

***BETTER MANAGING NORTHERN IRELAND'S
ALCOHOL AND DRUG PROBLEMS***

**A Review of the Northern Ireland Alcohol and Drug
Strategies and the Efficiency and Effectiveness of
their Implementation**

by

Professor Howard Parker

March 2005

CONTENTS

	Page
ACKNOWLEDGEMENTS	1
EXECUTIVE SUMMARY	2
1. CONTEXT: The background and purpose of the Review	7
1.1 <i>Brief History of Strategic Development</i>	7
1.1.1 <i>Drugs strategies</i>	7
1.1.2 <i>Alcohol strategies</i>	7
1.2 <i>The Joint Implementation of the Two Strategies</i>	8
1.3 <i>The Purpose of the Review</i>	10
1.4 <i>Support for the Review</i>	10
1.4.1 <i>The Desk Top Review</i>	10
1.4.2 <i>The Stakeholder Consultation</i>	10
1.4.3 <i>Documents and data</i>	11
1.5 <i>The Structure of the Report</i>	11
2. ACTIVITY: Has the joint implementation business plan been delivered successfully?	12
2.1 <i>Introduction to Auditing Outcomes</i>	12
2.2 <i>Alcohol (Harm Reduction) Strategy: Critical Outcomes</i>	12
2.2.1 <i>Identifying the core</i>	12
2.2.2 <i>Encouraging responsible drinking</i>	13
2.2.3 <i>Promote and improve 'effective' treatment services</i>	13
2.2.4 <i>Protecting the Community</i>	13
2.3 <i>Drugs Strategy: Critical Outcomes</i>	14
2.3.1 <i>Identifying the Core</i>	14
2.3.2 <i>To protect young people from the harm resulting from illicit drug use</i>	14
2.3.3 <i>To protect communities from drug related anti-social and criminal behaviour</i>	14
2.3.4 <i>To enable people with drug problems to overcome them and lead healthy crime free lives</i>	14
2.3.5 <i>To reduce the availability of drugs in communities</i>	15
2.4 <i>The Joint Implementation Regional and Local Action Plan</i>	15
2.4.1 <i>An indicative audit</i>	15
2.4.2 <i>The Education and Prevention Working Group</i>	15
2.4.3 <i>The Treatment Working Group</i>	17
2.4.4 <i>The Communities Working Group</i>	19
2.4.5 <i>The Information and Research Working Group</i>	21
2.4.6 <i>The Social Legislation Working Group</i>	23
2.4.7 <i>The Criminal Justice Working Group</i>	23
2.5 <i>Overview of Regional Action Plan Delivery</i>	25
2.6 <i>The Drug and Alcohol Coordination Teams and Local Action Plans</i>	26

2.6.1	<i>Problems auditing delivery at the local level</i>	26
2.6.2	<i>Northern DACT Local Action Plan</i>	27
2.6.3	<i>Southern DACT Local Action Plan</i>	27
2.6.4	<i>Western DCT Local Action Plan</i>	28
2.6.5	<i>Eastern DACT Local Action Plan</i>	28
2.7	<i>Delivery of DACT's Local Action Plans</i>	29
2.8	<i>Delivery Performance of the Joint Implementation Agenda</i>	29
2.8.1	<i>Introduction</i>	29
2.8.2	<i>Uneven but steady progress</i>	30
3.	IMPACT: To what extent have the critical objectives of the Alcohol and Drug Strategies been achieved?	32
3.1	<i>An Indicative Assessment</i>	32
3.2	<i>Progress Against Objectives in the Alcohol Strategy</i>	32
3.2.1	<i>Responsible and binge drinking measures</i>	32
3.2.2	<i>Reduction of negative outcomes</i>	33
3.2.3	<i>Better protection from anti-social and criminal behaviour</i>	34
3.2.4	<i>Promote and improve treatment</i>	35
3.2.5	<i>Reduce access to alcohol for Under 18s</i>	36
3.3.	<i>Progress Against Objectives in the Drugs Strategy</i>	37
3.3.1	<i>Reduce illicit drug use and related harm for Under 25s</i>	37
3.3.2	<i>Better protect communities, reduce drug related crime and insecurity</i>	38
3.3.3	<i>Reduce availability of drugs</i>	39
3.3.4	<i>Overcome drugs problems through service provision</i>	40
3.4	<i>The Aspirational Goals of the Strategies have not yet been met</i>	42
4.	APPRAISAL: Stakeholder perspectives and analytic assessment of strategic and operational performance	44
4.1	<i>Introduction to the Consultation</i>	44
4.2	<i>Are Two Strategies Better Than One?</i>	44
4.3	<i>Should Joint Implementation be Maintained?</i>	45
4.4.	<i>Strengths and Weaknesses of Current Arrangements</i>	46
4.4.1	<i>The politics of consultation</i>	46
4.4.2	<i>All about JIM: Views from stakeholders at all levels</i>	47
4.4.2.1	<i>The JIM Structure and action plans</i>	47
4.4.2.2	<i>Funding community projects</i>	47
4.4.2.3	<i>Monitoring and evaluating community projects</i>	48
4.4.2.4	<i>Working groups</i>	48
4.4.2.5	<i>Information, monitoring, evaluation and research</i>	49
4.4.3	<i>Regional Structures</i>	50
4.4.3.1	<i>Drug and Alcohol Implementation Steering Group</i>	50
4.4.3.2	<i>Drug and Alcohol Strategy Team</i>	51
4.4.4.	<i>Overarching issues, inclusivity, service user involvement and training</i>	52
4.4.4.1.1	<i>Inclusivity and service user involvement</i>	52
4.4.4.1.2	<i>Training strategy</i>	53
4.5	<i>Agenda for Change</i>	53

5.	REFOCUS: Revising the alcohol and drug strategies and joint implementation	55
5.1	Significant Renovation Required	55
5.2	Changes in the Alcohol and Drugs Landscape since yr 2000	55
	5.2.1 <i>Drinking rates</i>	55
	5.2.2 <i>Drug use and availability</i>	56
5.3	Maintain but Revise the Critical Aspirational Goals	56
5.4	Revision and Extension of Alcohol Strategy's Domains	57
	5.4.1 <i>Goals must impact at local level</i>	57
	5.4.2 <i>Managing the night-time economy</i>	57
	5.4.3 <i>Liquor licensing review</i>	57
5.5	Extending the Drug Strategy's Domains	58
	5.5.1 <i>Treatment and criminal justice interventions</i>	58
	5.5.2 <i>Harm reduction</i>	58
	5.5.3 <i>Map and challenge drug markets</i>	58
	5.5.4 <i>Introduce an early warning system</i>	59
5.6	Cross-Cutting and Joint Implementation Domains	60
	5.6.1 <i>Target vulnerable young people</i>	60
	5.6.2 <i>Uplift monitoring, evaluation and research, review data bases</i>	60
	5.6.3 <i>Modernise treatment provision</i>	61
	5.6.3.1 <i>Provision not meeting need</i>	61
	5.6.3.2 <i>Models of Care</i>	62
	5.6.3.3 <i>Commissioning of services</i>	63
	5.6.3.4 <i>Training and DANOS</i>	63
	5.6.3.5 <i>Best practice organisational standards</i>	63
	5.6.3.6 <i>Hepatitis programme</i>	64
	5.6.3.7 <i>Service users, inclusivity and stigma</i>	64
5.7	Refocus, Strategic Goals for Compatibility with the Multiplicity of Other Regional Strategies	64
6.	RETHINK: Redesigning strategic, organisational and operational arrangements to improve efficiency and effectiveness	66
6.1	A Critical Moment for Re-addressing Alcohol and Drugs Problems	66
6.2	The Estimated Costs of NI's Alcohol and Drug Problem	67
	6.2.1 <i>Alcohol estimates</i>	67
	6.2.2 <i>Drugs estimates</i>	67
6.3	Funding and Investment 1999-2005	67
	6.3.1 <i>Funding arrangements difficult to collate</i>	67
	6.3.2 <i>'Treasury' NIO, DENI and DHSSPS Investment</i>	68
	6.3.3 <i>Recent and current resources</i>	69
	6.3.4 <i>Difficulties related to recent funding streams</i>	69
6.4	Reviewing the Strategic Plans	70
	6.4.1 <i>The strategies and JIM</i>	70
	6.4.2 <i>Carefully crafted critical goals: three principles</i>	70
6.5	Rethinking Joint Implementation: Principles to Practice	71
	6.5.1 <i>Partnership</i>	72
	6.5.2 <i>Information sharing</i>	72
	6.5.3 <i>Monitoring</i>	73
	6.5.4 <i>Evaluation</i>	73

6.5.5	<i>Research</i>	74
6.5.6	<i>Inclusivity</i>	74
6.5.7	<i>Coordination</i>	75
6.5.8	<i>Accountability</i>	75
6.5.9	<i>Additional principles: communication and value for money</i>	75
6.6	Regional Hub	76
6.6.1	<i>Under-resourced and underpowered DAST</i>	76
6.6.2	<i>A regional hub fit for purpose</i>	77
6.6.2.1	Regional team structure	77
6.6.2.2	Implementation Teams	79
6.6.3	<i>DACTs Role</i>	81
6.6.4	<i>In conclusion</i>	82
	ACRONYMS	83

ACKNOWLEDGEMENTS

Howard Parker would like to thank the large number of individuals, teams and organisations that have given him so much of their time and effort in collecting the information and evidence which underpins this report. Over 200 people have engaged in the consultation process both directly to the Reviewer and via the Deloitte Stakeholders' Consultation and the E and written consultation pathways. DAIRU's desk top review has also been a very important source of evidence for Section 3 and their free standing review is essentially a sister document to this report.

EXECUTIVE SUMMARY

1. In 1999 Northern Ireland developed its first coherent strategic plans to respond to the region's alcohol and drug problems. ***The Drug Strategy for Northern Ireland*** prioritised aspirational goals: to reduce drug taking amongst young people and protect from harm those using drugs, to protect individuals and communities from anti-social/criminal behaviour related to drugs, to reduce the availability of drugs and to help those with drug problems overcome them. The critical goals in ***Reducing Alcohol Related Harm in Northern Ireland*** were to: encourage responsible drinking and reduce binge drinking, to protect individuals and communities from alcohol related harm and to promote effective treatment services. Both strategies emphasised the need for a strong monitoring-research-evaluation system.

Two New strategies
2. These 2 strategies were jointly implemented with a new organisational and delivery structure overseen in the absence of sustained devolution by a minister led steering group (Drug and Alcohol Implementation Steering Group), a new coordination team (Drug and Alcohol Strategy Team), 6 partner Working Groups and 4 re-focused Drug and Alcohol Implementation Teams to ensure appropriate local delivery arrangements. Between 1999 and 2004 around £15 million of new Treasury investment was distributed through JIM (from 2001). The delivery also relied on partnership working embracing government departments, voluntary and community agencies and enforcement and criminal justice agencies to share the overall programme roll out.

New Joint Implementation Structure (JIM)
3. This external Review has been tasked to assess the efficiency and effectiveness of this strategic approach and identify strengths and weaknesses before suggesting how the next cycle's (ie. 2006-2011) structure and approach might be improved.

Purpose of Review
4. The Review has been supported by a desk top analysis of key survey/research data and by a stakeholder consultation exercise.

Support and evidence for the Review

This said the current monitoring and performance management systems are not fully fit for purpose with several strategic objectives either unmeasurable or devoid of any tracking data. The Review has managed to overcome some shortcomings and offers a template for the future.

5. The JIM system and business plan have been audited against the priority tasks. Delivery has been satisfactory rather than impressive. Over half of the key priority activities have been completed successfully by mid 2004 with new resources distributed to set up or enhance over 40 projects and related initiatives. DACTs had a similar success rate at locality level.

***Satisfactory
Development
of
New provision***

The region now has:

- More robust education and prevention provision especially via schools.
- A range of new community and voluntary projects delivering information, training, awareness, counselling, brief interventions, etc.
- Several new treatment projects seen to support statutory provision.
- Increasingly available treatment interventions for young and adult offenders and prisoners with substance problems.
- A range of new policies and procedures variously bedded into prisons, the sports and leisure sector, the entertainment industry and the workplace.

6. The Review audited progress against the critical strategic objectives. Only limited success is apparent. Alcohol consumption continues to rise for the whole population and binge drinking remains unchecked. Morbidity and health problems associated with alcohol continue to increase leading to more hospital admissions. Community concern about nuisance and anti-social behaviour and under-age drinking remains high. Alcohol related traffic accidents have reduced however.

***Strategic
Alcohol Goals
not achieved***

7. The use of drugs particularly by young people began increasing during the 1990s and has continued to do so into the new millennium although there are signs of a plateau. Currently cannabis, ecstasy and cocaine are the most used drugs. Problem drug use associated with heroin appears fairly stable with around 1,000 heroin users estimated to live in NI. However, there are indications that this may be a conservative figure and that crack use are beginning to increase.

***Strategic
Drugs Goals
Not Fully
Achieved***

Whilst the goals of increasing drugs seizures, asset forfeiture and reducing drugs availability in prisons are being achieved, the overall availability of drugs has not been reduced. Street prices are actually falling and population surveys report easy availability.

There are encouraging signs that criminal justice interventions are reducing drug related offending although not all offenders can access these so far.

8. ***Improving Treatment for Alcohol and Drug Misusers*** Both strategies aspired to creating an effective accessible treatment system. Much progress has been made through JIM investment in terms of provision. However alcohol services have suffered from the drugs focus of Treasury money. Statutory treatment services, whilst supported by new JIM projects, have not been uplifted despite a 15% increase in referrals and so remain under-resourced.

Monitoring and Evaluation A critical issue is that despite strategic requirement there is no adequate system to measure the effectiveness of either statutory or voluntary provision. Even basic monitoring systems have under-performed.

9. ***Weaknesses Identified*** Thanks to coherent stakeholder feedback the Review has been able to identify a range of weaknesses in JIM arrangements which have frustrated efficiency at all levels. Current arrangements are too bureaucratic and there are numerous shortcomings in respect of communication, coordination, monitoring and evaluation, funding, leadership and, most of all, accountability. The whole programme needs re-configuring to enhance efficiency and effectiveness in the next strategic cycle.

10. ***Resetting Strategic Goals and JIM Priorities*** The Review finds that the critical aspirational goals set around yr 2000 although unachieved remain broadly appropriate but need redrafting and extending. For alcohol a new emphasis needs to be the management of a burgeoning night-time economy. For drugs there needs to be more guidance about policing regional and local drug markets and the introduction of an 'early warning system' to help protect NI from drugs supplying and dealing and more 'problem' drug use.

Vulnerable young people must become a cross-cutting strategic priority given this population's high rate of alcohol and drug misuse woven into other risk factors. There needs to be a major modernisation programme for statutory treatment provision and far more scrutiny and development of voluntary and community projects. An Under 18s substance misuse service needs developing. The 3 treatment data bases might be merged for cost-effectiveness.

11. The redrafting of strategic goals should be guided by 3 principles which might reduce the current weaknesses identified.

**Redrafting
Strategic
Goals**

- (i) The goals must be consistent with strategic priorities found in the myriad of other strategic plans including but also beyond Investing for Health, for instance community safety, regeneration, enforcement, child and young people's services.
- (ii) All the critical goals should be designed to operate at both regional and community level.
- (iii) All goals should be measurable and have performance indicators attached to them which are EU comparable.

12.

**JIM
Best Practice
Principles**

Joint Implementation can be significantly improved if 10 key principles are actually fully practiced and applied. These are partnership, information sharing, monitoring, evaluation, research, inclusivity, coordination, accountability, communication and value for money. An inability to fully follow these best practice principles has been at the heart of most under-performance. The DAST 'regional hub' is seriously under-powered and has been overwhelmed and unable to work to or drive these standards.

13.

**Costs of
Alcohol and
Drug Problems**

The estimated economic and social costs of alcohol misuse to NI include 730 deaths a year and 12,000 expected years of life lost. The additional costs for government spending and working days lost come to £1.5billion. Costs associated with the drugs problem are estimated to be at least £300 million a year.

14.

**Funding
Investment in
the Alcohol
and Drug
Strategies**

Currently overall direct resources dedicated to programme delivery are about £12.5 million a year. Several problems created by recent funding streams are identified including undermining project development with unrealistic deadlines and inadequate information about sustainability and funding core provision (e.g. dual diagnosis work) from project money *outside* HSSB statutory provision.

15.

**Accountability
and
Performance**

Current arrangements for accountability and performance management have suffered from the suspension of devolution. The future senior steer should come from a carefully constructed ministerial/senior officer group which must be far more thorough and assertive in driving performance and ensuring best practice principles are operated by all stakeholders.

16.

**Regional
Hub**

DAST has been much criticised by stakeholders but in truth has not had adequate resources or support from above to undertake its complex and demanding roles. Some new or diverted investment is required to allow this Regional Hub

to be re-configured, upgraded and made fully fit for purpose. Strategic leadership and visibility might be enhanced by appointing a non-executive 'Champion'.

17. If fully implemented these revisions, especially at the Regional Hub, should reduce the operational problems at DACT level and clarify their roles although their full accountability will not be easily achieved.

DACTs

18. Northern Ireland is at a critical moment in terms of its alcohol and drugs problems. Public concern is at a high level. Having learnt so much from this first strategic roll out, the region now has the opportunity to create a more efficient and effective structure for the next cycle.

New Opportunities

1. CONTEXT:

The background and purpose of the Review

1.1. Brief History of Strategic Development

1.1.1 Drugs strategies

Northern Ireland's first drug misuse policy for managing its drugs problem was launched in 1995 as the ***Drugs Campaign for Northern Ireland***. The approach was overseen by a Central Coordinating Group for Action Against Drugs (CCGAAD). In 1998 a review was undertaken to update the regional strategy to take NI into the new millennium.

In mid 1999 a new strategic plan was launched namely the ***Drug Strategy for Northern Ireland***. This plan mirrored the UK strategic framework and contained 4 inter-related aspirational goals:

- To protect young people from the harm resulting from illicit drug use.
- To protect communities from drug related anti-social and criminal behaviour.
- To enable people with drug problems to overcome them and have healthy and crime free lives.
- To reduce the availability of drugs in communities.

During a temporary period of devolved government the oversight for this strategy was passed to a new ministerial group chaired by a DHSSPS minister and representing a range of government departments seen as stakeholders. The Northern Ireland Office functions (e.g. around enforcement) were not devolved. This renamed ministerial group (Drug and Alcohol Ministerial Strategic Steering Group) (DAMSSG) became inactive in 2002-03 with the suspension of devolution.

1.1.2 Alcohol strategies

In June 1999 a DHSSPS report was published as ***Reducing Alcohol Related Harm in Northern Ireland*** which reviewed the current ad hoc arrangements, available data and evidence and produced a strategic plan based on the conclusion that problems related to alcohol use and misuse were growing. The four aspirational or core goals were to:

- Encourage a responsible approach to drinking.
- Promote effective treatment services.
- Protect individuals and communities from alcohol related harm.
- Develop a research and information programme.

This strategy was launched in 2000 with the stated aim that its effectiveness should be reviewed by the end of 2006.

