic and an operational level. Although the relationship between substance use and domestic and sexual violence is complex, there are clear indications that alcohol use, particularly heavy drinking and binge drinking, not only complicates the extent and nature of such violence, particularly among intimate partners, it also increases the likelihood of re-assault and reduces the likelihood of perpetrators of domestic violence completing treatment. It should also be noted that the trauma suffered by victims could lead them into a spiral of using prescription medication, drugs and alcohol in an attempt to alleviate their circumstances. In October 2005, DHSSPS in conjunction with the former Northern Ireland Office (NIO) responded to the issues in publishing an inter-agency Domestic Violence Strategy "*Tackling Violence at Home*". In June 2008, DHSSPS and the former NIO published a five-year Strategy '*Tackling Sexual Violence and Abuse'*. The Strategy highlights a number of risk factors in relation to the vulnerability of certain groups of people to sexual violence and abuse, including drug and alcohol use.
Alcohol	Previously the NSD focused on reducing specific behavioral patterns of alcohol misuse, such as "binge drinking". The NSD Phase 2 is taking a population approach to address alcohol misuse and is seeking to reduce overall consumption by having a much greater focus on reducing the health and community harms, including anti-social behaviour and serious violent crime, arising from alcohol misuse. Therefore, a range of outcomes has been developed to begin to prevent, address and treat Northern Ireland's increasingly unhealthy relationship with alcohol. Through the development of the Young People's Drinking Action Plan, there is a greater emphasis on addressing issues such as the advertising, marketing, labelling and pricing of alcohol. Addressing underage drinking and improving alcohol education are also included.
Local Funding	To date, two tendering rounds have been completed by the legacy Health and Social Services Boards in support of DACT Action Plans. The learning from both these tendering rounds should be built into any future decisions in relation to the local funding processes. In addition, where services are being funded across more than one DACT area, consideration should be given to producing a regional

	tendering process that would simplify the application process for community/voluntary service providers.
Review of Public Administration	The delivery structures for the NSD Phase 2, at both the local and regional level, should take account of the RPA changes that have been completed to date, and prepare for those changes still being planned. With the establishment of the Public Health Agency and the Health and Social Care Board, we would like to see a more consistent approach taken to prevention, education, workforce development, treatment and support across Northern Ireland.

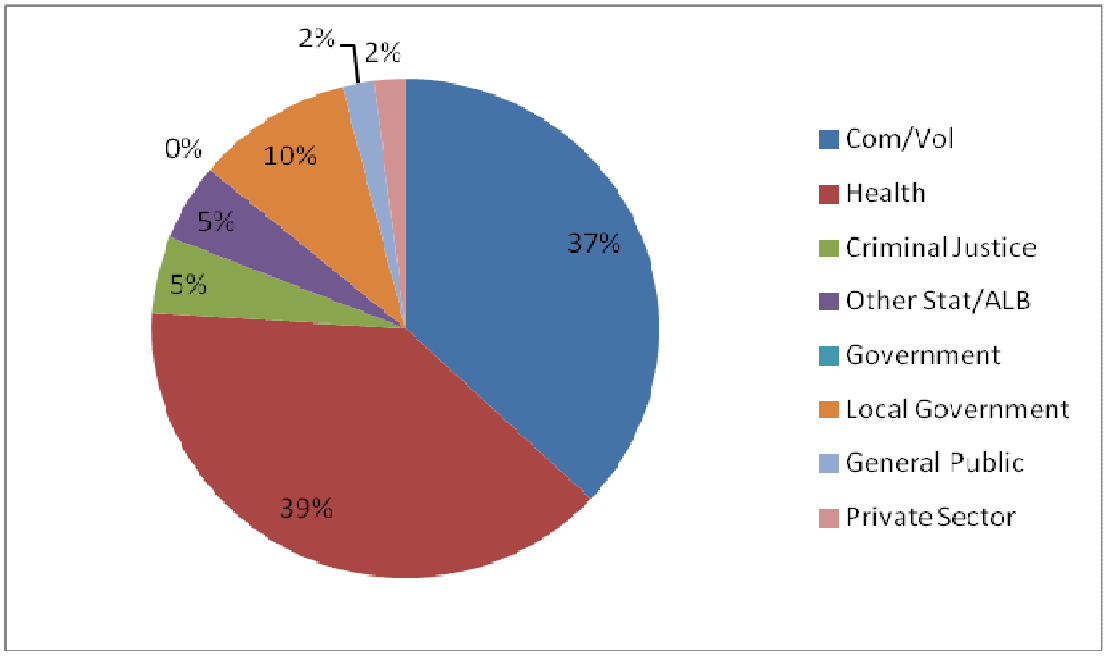
Consultation

4.9 The NSD Phase 2 was issued for public consultation on 04 March 2011, and the process ran until 31 May 2011. In order to aid the analysis of the responses to the consultation, the Department provided a consultation 'Response Questionnaire'. The questionnaire focused responses on the main proposals in NSD Phase 2. In addition to this, respondents were encouraged to provide any general comments.

4.10 The Department also sought comments on the Equality Impact Assessment Screening that was undertaken as part of the development of the draft consultation document. These consultation documents are available online at: http://www.dhsspsni.gov.uk/showconsultations?txtid=47600**.**

4.11 105 individuals (or organisations) were involved in the consultation. Direct work was also undertaken with children and young people (through work with the Participation Network and the development of a young person's version of the consultation document); however for the most part they did not complete the questionnaire.

4.12 A breakdown of the responses by sector is shown in the pie chart below – this does not include information on the young people involved.



4.13 The Minister, the Department, and the NSD Steering Group would like to thank everyone who took the time to respond to the consultation. All views were taken on board and have helped inform the final version of the NSD Phase 2.

4.14 Overall the consultation highlighted that there was very strong support (80-100% of those who responded said they agreed with the approach taken) for the process of revising and updating the NSD and the various questions in the consultation process.

4.15 Many responses picked out specific issues, and where appropriate these have been highlighted and reflected in the NSD Phase 2. A summary analysis of the consultation process and details of those who took part is available online at www.dhsspsni.gov.uk.

5 NSD Phase 2 - The Revised Approach

5.1 Variations in use, both temporal and spatial, present particular challenges for prevention and treatment, especially in assessing need, planning future services and campaigns and allocating finite resources. For prevention, there is the risk of appearing to encourage a trend instead of anticipating it. For treatment, there is the issue of workforce capacity and the difficulties and time lags involved in any reorientation of services.

Treatment

5.2 Most treatment provision for alcohol and drug users is delivered within the community and primary care setting by statutory and non-statutory services. Within the statutory services, treatment is typically provided through a community addiction service consisting of a multi-disciplinary team of nurses, social workers and a consultant in addictions psychiatry.

5.3 In addition, there are in-patient treatment programmes with supervision in a controlled medical environment. Such services also act as a valuable resource for the management of complex cases within the community. The voluntary sector provides a range of services covering counselling and residential places.