1.2 The Joint Implementation of the Two Strategies

In May 2001 the Executive endorsed a Joint Implementation Model (JIM) to deliver both strategies together under the auspices of DAMSSG and DAISG – the Drugs and Alcohol Implementation Group. With the suspension of devolution DAISG has become the highest functional level of accountability. The Drugs and Alcohol Information and Research Unit (DAIRU) set up in yr 2,000 took on part of the monitoring and research role required in the two strategies although it remained outside the programme structures in terms of line management.

New 'Treasury' funding beginning in 1999 and continuing into 2004 via 2 tracts of ring fenced 'drugs' (not alcohol) money allowed £15 million to be distributed. The JIM structure became the mechanism to deliver this investment to uplift education and prevention, treatment and community and voluntary projects offering a wide range of services. Alcohol provision was not formally supported but has increased, riding on the back of many of the funded projects.

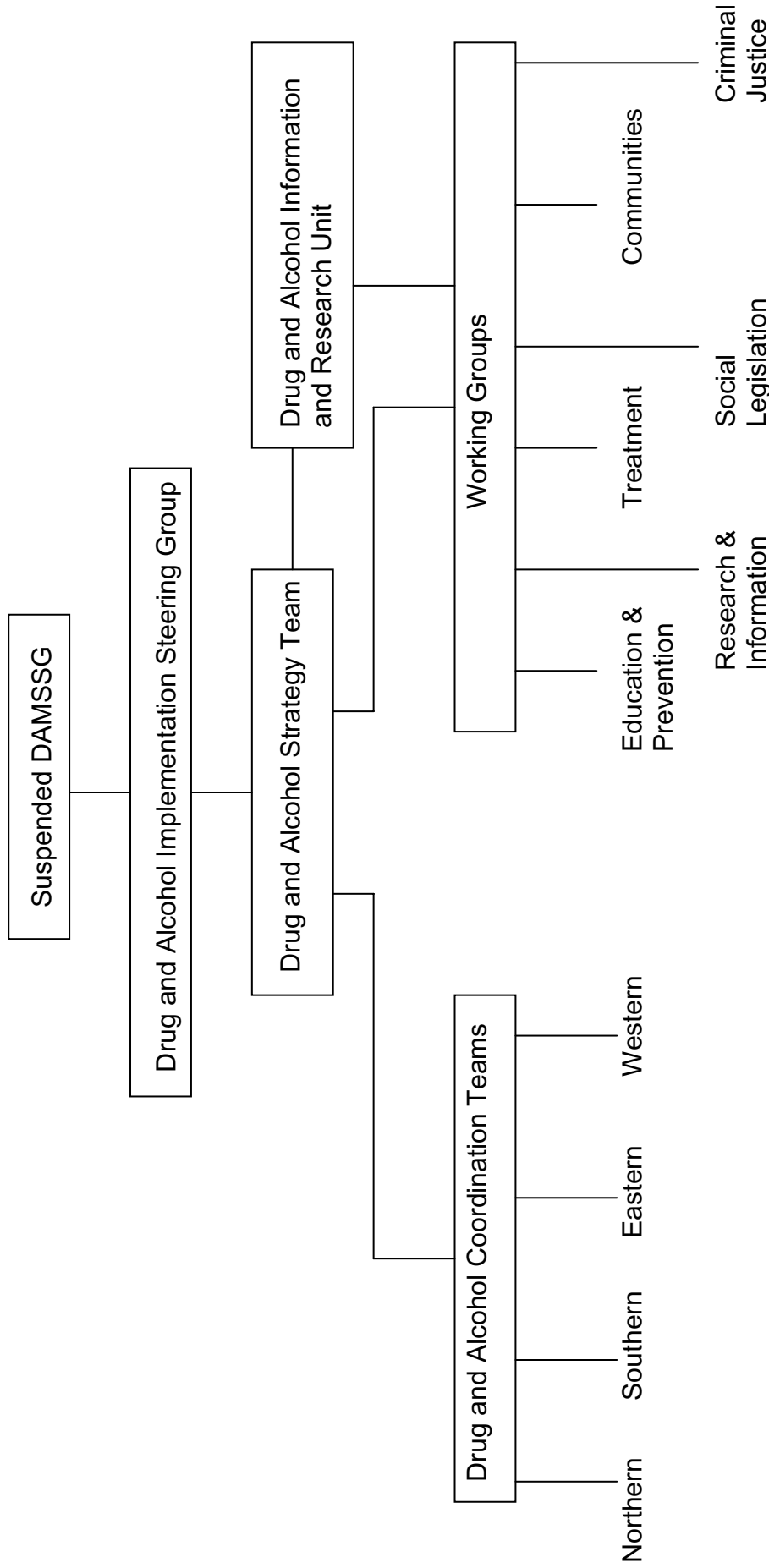
The JIM structure was coordinated by a newly appointed Regional Drugs and Alcohol Strategy Coordinator. She was supported by DAST (Drug and Alcohol Strategy Team) based in the Health Development Directorate of the DHSSPS.

At community level the Drug and Alcohol Coordination Teams (DACTs), which had been in existence for several years, were reconfigured by JIM to ensure the delivery of the strategy as outlined in the business and organisational plan ***Drugs and Alcohol Regional Action Plan***. DACTs were also tasked to take account of local issues and priorities and each had their own local action plan.

Because funds had to be dispersed quickly and a large amount of developmental business was required to set up policies, structures, needs assessments, etc. JIM introduced 6 working groups to focus on Education and Prevention, Treatment, Information and Research, Social Legislation, Communities and Criminal Justice (see Chart 1.1).

There have been several important changes to JIM during the first implementation which will be referred to in the Review. Firstly, there have been changes in the funding stream. With the end of Treasury campaign money in April 2004 the DHSSPS has picked up the most of on-going funding of JIM although other streams are found via NIO, DENI and HSSBs. Secondly, a review of the DACTs' role took place in 2001 eventually leading to changes in 2003. Thirdly, since 2002 the Alcohol and drug Strategies have been placed within the 'Investing for Health' framework. Finally a successor regional coordinator was appointed in late 2003.

Chart 1.1: Joint Implementation Model 2002-05



1.3 The Purpose of the Review

The Review's primary purpose as laid out in its terms of reference is to:

Determine the overall effectiveness of the Northern Ireland Drugs and Alcohol Strategies and the joint implementation structures and activities developed to take them forward. To inform the development of strategic recommendations to address alcohol and drug-related harm in Northern Ireland.

The Review is charged with assessing the original intentions of the 2 strategies and JIM and establishing the accomplishments or effectiveness of the recent delivery cycle (2002-05). It should advise on whether JIM is fit for purpose by reviewing the roles and responsibilities of stakeholders and the strengths and weaknesses of current arrangements including funding. The Review should also make reference to best practice within and beyond the region and comment on the linkages between alcohol and drug strategies and other regional strategic frameworks, reviews and public service goals. It is expected to consider the issue of monitoring, evaluation and research and whether the current arrangements are adequate and constitute an adequate performance management system.

This Review thus provides not only an audit of recent efficiency and effectiveness but provides or creates comparisons, information, ideas, principles and structures which can inform the renovation of the current strategic plans and the implementation of a further 'cycle' from 2006.

1.4 Support for the Review

1.4.1 The Desk Top Review

The Review has been supported by 3 important activities. Firstly, DAIRU was tasked to provide a comprehensive literature/desk review of alcohol and drug misuse in NI which was to include trends and patterns around consumption and related 'harm' set against GB and international comparisons. This report (*NIDAC /Joint Implementation Model Review: Desk Review* (DAIRU, 2005)) was also required to provide information on the costs associated with or attributed to alcohol and drug related harm. This desk top review was also to provide, where possible, information to assist with the external Review.

1.4.2 The Stakeholder Consultation

Secondly, whilst the Review undertook a wide ranging consultation with most senior players and stakeholders it has also relied on a stakeholder consultation undertaken across the region focusing on DACT/community level professionals, providers and associated interested parties. Around 130 individuals took part in 19 focus groups, the results of which are summarised

by the contractor, Deloitte in their *Summarised Thematic Analysis of Focus Groups* (Deloitte, 2005).

In addition the Review received around 30 'E' and written consultation replies.

1.4.3 Documents and data

Thirdly, whilst numerous agencies and individuals have provided data, research reports, planning and implementation frameworks, guidance documents and so on, it has been through the good offices of DAST and NIO/Community Safety that most information has been generated. Over a hundred discrete pieces of information have been 'digested' during the Review and have proved vital in helping produce a rapid overview of the current drugs and alcohol programme.

1.5 The Structure of the Report

Section 2 considers the extent and degree to which the JIM structure has delivered its business plan successfully and efficiently via the regional and local action plans and the Working Group and DACT structures.

Section 3 assesses the impact of this activity and the extent to which the critical objectives outlined in the alcohol and drug strategies have been achieved.

Section 4 focuses on stakeholder perspectives on current programme arrangements and undertakes an analytic assessment of the factors which have weakened efficiency and effectiveness and allowed key principles (e.g. inclusivity, accountability) to be compromised.

Section 5 reviews the appropriateness of the current strategic objectives and discusses how they can be re-focused and extended to provide a more comprehensive strategic approach and good compatibility with other strategic plans.

Section 6 provides a range of suggestions and recommendations to underpin the redevelopment of the whole programme. In particular it offers a set of principles and organisational arrangements which if applied holistically might enable a more efficient and effective apparatus to be developed for implementation from 2006.

2. ACTIVITY: Has the joint implementation business plan been delivered successfully?

2.1 Introduction to Auditing Outcomes

This Section identifies the range of *critical* and *secondary* outcomes laid out in the two strategies and the joint implementation plan. It then concentrates on auditing the extent to which the essentially secondary outcomes listed in the Regional and Local Action Plan have been delivered. We are measuring the ability of all the stakeholders identified in the plan to work together and deliver to target priorities. This is a measure of *efficiency*.

The joint implementation regional plan assumes that the critical goals found in the original strategies can be largely achieved through development activity and building up the infra-structure and capacity of agencies, services and community activists, etc. Thus priority activities are set for education, public health, enforcement, regulation, treatment services and so on. There are literally hundreds of target activities to be audited.

Crucial or *critical outcomes* are defined as those which lie at the heart of the two strategies and relate most closely to the core aspirational goals. In both strategies these relate to concrete improvements within the population or community. They are concerned with personal and public health gains, crime and disorder reduction, enhanced public safety, the recovery of problem drinkers and drug users and so on. *Secondary outcomes* are primarily about process and the delivery of outputs

2.2 Alcohol (Harm Reduction) Strategy: Critical Outcomes

2.2.1 Identifying the Core

The five main objectives in the original strategy were to:

- (i) Encourage a responsible approach to drinking.
- (ii) Promote effective treatment services.
- (iii) Protect individuals and communities from alcohol related harm.
- (iv) Develop a research and information programme.
- (v) Implement and manage the Strategy effectively.

Whilst (iv) and (v) are listed as critical outcomes they are also partly 'secondary' in nature in that they potentially enhance the effective delivery of the regional business plan.

2.2.2 Encouraging responsible drinking

The Strategy set particular critical outcome targets in its interpretation as to how to encourage responsible drinking.

To reduce binge drinking amongst teenagers, young adults (16-25s) and adults.

To reduce alcohol misuse and so reduce negative outcomes.

The suggested target areas were: unprotected sex, drink driving, accidents, alcohol related crime, alcohol related disorder and alcohol related violence in the home. We would hope to see reductions in the incidence of all these 'negative' indicators (Section 3).

The suggested programmes to achieve these quantifiable gains were to uplift alcohol education for 5-18 year olds through school based activities, to develop an awareness campaign for 16-25s, women and older people, to introduce workplace policies on alcohol, to work within the leisure and sports sector and to engage with the drinks industry.

2.2.3 Promote and improve 'effective' treatment services

The original alcohol strategy emphasised the need to uplift alcohol treatment services on the basis of need and in an equitable and accountable way. It emphasised the importance of following best practice to achieve effectiveness. The only critical target was "to help people overcome their alcohol misuse problems". The remainder of the focus was on auditing and enhancing current provision but with the aspiration of delivering high quality treatment which was based on a dynamic search for *effective* treatment outcomes.

2.2.4 Protecting the community

The aspirational goal to better protect individuals and communities from anti-social and criminal behaviour arising from alcohol misuse set two critical outcome measures.

To reduce the number of alcohol-related casualties amongst road users.

To reduce access to alcohol by under-age drinkers.

The original strategy thus lacked detail as to how to protect the community, tending instead to focus on licensing, work with the drinks industry and licensed trade – secondary processes.

2.3 Drugs Strategy: Critical Outcomes

2.3.1 Identifying the Core

The 2000 revised Drugs Strategy, in order to reduce the level of drug related harm in NI, identified four overarching aims:

- To protect young people from the harm resulting from illicit drug use.
- To protect communities from drug related anti-social and criminal behaviour.
- To enable people with drug problems to overcome them and have healthy and crime free lives.
- To reduce the availability of drugs in communities.

The drug strategy identified a number of core outcomes to be achieved under each of these four pillars.

2.3.2 To protect young people from the harm resulting from illicit drug use

The particular performance indicators nominated in the strategy were:

To reduce the percentage of young people under 25 reporting use of illicit drugs.

To delay the age of first use of illicit drugs.

All other targets for 'young people' are secondary in nature.

2.3.3 To protect communities from drug related anti-social and criminal behaviour

There were three core outcome measures identified.

To reduce drug related crime.

To reduce community concerns and/or fear about drug related activities.

To reduce drug related problems, including accidents in the workplace.

All other targets for 'communities' were secondary in nature.

2.3.4 To enable people with drug problems to overcome them and lead healthy crime free lives

There were no core outcome measures set for this aspirational goal. The strategy instead emphasised auditing and uplifting treatment provision and forging inter-agency collaboration.

2.3.5 To reduce the availability of drugs in communities

There were four core outcome measures identified:

To reduce the availability of drugs in prisons.

To increase the value of illicit drugs seized in NI.

To seize assets of convicted drug traffickers/suppliers.

To reduce the percentage of young people (under 25) who have ever used illicit drugs (shared goal).

The remainder of targets and desired outcomes were secondary in nature.

2.4 The Joint Implementation Regional and Local Action Plan

2.4.1 An indicative audit

The business plan was delivered between 2002-04 under the auspices of DAISG and DAST and via the six working groups. The four DACTs were charged with enhancing delivery locally and implementing their own local action plans where these differed from regional priorities. This delivery plan has been fully audited as part of the Review.

The data used to audit delivery is primarily found in the *Report on Progress Towards Targets* (DAST, 2004) which is a collective internal self-reporting assessment system. Whilst there are some shortcomings to this system it is the only coherent data set available. Here only a schematic summary is provided since the full report is over 90 pages long. Whilst this report finishes monitoring at March 31st 2004 an attempt has been made to extend the regional plan audit to December 31st using information and evidence from Chairs, DAST and recent working group minutes.

2.4.2 The Education and Prevention Working Group

The original strategic goals of the two strategies to 'reduce harm' are revised in the working group's overarching aim whereby the new mission is

Through Education and Prevention Programmes reduce the harm caused to individuals and society by illicit drug misuse and by the misuse of alcohol.

The group's terms of reference and output areas become specific.

Terms of Reference/Responsibilities

- Suggest measures to prevent drug and alcohol misuse, and promote these measures in health education.
- Encourage a coordinated and consistent approach to drug and alcohol education and prevention based on acknowledged and current good practice.
- Monitor how the relevant sections of the drug and alcohol strategies are put into practice.
- Make sure that outcomes and targets for education and prevention are achieved.
- Encourage the use of best practice and promote what works.

Output Areas

Programme of health education for teenagers and young adults (16-25yrs).

Programme of age appropriate health education (5-11yrs and 12-18yrs).

Adult awareness programme, to include domestic violence, needs of parents/carers.

Training for trainers.

Delivery Progress

Chart 2.1 describes the key target activities in the business plan of the EPWG. In line with the terms of reference the focus has been on establishing alcohol and drugs education programmes both in schools and through public health awareness campaigns. Some progress has been made here but there are also signs of slippage and some non delivery. In respect of workplace policies there has been successful delivery and the production of an impressive portfolio of guidance for employers and other stakeholders. Some significant progress has taken place in respect of work within the sports and leisure sector but again target delivery has only been partial.

Chart 2.1: The Education and Prevention Working Group

Target Activity	Progress at end of 2004
Auditing, piloting and roll out accredited professional development/ training courses for the deliverers of health education programmes	Not fully delivered. Auditing difficulties
Resource an audit of courses available for drugs and alcohol education professionals	Activity achieved successfully
Misuse of Drugs Act guidance for schools	New guidance delivered to Department of Education. Fully implemented
Public information campaign 8-25 yr olds	Several campaigns on alcohol and solvents delivered. Steady progress. New campaign for 8-14s not delivered due to resourcing problems
Produce workplace guidelines for employers to develop drug and alcohol policies. To promote their implementation	Policies and guidelines largely successfully 'delivered'. Some successful promotional work. Further development work in progress
To audit leisure and sport sector, to design policy and around alcohol/drugs to pilot, implement and monitor programme	Audit eventually completed. Policy development part of action plan. New bid for continuation given slippage. Partial delivery

2.4.3 The Treatment Working Group

The original strategic goals in the alcohol and drug strategies have been merged. The Treatment Working Group thus operates under the goal – ***to enable people with drug and alcohol problems to overcome them and have healthy lifestyles.***

Terms of Reference/Responsibilities

The originally defined output areas were:

- Treatment services – audit and uplift.
- Service effectiveness – develop effectiveness/outcome monitoring and create best practice and information exchange. Consider new approaches to service delivery.
- Review provision for young people.
- Training programme expansion in brief interventions and for entertainment staff venue.

Delivery Progress

The TWG has dealt with a complex and demanding agenda. As Chart 2.2 shows, considerable progress and success has been achieved. In particular treatment provision has been uplifted in terms of extra staff for CATs, a new Youth Counselling Service, dual diagnosis provision and a fully kitted Substitute Prescribing Service. Steady progress has been made on hepatitis services and the development of guidelines for staff in entertainment venues. There has however been slippage in respect of commissioning audits and needs assessments in respect of guidance for working with young people and training needs and the value of a rehabilitation unit. Most importantly little progress has been made on the treatment effectiveness agenda.

Chart 2.2: The Treatment Working Group

Target Activity	Progress at end of 2004
Set up Youth Counselling Service in partnership with Community Addictions Team	Task successfully completed
To create guidelines for working with young people including needle exchange schemes	Not delivered, delayed by slippage of needs assessment
Assessment and provision audit of alcohol/drug treatment services	Partly delivered. Not completed
Needs assessment for young people and recommendations	Problems with quality of report delivered 2004. Needs assessment now progressing
Conduct a training audit on needs of health and social care workers including all who work with substance misusers. Review available training modules set up, roll out programme	Merged with training audit for treatment providers. Much work completed but suspended. Not a comprehensive review
Appoint dual diagnosis workers into each CAT	Task successfully completed
Develop prescribing services for NI in partnership with doctors and provide opiate management procedures	Major task successfully completed
Produce licensing structure and training for relevant professionals and pharmacists in respect of prescribing	Delivered successfully
Additional substance misuse worker and doctor time for each CAT	Delivered successfully
Develop effectiveness measurement systems for alcohol and drug treatment services in NI	Slippage, not delivered. Still under discussion
Assess need for a long term rehabilitation unit in NI. Make recommendations	Slippage, not delivered

Set up community awareness programme on prescription drugs and dangers of mixing with alcohol	Still under consideration. Not delivered regionally but a local output delivered
Develop and roll out hepatitis programme with procedures, training and vaccination programme (hep B)	Some slippage, partly delivered. Still under development
Develop through consultation Safer Entertainment Guidelines for all relevant venues. Review legal implications. Develop training policy for staff in entertainment venues	Some slippage, largely delivered. Awaiting publication for public consultation.
Set up information exchange for Community Addiction Teams and stakeholders	Delivered successfully through conference and forum
International Harm Reduction Conference to be hosted in Belfast	Delivered successfully in March 2005
Develop MSc in Addiction Studies in NI with universities	Delivered successfully

2.4.4 The Communities Working Group

Under the revised goal – ***to promote and support community action to reduce the harm caused by alcohol and drug related anti-social behaviour***, the CWGs terms of reference were at an unusually high level of generality for a business plan.