5.4 These services collectively provide a full range of treatment options – detoxification, rehabilitation, substitute prescribing and therapeutic counselling. They also provide a counselling and education service for young people through a partnership with a local voluntary organisation. Many people also choose to access self-help organisations for support and

advice. Various self-help groups cater for those with specific issues in alcohol and drug misuse and their families and carers.

5.5 In order to be effective and deliver the best outcomes for patients, care pathways are important, and support is vital in respect of throughcare, aftercare, reintegration and recovery.

Education and Prevention

5.6 A great deal of positive prevention work is carried out in Northern Ireland targeting a wide range of groups and delivered by a wide spectrum of statutory and non-statutory organisations and agencies.

5.7 A significant portion of this work has been carried out within the formal education and youth setting, i.e. schools and clubs. There has also been an increasing emphasis on developing and promoting prevention work in the community and neighbourhood setting, with a greater emphasis on informal and outreach approaches, especially in respect of “hard-to-reach” groups and areas typically described as disadvantaged. Increasingly such work has been guided by known good practice. Youth work, especially “detached”, also plays an important role in reaching out to our young people, and provides them with support and interventions in a less formalised setting.

Criminal Justice

5.8 The criminal justice system has made a major contribution to addressing alcohol and drug misuse in Northern Ireland. The Police Service for Northern Ireland (PSNI) is actively tackling the issue of the organised crime gangs and their involvement with illicit drugs.

5.9 As the link between the misuse of alcohol with serious violent crime and instances of anti-social behaviour is well established, the PSNI, and others, have developed regional and local alcohol initiatives. They have been

contributing to prevention efforts through education and support to local communities in an effort to address both of these issues. The Probation Board for Northern Ireland (PBNI) and the Northern Ireland Prison Service (NIPS) also play a major role in both prevention and support and the issue of 'at risk' and vulnerable groups is one which the Youth Justice Agency has also given a high priority to.

5.10 In addition, the criminal justice system and the health service continue to work closely to develop a partnership approach to offenders who have substance misuse problems. Through referrals from criminal justice projects, Community Addiction Teams have seen people who have never had any previous contact with treatment services. There are also schemes and projects involving the NIPS, the PBNI and the PSNI. It is important we continue to build on this work and ensure a continuity of service for all people in Northern Ireland.

The Five Pillars

5.11 Bearing this in mind, five supporting pillars have been identified in the development of the NSD Phase 2, and these pillars provide the conceptual and practical base for the NSD. The five pillars are:

Pillar	Rationale
Prevention and Early Intervention	Prevention and Early Intervention is largely concerned with encouraging and developing ways to support and empower individuals, families and communities in the acquisition of knowledge, attitudes and skills. A particular focus should be placed on the importance of early intervention (especially young children and families, and to address Hidden Harm), and the adoption of targeted, as well as universal types of prevention which will lead to the reduction of risk factors and the development of protective factors associated with the prevention of alcohol and drug-related harm. Volatile substances and alcohol are often the first substance tried by many young people; this should be recognised and addressed.

	Interventions must be tailored to particular settings such as the school, community and workplace. In this respect, the importance of formal and informal education and community-based approaches is acknowledged.
Harm Reduction	Harm reduction refers to policies, strategies and programmes designed to reduce the harmful consequences of substance misuse. While the ultimate outcome of harm reduction should be to promote recovery through encouraging users towards abstinence, it is acknowledged that a feature of harm reduction is the focus on the prevention of alcohol and drug-related harm for those users who are unable or unwilling to stop using substances. This includes reducing the harm at the individual, family and community levels. Harm reduction is not about condoning alcohol and/or drug use, but it should be seen as those policies, programmes and approaches that aim to prevent anticipated harm and reduce actual harm.
Treatment and Support	A comprehensive range of treatment, rehabilitation and aftercare services for individuals and families affected by alcohol and drug use should be in place. There is also a need to acknowledge the wide range of substances which is misused, including prescribed and 'over the counter' preparations as well as 'illicit' drugs. Particular importance needs to be placed on the continuity of care, and the need to develop greater linkages across agencies and the Health and Social Care system. There is also a need to ensure that those providing first-line support to patients (e.g. GPs/Community Pharmacists) are provided with appropriate training and support to help them meet the needs of their substance misusing patients – and their families. Similarly, people should be able to access a comprehensive range of community-orientated, evidence-based treatment and support services responsive to client needs. Where appropriate, family-based interventions should be encouraged. Multi-disciplinary approaches and partnership working should be a key focus of Treatment and Support, where appropriate. In addition, there should be clear care pathways in place that also encompass throughcare, aftercare, reintegration and recovery.

Law and Criminal Justice	The NSD will continue to stress the importance of addressing those issues that fall within the domain of the law and criminal justice. As well as continuing those efforts aimed at reducing the supply of illicit drugs and irresponsible sale (particularly underage sales) of alcohol, the NSD will continue to support those justice and correctional initiatives that aim to reduce the level of harm associated with alcohol and drug use, such as the increased emphasis on diversion to treatment.
Monitoring, Evaluation and Research	It will be essential that the resources available to deliver the NSD be properly targeted at activities and programmes that have been shown by previous research and evaluation to be effective. This does not devalue the need for innovation. Arrangements for evaluation will be an integral part of all current and future services funded as part of the NSD. It is recognised that it is of vital importance at both regional and local levels to monitor and evaluate processes, outputs and outcomes in order to inform the overall implementation of the NSD and ultimately measure its success. Where appropriate, existing systems and surveys will help to set baselines and monitor progress and changes, however it may be necessary to develop new monitoring systems or build on existing ones to provide additional information required. In addition, well-designed and targeted research projects can address gaps in knowledge and seek to explore specific topics and issues in detail.

Themes

5.12 Two broad themes, "Children, Young People, and Families" and "Adults and the General Public", have also been identified to enable the development of an integrated and co-ordinated approach to tackle the issue. **In delivering on the NSD, organisations are encouraged to focus on specific sub-groups within these themes.**

Values and Principles

5.13 The values and principles set out in the NSD are the basic tenets on which the strategy, and its implementation, is built. These are:

Values and Principles	Description
Positive, Person Centred, Non-Judgmental and Empowering	Each person has individual circumstances, experiences and needs. By developing and delivering services that seek to extenuate the positive and are congruent, respectful and relevant to each person, people can be empowered to make healthier choices. Everyone should feel able to engage freely with services without feeling prejudiced, isolated, stereotyped or stigmatised.
Balanced Approach	The rights of the individual to make health-related choices should be balanced with the need to protect families and communities from any adverse effects of such choices.
Shared Responsibility	Substance misuse is complex and multi-faceted. Effectively preventing and addressing this issue will require a co-ordinated approach, and a shared responsibility and commitment, across Government Departments, Sectors, Professions, Communities, and Individuals.
Equity and Inclusion	Each person has equal worth and rights regardless of differences in race, gender, age, ability, religious belief, political affiliation, cultural outlook, origin, sexual orientation, citizenship, nature, lifestyle, or geographical location.
Partnership and Working Together	Effective partnership has a far greater potential to impact on the complex area of substance misuse rather than fragmented actions carried on in isolation. This Strategy will seek to ensure joint action at every level of implementation and encourage seamless service between sectors.
Evaluation, Evidence and Good Practice Based	A commitment to taking action informed by evidence about what the problems are, 'what works' and by information on cost-effectiveness. The Strategy will also seek to improve the evidence base, and will ensure that appropriate evaluation and reviews are undertaken to ensure all programmes and initiatives are effective.
Consultation, Engagement, Transparency	Commitment to continued consultation, engagement and communication with key stakeholders at every level.
Addressing Local Need	Local needs should be identified and the appropriate resources effectively used by local stakeholders and organisations. Any local action must take into consideration plans already developed.
Community Based	Alcohol and drug misuse is a community issue. The importance of the community dimension is recognised, and we acknowledge the work carried out by, and within, the community in addressing this issue, and will continue to support good practice in this area.