Terms of Reference/Responsibilities

- Secure a coordinated approach to tackling alcohol and drug misuse at community level.
- Tackle the needs of drug and alcohol users (e.g. health education, accommodation, childcare, employment).
- Monitor how the relevant sections of the Drug and Alcohol Strategies are put into practice.
- Make sure that outcomes and targets on the relevant sections of the Drug and Alcohol Strategies are achieved.

Output Areas

Reduce anti-social and criminal behaviour through health education promotional campaigns.

Enhance partnership including the business sector and coordinate care.

Prevent under 18s getting access to alcohol.

Ensure community based services deliver appropriate programmes and identify gaps and needs evident at community level.

Delivery Progress

The terms of reference and agenda for the CWG do not easily generate targets with observable outcomes. There has been a rather mixed delivery programme given the problematic agenda. Work with the drinks industry has been established through liaison with the Federation of Retail Licensed Trade (NI) and some progress has been made. The consultation around national entitlement cards has stalled but is found in the ongoing LLR.

Little progress has been made in developing a regional directory of services. Progress has occurred in respect of the needs of families with substance misusers following a competent needs audit. Some progress has been made over developing liaison with substance users but this initiative has stalled. A publicity campaign and information leaflet has been delivered successfully. In conjunction with TWG the safer dancing/entertainments guidance has made progress. Several small tasks have been completed successfully.

Chart 2.3: The Communities Working Group

Target Activity	Progress at end of 2004
Work with drinks industry to develop voluntary codes of practice around alcohol sale and use	Successful delivery of guidelines. New steer required
To consult on the utility of a national entitlement card for young people	Work undertaken but now 'suspended' awaiting governmental decisions.
Assess training needs and provide training around 'Safer Entertainments' agenda	Steady delivery progress mainly via TWG Safer Dancing sub group. Some training delivered locally
Encourage DACTs to discuss 'carrier bags' and off licences with local community	Not regarded as priority
To develop a best practice model of partnership working through literature review, training development and delivery	Review completed but slippage. Carrying forward. Wider review of partnership underway outside
To establish a communication data base with DAIRU	Not delivered
To develop a regional directory of services and maintain it	Activity redesigned, on-going, not delivered.
To undertake needs assessments of parents and families of drug and alcohol misusers. To then deliver appropriate training and support	Only report delivered. Further progress likely
To identify and contact users and set up a users' network or liaison group	Users' seminar held but slippage in establishing a liaison group. Difficult

	to progress. Further development now likely
Run publicity campaign around binge drinking (and violence) associated with alcohol and drug misuse	Delivered both elements of one campaign. Binge drinking task force set up
Community awareness about alcohol and drug strategies and structures	Delivered booklet for distribution

2.4.5 The Information and Research Working Group

In their different ways both the Alcohol and Drugs strategies saw information gathering, monitoring, research and evaluation as an integral element of guiding and assessing delivery of the core outcomes. In particular the need to establish base lines for performance monitoring was highlighted. Here the agenda and performance of the IRWG is described. The review will return to this whole issue in Sections 4 and 5.

Importantly the centrality of monitoring and evaluation is found in the terms of reference of DAISG placing a primary responsibility on the minister led group to ensure delivery. This priority is also passed down to the Working Groups and DACTs. The revised primary goals for IRWG are to:

Monitor how the drug and alcohol strategies are put into practice and monitor their progress regularly.

Make sure that where possible all activities are based on proven best practice.

The JIM aim for the working group was – ***to advise on the development and implementation of the Drug and Alcohol Information and Research Strategy and to support the strategies with new information and research programmes.***

Terms of Reference/Responsibilities

- Develop and take the lead in putting an agreed information and research strategy into practice to support putting the drug and alcohol strategies into practice.
- Lead in developing targets and performance indicators and in monitoring progress towards specific outcomes.
- Put into practice the Drug Misuse Database project and to develop proposals to enhance and improve its effectiveness.
- Produce a system of monitoring support, especially baselines.

Delivery Progress

The IRWG has made good progress in terms of its target activities. Most of the research agenda laid out in the business plan has been completed. Reasonable progress has been made in utilising regional surveys to begin setting 'baselines'. Slippage has occurred in respect of surveying primary school children. The significant dysfunction between primary objectives and the business plan will be discussed in due course.

Chart 2.4: The Information and Research Working Group

Target Activity	Progress at end of 2004
Secondary analysis of Young Person's Behaviour and Attitudes Survey 2000 and NISRA omnibus survey drugs module analysis	Delivered successfully
(All Ireland) survey of drug and alcohol use amongst adults	Survey completed and results published. Successful delivery
Qualitative study of 18-35 year olds attitudes and behaviour re: alcohol	Study completed and report published. Successful delivery
Upgrade and run the Drug Misuse Database	Delivered and maintained
Estimate size of opiate using population and assess need for a substitute prescribing service	Delivered fully
Set up NI survey of salivary antibodies to HIV/Hep	Steady progress, partly delivered
Carry out primary school survey around substance use 8-11 year olds	Slippage over design, not yet delivered. On-going
Research into young vulnerable groups. Size, nature and location of this group.	Slippage through inadequate external research. Part delivery only
Gather data and explore links between drug and alcohol misuse and employment, absenteeism, accidents at workplace, etc.	Some limited progress
Explore with PSNI and HM Customs distribution of key statistical data and improve coordination and dissemination	Largely delivered
Create accessible information register of drug and alcohol related research. Maintain and disseminate	Delivered initial directory. This project stalled in 2003
Produce in-depth studies of high risk drug using behaviour (e.g. injecting)	Largely delivered. One project completed
Needs analysis of homeless people with problem substance use	Completed and report published

2.4.6 The Social Legislation Working Group

The SLWG stands out from the other working groups in its specificity – a primary focus on legislation and regulation about alcohol. The guiding aim has been to – ***reduce the harm caused by individuals and society by the misuse of drugs and alcohol.***

Terms of Reference/Responsibilities

- Further develop close cooperation between enforcement agencies and statutory, non statutory and community organisations to make sure that current legislation including alcohol bye-laws are enforced.
- Develop close cooperation between the drinks industry and statutory, non-statutory and community organisations to develop measures that encourage and support responsible trading practices.

Output areas involved investigating licensing options/bye-laws and their enforcement. To support responsible trading practices and tackle, with the drinks industry, 'areas of concern'. Interestingly investigating the Misuse of Drugs Act (left to the CJWG) or children's or mental health legislation in respect of alcohol and drugs was outside the remit.

Delivery Progress

The Social Legislation Working Group did not complete its programme of work. A NI wide review of liquor licensing is underway and the Group has not met for over a year.

Chart 2.5: The Social Legislation Working Group

Target Activity	Progress at end of 2004
Produce guidance on current legislation for all stakeholders	Not delivered in light of NI review of liquor licensing
Letter to all enforcement agencies emphasising seriousness and costs of alcohol abuse. Letter to PSNI about implementing relevant legislation	Activity completed
Internal review of licensing, opening hours, poor trading practices and bye-laws	Not delivered, subsumed by NI liquor licensing review

2.4.7 The Criminal Justice Working Group

The CJWG had an extensive business plan under the aspirational banner – ***to reduce the availability of drugs and work in partnership with others to***

reduce harm caused by the misuse of drugs and alcohol within communities and in contact with the criminal justice system.

Terms of Reference/Responsibilities

- Work together and improve the overall effectiveness of criminal justice agencies in tackling drug and alcohol misuse.
- Develop an action plan for criminal justice agencies to tackle drug misuse that will support the Drugs Strategy for NI and the Strategy for Reducing Alcohol Related Harm, and coordinate the delivery of the plan.
- Monitor progress on the delivery of the action plan.
- Look for opportunities to work in partnership with the 5 other working groups to deliver the outcomes identified in the 2 strategies.
- Consider the best use of resources in the criminal justice system to tackle drug and alcohol misuse.

Output areas included a focus on developing treatment options for sentenced offenders. Attention was to be paid to reducing drugs availability in prisons and the community, to enhancing seizures and confiscation of assets. Illegally imported alcohol was also to be a priority.

Delivery Progress

The CJWG had an ambitious work plan. Delivery progress has been satisfactory but there has been slippage in several arenas.

Chart 2.6: The Criminal Justice Working Group

Target Activity	Progress at end of 2004
Develop-deliver sustainable drugs education programme for PSNI	Delivered successfully
To review the arrest referral schemes and consider extension into the regional areas	Partly delivered
To explore multi-agency training in respect of work with substance misusing offenders	Slippage, partly delivered
Develop an accredited substance misuse programme for offenders under probation supervision	Slippage, not delivered
Practice-theory research and feasibility studies around drugs-crime relationships and alcohol and crime. Conduct new offender survey.	Only partly delivered. Several projects not rolled out

Improve liaison with judicial associations and court user groups	Some progress. Partly delivered, on-going.
Information exchanges and secondments for PSNI, Prison Service, Customs and Excise	Some progress and achievement. Some targets not yet delivered
Improve search and drug detection system for police stations and prisons	Some progress. Some non delivery
Improve joint work/collaboration between PSNI and prisons through prison placements	Not achieved. PSNI can't resource
To improve forensic intelligence on illegal drugs and improve heroin sample profiling	Partly delivered through equipment enhancement. Sampling process delayed
Forfeiture orders and asset seizures significantly uplifted and operated	Good progress, largely delivered through new legislation, guidance, training and implementation
'Criminal Justice' media strategy, drugs bulletin and asset recovery publicity	Bulletin 'delivered' – now published 3 monthly. No progress on media strategy or asset recovery information
Set up prison drug treatment project and pilot community programme	Activities achieved. Services up and running and monitored

2.5 Overview of Regional Action Plan Delivery

The development of the regional business plan via DAST and the working groups was done in haste, in part driven by the need to spend over £9 million of new resources. The design and methodology of this programme of work is not without its problems (see Section 4). Nevertheless the key players have worked within the framework and produced some impressive progress. Table 2.1, based on the internal 'self completion' audit system, suggests that around half of 120 priority activities have been completed by late 2004.

Table 2.1: Progress towards meeting targets in the Regional Action Plan

	No of Activities	Achieved	On track for achievement	Likely achievement with slippage	Unlikely to be achieved
Education & Prevention	10	2	1	7	-
Treatment	33	14	4	11	4
Community	18	7	5	5	1
Information & Research	16	11	-	5	-
Social Legislation	6	3	1	2	-
Criminal Justice	37	19	-	6	12
TOTAL	120	56	11	36	17

2.6 The Drug and Alcohol Coordination Teams and Local Action Plans

2.6.1 Problems auditing delivery at the local level

This Section has attempted to use the internal auditing systems of the JIM to assess whether the secondary outcomes or target priorities of the regional and local action plans have been delivered. Unfortunately once we get to the local level of the 4 DACTs the internal system is difficult to utilise. This is **not** a criticism of the DACTs but a consequence of 'structural' problems in the JIM and the monitoring of performance at regional level – issues which will be discussed in Section 5. Each local action plan is a distinctive hybrid of priority targets from the Regional Plan found in the 6 working groups, plus local priorities set back in 2002 and more recent 'add ons', again with a local flavour. Moreover the self assessment pro-formas have been completed differently by each DACT and each has used a different 'measure' of what a successful activity achievement is. These difficulties have been exacerbated by a review of the organisation, role and management of DACTs in 2001 and a revised set of terms of reference impacting in 2004.

The actual results of the DACTs' self audit are available in *Report of Progress Towards Targets* (DAST, 2004). Some 46 pages of data describe each priority target area and delivery progress. Given the inconsistency of reporting, only brief summaries for each DACT's self assessment are provided here.

Table 2.2: Progress towards meeting targets in Local Action Plans 2002 – March, 2004

Area	No. of activities	Achieved	On Track	Likely achievement with delay	Unlikely to be achieved
NDACT	54	45	1	3	5
EDACT	42	27	5	10	-
WDACT	70	34	11	18	7
SDACT	38	29	5	2	2
TOTAL	204	135	22	33	14

2.6.2 Northern DACT Local Action Plan

In terms of *Education and Prevention* the DACT's activities were largely shaped by Regional Plan targets. Progress was hampered by slippage regionally in respect of training needs of the workforce and setting up a register of accredited trainers. Targets met were in respect of delivering local information campaigns, the development of workplace policies and guidance for employers. *Treatment* targets were largely met in respect of audits, needs assessments and workforce training, safer dancing guidelines and setting up local networks. Within the *Communities* arena the DACT successfully contributed to a voluntary code of practice around managing alcohol sales, safer dancing and supporting community projects. It also conducted activities around auditing partnership working and related training needs. NDACT was active in supporting regional publicity campaigns. Its activity in supporting *Information and Research* was 'achieved' but largely symbolic in nature. In terms of *Social Legislation* activity was limited by regional difficulties. In respect of *Criminal Justice* the DACT oversaw several new funded initiatives delivering locally (e.g. court referral scheme, prison projects).

Overall NDACT identified 54 deliverable activities in the audit template and assessed itself on having achieved 45 with 4 more likely to deliver during 2004 (see Table 2.2). This DACT was without a coordinator for 12 months.

2.6.3 Southern DACT Local Action Plan

In terms of *Education and Prevention* the DACT's target activities were largely achieved with workforce training audits, resources and accredited training rolling out and workplace alcohol and drugs policies being put in place. In terms of *Treatment* SDACT contributed to developing young people's services including guideline development at a local service. It contributed to audits of alcohol service provision and staff training around pharmacist services. Nearly all the activities signed off as delivered were in respect of regional implementation priorities. Under *Communities* SDACT provided financial support around accredited training, produced a 'dance scene' education video and ensured an uplift in the local workforce through alcohol and drugs community support workers. Activity around *Information and Research* was primarily in respect of development work with a local A & E Department.

Social Legislation was undermined by regional difficulties. *Criminal Justice* activities were limited and not fully delivered.

Overall SDACT identified 42 deliverable activities in the self-audit template and assessed itself as having achieved 27 with the remainder being perceived as deliverable in the future (see Table 2.2).

2.6.4 Western DACT Local Action Plan

In respect of *Education and Prevention* most activities were shaped by regional priorities in terms of training education professionals, auditing and ensuring School's Guidance is delivered locally. Most activities were achieved. Local 'information' activities were completed (e.g. for parents). Workplace guidelines were delivered locally supported by promotional seminars. The regional 'sport and leisure' priority was supported locally. For *Treatment* no less than 33 activities were listed by WDACT as they fully followed the regional treatment working group plan. Thus the roll out of dual diagnosis staff, the development of a prescribing service for opiate users and related guidance and training and uplifting core staffing levels developing a young person's service, all regional targets, were defined as having local delivery activity implications. A community awareness programme in respect of prescription drugs was delivered locally. WDACT also delivered activity in respect of audits and needs assessments around a range of alcohol and drug 'service' needs including training. The Safer Dancing campaign was 'coordinated' locally and activity was delivered in respect of training of the licensed and entertainment trade. From a *Communities* perspective WDACT successfully delivered the setting up local community fora, ensuring new services were (regionally) funded including for 'parents and families'. In respect of *Information and Research* notable activity was a local research project into nubain use and plans for a local website. Under *Social Legislation* little progress was made in 5 target areas given regional problems. For *Criminal Justice*, of the 5 targets most progress was delivered in respect of seized assets and liaison work with a local prison.

WDACT identified no less than 70 target activities in the audit template and assessed itself as having achieved 34 with 11 more likely to deliver across 2004 and a further 18 delayed. Seven targets were essentially displaced as not deliverable (see Table 2.2).

2.6.5 Eastern DACT Local Action Plan

In respect of *Education and Prevention* the DACT local action plan was less defined by regional targets than elsewhere. A focus on young people saw a developmental review of harm reduction drugs education and a heavy emphasis on commissioning services around education programmes especially in respect of excluded pupils. In terms of *Treatment* 11 target activities focused on young people's service development, a service for people misusing prescribed drugs and the development of Hepatitis guidelines and interventions and safer dancing guidelines. For *Communities*, projects were funded to facilitate community engagement (e.g. fora and network

development including a Youth Forum). Outreach services for hard to reach substance misusers have been enhanced in one priority area. *Information and Research* activities have seen a local website created, annual EDACT reports published and some development work around local research. The DACTs *Social Legislation* agenda has been mainly concerned with creating partnerships with District Councils and Community Safety Partnerships. *Criminal Justice* activities were limited to helping local prisons develop alcohol and drug policies, campaigning for a local arrest referral scheme and sharing information locally.

EDACT identified 42 deliverable activities in the audit template and assessed itself as having achieved 27 with the remainder either on track or considerably delayed.

2.7 Delivery of DACTs Local Action Plans

The inadequacies of the internal self auditing system will need addressing for the future (see Section 3) but should not detract from the achievements of the DACTs. In practice each DACT has been allowed considerable freedom to define local plans and this has led to 4 quite distinctive team outputs. Within each we see regional priorities maintained but to varying degrees. Well over half of local priority activities had been delivered 'successfully' by mid 2004. Some activity delivery was delayed by the knock on effects of delays regionally.

2.8 Delivery Performance of the Joint Implementation Agenda

2.8.1 Introduction

This Section has defined both the core and secondary outcomes found in the original strategies and joint implementation plan. It has focused on the ability of the regional JIM structure of DAST – Working Groups – DACT, with partners, to deliver the 200+ defined secondary outcomes or 'target' priorities'. In the main this assessment has been conducted utilising the internal self auditing system.

This method was the only approach available within the terms of reference of the Review. However, the internal monitoring audit system is seriously flawed. Firstly, numerous targets have been lost both in translation and through time by Working Groups and from the DACTs' local action plans. Secondly, the self-assessors have used different definitions of successful delivery. At times an 'activity achieved' insert stretched credibility. Thirdly, there is no 'weighting' given to different tasks. So some Working Groups or a DACT report a high rate of activity completion but in fact many outputs were no more than writing a letter to a partner agency. Developing a new service – a major task – can also be simply recorded as an activity completed. Finally, the DACTs in particular have not all reported on their activities in

implementing the regional plan but focused mainly on their locally defined priorities.

2.8.2 Uneven but steady progress

These concerns about monitoring aside it remains possible to offer a 'rough guide' to delivery progress. The JIM business plan has been about research, development and enhancing services and programmes through intensive resource investment. Overall there has been steady progress in delivering outputs in key arenas.