Long-Term Focus	There is no simple or immediate solution to the complex issue of substance misuse. A sustained, long-term strategic approach, with measured shorter-term milestones, must therefore be taken.
Value for Money and Invest to Save	Work must be taken forward in a way that maximises impacts and their cost-effectiveness. Resources should also be invested in those initiatives that have been proven to make greater savings by supporting people not to utilise expensive services.
Built on Existing Work	It is recognised that there is much good work already underway, particularly in relation to the NSD, Hidden Harm, and Young People's Drinking. This Strategy, and its implementation, should seek to build on this good work where possible.
Access to information	Organisations should be obligated to share data (subject to any confidentiality/data protection issues) both at a regional/local and statutory/community level, that allows us to assess need, and help providers optimise care for clients.

6 NSD Phase 2 – Aims, Objectives, and Key Priorities

6.1 The overall aim of NSD Phase 2 is to reduce the level of alcohol and drug-related harm in Northern Ireland.

6.2 The NSD has a set of overarching long-term objectives to:

- provide accessible and effective treatment and support for people who are consuming alcohol and/or using drugs in a potentially hazardous, harmful or dependent way;
- reduce the level, breadth and depth of alcohol and drug-related harm to users, their families (including children and young people), their carers and the wider community;
- increase awareness, information, knowledge, and skills on all aspects of alcohol and drug-related harm in all settings and for all age groups;
- integrate those policies which contribute to the reduction of alcohol and drug-related harm into all Government Policy;
- develop a competent and skilled workforce across all sectors that can respond to the complexities of alcohol and drug use and misuse;
- promote opportunities for those under the age of 18 years to develop appropriate skills, attitudes and behaviours to enable them to resist societal pressures to drink alcohol and/or misuse drugs;
- continue to effectively tackle the issue of availability of illicit drugs and young people's access to alcohol; and
- to monitor and assess new and emerging illicit drugs and take action when appropriate.

Key Priorities

6.3 Although the NSD will address a wide range of issues, a number of Key Priorities have been identified. These will form the cornerstone of work over the next five years and reflect those issues that have been identified to be of crucial importance through the Review and the extensive pre-consultation exercise. It is anticipated that resource allocation will reflect these priorities. The Key Priorities are set out in the table below:

Key Priority	Description
Developing a Regional Commissioning Framework for treatment	There is support in Northern Ireland to consider this issue in more detail and develop a strategic framework that would both cover service delivery and the development of local needs-based plans.

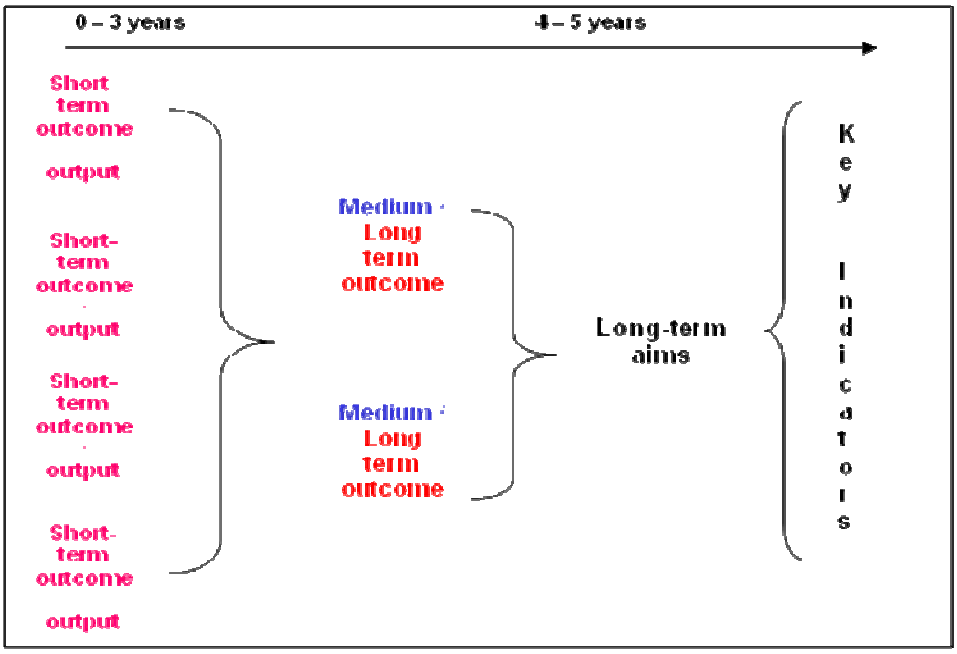
Targeting those at risk and vulnerable	Although it is an issue which is typically associated with 'at risk' young people, within the context of the NSD vulnerability refers to both young people and adults. The following groups have been described as potentially vulnerable in respect of alcohol and drug misuse, although the list is not exhaustive:
	• Homeless, including rough sleepers.
	• Refugees and asylum seekers.
	• Ethnic minorities.
	• People living with domestic and sexual violence.
	• Sex workers.
	• Offenders/Ex-offenders.
	• Vulnerable young people including -
	  o Children of substance using parents (*Hidden Harm*).
	  o Looked-after children.
	  o School excludees.
	  o Those Not in Education, Employment, or Training (NEET)
	• Older people drinking hazardously, dangerously or dependant on alcohol and/or addicted to/misusing drugs.
	• People with mental health problems.
	• Those affected by "the troubles".
	• People with learning disabilities.
	• Street drinkers.
	• Those excluded from communities because of their alcohol and/or drug use.
	• Pregnant substance misusers.
	• Travellers.
	• LGBT groups.