In respect of *Education and Prevention* much progress has been made training health education deliverers, developing coherent appropriate modules for secondary schools and introducing regional guidance on prevention, education and dealing with alcohol and particularly drugs incidents. Progress has been made with the sports and leisure sector's workforce in terms of auditing staff and producing guidance although not without some slippage. Several campaigns have been run in respect of awareness around alcohol and drugs and problems misuse can generate (e.g. binge drinking, drinking and violence, mixing alcohol with prescribed drugs). Local DACTs report considerable activity here as well.

Employers in NI now have a policy and procedure toolkit to manage alcohol and drugs incidents/issues in the workplace. This is a prerequisite to delivering reductions in accidents or illness amongst the workforce.

Much progress has been made in terms of focusing on the Training Needs of multiple groups in the community. Audits have been undertaken around education, treatment workforce, community groups and parents and carers, prison staff, police officers and so on. Whilst accrediting training and introducing 'best practice' is still in progress a large number of training courses have been successfully delivered. Diplomas and degrees around addiction are more available.

Some progress has been made at a *Communities* level. The business sector and drinks industry are better engaged and responding to concerns about under-age alcohol sales and poor on-license practices around drinks promotions and door staff. Two DACT areas have made progress around engaging and supporting families and carers of substance misusers. Some progress has been made of developing a Users Forum. Safer entertainment/dancing guidelines have been produced and will be rolled out for consultation during 2005.

There has been extensive progress uplifting *treatment provision* and several millions of pounds have been invested. Key accomplishments include uplifting Community Addiction Teams, enhancing prescribing provision, pharmacy services, dual diagnosis work and youth counselling. Databases are now in place to monitor treatment entry and interventions. A hepatitis management system is developing. The training needs of the workforce are

starting to be attended to. Work is beginning around improved assessment procedures and how to measure treatment effectiveness.

Much of the priority agenda around *Criminal Justice* has been successfully delivered. Arrest referral and court referral work have been enhanced. Liaison between court users and other agencies has improved. The regional prisons have new alcohol and drug policies, improved links across strategic stakeholders and an effective system to manage drugs availability inside prisons. Progress has been made on delivering healthcare and substance treatment inside and the beginnings of an after-care and resettlement programme are visible. Asset forfeitures and redistribution of convicted offenders' income is now established. More key data around drugs enforcement is in the public domain.

The *Information and Research* priorities within the Regional Plan have largely been met in terms of supporting regional surveys, small research projects and developing the DMD and Substitute Prescribing Service monitoring. We know far more about homelessness and substance use, more about the scale of heroin use and a little more about vulnerable young people's needs. However this group did not fully respond to its wider more strategic terms of reference.

Only in respect of *Social Legislation* have no substantive priority targets been met given a regional review of liquor licensing has overtaken the working group agenda.

3. IMPACT:

To what extent have the critical objectives of the Alcohol and Drug Strategies been achieved?

3.1 An Indicative Assessment

We have identified substantial delivery progress through the JIM. An array of secondary outcomes have been achieved, all assumed to build into an apparatus for achieving improvements in the well-being of the Northern Ireland community in respect of problems associated with alcohol and illicit drugs. This Section returns to the critical goals/outcomes summarised early in Section 2. What progress has been made in achieving these since 2001?

A short Review of this nature can only utilise data bases, research project results, surveys and internal audits already available and must live with information gaps and the uneven quality of monitoring and evaluation information. A primary source of assessment data is found in DAIRU's literature and desktop review (*NIDAC/Joint Implementation Model Review-Desk Review 2005*).

The terms of reference for this literature and research review were however far too limited, reflecting structural problems created in the JIM design which did not fully embrace the requirements of a comprehensive dynamic monitoring and evaluation process to support the strategies. Consequently this Strategic Review has had to attempt a rapid and inevitably incomplete audit of other key data sources. This has involved gathering, monitoring and evaluation data from multiple sources including PSNI, NIO, Community Addiction Teams, research project results and so on. Numerous gaps remain. Most will be 'genuine' in that there is no monitoring information available or any practical way of creating tracking data. Some however will be a consequence of a lack of time and resources to undertake a complete trawl in the absence of routine production system attached to DAST or DAIRU.

In order to provide a template to support what will be a strong recommendation to completely redesign research, information and monitoring activity for 2006, this Section will also describe important missing data sources identified by the Review and illustrate indicative data that might be introduced in the future.

3.2 Progress Against Objectives in the Alcohol Strategy

3.2.1 Responsible and binge drinking measures

Has responsible drinking been encouraged and has there been a reduction in binge drinking across the population especially in respect of teenagers and young adults?

Desk Top Review

Prior to the implementation of the current strategy overall rates of alcohol consumption had been rising in the NI drinking population since the 1980s. Drinking above sensible limits and drinking above dangerous limits still remain on an upward trajectory today. Regional surveys reviewed are consistent and clear here. Unwise drinking rates have risen across all age groups and for men and particularly women. Amongst young people (11-16yrs), a priority target group, drinking levels are rising more quickly and with each consecutive age cohort. Overall drinking rates are higher in NI than England and Wales but lower than in Ireland.

In respect of binge drinking there are no time trends and only one substantive study. This showed binge drinking to be a weekend activity with 48% of adult males and 35% of females bingeing at least once a week. These rates are far higher for 18-29s being 72% for males and 57% for females. A comparable survey is to be repeated.

Review Evidence and Requirements

There is a lack of focus on binge drinking measures amongst young people in the regional surveys. There are some inconsistent measures available showing young people are more likely to binge. There is also evidence found in surveys of 'vulnerable' young people for instance in custody showing much higher rates of heavy drinking. Given the strategic focus on reducing binge drinking more attention should be given to this measure in future.

Ideally other data should be collated to support the impact assessment, in particular the effectiveness of public health campaigns and local projects undertaken in recent years, some of which are collated and evaluated by the Health Promotion Agency.

3.2.2 Reduction of negative outcomes

Has alcohol misuse been reducing so negative outcomes also reduce? The alcohol strategy identified reductions in unprotected sex, 'unsafe' and drink driving, accidents especially at work, alcohol related crime, alcohol related disorder and violence in the home as priority indicators

Desk Top Review

The review does not really provide statistical information on many of these indicators. In respect of drinking offences the number of breath tests has fallen in recent years as have prosecutions for drink driving. Encouragingly there is now a downward trend in both road traffic collisions and those where alcohol is involved. Deaths and injuries remain an endemic problem with no downward trend. Trends analysis is not possible in respect of alcohol in the workplace. A survey in 2000 suggested there is cause for concern however.

Assuming drunkenness *per se* is a quasi 'misuse' measure this appears to be rising in the general population. However the number of persons proceeded against and convicted for drunkenness has actually been reducing dramatically since 1999. This may be a product of changes in policing priorities.

The desk top review analysed useful morbidity data. Essentially there has been a steep rise in hospital admissions for alcohol related diagnoses (4776 in 1998/89 to 6763 in 2003/04). A similar scale of rise is found in Alcohol Liver Disease admissions for both sexes. These rates of increase are greater than those in Scotland.

Review Evidence and Requirements

There does not appear to be any easily accessible data on unprotected sex and alcohol and in respect of alcohol related teenage pregnancies in spite other policy initiatives prioritising this problem. The Review has, through the NIO, established that PSNI is now collating information about domestic violence and contributory factors. Whilst possibly a product of improved reporting recorded rates of domestic violence are rising with a substantial increase in 2003-04 to 8,565 cases. This new data set also shows that over the past year alcohol is deemed to be related to or a contributory factor in around half of all recorded cases and right across the region and in urban and rural areas. This measure should be maintained into the next strategic cycle.

PSNI is undertaking analyses of crime patterns in respect of alcohol and this source should be integrated into the future strategies' monitoring system. It would be sensible to extend the range of indicators to include alcohol and sexual offences and arrest for assaults in public which are alcohol related.

There are important data concealed within regional surveys which have not yet been harvested. For instance the *Crime and Justice Survey in Northern Ireland* when published will help identify excessive drinking and reported problems in both the general and offender populations.

3.2.3 Better protection from anti-social and criminal behaviour

Are individuals and communities being better protected from anti-social and criminal behaviour arising from alcohol misuse?

Desk Top Review

The review confirmed the number of alcohol related casualties amongst road users is falling. Other evidence made available involved a Public Attitudes Survey (2004) which in relation to Assets Recovery asked a representative sample about which organised crime activities should be prioritised for enforcement. Alcohol (e.g. illegal importation) was a very low priority with only 9% viewing organised crime and alcohol as a priority. Finally, there is evidence from a regional survey that 24% as respondents felt that people being drunk and rowdy in public places was a 'very' or 'fairly big' problem in

the region in 2003/04. This should become a baseline measure for a repeat question.

Review Evidence and Requirements

There are too few measures reviewed to fully assess whether progress is being made on community protection. Indicators may well be available from within the current package of regional surveys or via local surveys and studies which need collating for the future. Additional questions can perhaps be commissioned to ride on repeat population and crime surveys.

An Omnibus survey commissioned by the Liquor Licensing Review reported high levels of concern about disturbance and disorder related to alcohol consumption. Two thirds of respondents and across the whole region felt alcohol related disorder was 'high'. Violence was of particular concern. Here is evidence of a range of serious community safety issues but as yet no adequate monitoring arrangements to assess whether community concern is rising or falling. Ideally we need to commission a basket of questions to ride on repeat community surveys and so produce a performance measure.

Without direct indicators and time trends analysis it is not possible to fully assess whether community protection is being enhanced. This is another critical strategic target which lacks sufficient tracking indicators.

3.2.4 Promote and improve treatment

Have treatment services for people with alcohol misuse problems been promoted and improved since 2001?

Desk Top Review

There is no input from this review which can be used to assess this primary goal.

Review Evidence and Requirements

The statutory provision for alcohol treatment is provided across 4 HSSBs by community addiction teams and hospital/residential units. The rate of alcohol referrals has been rising steadily over the past 3 years. This suggests more people are being helped. Currently there is no system for measuring treatment outcomes but much indicative data suggesting gains are routinely made.

In terms of the core goal of promoting and improving services this increased treatment entry has not been matched by any increased funding by the DHSSPS/HSSBs. Freezing funding for services which have seen a 15% increase in referrals over the past 3 years seems to be contrary to the achievement of this strategic goal.

However an uplift in provision which has promoted and improved alcohol treatment has come about through JIM funding which despite a drugs bias

has allowed many community and quasi statutory services to undertake more alcohol interventions.

The RES monitoring system was interrogated for the Review (*Analysis of Selected RES Questions*, Deloitte, 2005). Nineteen 'treatment' projects allied to statutory provision self reported activity which successfully reduced alcohol consumption and associated risks amongst service users.

Significant improvement in provision has also occurred through the funding of community/ voluntary projects. Fifty one diverse projects providing a wide range of support, advice, education, counselling, work with families etc have been funded since 2002 over and above an earlier tranche. Seven reported on having a positive impact on alcohol (and drug) use claiming reduced primary substance use and reduced associated risks. This kind of assessment data should be routinely available both for DAIRU and for performance monitoring.

There has been considerable progress in promoting alcohol misuse screening, brief interventions and treatment in and around the criminal justice system. Adult prisons now have alcohol and drug policies and provide variable levels of assessment and treatment. There are now initiatives within the Probation Board including 'Rapid Assessment and Treatment Service for (Drug and) Alcohol Misusers' which promotes and provides treatment access for defendants and offenders.

There is no longer any reportage of the nature of call traffic from NI to the National Drugs Helpline which is presumably promoting the region's alcohol services when enquirers ring in. This important data source needs tapping in future given over £20,000 a year is provided to run the Helpline in NI.

A research study into Homelessness and Substance Misuse has identified opportunities for further development work promoting alcohol treatment with this population in which women's alcohol mis-use appears more salient.

3.2.5 Reducing access to alcohol for Under 18s

Desk Top Review

There is no data available in respect of access to alcohol by under 18s in this review.

Review Evidence and Requirements

The Review could not identify any statistical data around reducing access to alcohol by under-age drinkers. Some data may be collatable via Trading Standards and PSNI at a district level for the future. The LLR Omnibus found 96% of the population surveyed thought under-age drinking and access to alcohol was a serious problem. If public concern is respected this issue should remain in the revised strategic priorities as long as it is measurable.

3.3 Progress Against Objectives in the Drugs Strategy

3.3.1 Reduce illicit drug use and related harm for under 25s.

Have young people been protected from the harm resulting from illicit drug use? In particular has the goal of reducing the percentage of young people under 25yrs reporting the use of illicit drugs been achieved and has a delay in the age of first use of illicit drugs been generated?

Desk Top Review

This review has identified real difficulties in making assessments of drug taking rates in NI especially by specific age groupings. There are different types of regional surveys using different methodologies all being funded. The situation will improve with baseline and trends analysis likely to be better generated in due course. Currently however the picture is confused. The Northern Ireland Crime Surveys point to the upward trend in drug taking generated in the 1990s continuing into the new decade. A thus far one off All Ireland drug use survey reports lower rates of drug use in the NI population and amongst younger people than the crime surveys. A survey of 11-18 year olds in NI, as part of a European wide repeat survey system, has shown a substantial increase in drug taking between 2000 and 2003 with lifetime rates rising from 15.8% to 22.3%. A repeat survey by NISRA focusing on young people (11-16 year olds) reports a fall from 24.5% in 2000 to 22% in 2003.

The age of onset for 16-24 year olds has been identified as 16.2 years and this baseline will allow future assessment of successful onset delay.

Drug usage rates in the past year are now a little dated and survey results difficult to compare but range between 6-18 % for the overall population but with younger people being far more likely to be recent drug users (e.g. 28% for 16-24 year olds). Cannabis use dominates. Males are more likely to use drugs.

In summary, on-going survey activity based on several sources does not present a wholly consistent picture. A 'rough guide' conclusion is that drug prevalence rates amongst younger people in NI climbed substantially from the mid 1990s well into the new decade. This upward trend may be continuing but with some evidence of an emergent plateau. There is certainly no rapid deterioration underway and no evidence of heroin or crack use bedding in. The desired reduction in illicit drug use amongst under 25s has not occurred however.

Review Evidence and Requirements

Regional surveys are expensive to conduct. The present basket of surveys do not allow for veracious comparison given different methods, techniques, age brackets and representativeness. The DAIRU review acknowledges this and it is important in the future that comparability becomes a critical

commissioning goal. The situation will improve even within current arrangements however and it can be anticipated that within a few years a relatively reliable baseline and trends analysis will be forthcoming.

On balance it is probably safe to conclude that rates of ever taking an illicit drug by younger people in NI which began increasing in the early 1990s have continued to rise in the new decade but with some indications of an emergent plateau. It seems unlikely that rates of drug use amongst under 25s have reduced or that age of onset has been reduced. The rates of illicit drug use in NI are similar but slightly lower than those elsewhere in the UK. We have not yet seen any significant falls in lifetime prevalence anywhere in the UK.

There are real difficulties in assessing whether, for young drug takers, 'harm' is being reduced. Some developmental work will be needed if this goal remains. Perhaps we need to focus on community projects with a harm reduction agenda to identify realistic indicators (eg. Western DACT)

3.3.2 Better protect communities, reduce drug related crime and insecurity

Are communities being better protected from anti-social and criminal behaviour? In particular is there a reduction in drug related crime, in community concerns and/or fear about drug related activities and in drug related problems including accidents in the workplace?

Desk Top Review

The number of drug trafficking offences recorded rose in 2003-04 to 405, a new peak. Recorded trafficking and non trafficking drugs offences have also risen rapidly over the past 2 years. The rate of offenders for all drug offences has also risen per 100,000 population.

There is no trends data for self reported/survey reports on drug driving although 13% of a sample admitted driving within a few hours of taking drugs in 2003.

In terms of community concerns about drug related behaviour only one survey is cited. This showed 71% of respondents (Northern Ireland Omnibus 2004) felt drug dealing and organised crime should be a policing priority. This again indicates a relatively high level of public concern around drug 'problems'.

The Review reports on hospital admissions associated with drug using behaviour. In a recent month 210 individuals were hospitalised for alcohol and drug related mental or behavioural disorders of which only 5 were related to prescription and street drugs.

Review Evidence and Requirements

The NIO commissioned the evaluation of two arrest-referral–treatment projects which indicate they are reducing drug related crime amongst retained participants. The delays in commissioning studies into drugs-crime relationships in NI is unfortunate. The international literature is clear that certain types of treatment can reduce acquisitive crime amongst dependent heroin and crack users. It should be with the patients in the new Substitute Prescribing Service that the biggest impact will be seen in terms of crime reduction but there is currently no monitoring data.

The 2005 Omnibus survey reports high levels of public concern about drugs and particularly drug dealing which are summarised in the final Section.

A proxy measure of anti-social behaviour and ‘concern’ in relation to drug use in local communities used elsewhere in Europe is ‘needle finds’. This measure should be introduced nationally in future given District Councils/PSNI collect information locally and that 50%of needles distributed by pharmacies in Northern Board, for instance, are not returned.

There is no way of recording accidents in the workplace related to drug use yet in place.

One way of creating a more robust way of measuring the harms produced by the drugs ‘problem’ is to utilise the new Drugs Harm Index being introduced in England. There is a helpful manual showing how to measure and collate multiple harms. This would also allow NI to compare performance with England.

3.3.3 Reduce availability of drugs

Has the availability of drugs been reduced in communities? Specifically has the availability of drugs in prisons been reduced and the value of illicit drugs seized increased?

Desk Top Review

The internal review provides data on drugs seizures based on PSNI records. Aside from a dip in 2001/02 drugs seizures have generally increased in the new decade from 1750 seizures in 2000/01 to 2347 in 2003/04. The value of drugs seized has more than doubled over the same period with £15 million being the current grand total. Cocaine seizures have grown rapidly in recent years whilst opiate seizures are falling, unlike in the rest of the UK.

Review Evidence and Requirements

The notion of ‘eradicating drugs importation into NI’ found in the original strategy seems unrealistic and may best be removed from future strategic plans. Moreover the availability of drugs in a large community is essentially ‘mission impossible’ to deliver or demonstrate. However there are several

proxy measures that can be used beyond seizure data. The purity levels of street drugs (e.g. heroin) are often cited on the assumption that falling purity levels mean availability and supply levels are being somehow constrained. This measure is not currently available.

The price of street drugs is another proxy measure. A fall in street prices is assumed to indicate strong availability, a rise being a sign of reduced supply. Whilst slightly higher than in Great Britain PSNI figures show street prices for cannabis, cocaine and ecstasy are on a downward trajectory in NI.

The Northern Ireland Prison Service has a useful monitoring system in respect of drugs issues which collates data on an important set of variables. Cumulative data suggests that there is relatively limited availability of drugs in prisons and that the situation is being effectively managed with small but regular drug finds. Our prisons will never be drug free but the indications are that in N.Ireland's small prison population of about 1,300, drugs availability and misuse is at a relatively low level and being maintained despite media headlines to the contrary. Importantly a high proportion of prisoners are on prescribed psycho-tropic drugs and often misuse these drugs on the inside. A high rate of remand prisoners have been charged with drug related offences.

A further measure of drugs availability is 'intelligence' held by police, customs and organised crime teams. In GB police services are showing an increased willingness to share this information within multi- agency structures.

Finally, drugs availability can be assessed through self report surveys amongst the younger population. Three surveys (identified by the Desk Top Review) report on levels of access to illicit drugs. They provided different rates but all suggest that 50-60% of younger people report obtaining drugs is fairly to very easy with cannabis and ecstasy being the most accessible.

In summary, using a range of proxy indicators, it appears that the availability of illicit drugs remains strong in the region. Cannabis, ecstasy and increasingly cocaine appear the most accessible drugs with the heroin market being more 'closed'. Whilst drug seizures and their value are rising suggesting continuing successful enforcement activity the fall in price and the 'steady' rates of drug use and accessibility found in self report surveys point to stable if not slightly increasing overall availability. Drugs availability in prisons is probably not increasing however.

3.3.4 Overcome drugs problems through service provision

Have people with drugs problems been enabled to overcome them and lead healthy and crime free lives?

There were no critical outcomes attached this strategic goal. By implication we must assume that enhancing brief interventions and drugs treatment will support the achievement of this goal.

Desk Top Review

This review identifies a steady increase in the numbers of individuals presenting for treatment rising from 916 clients in 2001/02 to 1409 clients in 2003/04. In particular more 16-19 year olds are presenting particularly with cannabis related problems. The impact of investment in non-statutory services is clearly seen with a doubling of presentations in 3 years. Data from the Drug Misuse Database suggests that the numbers of drug injectors in treatment is falling slightly – an implied health gain. Equipment sharing remains stable.

In terms of hepatitis 3,673 diagnoses of Hep C infection are recorded. In 2003 there were 83 new diagnoses, the highest annual total so far. Fifty three per cent of infections in individuals with a known risk factor were associated with injecting. Infection rates for those in treatment are also rising slightly.

In relation to deaths indirectly related to drug misuse, there have been no HIV/AIDs related deaths since 1997 – an important ‘health’ related success for the region.

Although of no comfort to those affected, formally recorded drug related overdose deaths are very low and falling in NI. This is a situation to protect whereby per 100,000 head of population, death rates in the region are 1.47 compared with 5.11 for England and Wales.

Review Evidence and Requirements

Most drugs treatment is provided by statutory services namely the CATs and hospital units. Currently there is no system for measuring effectiveness in the sector although we can be confident that most service users will be variously helped given the track record of the sorts of therapies employed.

The Audit of Statutory Addictions Services (Kenny, 2003) notes that in a typical year over 900 people undergo inpatient treatment and nearly 8,000 have face to face contacts with community based practitioners who offer a wide range of interventions. The Review would fully expect health gains, reduced drug use and crime reduction to flow from these activities but the ‘system’ cannot yet demonstrate these outcomes.

The official estimated number of heroin users in the region is around 1,000. Most experts expect this to be increased once a recently commissioned research project has reported. It will then be important to assess what proportion of problem users are in treatment and the level of unmet need. The new Substitute Prescribing Service is currently treating about 150 individuals with methadone/Subutex. If evaluated, this service will almost certainly be able to identify positive outcomes. DAIRU’s basic monitoring system could be harnessed to this purpose as an interim measure.

There is ‘indicative’ evidence of reductions in drug use and risk behaviours in the RES monitoring of the JIM funded treatment and community projects.

Nineteen of forty one projects report on such gains. Again however the RES system is not an evaluative tool and as currently designed is only a basic monitor.

Whilst Needle Exchange Schemes are primarily harm reduction led they do reduce morbidity and blood borne virus spread. In NI the pharmacy based schemes are increasing their activity in terms of the number of visits. Currently they issue around 82,000 syringes and needles a year.

Finally we need to analyse the call traffic to the National Drugs Helpline to assess whether calls from people with drug problems is rising and referrals are being made to appropriate agencies.

3.4 The Aspirational Goals of the Strategies have not yet been met

This Section has described an evidential assessment of the extent to which the aspirational goals found in the Alcohol and Drug strategies have been met. The assumption in rolling out and resourcing JIM was that all the activity would impact positively on the Region's alcohol and drug problems.

By having to identify a long check list of how the strategies might be better evaluated the Review concludes that current monitoring and evaluation arrangements are inadequate and lack integration. This subtext is consequently outlining how a performance management system might be constructed for the next strategic cycle. Currently there are too many critical goals for which we either have no method of assessing change or no one has sought the data.

In summary and overall very few strategic objectives have been achieved. Drinking and drug use trends on the rise since the 1990s have not been diverted downwards. Binge drinking remains at a high level. Drug use rates around cannabis and cocaine are not falling amongst under 25s. We are not able to show that age of first use has been delayed.

Negative outcomes associated with alcohol such as drink driving and traffic accidents may be falling or may be a product of changing policing priorities. There is little evidence that individuals and communities are being better protected from nuisance and anti-social behaviour related to drinking and drunkenness. Community concern about alcohol, gauged through population surveys, remains high. Community concern about drug issues seems stable but quite high, although this view is based on limited measures. In respect of drug related offences recorded rates are rising but this may be a product of improved reportage. There are few handles on acquisitive drug driven crime. Good progress has been made in achieving the goals of increasing drug seizures and recovering assets from convicted offenders and managing drugs availability in prisons. Overall drugs availability seems stable or perhaps rising slightly but has not been reduced on current indicators.

In respect of promoting and enhancing treatment for alcohol and drug users some progress has been made through intense JIM investment. However we do not have scientific evidence that the voluntary or the statutory provision is effective, although there are signs of success. Of concern is the fact that, despite a 15% increase in referrals over 3 years, the DHSSPS/HSSBs have not honoured the strategic goal around enhancing and promoting treatment provision with needs-led matched investment.

Finally both strategies clearly required a coherent information-monitoring-evaluation and research system and tasked DAISG, DAIRU and the I and R working group to ensure this was bedded into the whole enterprise. As this Section has illustrated there is considerable confusion about responsibilities here and this activity has not been fully developed and delivered. The final Section describes how this might be rectified for the future.

4. APPRAISAL: Stakeholder perspectives and analytic assessment of strategic and operational performance

4.1 Introduction to the Consultation

This Section focuses on the strengths and weaknesses of the current arrangements in respect of 2 strategies, joint implementation, organisational structures, funding, performance and communication. It utilises findings from several sources. Firstly, a far-reaching stakeholder consultation across the region undertaken by Deloitte (*Review consultation: Summarised Thematic Analysis of Focus Groups, 2005*), which will be referred to as the 'stakeholder consultation'. This exercise involved obtaining the views from around 130 individuals covering each DACT area staff and partners, funded projects from each Board area, voluntary and community stakeholders from 3 Board areas, the 5 functioning Working Groups' representatives, youth and PSE advisors and 4 service users.

An 'E' consultation also produced 25 returns, many of high quality and from key statutory, voluntary and community groups and projects charged with delivering the strategies/plans. Whilst some DACT areas expressed concern about not being adequately consulted only one provided a considered written submission. Four extended written submissions were received from other stakeholders. A meeting was also held with the Chief Executives of the 4 HSSBs.

Thirdly, the Review conducted interviews and discussions with over 30 senior players including the Chief Medical Officer, DHSSPS staff, DAST staff, DAIRU staff, Working Group Chairs, Probation Board, Youth Justice Agency, Northern Ireland Office/Community Safety, PSNI Drugs Squad and 'night time economy' managers, DCAL, Community Addiction Teams, Health and Safety Executive, DEL, 'Young People's' professionals, Prisons, DACT coordinators and the Licensing Review lead officer.

In this Section the Review begins the analytic process of trying to collate and interpret such a wide range of experience and opinion. In particular do stakeholder perspectives share commonality and consensus about current arrangements? Can overall agreement about future arrangements be easily reached – are there disagreements and divergence which may frustrate future collective endorsements?

4.2 Are Two Strategies Better Than One?

Northern Ireland developed a discrete alcohol strategy in 1999 both before Ireland and 5 years before England. This initiative was welcomed at the time by most stakeholders given the high levels of demand for alcohol dependency

treatment, a rise in health related problems and community issues around under-age drinking, licensing and alcohol related accidents and offences, etc.

According to the main Stakeholder Consultation there is now far less enthusiasm for maintaining a separate alcohol strategy. Two thirds of the focus groups expressed concern that alcohol has not been given sufficient priority within the JIM activity. Stakeholders note that alcohol referrals for treatment are greater than for drugs and that alcohol generates more problems in town/city centres and local communities than drugs yet is routinely marginalised in terms of investment.

On these grounds the majority of consultees gave support to a holistic alcohol and illicit drug strategy believing such an approach would bring the alcohol agenda into sharper focus. Interestingly some felt tobacco should be included in the strategy. Others warned against this seeing such an approach as casting the whole strategic approach in a health context bringing the risk of marginalising other key components around enforcement, community safety, etc.

There was less enthusiasm for an integrated strategy amongst senior players, some feeling the construction of such a document would be too problematic. However there was no clear opposition to such an approach.

The Review assessment is that there are advantages/disadvantages in either approach. The marginalisation of alcohol issues has been mainly a product of 'ring fenced' campaign (Treasury) money up until 2004 promoting investment almost exclusively in drugs programmes. This partiality can now be overcome given project funding is within the DHSSPS core budget. It can be argued that a revised discrete alcohol strategy might better prioritise alcohol issues by spelling out very clearly what needs to be achieved, how and by whom. This said, unless other reasons emerge as to why a holistic strategy is impractical it seems sensible to hear the stakeholders and seriously consider the development of a holistic substance misuse strategy.

4.3 Should Joint Implementation be Maintained?

There is strong support for maintaining the principle of joint implementation. The vast majority of stakeholders with a view supported this approach. The main Stakeholder Consultation showed that local practitioners recognised the inter-play of alcohol and drugs in their work, be it drugs education, youth work, counselling or treatment provision. Senior players, with a view, largely supported a joint approach again given the overlap in the youth and criminal justice systems, prisons and workplace policies.

From an organisational perspective we should also note that in such a small country joint implementation is necessary to produce economies of scale. Separate alcohol and drugs treatment provision would be far too expensive to deliver. From a community level perspective joint implementation is also

consistent with the 'one stop shop' approach aspired to by many local service providers and the integration of community safety partnerships, etc.

It should also be noted that this integrative approach is becoming recognised across Europe as more efficient. Even in England where the 'drugs-crime' strategic priority overshadows all else there is a recognition this has stifled responses to alcohol misuse whereby an emergent integrated approach is developing in respect of treatment and crime and disorder/community safety agendas.

4.4 Strengths and Weaknesses of Current Arrangements

4.4.1 The politics of consultation

Whilst there is a broad consensus for moving forward with one integrated strategy and a joint implementation approach there is rather less consensus and far more dissatisfaction with the current processes and the first roll out of JIM. The Stakeholders and E consultation responses are dominated by fairly negative feedback about almost all aspects of process and delivery. It is vitally important to collate and analyse this feedback with a view to renovating the current strategic and delivery framework to reduce dissatisfaction, raise collective and especially locality level commitment and improve efficiency and effectiveness.

From the Review perspective it is also important to try and distinguish between those consultee perspectives which are focused on the alcohol and drugs agenda and those which are influenced by historical and ideological perspectives.

Historical context is important here. The JIM was somewhat imposed on the alcohol and drugs field. There was little consultation and a regional plan was constructed far too hastily, primarily to ensure the rapid dispersal of around £10 million of resource investment. As we have seen in Section 2, rolling out the new 'activity' did produce a degree of inefficiency, slippage and several disappointments.

This recent history has almost certainly re-fed a discourse amongst local, community level players that regional staff and government departments do not appreciate the importance of consulting, listening and trusting local stakeholders or recognising local conditions in respect of alcohol and drugs issues. Top down programmes are generally viewed with scepticism especially if consultation and two way communication are lacking. Possibly some consultees have responded negatively as a matter of course therefore. Some also abandon the principles of regional equity and inclusivity by insisting only local players understand local alcohol-drug issues and so should simply be resourced to respond to their definition of local need. The danger here is that citizens across NI cannot access services equitably and on the basis of need, given provision will be uneven.

Not surprisingly regional players regard this critique as unfair and develop their own defence mechanisms and accounts. The important issue is that there is an unusually acrimonious historical backcloth evident which the Review must acknowledge may have impacted upon the results of the consultations. The next strategic cycle rests, unfortunately, on this less than happy history yet to succeed requires a revitalised partnership whereby vertical 'trust' and two-way communication must be established.

4.4.2 All about JIM: Views from stakeholders at all levels

Starting at the front-line most participants in the Stakeholder and E Consultations were representatives of local communities and service providers. Very few service-users' voices were heard. These perspectives mainly focused on experiences of JIM delivery. Many respondents knew little or nothing about how regional government has operated, via DAISG and DAST, in the roll out – a telling point in itself. Others at the inter-face between the local and the regional, for instance DACT players, regional voluntary and statutory providers and Working Group co-optees had an understandably wider view. It is apparent that whilst the extensive funding of community and treatment related projects since 2002 has been widely welcomed it has nevertheless produced a basketful of perceived problems, inefficiencies and inequities. It is around these issues that the bulk of feedback was generated.

4.4.2.1 The JIM structure and action plans

Many consultees noted the time pressures put on the creator of the JIM structure were unreasonable. Nevertheless the over-riding conclusion from consultations at all levels was that having operated around or within the current structure for over 2 years most had numerous suggestions for improvement. The JIM structure is seen as over-bureaucratic with too many layers (70% of respondents). The regional and local action plans do not relate to each other consistently or easily. Local players/providers have difficulty understanding how their activities and targets fit into the secondary and critical strategic objectives. There was however little agreement about whether local action plans should be extensions of the regional plan across the 4 DACT areas. There is also little consensus about the role of the DACTs and their relationship to DAST and the regional plan other than it is currently ambiguous and less than effective.

4.4.2.2 Funding community projects

There was extensive concern and from multiple sources about the problems that have been generated by the dispersal of resources to the community and voluntary sectors. With over 40 projects created or uplifted by 'campaign' money new difficulties have emerged. The most repeated concerns were in respect of deadlines and lack of notice for applying for funding or re-funding. Project developers often felt they did not have the skills or support to make appropriate bids. Funding has been short-term without the promise of sustainability. This in turn has led to high staff turnover and difficulties appointing 'the best' people. Over two thirds of the focus groups identified

short-term funding as a major problem. The whole process has, for many, also felt too bureaucratic. Many observers believe some of the funding has been wasted through operational slippage as a consequence of the funding difficulties. Several groups believed an unfortunate competition has emerged between projects and areas leading to duplication of provision or 'pet projects' which are too exclusive. Currently a high level of concern remains about funding arrangements beyond 2005-06.

4.4.2.3 Monitoring and evaluating community projects

An almost universal frustration emerged from the Stakeholder Consultation in respect of the monitoring and evaluation of community projects. The 'RES' monitoring form, which funded projects must complete and return to DAST has proved unpopular. In particular it is felt the structure and content cannot capture many of the positive elements of particular projects. Some consultees believed projects were too nervous about identifying problems/difficulties for fear of losing future funding.

Most importantly project stakeholders note that they do not receive any feedback from DAST as to how well they are doing whereby (re)funding seems totally independent of performance monitoring. Two consultees pointed to the lack of 'praise' in the whole process whereby successful projects are not publicly affirmed. On the other hand there is evidence that RES forms were not always returned to region as required.

There is no general reluctance to be monitored and evaluated. Many stakeholders wanted their projects to be independently and fully evaluated and also believed the lack of locality 'needs assessment' research hindered their ability to configure local projects appropriately. The SMART framework was mentioned as a possible way forward.

4.4.2.4 Working groups

Both community level stakeholders and many Working Group members/chairs voiced concern about the 6 Working Groups charged with delivering the Regional Action Plan. The main issues were as follows. A quarter of the focus groups felt the **role** of the Working Groups was **unclear**. In terms of **communication** both horizontally and vertically 43% of stakeholder consultation groups noted this was ineffective. A more robust communication system (e.g. Minutes distribution and accessibility) is required. The DACTs seemed better informed about Working Group activity than other locality players. The Review evidence also pointed to a lack of **accountability** whereby the Working Groups are not in a secure loop. In Section 2 we looked at the uneven **efficiency** of the Working Groups. There is a general view that the Criminal Justice Working Group was the most efficient. This group had dedicated funds, a well resourced secretariat which drove progress between meetings and a realistic agenda and might be used as a template for the future if a reconfigured Working Group structure is endorsed.

Importantly a substantial minority of stakeholders called for the removal of Working Groups from the structure altogether. This will need to be considered but abandoning working groups and sub groups (e.g. EPWG had 7 sub groups) will probably require both DACTs and a re-configured DAST to take up far more functions with consequent resourcing issues.

4.4.2.5 Information, monitoring, evaluation and research

The Stakeholder and E Consultations identified an encouraging commitment to monitoring and evaluation although filtered through a strong sense of concern about the lack of needs-assessment locality research, appropriate monitoring systems and the absence of feedback and guidance about best practice.

The Review fieldwork and assessment has identified the current ad hoc arrangements as one of the most critical shortcomings of the present structure. Despite clear guidance from the mother strategies there is no coherent system in place to support the roll out of the business plan.

Currently I and R is found in NIO which conducts its own competent evaluations of funded projects and commissions pieces of research and needs assessments/audits within the community safety-criminal justice domain. The Drug and Alcohol Research and Information Unit (DAIRU) has a brief to support the drug and alcohol strategy roll out but in a rather confusing way. DAIRU links into all the working groups especially the I and R Working Group however the business plan for this group is very partial in both senses. DAST is responsible for the auditing and monitoring of campaign money which goes to both community projects and to enhance statutory treatment provision. As already discussed, this function has not been carried out properly. Essentially no one person or Unit will accept overall accountability given the way current arrangements are structured. This confusion can be traced back to the way JIM was set up back in 2001-02.

Substantial funds have been spent between 2002-04 commissioning a range of needs assessments, audits and small research projects, many triggered by Working Group priorities. The Review has found widespread concern about the quality of these external commissions. Too often strategic planning and resource allocation has been undermined by delayed and/or inadequate reports. A full Review assessment of these commissioned projects confirms their variable quality and failure to deliver to specification. A needs report around vulnerable young people which could not deliver to specification is the most quoted example of poor commissioning/delivery. However similar initiatives in the sport and leisure and Treatment sectors have also been delayed or undermined by a lack of preparatory scoping. Specifying deliverables and commissioning audits etc., need to be more authoritative in the next cycle.

There are numerous references and requirements in the strategies and JIM to provide best practice guides and disseminate information, evaluation outcomes and the results of regional and local research and surveys to the

whole alcohol and drugs sector. Although several relevant publications are on the DHSSPS website there is no easily accessible, up to date 'library' of relevant material with an updating system in place for Northern Ireland. The Health Promotion Agency has failed to maintain a contracted drugs and alcohol information website.

As worryingly, an expensive government funded longitudinal study (The Belfast Youth Development Study) has not been sufficiently engaged to provide important trends information about alcohol and drug use in a representative sample of young people in NI. This breaches the value for money principle.

The Review has itself been hampered by this lack of coherent monitoring. As we noted in Section 3 it has simply not been possible to fully assess progress in respect of the critical goals of the alcohol and drug strategies because different monitoring functions at DACT and regional level have not been synthesised or properly collated. No one took responsibility for ensuring I and R resources were adequate or targeted to monitor strategic performance back in 2001-02. Consequently we now have a large partnership structure which cannot adequately audit itself nor indeed easily re-focus its efforts because there is inadequate capacity to identify 'success' and 'failure' or have an impartial sense of where unmet need is located.