Alcohol and drug-related crime including anti-social behaviour and tackling underage drinking	There is increasing public concern about those types of crime associated with and exacerbated by alcohol and/or drugs. The misuse of alcohol has been associated with a range of anti-social behaviours including noise, nuisance, litter, criminal damage and verbal or physical abuse. Serious violent crime statistics also show that alcohol is a major contributory factor. Both these types of incidents have been associated with the 'night-time economy' in urban centres, but are also recognised as a problem in rural and/or residential areas. The impact of alcohol-related crime on public services such as police, fire, ambulance and transport, and on the public, is acknowledged. Activities that aim to address these issues, especially within the community setting, are to be encouraged. One of the issues to be tackled is the availability of alcohol to under 18s, which is a contributory factor in some instances of anti-social behaviour.
Reduced availability of illicit drugs	Continued emphasis will be placed on those efforts and activities within the law and criminal justice sector that aim to reduce the availability of drugs, with particular attention being paid to the complex supply chain involved. Action should also be undertaken to reduce the availability of Volatile Substances through the enforcement of supply control legislation and retailer educations.
Addressing community issues	The importance of the community sector in respect of addressing alcohol and drug misuse is recognised, and particular emphasis needs to be placed on supporting community-based activities, especially strengthening community capacity to respond to alcohol and drug issues through identified outcomes.
Promoting good practice in respect of alcohol and drug-related education and prevention	In developing or implementing education and prevention programmes, regardless of the target group or setting, due attention must be made to ensure that they are following sound conceptual principles and that they are following acknowledged and, where possible, evidenced good practice. In addition, cognisance should be taken of emerging patterns and trends of misuse (including new substances) – and approaches developed to address these.
Harm Reduction approaches	The overall aim of the NSD is to reduce alcohol and drug-related harm. Continuing support should therefore be given to further developing appropriate harm reduction approaches and strategies, which reduce the harmful consequences of substance misuse, with particularly a closer look at such approaches in respect of alcohol misuse.

Workforce Development	A broad range of workers has a key role to play in addressing substance misuse, and reducing substance misuse should be regarded as a core business to many services. It is clear that the successful implementation of the NSD will require colleagues in related sectors to recognise the significant contribution they can make to addressing drug and alcohol issues. Although numbers in the workforce are important, the competence of those staff has the most crucial relationship to achievement of the NSD aims. In particular, all those working with vulnerable individuals need to have a basic substance misuse knowledge and understanding. Therefore, a priority will be given to the development of agreed and appropriate competences across all sectors and access to supportive training, and agreed protocols for inter-service working/co-operation. There is also a need to ensure that those providing first-line support to patients (e.g. GPs/Community Pharmacists) are provided with appropriate training and support to help them meet the needs of their substance misusing patients – and their families.

7 Outcomes and Indicators

7.1 In order to deliver the overarching long-term aims of the NSD, a series of outcomes has been developed. Following the logic model approach a number of long-term outcomes was initially developed. A number of regional and local short and medium-term outcomes and outputs have subsequently supported these. These will provide the focus for activities and future work. *(By short term, this means within 3 years, and medium to long-term within 4 - 5 years)*



7.2 Outcomes will be measured, and the overall success or otherwise of achieving the long-term aim will be measured by the Key Indicators previously described. The outcomes have been structured in a manner that not only demonstrates their sequential nature across the five years of the NSD, but also their relationship with the themes, long-term aims and Key Priorities.

7.3 The outcomes have been grouped within the themes based on certain issues or topics as follows:

- Adults and the General Public - 1 (Treatment and Support)
- Adults and the General Public - 2 (Prevention and Early Intervention)
- Children, Young People and Families - 1 (Treatment and Support)
- Children, Young People and Families - 2 (Prevention and Early Intervention)
- Community Safety and Anti-Social Behaviour
- Monitoring, Evaluation and Research
- Workforce Development

7.4 The outcomes set out the overall direction of travel. **The Public Health Agency should continue to develop local and regional plans that support the achievement of the NSD outcomes, and that identify and address local needs.**

7.5 They are set out in detail in **Annex A**.

Key Indicators

7.6 To measure the extent to which the overall aim of reducing alcohol and drug-related harm is met, we have established a set of Indicators that can be used for this purpose. Progress against these indicators will be reported as the information becomes available. It should be noted that for the majority of these outcomes we would be seeking to reduce the figures. However in respect of some of the areas – particularly those presenting to treatment and possibly hospital related admissions – an increase in the numbers is actually positive as it means more people are seeking help for their misuse and this should lead to long-term reduction in related harm. When reporting against these indicators, where possible and appropriate, figures will be broken down by Section 75 groups and particularly in terms of age, gender, and geographical area. The Key Indicators identified for alcohol and drugs are:

Alcohol	Drugs
• Prevalence • Binge drinking prevalence • Alcohol-related deaths • Numbers presenting to treatment • Related hospital admissions • Alcohol-related crime • Drink Driving • Public confidence that alcohol-related problems are being addressed	• Prevalence • Blood Borne Viruses among Injecting Drug Users • Drug-related deaths • Numbers presenting to treatment • Related hospital admissions • Drug-related crime • Drug driving (including prescription drugs) • Number of gangs (criminal) dismantled, disrupted or frustrated • Public confidence that drug-related problems are being addressed.

8 Implementation and Delivery

NSD Implementation Structures

8.1 The NSD Steering Group will continue to oversee and drive forward work to achieve the outcomes contained in the NSD. It will also consider and make recommendations in respect of policy and action on relevant issues raised by members, and those teams and groups who report to it. The Chief Medical Officer will continue to chair the Steering Group. Membership of the Steering Group will continue to include relevant professionals, statutory bodies and agencies, Government Departments, and voluntary/community sector representatives. The Steering Group will continue to report progress to the Ministerial Group on Public Health.

8.2 Following the update process and the consultation, the membership and terms of reference of the group are to be revised and agreed to take on board many of the issues raised.

Advisory Groups

8.3 The Advisory Groups will continue to play a key role in providing advice and policy guidance on specific priorities contained within the NSD, and informing the work of the NSD Steering Group. These groups are :

- Children, Young People and Families;
- Treatment and Support
- Alcohol Advisory Group; and
- Law and Criminal Justice.

8.4 The function of each group is to provide advice that draws on expertise in relation to the individual groups' strategic priorities and needs of specific

strategic areas. Each group advises, recommends and provides informative feedback on the NSD and its outcomes, and on relevant issues related to its own specific remit.

8.5 One outworking of the Bamford Review has been the establishment of a Bamford Substance Misuse Group that is chaired by the PHA. The NSD recognises this important development in taking forward implementation of the strategy, and acknowledges the vital role it will play in supporting and co-ordinating key elements of the NSD, particularly in respect of treatment services redesign and modernisation.

8.6 Following the consultation process, the NSD Steering Group has agreed to reinstate the Treatment and Support Group in the interim to provide policy advice in respect of this issue. In due course, this responsibility may pass back to the Bamford Substance Misuse Sub-group – but at the current time, the Bamford Sub-group should focus on implementation and not policy advice.

8.7 An initial task for all the advisory groups will be for members to consider their remit and terms of reference to ensure they are fit for purpose in terms of supporting the delivery of the NSD Phase 2, particularly in relation to the new structures following the Review of Public Administration (RPA).

8.8 The Liaison Group, consisting of the Chairs of each advisory group along with the senior staff within the PHA responsible for alcohol and drug misuse and representatives from the Public Health Information and Research Branch and the Health Development Policy Branch in the DHSSPS, will continue to meet to integrate and co-ordinate discussions on issues that cross the remit of more than one of the advisory group's relevant issues.