4.4.3 **Regional structures**

4.4.3.1 Drug and Alcohol Implementation Steering Group

With the suspension of devolution and the loss of a dedicated ministerial drive, final accountability now, in practice, rests with **DAISG**. Several observers and members of DAISG told the Review that DAISG is not able to perform to its terms of reference which oblige it to: monitor progress, be responsible for coordination, to overcome policy or organisational difficulties and secure coordination at all levels of government. These responsibilities match with the main difficulties identified in this Section.

There are several reasons identified for this under-performance. Firstly, the current minister has inadequate time to fully steer performance. Secondly, actual meetings tend to be primarily reporting sessions with little critical questioning and informed discussion. Thirdly, the DAISG members are not tabling critical questions for discussion thus in practice relying on DAST, who produce the agenda and service the meetings, to make judgements about the business agenda. There is an obvious danger here for creating an accountability cul -de-sac.

Several observers believe a far stronger ministerial steer is required in the future. Sinn Fein, for example, suggest a joint ministerial committee should oversee strategy and implementation. A quarter of stakeholder consultees believed the whole strategy and DAST should be located in a cross-cutting department such as the Office of First Minister.

4.4.3.2 Drug and Alcohol Strategy Team

A good deal of negative criticism of **DAST** emerged from both the Consultations and Review fieldwork. Whilst we need to hear these critical themes in order to address them in the future it is important to state that DAST is current under-powered and poorly configured and should not become the focus of 'blame'. Many of the criticisms summarised below are a product of under-resourcing and a lack of appreciation as to DAST's overall workload. DAST has only two senior officers nor was it given additional resources when it took on the additional alcohol brief. For those closest to neighbourhood and front-line delivery DAST is not well known or understood. Consultees connected to DACTs and Working Groups and the senior players consulted for the Review fieldwork had a much clearer set of observations about DAST.

There were concerns about efficiency, effectiveness, communication, accountability and leadership. In terms of **efficiency**, the inability to time-table, service and 'direct' meetings of working groups, sub-committees was seen as inefficient, with too many meetings cancelled or re-scheduled and several sub groups not completing their work. DAST however point to the Chairs as being in charge of 'direction' and the fact they simply don't have the capacity to service 15 parent groups without some occasional re-timetabling.

The failure of the Training sub-group to complete its work was highlighted by consultees. DAST note difficulties in finding a willing Chair. The critique of unrealistic funding timelines was also largely directed at DAST rather than the inflexibility of the CAD financial arrangements. DAST anyway believes it offered signposting for advice and help feasible deadlines and support.

In terms of **effectiveness** DAST's perceived failure to performance manage the funded community and treatment projects was of considerable concern. Whilst the Review requested and received an assessment of the community and treatment 'RES' and monitoring forms the reality is that these forms are not receiving the degree of scrutiny and analysis to allow them to inform future funding or provide robust feedback to the projects. Some DACT stakeholders believe that regionally funded treatment projects (eg. Youth Counselling, Dual Diagnosis) vary considerably in terms of performance yet this is not being picked up and addressed by DAST. The current plan within DAST is to undertake an overall retrospective external evaluation during 2005. This proposed evaluation will however be somewhat compromised by the shortcomings of the RES system.

The DACTs are also required to make monitoring returns but are not currently receiving feedback. This is an unsatisfactory state of affairs with consequences for performance management and value for money. For example should the dual diagnosis workers' funded by project money now be incorporated into statutory provision? How can HSSBs be expected to take this provision if it has not been evaluated and there is no assessment of cost-effectiveness to support such a proposal?

The lack of **communication** across the partnership arena discussed earlier was felt by many observers to be primarily a DAST responsibility. Some consultees noted that the planned Communications Strategy has not been developed.

Finally, nearly half the Stakeholder consultees and around a third of the senior players felt that DAST was not providing strategic **leadership** or driving the strategic and operational plans sufficiently. Many however recognised that DAST has become swamped with administrative and funding tasks and that such a small team has genuine difficulty providing the degree of leadership originally envisaged.

The Review fieldwork with senior players found a more sanguine assessment of DAST amongst long-time watchers. DAST for some is a 'poison chalice' because the whole structure, in the absence of devolution, lacks accountability. A coordination team cannot demand anything from a pragmatic partnership and so cannot drive performance. The Review assessment is that whilst this is indeed the case and must be resolved for the next roll out there is little doubt that DAST began badly, being under-resourced and poorly configured and has never really managed to develop into an effective unit as a consequence. Of some comfort is that it is well understood in the field that DAST has had inadequate resources to manage all that is expected of it.

4.4.4 Overarching issues, inclusivity, service user involvement and training

4.4.4.1 Inclusivity and service user involvement

The majority of community, locality level stakeholders consulted noted the lack of inclusivity in current arrangements. Forty three per cent of focus groups made this a key observation. At a general level this observation highlighted the non engagement of local people and organisations and specifically in respect of service user involvement.

As if to confirm the difficulties of delivering inclusivity at all levels of the programme only 4 service users were involved in the Stakeholder Consultation. In fact this focus group provided an articulate and original contribution to the consultation in respect of drugs consumption trends, difficulties in accessing appropriate treatment and attitudes of medical staff.

There are clearly personal challenges for (ex) problem substance users becoming champions, advisors and advocates with the strategies and their delivery thanks to conservative and discriminatory attitudes about drug users in NI and in fairness competing agendas amongst different groups of substance users. The JIM attempt to empower service users has struggled to make progress. A renewed effort needs promoting in the next cycle with drinkers and drug users who are not service users joining those with an experiential treatment perspective. The Review also notes that benzodiazepine users and misusers are not much included in the official

agenda despite the major problem of psycho-tropic prescribing and diversion of these medications. Solvent misuse was highlighted as lacking due attention by some consultees, although there does seem to have been several ad hoc initiatives rolled out in the current cycle. The case for extending the drugs agenda to formally embrace volatile substances and misused prescribed or diverted medications is a strong one. There is currently no effort to address ethnicity and disability issues in a strategic, inclusive way. With the high level of 'migrants' coming to work in NI and new requirements in Disability legislation about accessibility to services the revised strategies should address inclusivity more holistically.

4.4.4.2 Training strategy

A concern amongst many stakeholders which peppered the consultation was in respect of training, be it for volunteers, professional staff, community project administrators or 'Tier One' staff (e.g. staff working in housing and social security). A Training Audit has not delivered a training strategy or roll out and there is a strong request for enhanced, accredited and multi disciplinary training and professional development perhaps within the English DANOS framework.

Finally, a training strategy needs to embrace the dissemination of best practice according to consultees. This will not be possible until NI has a dedicated evaluation and 'knowledge' system built through an integrated monitoring, evaluation and research unit.

4.5 **Agenda for change**

Although this Section has been obliged to focus on the weaknesses in performance, given the high levels of stakeholder concern, it does provide an agenda for change and improvement. The key issues can be forwarded to the last Section where the Review outlines the components and principles required to inform the next strategic cycle.

The case can be made for both a unified substance strategy and the continuation of 2 separate documents. Whichever route is chosen there is strong support for joint implementation and the Review recommends this approach also best fits a small country.

This said the current JIM structure must be uplifted to reduce bureaucracy and 'layers' of meetings. If Working Groups are maintained there must be greater clarity about their role and accountability. Communication both vertically and horizontally needs improving. The funding arrangements for community and treatment projects have caused major difficulties and inefficiencies for DACTs and their projects. Timelines and deadlines have been defined as 'unreasonable' by the frontline. The problems created by short term funding have been numerous and the worse for poor communication from government. The monitoring and evaluation of these projects has been inadequate.

At regional level DAST has not been resourced or configured to coordinate, service and lead programme development. DAST has been criticised on all fronts yet most of its difficulties have been built into the current arrangements. This situation can hopefully be resolved through increased resourcing and redesign.

In terms of accountability the Review notes that with devolution suspended early in this cycle accountability has become diluted. DAISG has not fully embraced its responsibilities by working to its terms of reference and DHSSPS has not fully appreciated the weaknesses in current arrangements. Again this situation can be corrected with appropriate restructuring and investment.

5. REFOCUS: Revising the alcohol and drug strategies and joint implementation

5.1 Significant Renovation Required

The Review is required to identify how the current alcohol and drugs strategies might be redrafted to reflect changes in the alcohol and drugs situation over the past few years. It is also tasked to consider whether the current core objectives are appropriate. This appraisal should extend to joint implementation.

This Section is thus concerned with outlining how we might refocus the strategies and also ensure any joint implementation process is more efficient and effective than its predecessor. The Stakeholder Consultation and the appraisal suggest the need for significant renovation. Finally, this Section addresses the relationship between the alcohol and drug strategies and a myriad of other strategic and priority plans and related on-going reviews.

5.2 Changes in the Alcohol and Drugs Landscape since yr. 2000

5.2.1 Drinking rates

As we have shown, the rates of drinking for the whole NI population of drinkers continue their incremental rise. In particular the younger population continue to indulge in so called binge drinking. Rates of alcohol misuse are particularly high amongst vulnerable-delinquent young people and adult offenders. There is no sign of alcohol related disorder or nuisance becoming less of a concern for the general population. Indeed the night-time economy is burgeoning with the current 1,300 licensed premises, the latest peak of a continuing upward trend.

We have noted that alcohol related health problems are rising, for instance in relation to the treatment of liver disease. These trends once set take many years to re-direct, or simply take their course, and it is quite clear that the costs to the NI health service are significant and rising.

Most importantly we have seen that many of the core objectives in the alcohol strategy are not being achieved. Whether it is encouraging responsible drinking, reducing binge drinking, reducing harm, ill-health or indeed investing in treatment on the basis of need – there have been few signs of success. We cannot assess whether this deterioration would have been greater but for strategic and operational activity, although it is a reasonable assumption.

5.2.2 Drug use and availability

In respect of the drugs 'problem', the rise in drug taking by younger people which began in the 1990s appears to have continued into the new decade although there is some survey evidence of an emergent plateau. The spread of cocaine availability and use is probably the single biggest change since yr 2000 which needs our attention. Heroin usage appears fairly stable although with some spread to rural areas. A forthcoming study should produce an updated and probably higher estimate however.

Whilst enforcement activities against drugs have met their targets there is no evidence that the overall level of availability of illicit drugs has been reduced in recent years, on the contrary prices have fallen despite increased drugs seizures. Community concern based on population surveys remains high. Again the situation might have been worse but for strategic and operational interventions but this is difficult to demonstrate evidentially.

5.3 Maintain but Revise the Critical Aspirational Goals

Despite this gloomy backcloth we should remember that NI is not alone in struggling to meet its aspirational goals. Most 'western' societies have adopted similar packages of goals and struggle similarly with upward consumption trends and related problems. Neither Ireland nor Greater Britain, with very similar critical goals, have achieved the desired outcomes. Similarly cocaine use for instance has grown right across Europe with Spain and Germany in particular currently attempting to control availability and use. Binge drinking whilst particularly high in Ireland and the UK is at similar levels in Denmark and other northern European countries.

The failure to achieve success with the current alcohol and drug strategies is not a reason to abandon the aspirational goals. They are currently largely consistent with international treaties and the global perspective of international organisations such as the EU and WHO.

The consulted stakeholders showed no appetite for re-defining the core goals but rather re-financing and extending their locus and in particular ensuring the associated implementation programme is far more efficient and effective than its predecessor. We begin with the extension and inclusion agenda recommended by the Review. Whilst acknowledging the potential for an integrated alcohol-drug strategy this Section highlights alcohol and drug specific issues before turning to cross-cutting agendas.

5.4 Revision and Extension of the Alcohol Strategy's Domains

5.4.1 Goals must impact at local level

The overarching issue identified by the Review is that the 1999 Strategy was light on detailed priorities and targets and restricted in its vision of essential stakeholders and partners. It was particularly reticent at the community level, offering a weak agenda to local stakeholders. With the development of the PSNI and its district policing partnerships and District Command Unit approach to community policing plus emergent community safety partnerships it is important to create a revised strategy which rolls out from regional goals in a coherent manner whereby such national objectives are represented in local arrangements and targets. The local beat officer, youth worker, hostel manager, etc. should be able to better understand how their activities in respect of alcohol link to and indeed contribute to the region wide goals.

5.4.2 Managing the night-time economy

The 'steady' normalisation of civic life in NI and the continued expansion of licensed premises and the scale of 'going out' drinking requires the revised alcohol strategy to ensure a specific focus on ***the management of the night-time economy***.

Much progress has been made identifying the nature of the problems and their successful management. PSNI and multiple partners have been able to demonstrate that extensive collaboration and intensive resourcing can reduce the problems associated with Belfast's night-time economy. By attempting to learn from best-practice elsewhere and with initiatives such as 'Get Home Safe' there are signs of a good practice agenda. There is a clear need to extend night-time economy management across the region and to monitor and evaluate effectiveness. Given the additional difficulties presented by weekend visiting revellers and a growing student population intent on enjoying intoxicated weekends, the revised alcohol strategy should pay due attention to the management of entertainment quarters and rights of local residents. Targets could include minimising alcohol related disorder, violence and sexual offences, better protecting A and E departments from overload and getting 'the punters' home safely. More work with the drinks and restaurant industries including registering door staff is required, building on the work of the current Safer Entertainments initiative.

5.4.3 Liquor Licensing review

The on-going Liquor Licensing Review appears to be well integrated into the wider strategic goals of the alcohol strategy. It is important to integrate its agenda with any second cycle of joint implementation plans however.

5.5 Extending the Drug Strategy's Domains

5.5.1 Treatment and criminal justice interventions

The aspirational goals in the NI drug strategy are based on those found in the 1998 United Kingdom strategy but with fewer explicit targets attached. Importantly the updated English version of their drugs strategy in 2002 removed numerous targets and adopted a more managerialist approach.

As with alcohol these aspirational goals remain salient and important and the Review found no widespread concern about their relevance. The far lower rates of problem drug use and associated crime in NI do not require the emphasis given to the drugs-crime agenda found in Scotland and particularly England where crime reduction is now their strategy's primary focus. This said it is important to maintain and extend ***programmes building links between treatment and criminal justice which aim to reduce drug related crime.***

The evaluations of Railway Street and DART are very promising, suggesting cost-effective interventions in terms of reducing drug related crime. There is far more potential in these sorts of programmes and a revised drugs strategy should continue to prioritise their further development and endorse the need for continuing evaluation.

In terms of joint implementation this portfolio of work should be linked to future developments within Youth Justice.

5.5.2 Harm reduction

One specific community 'provider' perspective from stakeholders concerned the concept and delivery of ***harm reduction***. There was a concerted call for this concept to be defined in the revised strategy and guidance given to its application for instance with young drug users and in secondary prevention initiatives with injecting drug users.

5.5.3 Map and challenge drug markets

The Review assessment identified two initiatives which are advised for the NI context. Firstly, as confidence in PSNI community policing hopefully increases, it should become possible to begin to map 'Level 1' or community-street level ***drugs markets***. PSNI Drugs Squad currently focus on Level 2 drug markets and supply routes in collaboration with GB and European drugs intelligence and enforcement systems. Whilst enforcement against community level markets (e.g. open street markets, residential addresses, 'mobile' drugs deliveries) has been found unable to reduce drugs availability significantly, well organised multi-agency partnerships can 'keep the lid on' these drug markets and reduce community concern by displacing them away from residential areas. Moreover, understanding local drug markets and sharing intelligence between services (e.g. Police, Community Groups,

Treatment Services, Community Safety Units) can help 'joined up' policy and practice. For instance there are numerous reports in England of successfully delivered initiatives which involved the removal of targeted drug dealers backed up with outreach work with their customers and fast tracking some of the customer base into treatment.

5.5.4 Introduce an early warning system

The Review strongly recommends priority is given to the setting up of an '**early warning system**' for Northern Ireland. The region's current drugs status is more benign than all nearby countries and provides a unique opportunity for a proactive approach to protecting this status. With a maximum of 1,500 heroin users and only the first signs of crack cocaine use bedding in, it should be possible to create an 'intelligence' led monitoring system to trigger rapid responses to any deterioration. There is a best practice literature available for guidance. Essentially a jigsaw analysis system brings together information from multiple sources about drugs availability and consumption patterns based on arrests, needle exchange information, prison drug finds data, treatment referral patterns, A and E admissions, National Drugs Helpline calls, drugs users' accounts, community observers, night-club staff observations, taxi drivers' accounts, etc. A system administrator is required supported by good analytical work. The purpose of such a system is to advise all stakeholders and the general public of any negative changes in the drugs scene. This should then trigger rapid responses whether through public information, targeted enforcement or drugs interventions such as outreach work.

We know from observing the spread of crack use in GB that cocaine powder use stimulates crack use not least because crack can be easily produced from cocaine hydrochloride. Crack use tends to bed in first amongst current heroin users. This process may be underway given a recent qualitative study of drug injectors in NI found half had tried crack. We also know that crack users often turn to benzodiazepines as a depressant 'come down' drug to minimise the 'wired' effects of crack. Given the widespread use of benzos through prescribing and a diverted medications market, this combination of heroin-crack-benzos would seem a likely poly drug repertoire for the future. With 8 in 10 adult offenders arriving in prison prescribed benzodiazepines there are numerous indicators that should availability of crack increase, the region's drug problem could deteriorate over the next few years. An important early warning indicator is thus the activity of organised crime groups linked to paramilitaries 'allowing' further drug supplying in the region.

This is not scare-mongering but an illustration of how we can utilise drug epidemiology to risk assess NI's drug situation and drugs future. An early warning system is of greatest value if its collective owners know what they are looking for and actually utilise research and monitoring data pro-actively. This sophistication is currently lacking but an early warning system would bring together players who with some induction training could soon produce an 'intelligent' surveillance system.

5.6 Cross Cutting and Joint Implementation Domains

5.6.1 Target vulnerable young people

The main Stakeholder Consultation and Review appraisal both identify **vulnerable young people** as a group which have been neglected in the JIM plan. In particular the revised strategy should be explicit about the disproportionately high rates of alcohol and drug use in this population and focus on reducing consumption and related harm. This population is found in looked after/social services care, school truants and excludees and many of those brought to the attention of the youth justice system or in YOCs. The Youth Justice Agency, Youth Service and Children and Young Person's Unit should become new key partners in any future joint implementation programme. Their strategic priorities need embedding in a revised JIM.

This variously at risk and vulnerable sector of the youth population require 'joined up' interventions. There is a best practice international literature available and recently commissioned literature reviews to underpin any new programmes. Importantly it is primarily within this socially excluded youth population that any significant new uptake of heroin and crack will appear beyond established, older, problem user networks

Currently treatment provision for young people is uneven and limited despite the work of the new Youth Counselling Service. One of the few programme exports from England that can be recommended is the models of care/Under 18s substance misuse service plans currently being rolled out. This provides an effective developmental framework within which to establish young person's services. The framework brings together 4 tiers of provision and so embraces all agencies and groups which work with young people from the detached youth worker to the specialist addictions psychologist. This approach also allows an audit of care pathways for young people with substance related problems. It would for instance identify current under-investment in NI in specialist provision (e.g. CAMHS capacity; after-care for young offenders leaving custody). The Youth Justice Agency should be an important partner in the establishment of an integrated Under 18s Service as it moves towards developing a resettlement and aftercare service for young offenders with substance issues leaving custody.

In this respect the recent JIM roll out included one project concerned with the employability of young adults with alcohol and drug problems. This initiative led by the Department of Employment and Learning has struggled to develop and would benefit from being linked to a more strategic and holistic approach to working with young people as recommended.

5.6.2 Uplift monitoring, evaluation and research, review databases

The Review has already alluded to the disjointed and inadequate 'system' for **providing monitoring and evaluation support, primary research and information** (e.g. about best practice). This failure is not a product of the

mother strategies which emphasised the need for a robust comprehensive system to support strategic and operational roll out. Nevertheless the revised strategies must explicitly reiterate the need for such an approach. Most of the component parts of a holistic approach are in place but the key players have failed to provide sufficient coordination, coherence and strategic leadership not least because of their demanding workloads.

Specific issues identified by the Review which might be addressed in revising the alcohol-drugs strategies are as follows. The ***data bases for monitoring problem drug users entering/remaining in treatment*** – The Addicts Index and the Northern Ireland Drug Misuse Data base and Substitute Prescribing Data base could be merged. Whilst abolishing the Addicts Index would require a change in legislation the Review recommends that NI adopts one comprehensive system. This would reduce cost for DAIRU as administrator and if properly policed would produce a more authoritative picture. Currently there is much anecdotal evidence that treatment-medical staff, especially GPs, fail to report all their cases to relevant data bases. The Probation Board need to refer appropriate cases to this database in the future. This problem of under-reporting is a UK wide issue. However the introduction of one overarching treatment activity reporting system provides the opportunity to demand and promote greater compliance and should also produce economies which can be dedicated to more assertive policing.

A further data base also managed by DAIRU is the ***Northern Ireland Needle and Syringe Exchange Scheme***. This data base provides important information but could be of even greater value if participating pharmacies could collect further information. We ideally need to know the number of unique individuals using the service, which drugs they inject including steroids and whether they are currently in treatment. It is quite possible to do this without breaching confidentiality or ‘putting off’ customers. This new information would feed into the envisaged early warning system and general treatment commissioning. This would be joint implementation business led by DAST which oversees this provision.

5.6.3 Modernise treatment provision

5.6.3.1 Provision not meeting need

Treatment Provision remains under-resourced and under-developed. The original strategies prioritised the development of ‘best practice’ treatment interventions around alcohol and drug misuse to allow people to live healthy, crime free lives and overcome their substance misuse problems. Both strategies were light on detail which was instead found in the JIM business plan. Had campaign/project funds not been made available to enhance drugs (and alcohol to a small extent) treatment it can be argued, and is by some treatment providers consulted, that very little has improved over the past few years. Despite a steady increase in referrals (15% over the 3 years to 2004), primarily alcohol related, there has been no increase in funding from DHSSPS and the HSSBs. Current services are thus under serious pressure as noted in

the Kenny Report (2003) audit and now in submissions to the Mental Health Review.

This under resourcing has also been identified by the Northern Ireland Affairs Committee (2003) report 'The Illegal Drugs Trade and Drug Culture in Northern Ireland' which recommended immediate new investment. The Review fully concurs with this recommendation. There is a case therefore for making this a more detailed and explicit strategic priority for the next cycle. Essentially the aspirational goal would be to enhance treatment provision on the basis of need, accessibility (e.g. no waiting lists) and equity across NI and to ensure service users can be sure they receive 'best practice' regimes and care on the basis of their assessed need. The case for targets linked to additional resources is a strong one here.

5.6.3.2 Models of care

There is already a template for modernising and professionalizing treatment provision submitted to the Mental Health Review. This developmental plan with further additions is recommended by this Review. The detailed agenda might be built into a future joint implementation plan.

The in-house development plan for the treatment sector intends to adopt the Models of Care framework approach. As stated earlier this is one initiative in England which is proving highly beneficial in the quest to improve the efficiency and possibly effectiveness of substance misuse treatment. Alcohol interventions can be successfully designed, audited and managed within this framework.

If fully implemented in NI and backed by appropriate resources and a performance managed JIM/HSSB delivery system it should be possible to genuinely enhance the effectiveness of treatment provision in the region. However modernisation is a slow process and best managed from within the sector as it involves significant change for the 150 or so core staff and hundreds of other Tier 1 and 2 'professionals' (e.g. GPs, hostels, youth workers, voluntary agencies working with substance users, self help groups) who refer or jointly work with Tier 3 (e.g. CATs) providers. The current search for a simple validated tool to measure dependency and recovery should be part of the development plan. However a performance management system requires multiple measures whereby even if abstinence is not achieved improvements may be found across domains such as physical health, risk taking, blood borne virus status, mental health, personal and family relationships, child care practice, employability and offending. Within the Models of Care framework we need triage and comprehensive assessment tools which create baseline measures across these domains followed up by re-assessment or treatment review. These become a quasi-effectiveness measure as well as informing an on-going care plan. It will be important to undertake a feasibility study which actually costs say a 3 year programme, as experience from GB is that significant new investment is required to deliver quality treatment provision. A major stumbling block to creating an outcome and performance management system is the incompatible IT systems within the Health Boards. Currently information required for monitoring throughputs

and outcomes is located in 5 different data bases. The eventual goal must be to have one unified IT system for all statutory drug teams. This will require extensive collaboration across the HSSBs. There would be difficulties bringing voluntary sector 'treatment' services into this system particularly in respect of confidentiality and information sharing but a consultation would be desirable.

More progressive DAATs in England are working with the concept of 'care pathways' found in Models of Care. The Review recommends that in modernising and renovating treatment provision that this concept is applied to 'testing' services. Essentially we take 'scenario' cases and test our provision's ability to provide an integrated care pathway utilising 'best practice' and a holistic approach to need. So if a 23 year old female poly drug user presents because her crack use has created a crisis for her, her children and family at any of 50 plus treatment entry points in the region do we have a framework of care which can address her needs? Stakeholders consulted acknowledged there were numerous gaps in provision which would make the successful treatment of such a service user unlikely. Service users in the consultation identified several such shortcomings in responding to complex needs. Services for stimulant users need developing in preparation for new kinds of drug repertoire presentations (eg. cocaine casualties).

5.6.3.3. Commissioning of services

The Review was not tasked to look at commissioning standards and practices but poor commissioning standards have been identified as a major weakness in GB. Historically commissioning alcohol and drug services have been after-thoughts in mental health and primary care commissioning systems and have failed to follow the recommended cycle of 'needs assessment-strategic planning > operational planning-monitoring > evaluation'. Best practice guidance is now available. It is recommended that a review of commissioning practices is undertaken in partnership with the HSSBs and Trusts. A peer led forum might start off this process using one of several self -auditing tools.

5.6.3.4 Training and DANOS

A training strategy is vital to underpin this agenda. According to the stakeholder consultations training is currently too ad hoc with little accredited provision. Many consultees believed 'DANOS' (Drug and Alcohol National Occupational Standards) should be utilised to accredit training and occupational competence. The Review recommends that as the basis of the English experience DANOS has poor spontaneous take up without a strong lead and support system.

5.6.3.5 Best practice organizational standards

The stakeholder consultations identified a large amount of inconsistency in treatment services across the 4 Board areas and a lack of best practice sharing. An inexpensive and rapid auditing system for drug and alcohol agencies in respect of their governance, organisational and delivery standards

is found in QuADs (produced by Drugscope). This self audit, but best led by an independent consultant/advisor, would allow a baseline to be produced for all Tier2 and 3 provider agencies in respect of policies, procedures, accessibility, service user involvement, etc. and action plans to allow agencies to move towards meeting best practice standards. Thereafter it also allows better practice in one agency or Board to be identified and shared with others. **A QuADs programme** might be drafted into a future implementation plan and set alongside the models of care development .Currently there is a batch of voluntary and community projects which have no best practice governance or validated organizational standards in place. QuADs should be extended to some of the larger projects by way of a pilot.

5.6.3.6 Hepatitis programme

The recent review of the prevalence of **Hepatitis** in the NI population and amongst injecting drug users, plus a qualitative study of heroin injectors, suggest the need for an improved programme of intervention. Rates of positivity are comparatively high and needle sharing more prevalent than in GB. The next cycle should deliver the programme of Hep screening, B vaccinations and safer injecting practices currently in development. At present provision is too defined by Health Board activity or in one case, inactivity.

5.6.3.7 Service users, inclusivity and stigma

The noted lack of **inclusivity** within current arrangements is best illustrated in respect of involving **service users** in delivering the alcohol and drugs strategies. There is strong support for re-emphasising the involvement of both substance users and service users in the next cycle. Given one reason for a lack of involvement of drug users in and around JIM is the enormous stigma heroin users and especially injectors face in NI the Review recommends that **reducing stigma and discrimination** faced by drug users and their families should be an additional objective for the future. There is evidence from recent research that many problem drug users in NI will not attend Needle Exchanges or treatment services particularly in rural areas in part at least for fear of being publicly identified and stigmatised. Nearly 1 in 10 of those entering treatment refuse to consent to their details being entered on the Drug Misuse Data base.

5.7 **Refocus Strategic Goals for Compatibility with the Multiplicity of Other Regional Strategies**

The Review has tried to locate how the alcohol and drug strategic goals interface with other initiatives, strategic plans and reviews. It ran out of time before completing this exercise overwhelmed by the number of special programmes, strategic plans and public body agendas. There are 119 public bodies in NI. The public sector accounts for 32% of all jobs in the region compared with 22% in Scotland. The Review of Public Administration is shortly to publish its findings on the governance of the region but background papers already acknowledge that over complex governance is a serious problem.

The current alcohol and drug strategies for each UK country are genuinely cross-cutting and each country has struggled to find a best fit for such a diverse strategic bundle and there is no best practice example evident. The alcohol and drug strategies are broadly consistent with Investing for Health and Working for Health. Priority activity around alcohol and drug use in health education for young people, services to address the mental and physical health of those with alcohol and/or drugs problems including in prisons, services to manage blood borne viruses etc., all fit well with a public health agenda. The alcohol and drug treatment agenda is also being considered by the Mental Health Review (Alcohol and Substance Misuse Working Committee). There is also a Review of Public Health and a Ministerial Group on Public Health. A Healthy Cities Initiative is in place and at a local level there are Health Action Zones and Local health and Social Care Groups with specific strategic targets. The Teenage Pregnancy and Parenthood strategy can also be seen as health promoting.

However the strategies and JIM activity are just as potently related to the NI Community Safety Strategy, to PSNI and Customs and Excise priority goals. From an enforcement perspective the current alcohol and drugs 'targets' appear variously in the terms of reference of the Probation Board, the Youth Justice Agency and the priorities for action against organised crime. There are strategic goals which link to the New Targeting Social Need policy, Health and Safety, road safety and the liquor licensing.

Alcohol and drug use amongst young people relates to the Children's Strategy, the Education Sector Plan, the Youth Work Strategy and Youth Sector Strategic Plan and the Children and Young Person's Unit's agenda.

This 'overlap' list can be extended to many other arenas which fall outside 'Health.' The critical point is that it is very difficult to drive the specific strategic priorities in the alcohol and drugs strategies through partnership working when the key partners are working to so many other organisational and regional 'special' programmes and strategic frameworks. The alcohol and drugs agenda gets somewhat lost in such a complicated set of arrangements and as we have seen sometimes perplexes other government departments. The DENI has voiced concerns about its role within JIM. The Review recommends that the next strategic plan actively attempts wherever possible to produce strategic goals which are consistent with and contribute to all other strategies where there is potential for goal sharing.

6. RETHINK: Redesigning strategic, organisational and operational arrangements to improve efficiency and effectiveness

6.1 A Critical Moment for Re-addressing Alcohol and Drugs Problems

Put starkly the current aspirational and critical goals found in the alcohol and drugs strategies have not been achieved. The audit of progress against objectives has shown how difficult it is to re-direct alcohol and drug consumption trends, manage alcohol use and the availability of street drugs and create projects and programmes which can reduce harm and provide appropriate treatment. Public appreciation of activity is not much recognized.

Even in respect of secondary goals distributing investment for the development of prevention, intervention and treatment through the JIM structure has clearly not lived up to expectation. Most stakeholders, particularly DACTs, service providers and community activists, are variously frustrated and disappointed with current organisational and funding arrangements. DAST in turn feels overworked and undervalued. The whole programme has not developed the required monitoring and evaluation system and has failed to routinely assess its own performance against strategic and business goals. There is confused and inadequate accountability throughout the whole system but most notably at regional government level.

We begin with this stark summary because NI is at a critical moment in respect of its response to alcohol misuse and the multiple problems associated with some illicit drug use. The current apparatus has developed rapidly via unexpected new 'Treasury' resources but the bill now transfers to the region in general and DHSSPS in particular. The present delivery arrangements via DHSSPS are not yet fully fit for purpose and need additional investment and a major restructuring.

Whilst the rest of this Section will focus on how this re-configuring might be achieved it is important to recognise that without a major rethink there is a serious risk that the next cycle will also fail to reach its full potential. The danger is that the opportunity to genuinely uplift the alcohol and drugs agenda will not be grasped because the time and resources required appear too great. Such a decision then becomes part of the problem in that a further 3-4 years of under-performance occurs, probably against a deteriorating alcohol and drugs landscape, before radical change is triggered by concern in the public and political domains.

6.2 The Estimated Costs of NI's Alcohol and Drugs Problem

6.2.1 Alcohol estimates

The Investing for Health strategy (2002) reports that excessive alcohol consumption in NI is responsible for

- Over 730 deaths a year.
- The equivalent of over 12,000 expected years of life being lost.
- Approximately 400,000 working days lost each year.
- Approximately £800 million costs to the economy.

The DHSSPS (*Reducing alcohol related harm in Northern Ireland*) estimates £34.3 million's worth of costs are incurred against government spending (e.g. hospital costs, prison costs). It is also estimated that £743 million per year is incurred in costs that impact on government spending less directly (e.g. road traffic accidents).

6.2.2 Drugs estimates

An Investing for Health review in 2002 estimated the cost of drug misuse in the region was

- Around 15 deaths per year.
- The loss of 10,000 working days each year.

The report also estimated that £8 million a year is spent on enforcement, prevention, treatment and rehabilitation. The DHSSPS estimate drug misuse results in additional costs of £300-£500 million per annum.

This kind of modelling by health economists is in its infancy and is extremely difficult to validate. Nevertheless even if the costs of drug misuse in NI are a little too high, which they appear to be, the important message is that the costs to the country of its alcohol and drugs problem can be counted in billions of pounds. We need to compare current investment in regional strategic delivery against this significant cost.

6.3 Funding and Investment 1999-2005

6.3.1 Funding arrangements difficult to collate

No costed record of direct expenditure on the alcohol and drug strategies has been produced recently across regional government. This seems a serious omission if we assume cost effectiveness and value for money are important principles in delivering public services.

The Review has struggled to produce a coherent funding tree. Some resources are not earmarked at the Centre, for instance statutory treatment

resources are not identified in the DHSSPS but assumed to be within a Mental Health and Disability basket forwarded to the 4 HSSBS who in turn rely on Trusts to commission treatment services. Ten trusts host Community Addiction Teams and other provision. We can only identify expenditure from the ground floor therefore. As a very 'rough guide' to funding the Review has brought together the main funding streams utilised over the past 5 years.

6.3.2 'Treasury', NIO, DENI and DHSSPS investment

Across 1999-2002 the Treasury provided £5.5 million ring fenced funds to help deliver the aims of the Drug Strategy (alcohol was broadly excluded). £4.5 million was allocated to 36 projects from the voluntary and statutory sectors (e.g. treatment projects, needle exchange schemes). Over £800,000 of this pot went to the DENI for health education work.

In Spring 2002 when Treasury money ran out the DHSSPS became a major funder allocating £2.4 million of its resources for 2002-3 to sustain 23 of an original 36 projects with a health or community focus. The DENI also took over the funding of 5 drugs education advisors/coordinators (about £250,000 a year).

Across 2002-4 a further £9.3 million of Treasury money was allocated under the Communities Against Drugs (CAD) initiative. Following governmental discussions it was agreed that £6.23 million would be allocated under the control of DAST. A number of conditions were attached, primarily that it was to be used to fund new and additional activities. Essentially this allocation funded the Regional Action Plan-JIM programme with £3.4 million going to regional delivery (of which £1 million was to set up the Youth Counselling Service) and £2.8 million to the DACTS for delivery of local action plans. From the balance the NIO received £3.15 million to allocate to criminal justice projects across 3 years including work in young offender and adult custodial facilities, police custody suites and arrest referral schemes.

With the ending of CAD money in March 2004 the DHSSPS allocated a further £3 million again to help sustain services with a health and community focus. Importantly, this funding stream allows alcohol provision to be more purposefully and transparently funded rather than being slipped into projects funded by 'drugs money'. The DHSSPS now directs around £7 million funding a year to support around 80 projects and the delivery infra structure.

From 2004-05 the NIO has taken over funding for criminal justice related drug projects with a baseline of £750k.

Three other funding streams emanate from DHSSPS. Firstly, DAST is able to bid for limited funds from within its host Health Development Directorate. Secondly, alcohol/drug projects can access funds from Local Health and Social Care Groups and Investing for Health Partnerships. Thirdly, statutory treatment services are funded from core DHSSPS money passed down to the Health Boards depending on local priorities. The Kenny Report (2003) estimated that for 2001-02 £4.2 million was allocated from core funding. More

recent funding appears to be at a similar rate. There is also funding given to voluntary Substance Misuse Services by Health Trusts. Finally, the alcohol and drugs strategy funding is currently being reduced by around £350,000 in 2004-05 then £700,000 in 2005-06 as part of a round of time limited departmental efficiency savings.

6.3.3 Recent and current resources

Over the past 5 years around £15 million of investment has emanated from Treasury time limited ring fenced drugs funds. It has been allocated via NIO and DAST/DHSSPS. The current infrastructure is now being funded from the DHSSPS with DENI and the NIO also providing resources from their own budgets.

With the DAST budget at around £7 million in 2004-05 and statutory treatment costing say £4.5 million and DENI £250,000 and NIO providing £750k it appears that a maximum of £13 million a year is currently being invested into the alcohol and drugs agenda. This is our rough guide working total although there are clearly other sources of funding we have identified that might be added in after further investigation.

6.3.4 Difficulties related to recent funding streams

The £15 million of Treasury 'drugs' money from 1999-2004 has been very welcome and has essentially kick started the development of an infrastructure of provision to support the implementation of the alcohol and drug strategies. However its dispersal has caused major difficulties. As we have described, its funding and re-funding criteria, deadlines and inadequate monitoring have produced disquiet on the front-line and overwhelmed DAST with administrative tasks which such a small team has struggled to manage. Other strategic responsibilities have suffered as a consequence and DAST becomes the target for criticism in the field.

The exclusive focus on drugs projects has been inappropriate for NI where alcohol problems dominate. This is primarily why stakeholders feel alcohol has been sidelined over the first half of the decade. In fact this need no longer be the case and the DHSSPS, as the new primary funder, explicitly welcomes alcohol intervention projects seeing these as supportive of Investing for Health. England has still not managed to fund alcohol interventions/treatment successfully.