Local Delivery

8.9 The NSD Phase 2 clearly recognised that local assessment of need, and the development and delivery of services, programmes and initiatives to meet these needs, is paramount to address this issue effectively. In support of this, the PHA develops local and regional implementation plans. These implementation plans must continue to match and reflect NSD priorities, and support the implementation of the NSD at the regional and local level.

8.10 In order to deliver on these implementation plans, the PHA tenders for the services they require, enabling all organisations to bid to provide these services.

8.11 **In light of the review of the NSD and RPA changes, it would now be appropriate for the PHA to review the role, function and membership of Drug & Alcohol Co-ordination Teams (DACTs) to ensure they are fit for purpose and strategically placed to support and monitor the local delivery of the NSD Phase 2.**

Involvement of the Voluntary/Community Sector

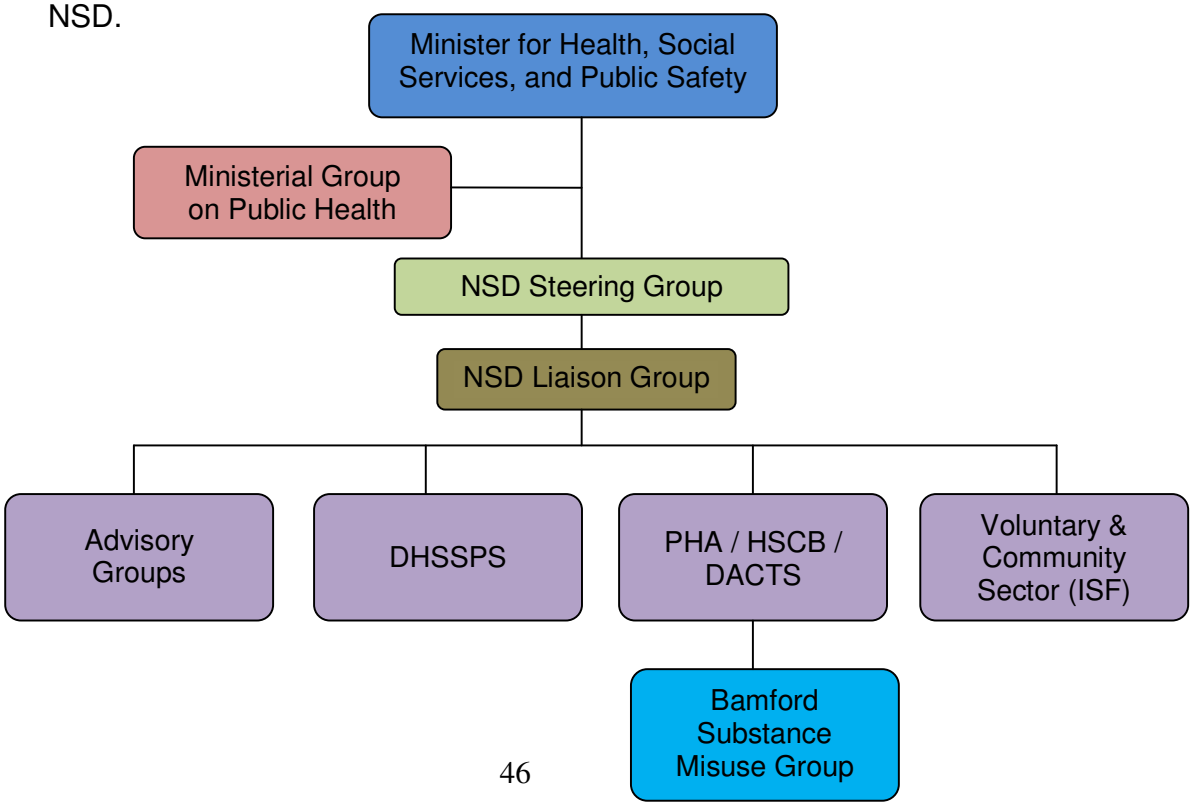
8.12 From the very outset, the development of the NSD has benefited from the input and expertise of the voluntary and community sector. This is facilitated through focus group discussions, the Independent Sector Forums and representation on the NSD Steering Group and the related Advisory Groups. This has continued throughout the reviews, update and consultation process and DHSSPS believes it is essential that such involvement should continue into the new structures of the NSD. **The Strategy commits us to ensuring the continued input and involvement of this key sector**.

8.13 In order to deliver on this commitment, we will ensure representatives from the voluntary and community sector are allocated places at the local level (via local DACTs and partnerships), at the policy Advisory Groups, and at the NSD Steering Group. This should continue to be delivered through the process used to nominate representatives through the local Independent Sector Forums (ISFs).

8.14 It is also important that those voluntary and community sector groups not currently funded by the NSD structures also have a chance to input to the process. This should be reflected at the local level through the DACTs and the ISFs, and the Advisory Groups should consider this issue when reviewing their own terms of reference and membership.

Revised Overall Structure

8.15 Given the RPA changes to the Health and Social Care settings, a slightly revised structure has been developed. The Consultation agreed that this revised structure was the most effective way of taking forward and overseeing the ongoing work of the NSD. The following diagram sets out the overall structure that oversees the ongoing implementation of the NSD.



Funding

8.16 DHSSPS currently allocates around £8 million to the HSC for the implementation of the NSD each year. Given the commitments to ongoing outcomes contained in the original NSD, and the ongoing demand for such services, this revised document will be delivered within that funding (subject to the outcome of the ongoing budgetary and Comprehensive Spending Review process). **If not all these outcomes can be achieved within the current funding allocation, then their implementation should be prioritised in line with the objectives and key priorities set out in earlier chapters.**

8.17 It should be noted that many other Departments and delivery partners, such as The Big Lottery Fund (BIG) through its Impact of Alcohol Programme, also invest in initiatives that help address this issue. These other Departments and organisations should utilise the NSD Phase 2 as a guide to how best to undertaken investment in this area. Overall, the updated NSD recommends making the most effective use of existing resources whilst investigating possibilities for gaining additional funding from a variety of sources.

Annex A - Outcomes

Adults and the General Public – 1 (Prevention & Early Intervention)

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. An integrated and targeted programme undertaken to raise awareness of the health impact of drinking above the relevant guidelines – messaging must be clear and consistent.	• Targeted local prevention programmes in place. • Reduction in the proportion of adults who have used drugs in the last year. • Reduction in the proportion of adults who have misused prescription drugs in the last year. • Reduction in the proportion of adults who binge drink. • Increase in the proportion of adults who drink sensibly. • Legislation in place to prevent and address substance misuse. • Greater dissemination of information in respect of emerging substance misuse trends. • Increase in number of workplaces implementing alcohol and drug policies. • Reduction in the level of use of prescribed drugs in Northern Ireland. • The committal screening process for all new prisoners refined by the NI Prison Service in partnership with the South Eastern HSC Trust to help ensure the early identification of drug and alcohol problems.
2. Improved understanding of the social norms associated with alcohol misuse, and work undertaken to challenge these and those factors driving the drinking culture; also work undertaken to challenge these norms.	
3. Local community support services reviewed and consideration given to increasing consistency across Northern Ireland.	
4. Health professionals, particularly within primary care and A&E, trained and encouraged to undertake brief alcohol advice/intervention programmes across Northern Ireland.	
5. Review of the role and capacity of alcohol liaison nurses, and consideration given to ensuring they are available in all relevant HSC sites across Northern Ireland.	
6. Proposals developed on how alcohol is: • priced (including consideration to minimum unit pricing) • promoted; • labelled; and • advertised.	
7. Workplace Alcohol and Drug Policy Guidance updated, disseminated and their usage supported and encouraged.	
8. Information on emerging trends and drugs of misuse shared across UK and ROI Jurisdictions, particularly in relation to helping to inform the statutory role of the Advisory Council on the Misuse of Drugs (ACMD) in respect of the Misuse of Drugs Act.	

9. NI continues to contribute to the ACMD and inputs to UK-wide legislation in relation to the misuse of drugs, particularly in relation to emerging drugs of concern.	• The rates of referral to Courses for Drink Drive Offenders increased. • Reduction in the proportion of drivers who are breath tested returning positive results.
10. All organisations promptly informed of changes to the drug and alcohol legislation.	
11. Parents, communities and key professionals provided with accurate and timely information in relation to emerging drugs, including legal highs.	
12. Group established to consider how the use of prescribed drugs can be addressed across Northern Ireland.	
13. Drink and drug driving (including prescription drugs) media campaigns continued and their impact assessed.	
14. Roadside drug screening devices in place when available.	
15. New roadside breath testing devices in place for drink drivers when available.	
16. The proportion of positive preliminary breath test results reduced.	
17. The Drink Drive (Blood Alcohol Concentration) Limit reduced.	

Adults and the General Public – 2 (Treatment & Support)

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. A Regional Addiction Services Commissioning Framework developed and implemented for Northern Ireland.	• Alcohol and drug users have access to appropriate and effective treatment and support services • Integrated, cross-departmental and cross-sectoral planning for treatment and support services in place. • Evidenced based alcohol and drug harm reduction approaches and activities promoted and expanded. • Service users adequately and appropriately involved in planning and provision of treatment and support services. • Increase in the number of problem users who access treatment and support services, including harm reduction services. • Co-operative working relationships further developed between statutory, voluntary and community sectors that deliver services to alcohol and drug misusing offenders. • Dismantling, disruption and frustration of organised gangs involved in supplying drugs to Northern Ireland.
2. The Framework should ensure that services are supported and encouraged to adopt a "recovery and reintegration" approach to treatment and support.	
3. Local and regional Service User developments encouraged and supported.	
4. Specific work in respect of identified vulnerable groups included in local action plans.	
5. Pilot scheme for 'Take Home Naloxone' to be evaluated and consideration given to its roll-out.	
6. Provision of needle and syringe exchange scheme continued, and consideration given to expanding the scheme to areas with an identified need.	
7. Learning from existing schemes/initiatives, work undertaken across Northern Ireland to reduce levels of prescribing and support people to reduce/stop taking unnecessary prescriptions.	

8. Services in place to assist clients with a common employability barrier, (e.g. history of drug/alcohol misuse, homelessness and ex-prisoners/ex-offenders) to enter employment.	• The NI Prison Service in partnership with the South Eastern HSC Trust work closely with the Community Addiction Teams across NI. • An interface protocol with Community Addiction Teams for a care pathway for prisoners leaving prison to return to the community developed by the NI Prison Service in partnership with the South Eastern HSC Trust. • Discharge procedures, involving both in-prison health services and Voluntary & Community agencies to ensure prisoners have access to services and support across NI, further developed by the NI Prison Service in partnership with the South Eastern HSC Trust. • The NI Prison Service in partnership with the South Eastern HSC Trust aim to reduce the use of illicit and non-prescribed drugs in prison, and reduction in dangers associated with drug misuse, particularly the risk of transmitting blood borne viruses. • All pre-sentence report authors and supervising staff receive the appropriate tools to undertake accurate and consistent screening and assessment of adjudicated offenders as determined appropriate by the Probation Board. • Drug testing for those offenders who volunteer or released from prison on a Life License. • A range of programmes developed to meet the priority needs of offenders (with particular emphasis on the Sentencing Framework).
9. Education and training for professionals, carers and families in relation to substance misuse problems in older people supported.	
10. Consideration given to extending arrest referral schemes to other areas across NI.	
11. Consideration given to how the current arrest referral schemes could be altered to address alcohol related offending, and depending on the outcome, consider the introduction of a pilot alcohol arrest referral project.	
12. A continuum of treatment and support opportunities between custody and release of offenders back into the community for young and adult offenders developed – linked to the Joint Agency Offender Management Process.	
13. The NI Prison Service in partnership with the South Eastern HSC Trust further develop services to ensure appropriate interventions are in place for prisoners, including for those with opiate dependency.	
14. Accreditation sought for the "Prisoners - Addressing Substance Related Offending" (P-ASRO) programme or other appropriate programmes delivered in prisons.	

15. The NI Prison Service in partnership with the South Eastern HSC Trust will have undertaken work to reduce the risk of drug-related death in prisons, and particularly on release from prison.	• The Addressing Substance Related Offending (ASRO) programme for offenders rolled out across Northern Ireland.
16. Education and information provided to parents of offenders regarding drugs and alcohol on a one to one basis and via the parent support groups.	• PBNI funding provided through its Community Development Budget to secure the provision of substance misuse services in the community and voluntary sector.
17. The NI Prison Service and the South Eastern HSC Trust work in partnership with Alcohol & Drugs: Empowering People through Therapy (AD:EPT) to deliver psychological and educational drug and alcohol programmes for all offenders.	• Partnership work in place to deliver ASRO programmes to complement the P-ASRO programme for offenders. • Targeted treatment for prolific offenders with substance misuse related crime.

Children, Young People and Families - 1 (Prevention & Early Intervention)

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. The "You, Your Child, and Alcohol" regional information campaign, aimed at reducing alcohol and drug misuse among young people (aged under 18), evaluated and consideration given to its future.	• Increase in the proportion of young people who see taking illicit drugs and getting drunk as socially unacceptable. • Reduction in the availability and accessibility of alcohol to young people. • Reduction in the proportion of young people who get drunk. • Reduction in the proportion of young people who drink on a regular basis. • Reduction in the proportion of young people who take drugs on a regular basis. • Opportunities exist for young people to make a positive contribution, including through reparative placement, to the drugs and alcohol strategy.
2. Targeted education and awareness-raising among children, parents, and families on the risks of drug and alcohol misuse and how to prevent harm.	
3. Schools support the development of skills and knowledge that enable young people to resist social pressures to experiment with alcohol and drugs, including volatile substances, emerging drugs of concern, etc.	
4. Young People's Drinking Action Plan implemented.	
5. Successful implementation of new liquor licensing regulations and laws.	
6. Improved co-operation and co-ordination to address alcohol and drug misuse and mental health, suicide and self-harm, and sexual health, at both the strategic and operational level.	
7. A One-Stop-Shop service, informed by the evaluation of the pilot project, available in areas of identified need to those young people affected by substance misuse, but also addressing issues such as suicide and self-harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping skills	

8. Greater information-sharing between PSNI, the Youth Justice Agency (YJA) and PBNI regarding the identification of children who offend and who are known to be using alcohol and drugs either in the commissioning of offences or to gain money to purchase drugs or alcohol.	
9. Opportunities in Youth Conferences for young people involved in substance related offending to hear first hand experiences from those who have experienced dependency but have addressed it.	
10. Education and awareness sessions provided to young people who, though the criminal justice system, are subject to statutory supervision in the community and are assessed as Tier 1.	

Children, Young People and Families - 2 (Treatment & Support)

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. Development of a framework of Treatment and Support Services for those aged under 18.	• All organisations with a responsibility for young people have an alcohol and drug policy in place.
2. Family support services available across Northern Ireland, and treatment services supported and encouraged to take a family orientated approach to provision where appropriate – reflecting the "Think Child, Think Parent, Think Family" strategy.	• Improved identification and signposting of young people who have alcohol and drug related issues, and ongoing monitoring of the Regional Initial Assessment Tool.
3. The Regional Hidden Harm Action Plan implemented.	• Children and young people have access to early interventions and appropriate support services directly related to their alcohol and drug use.
4. The Regional Initial Assessment Tool embedded within the Youth Justice Agency, and work taken forward to roll it out to other key sectors.	• Increase in the number of young people and parents accessing treatment and support services increased.
5. Within the custodial setting of Woodlands, young people assessed (and follow up action and support provided) regarding their drug and alcohol misuse, with appropriate screening and management systems in place to minimise risk to those young people who admitted to custody under the influence of substances.	• Protocols agreed with the Child and Adolescent Mental Health Service (CAMHS) across NI ensure a consistent approach to referrals by the Criminal Justice agencies where concerns about potential self-harm are raised.
6. Accurate sharing of information of alcohol and drugs risks at times of transition with the Criminal Justice system e.g. transfer to adult Probation Services or transfer to Hydebank Wood.	• Relationships with a wide range of community and voluntary drug and alcohol treatment providers maintained and YJA making appropriate referrals.

Community Safety and Anti-Social Behaviour

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. Existing relationships between Community Safety Partnerships, District Policing Partnerships and DACTs developed in respect of addressing alcohol and drug related anti-social behaviour.	• The working relationship between the criminal justice sector, the health service and other stakeholders further developed to ensure an integrated approach to tackling alcohol and drug offending behaviour improves.
2. Assess the level alcohol plays in Sexual Violence and Domestic Violence; further work will flow from that assessment.	• Increase in the level of public confidence in how alcohol and drug-related issues, and their impact at community level, are addressed.
3. Community Safety Strategy recognises the role of alcohol and drug misuse.	• Implementation of Strategies to tackle sexual violence and domestic violence.
4. Protocol developed to improve information sharing between PSNI, Health Trusts, Ambulance Service and others regarding alcohol related incidents, including hospital admissions and ambulance calls to inform local action planning.	• Community Safety Strategy fully implemented.
5. Promotion of schemes at a local level that tackle anti-social behaviour linked to alcohol misuse (and underage drinking).	
6. Cross-Government approach taken to addressing issues related to Alcohol and the Night Time Economy Seminar.	
7. Work with the Alcohol Industry and Pubs of Ulster on rolling out the Purple Flag accreditation.	
8. The Organised Crime Task Force Drugs Expert Group sharing information and intelligence, and monitoring and overseeing joint action by its partner organisations, to ensure ongoing disruption of the drugs market, and help reduce the availability for drugs.	

Supporting Outcomes – Monitoring, Evaluation and Research

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. The Regional Impact Measurement Tool continues to be completed for all initiatives funded as part of the New Strategic Direction.	• Improved response and dissemination of information in respect of emerging substance misuse trends. • More detailed and relevant information in respect of alcohol and drug misuse available. • Progress in respect of aims of NSD Phase 2 described accurately and reported on. • PBNI considered how best to deliver its Alcohol Management Programme and implement appropriate delivery arrangements. • Data gathered by PBNI on the impact of the ASRO programme and contributed to any local or national evaluation on the effectiveness of this programme. • The delivery of drugs and alcohol programmes, delivered with young people in the community, evaluated by YJA. • NSD Phase 2 reviewed and evaluated, and consideration given to the need for the development of a successor strategy.
2. Consideration given to developing one overarching monitoring system including Drug Misuse Database (DMD), Substitute Prescribing and Needle Exchange; also an Alcohol Misuse Database established.	
3. A rolling research programme developed and updated on an annual basis.	
4. Available statistics and research information published.	
5. A local "Drug and Alcohol Monitoring and Information System" in respect of alcohol and drug trends and developments in place which reports to the NSD Steering Group.	
6. The NI Prison Service in partnership with the South Eastern HSC Trust will have undertaken a review of the Prison Strategy to tackle alcohol and drug issues among prisoners.	
7. Improved quality and scope of data on drink and drug driving, including provision of separate data on drink and drugs present in road fatalities and separate trend data on fatal and serious injury collisions.	
8. Results of the Night-Time Economy module of the NI Crime Survey published.	

Supporting Outcomes – Workforce Development

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	**Medium Term / Long Term Outcomes**
1. Effectiveness of workforce development initiatives reviewed.	• Development of a training framework, which ensures that skill development (an individual's development of competency as defined by the occupational standards), is evidenced to a quality standard that is recognised throughout the UK. • Dissemination of DANOS across Northern Ireland. • Improved competence and capacity of the alcohol and drug misuse, and wider, workforce.
2. Informed by this review, workforce development initiatives are better co-ordinated, and front-facing workforce better equipped to provide early effective intervention.	
3. Improved awareness and opportunities for Criminal Justice Organisations to avail of training programmes.	
4. Organisations work together to share information and secure a greater understanding on the composition and impacts of legal highs (or any other new drug).	
5. Dissemination of the Drugs and Alcohol National Occupational Standards (DANOS) for all sectors in Northern Ireland.	
6. Training in respect of Hepatitis C and other blood borne viruses for those working with Injecting Drug Users continues to be delivered.	
7. YJA ensures that service delivery staff have the skills and knowledge to deliver alcohol and drugs interventions at Tier 2.	
8. YJA ensures that medical staff within Woodlands have access to updated information about new drugs and their effects in order to manage any presenting risk and to inform an ongoing treatment plan within custody.	

Annex B

Equality Impact Assessment

EQUALITY CONSIDERATIONS NORTHERN IRELAND ACT 1998

Section 75 (S75) of the Northern Ireland Act 1998 places the following statutory requirements on each public authority:

"(1) A public authority shall in carrying out its function relating to Northern Ireland have due regard to the need to promote equality of opportunity–

(a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;

(b) between men and women generally;

(c) between persons with a disability and persons without; and

(d) between persons with dependants and persons without.

(2) Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group".

POLICY AIM AND GROUPS AFFECTED

The proposals in this paper are intended to reduce the level of alcohol and drug-related harm in Northern Ireland. As part of its pre-consultation process, during the development of the original NSD, the Department conducted an Equality Screening Assessment on the issue of alcohol and drug misuse using focus groups, special interest groups and an e-consultation exercise. This was to indicate whether there is any likelihood that the proposals will have a significant differential impact on any of the Section 75 categories. The results from this showed that there were certain instances where vulnerability, gender and age are issues, and the NSD has been developed with clear aims, values, principles, and outcomes to acknowledge and address these. The Department also addressed the four standard screening criteria as recommended by the Equality Commission and considered available data and information in arriving at its initial screening decision that a full Equality Impact Assessment is not necessary.

Annex C

Notes: Admission to Hospitals with an Alcohol / Drug Related Diagnosis in Any Diagnostic Position

- Deaths and Discharges have been used as an approximation for admissions
- ICD 10 Diagnosis codes have been searched for in the first seven diagnostic fields
- Data relating to 2010/11 year is provisional and maybe subject to changes

ICD10 codes to identify Alcohol related admissions are:

E244	Alcohol-induced pseudo-Cushing's syndrome
E512	Wernicke's encephalopathy
F10	Mental and behavioural disorders due to use of alcohol
G312	Degeneration of nervous system due to alcohol
G621	Alcoholic polyneuropathy
G721	Alcoholic myopathy
I426	Alcoholic cardiomyopathy
K292	Alcoholic gastritis
K70	Alcoholic liver disease
K860	Alcohol-induced chronic pancreatitis
O354	Maternal care for (suspected) damage to fetus from alcohol
P043	Fetus and newborn affected by maternal use of alcohol
Q860	Fetal alcohol syndrome (dysmorphic)
T510	Ethanol
T511	Methanol
T519	Alcohol, unspecified
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent
Y573	Alcohol deterrents
Y90	Evidence of alcohol involvement determined by blood alcohol level
Y91	Evidence of alcohol involvement determined by level of intoxication
Z502	Alcohol rehabilitation
Z714	Alcohol abuse counselling and surveillance
Z721	Alcohol use

ICD10 codes to identify Drug related admissions are:

F11	Mental and behavioural disorders due to use of opioids
F12	Mental and behavioural disorders due to use of cannabinoids
F13	Mental and behavioural disorders due to use of sedatives or hypnotics
F14	Mental and behavioural disorders due to use of cocaine
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine
F16	Mental and behavioural disorders due to use of hallucinogens
F18	Mental and behavioural disorders due to use of volatile solvents
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances
X40	Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X41	Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified
X42	Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X43	Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system
X44	Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X85	Assault by drugs, medicaments and biological substances
Y10	Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent
Y11	Poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent
Y12	Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent
Y13	Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent
Y14	Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent

Annex D

Glossary of Terms

A&E	Accident & Emergency
ACMD	Advisory Council on the Misuse of Drugs
AD:EPT	Alcohol & Drugs: Empowering People through Therapy
ADPS	Adult Drinking Patterns Survey
ALB	Arms Length Bodies
ASRO / P-ASRO	Addressing Substance Related Offending / Prisoners - Addressing Substance Related Offending
BIC	British-Irish Council
BIG	Big Lottery Fund
CAMHS	Children & Adolescent Mental Health Services
CHS	Continuous Household Survey
CSP	Community Safety Partnership
DACT	Drug & Alcohol Co-ordination Team
DANOS	Drug & Alcohol National Occupational Standards
DHSSPS	Department of Health, Social Services & Public Safety
DMD	Drug Misuse Database
DPS	Drug Prevalence Survey
DPP	District Policing Partnership
EU	European Union
GP	General Practitioner
GRO	General Register Office
HIB	Hospital Information Branch
HIS	Hospital Inpatient System
HSC / HSCB	Health & Social Care / Health & Social Care Board
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
IDU	Injecting Drug User
IMT	Impact Measurement Tool
ISF	Independent Sector Forum
JIM	Joint Implementation Model
LGBT	Lesbian Gay Bisexual Transgender
LSD	Lysergic Acid Diethylamide
NEET	Not in Education Employment or Training
NIO	Northern Ireland Office
NIPS	Northern Ireland Prison Service
NISRA	Northern Ireland Statistics & Research Agency
NSD	New Strategic Direction for Alcohol & Drugs
OCTF	Organised Crime Task Force
OTC	Over-the-Counter
PHA	Public Health Agency
PHAROS	Barnardo's Support Service for Families & Children affected by Parental Substance Misuse
PBNI	Probation Board for Northern Ireland

PSNI	Police Service of Northern Ireland
RIAT	Regional Initial Assessment Tool
ROI	Republic of Ireland
RPA	Review of Public Administration
YJA	Youth Justice Agency
YPBAS	Young Persons' Behaviour & Attitudes Survey
UK	United Kingdom

Annex E

Useful References & Links

Drug Strategy for Northern Ireland (NIO 1999) http://www.dhsspsni.gov.uk/drugs_strategy.pdf
Strategy for Reducing Alcohol Related Harm (DHSSPS September 2000) http://www.dhsspsni.gov.uk/alcohol.pdf
Model for the Joint Implementation of the Drug & Alcohol Strategies (DHSSPS May 2001) http://www.dhsspsni.gov.uk/jointdrug.pdf
New Strategic Direction for Alcohol & Drugs 2006-2011 (DHSSPS May 2006) http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf
Regional Hidden Harm Action Plan (DHSSPS October 2008) http://www.dhsspsni.gov.uk/regional_hidden_harm_action_plan.pdf
Addressing Young People's Drinking in Northern Ireland (DHSSPS 2009) http://www.dhsspsni.gov.uk/dhs74109_web_pdf.pdf
NSD Update Report (DHSSPS April 2010) http://www.dhsspsni.gov.uk/nsd_update_report_-_april_2010.pdf
Social Costs of Alcohol Misuse in Northern Ireland for 2008/09 (DHSSPS 2010) http://www.dhsspsni.gov.uk/social_costs_of_alcohol_misuse_200809.pdf
Consultation on the New Strategic Direction for Alcohol & Drugs Phase 2 (2011-2016) http://www.dhsspsni.gov.uk/nsd_phase_2_consultation_document_-_january_2011_update.pdf
Minimum Unit Pricing of Alcohol http://www.dsdni.gov.uk/index/consultations/archived-consultations/consultation-minimum-unit-pricing-of-alcohol.htm
Census of Drug & Alcohol Treatment Services in Northern Ireland: 1st March 2010 http://www.dhsspsni.gov.uk/census_bulletin_-_1_march_2010.pdf
Statistics from the Northern Ireland Drug Misuse Database: 1 April 2010-31 March 2011 http://www.dhsspsni.gov.uk/dmd_bulletin_2010-11.pdf
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