DAST's problems remain unresolved however as they are still charged with distribution, accounting and monitoring of the main budgets and liaison with a large number of projects. Similarly front-line projects remain insecure and caught in planning blight with no public promise of sustained funding.

A particular problem has been inadvertently created in respect of funding statutory treatment provision. Core provision (at about £4.5 million a year) found in the HSSBs is being supported, or as some see it, 'propped up' by resources channelled as 'project money' via JIM and DAST (£2 million a

year). Thus, for instance, an expensive Substitute Prescribing Service, dual diagnosis work, and in one Board a hospital detoxification unit are being funded separately from HSSBs core monies. In any other UK country such provision would be seen as indisputably statutory, funding would be re-current and adjusted on the basis of need and indeed with demanding, audited targets to increase numbers entering treatment.

Finally, the low threshold JIM/DACT funding principles used to distribute several million pounds of new investment from a regional pot do not fit easily with the capitation principles applied in HSSBs. There is clearly much competition and disagreement at DACT level, evident from the Consultation, about resource allocation. Ideally the overriding and transparent funding principle should be **needs led** via a regional needs assessment framework for alcohol and drugs 'problems' as in GB. There is no immediate prospect of creating such a system but a more transparent, rigorous and needs informed framework should accompany the next role out. The DACTs with their HSSB connections and strong views might be tasked to lead on this development whereby they have to help seek resolution rather than blame the 'system'.

6.4 Reviewing the Strategic Plans

6.4.1 The strategies and JIM

The Review notes that most stakeholders would like to see an integrated, holistic alcohol and drugs strategy. This would be an ambitious project but should be considered alongside the second option of 2 discrete strategies. During further consultation it is important to communicate to stakeholders that the funding of alcohol services/projects is no longer stifled by ring fenced drugs money

However given almost all stakeholders wish to see the continuation of joint implementation the Review concludes that either integrated or separate alcohol and drug strategy documents are suitable vehicles as long as one joint-implementation approach is embraced. Joint implementation fits well with the NI situation in respect of alcohol and drugs and is anyway required to produce economies of scale in such a small country.

6.4.2 Carefully crafted critical goals: three principles

In respect of the aspirational goals and related targets there is no stakeholder concern about their general thrust and most should be maintained. The Review has identified specific refinements throughout the report but now suggests that there are important principles to be observed in drafting exact goals.

- ***All the critical goals should be operational at both regional and community level***

This should improve commitment to and understanding of the strategy and its roll out and give local stakeholders a clearer sense of purpose and partnership. The DACTs would be better connected to the national delivery plan.

- ***All the critical goals should have performance indicators attached to them to facilitate monitoring and performance management***

There are numerous objectives in the current strategies which cannot be monitored or measured so undermining performance management. This revised approach would not necessitate but does allow the introduction of targets. If targets are introduced they should have regional and HSSB level requirements.

Whilst redeveloping critical goals reference might be made to WHO's *European Alcohol Action Plan* to ensure NI can measure its performance against European wide indicators. There is already reasonable compatibility. Similarly with drugs the revised strategy needs to be consistent with the new *EU Drugs Strategy 2005-2012*. This strategy highlights enforcement priorities demand reduction, young people and treatment priorities and compatibility and comparability should be achievable. The Drugs Harm Index being introduced in England might be utilised to allow performance comparisons.

- ***All the critical goals should wherever possible be shared or consistent with those of other government departments, statutory or voluntary agencies, special programmes and initiatives***

The recent alcohol and drug strategies and JIM were not able to identify all the key stakeholders required to produce a comprehensive partnership. Some original and current partners have found it difficult to prioritise JIM work or in a few cases even accept their continued relevance to the programme. By crafting and matching critical goals it may be possible to foster new partners (e.g around vulnerable young people) and better engage current ones over the next roll out.

This might become an immediate developmental task whereby the mapping of strategic goals and targets in the plethora of other programmes which relate to alcohol and drugs can underpin the revision of the strategies and suggest who key partners might be. Due attention should be paid to non-health agendas whereby PSNI, Probation Board, Youth Justice Agency, Prisons, Community Safety Units are scrutinized. This process must also take place at the DACT level.

6.5 Rethinking Joint Implementation: Principles to Practice

Thanks to the efforts of the consulted stakeholders the Review has generated a useful agenda for improving a future joint implementation framework. If we return to the original guiding principles found in the drug strategy and included in the region's JIM structure they can be seen to remain pertinent and

relevant. It can be argued that if JIM and all the key players had been able to follow these then far fewer problems and inefficiencies would have presented. The 'system' and DAST were never sufficiently powered to work to these principles however. We will discuss each of the 8 principles in turn.

6.5.1 Partnership

Given the hurried implementation of JIM not all the partners brought together were fully committed to the enterprise. Partner agencies had to provide human and other resources often from within their own establishment and budgets and had to make a cost-benefit decision through time as to whether their commitment was worthwhile when set against their own agency or department priorities. Consequently some key players withdrew full commitment or missed meetings or did not prioritise JIM work. Whilst this is the eternal problem with partnership working, far more effort is required in future to ensure that the critical objectives and business plan for the next cycle recruits and nurtures those partners who are most relevant to delivery. This will involve establishing new partnerships and perhaps downsizing those non critical arenas where partnership work has not delivered.

There is a literature on creating effective partnerships and the best practice principles involved relate directly to some of the current shortcomings. Partners need to feel involved, valued and supported. Ideally their own agency achievement should be enhanced through partnership work and so on.

These partnerships should be represented at all levels. This Review has concentrated on critical regional partnerships but is important to look at local arrangements found within the DACT partnerships. We are looking for good practice which can be considered as a template for new arrangements. We have examples of PSNI /DCUs or local Community Safety Units working closely within the alcohol and drugs strategy at DACT level.

6.5.2 Information sharing

The JIM structure was not able to deliver effective methods of information sharing and disappointment was expressed at all levels about 'silo' work and poor information sharing. The requirements to produce a communications strategy were not followed through. The next roll out should be supported by a comprehensive communications system which deals with the media and external and internal customers and ensures information on all aspects of the programme is available to all stakeholders. Elsewhere in the UK there are units dedicated to this enterprise. Monthly interactive E bulletins have proved particularly effective and can be configured for different audiences (e.g. workforce, general public). Stakeholders have suggested that all Minutes and key documents should be accessible in the alcohol and drug 'E Room'. Information sharing would be part of this new structure. Once again present good practice should be identified and maintained and built into future arrangements. DAST notes that there is poor take up from the field when they do hold consultation and information sharing events.

6.5.3 Monitoring

Despite the requirement/principle that monitoring should underpin business activity we have seen numerous examples of poor practice. The monitoring of several million pounds worth of projects in the voluntary, community and treatment sectors has been inadequate. This current DAST role needs re-designing and integrating into a coherent IMERS system (Information, Monitoring, Evaluation, Research and Surveillance).

The most efficient monitoring systems are managed by DAIRU namely the Addicts Index, the Drug Misuse Database and the Substitute Prescribing Monitoring System. However the Review suggests there may be a more cost-effective and inclusive approach whereby these discrete systems are merged into one data base system and better reporting compliance achieved. The Needle Exchange Scheme monitoring system appears efficient but can be enhanced and made more strategically and practically useful by slightly extending its brief.

There has been fairly effective monitoring in the youth and adult custodial estate in respect of alcohol and drugs and NIO funded criminal justice projects are well monitored. The next cycle would benefit from collaboration with PSNI, NIPB and the Youth Justice Agency in respect of collating important statistics. As we have noted, it is possible to produce monitoring data on critical objectives such as reducing alcohol related domestic violence. The purity levels of street drugs, needle funds, etc. have been offered as examples of how to extend 'intelligent' monitoring which might feed into an 'early warning system' as well as help track performance.

The Review strongly recommends the development of an early warning drugs surveillance system as described in Section 5. This requires a dedicated 'monitor' to collate key data from all the other monitoring streams and key informants.

6.5.4 Evaluation

There have been some very useful evaluations undertaken over the current cycle, most notably around arrest referral and treatment interventions in the criminal justice system. The senior players in the statutory treatment sector are very aware of the need to introduce performance and outcome measurement systems and have a development plan. The Review fully supports this development and has made several recommendations in respect of Models of Care and QuADs and the complexities of modernising the treatment sector.

Evaluation has not been extended to the voluntary or community projects or those treatment initiatives funded through JIM/DAST. Currently there is no one taking responsibility for this development or indeed the lack of it. This activity has fallen down the cracks between DAIRU, DAST and the DACTs and has not been corrected by DAISG. Once again the Review suggests evaluation becomes part of an overarching IMERS system which supports the

whole system including DACT needs assessments and local monitoring and evaluation.

6.5.5 Research

The expensive regional surveys which are utilised to analyse critical trends in drinking and drug use will become more effective now some baselines have been established. However there is a case for reviewing cost-effectiveness and the current variables and categories employed to ensure better comparisons can be made (e.g. standardise age brackets in all surveys).

Several research projects commissioned during the present cycle have been of strategic value (e.g. around heroin users and the needs of homeless people). On the other hand the quality of needs-assessments and related audits have been variable with several funded contracts failing to deliver to requirement. There are several reasons for this including a shortage of skilled external contractors. Of most importance is poor **commissioning** and contractor management. Some guidance and peer training is required to ensure added value is generated.

Despite clear guidance about the dissemination of **'best practice' reviews** based on research and secondary analysis of the international literature little progress has been made in this cycle. Whilst dissemination should be part of a communications strategy, again an IMERS system function would be to collate such information. NI is too small to invest in a dedicated unit, as in Scotland. We merely need to tap into current systems without reinventing the wheel.

6.5.6 Inclusivity

Another established principle which needs re-affirming is inclusivity. There are signs of schism between regional and community level stakeholders which need healing via new communication and coordination arrangements. Alcohol and drug users and service users are notable in their absence. In order to better include these important voices the Review has suggested that an additional strategic goal should be to work towards the **removal of stigma and discrimination experienced by 'problem' drug users and their families**. The Review has also identified exclusivity in relation to **vulnerable young people** and made concrete suggestions for improvement. Some stakeholders rightly note that **benzodiazepine 'misusers'** are not adequately identified in current service delivery. This would require the Central Services Agency which oversees prescribing practices becoming a 'partner'. Elderly or older people's alcohol and prescribed drug problem have been identified in the Mental Health Review as requiring a specialist 'care' service. There are currently no references to including people with disabilities or from ethnic minority populations.

6.5.7 Coordination

Good coordination tends to be taken for granted whilst poor coordination generates much complaint and, in this case, blame. The Appraisal Section identified serious deficiencies in the current coordination arrangements as experienced by stakeholders and mainstream staff (e.g. DACTs). DAST received a lot of criticism for poor coordination. The Review accepts that DAST has not been able to provide high quality coordination. It concludes however that DAST is not sufficiently resourced to undertake all its duties and that good coordination has been one 'principle' which has been stifled by overload.

6.5.8 Accountability

The most breached principle under current arrangements has been accountability. There are accountability deficits at every level of the programme. Confused relationships remain at DACT level in respect of being line managed within Health Boards yet ambiguously accountable to DAST. The responsibility of effective project funding, monitoring and management appears similarly confused. The Working Groups were identified by consulted stakeholders and players as lacking clear lines of accountability.

DAST as a coordination unit with funding responsibilities also struggles with accountability. Its siting in the DHSSPS Health Development Directorate further complicates matters. Of greatest concern is the inability of DAISG to actually operate as the quasi senior accountability agent. In the absence of devolution the Review recommends that the more attention is paid to ensuring there is clear and active senior accountability for the next roll out.

This ownership of responsibility has to be cross-cutting whereby senior officers or ministers can exert a degree of authority on critical partner agencies where necessary. A radical option would be to situate the strategic and business hub in a cross-cutting department such as the First Minister's Office.

In configuring senior accountability it is important that the civil servants involved feel confident and comfortable in the alcohol and drugs field. Several current DAISG members told the Review they felt their lack of expertise and knowledge was disabling in terms of asserting accountability. Ways should be found to increase their knowledge. However the critical point is that as senior representatives of key government departments DAISG members are responsible for ensuring effective communications and the delivery of strategic goals which their departments have signed up to. Accountability must be strengthened in the next strategic cycle.

6.5.9 Additional Principles: communication and value for money

There are two further principles which the Review suggests might guide the forthcoming redrafting. Whilst information sharing has been highlighted this is only part of a wider principle of **communication**. The current alcohol and

drugs strategies and their implementation are not well known or understood outside the stakeholder population. It is very important to ensure communication in its widest sense forms part of the overall project. With a third of the working population of the region employed in public services the goals of the strategy are more likely to be achieved if there is a good awareness of 'alcohol and drugs' across the public sector.

A very recent Omnibus Survey (Central Survey Unit, 2005) has shown that there is a major concern about alcohol and drug misuse in the general population but with alcohol of greater concern especially amongst younger people. Over half this representative sample felt the government was not taking the alcohol and drugs problem seriously enough. Under-age drinking and drug dealing were most often mentioned. Furthermore only a small minority could identify the very activities which have been delivered and enhanced over the past 3 years. Aside from TV campaigns and health education in schools, there was very little awareness of other activities (e.g. counselling, advice, treatment, community safety initiatives) by age, by Boards or by urban-rural residence.

There was no explicit mention of **value for money** in the Regional and Local Action Plans. The Review has highlighted the lack of awareness in terms of what things cost and the principles of value for money. Currently any Best Value type audit would be highly critical and embarrassing. The Review recommends cost-effectiveness is introduced as a future guiding principle at all points of the programme.

6.6 Regional Hub

6.6.1 Under-resourced and under-powered DAST

Despite the concerns about an over bureaucratic system expressed elsewhere, the Review has to recommend a reconfiguration and significant investment in the DAST apparatus. Without a robust regional hub nearly all the current problems and deficiencies will re-present across 2006-09. A team of 4-5 staff simply cannot repair and resolve the problems of secretariat, information sharing, Ministerial and PQ/AQ business, communication, monitoring, funding allocations, coordination and strategic 'leadership'.

Merseyside has a population of 1.4 million, only slightly less than NI. The 5 Drug Action Teams alone, which are the metropolitan borough 'hubs', employ about 50 people. This gives some idea of how under-resourced the DAST/DACTs are in comparison with other similar 'systems' in England. Moreover we see far larger staff establishments in units in NI with much narrower and limited responsibilities. Similarly in terms of time frames if the Liquor Licensing Review Team of 3 staff plus budget are, quite appropriately, given 2.5 years to undertake their work we must wonder how DAST can be expected to develop and roll out a completely new alcohol and drug strategic business plan in little over a year given its current establishment.

The Review suggests that a new regional hub is developed with more senior grades responsible for specific organisational tasks (e.g. IMERS, Communications (see Chart 6.1).

To supplement 'DASTII' in respect of strategic leadership and communication one or more part-time or seconded 'champions' might be utilised. Such champions might have the task of inspiring the workforce and stakeholders as the Chair of a Quango might do, utilising the media, visiting projects, handing out awards, etc. This is one way of improving communication and facilitating a vertical corporate approach between the Centre and DACTs and local projects. A senior non executive 'champion' might actually be employed part-time and join the senior accountability group.

6.6.2 A regional hub fit for purpose

6.6.2.1 Regional team structure

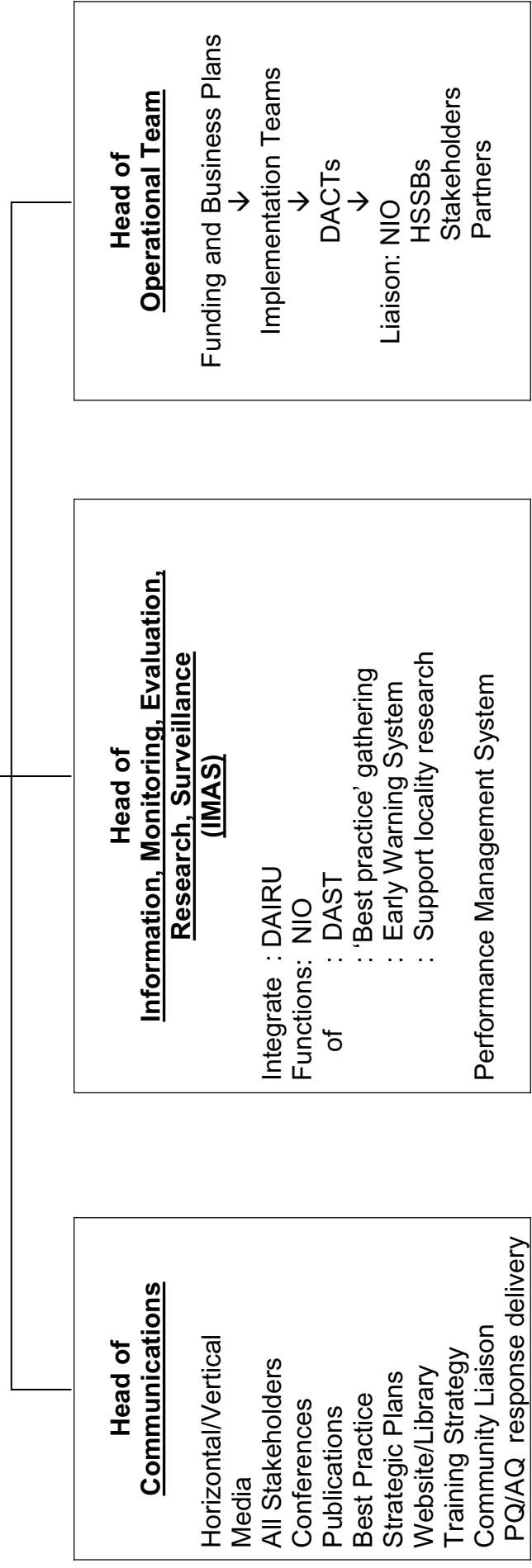
A re-configured Regional Hub Team, wherever located, should be designed to correct or reduce the current weaknesses in the overall programme. Chart 6.1 offers a 'starter' template. The top of the tree must have a completely revitalised DAISG equivalent with strong ministerial oversight and more expertise in respect of the drugs and alcohol field. The role of the Regional Coordinator or equivalent Head needs re-specifying. Within this Unit 3 specific arenas of work are suggested: Communications, IMERS and Operations. Chart 6.1 has started off a checklist of clustered functions which should sit well together.

Chart 6.1: Outline Structure of Regional Hub

Ministerial/Senior Accountability Group



Regional Drugs Coordinator



Head of Communications
 Horizontal/Vertical Media
 All Stakeholders Conferences
 Publications
 Best Practice Strategic Plans
 Website/Library
 Training Strategy
 Community Liaison
 PQ/AQ response delivery

Head of Information, Monitoring, Evaluation, Research, Surveillance (IMAS)
 Integrate : DAIRU
 Functions: NIO
 of : DAST
 : 'Best practice' gathering
 : Early Warning System
 : Support locality research
 Performance Management System

Head of Operational Team
 Funding and Business Plans
 ↓
 Implementation Teams
 ↓
 DACTs
 ↓
 Liaison: NIO
 HSSBs
 Stakeholders
 Partners

6.6.2.2 Implementation teams

Under operational work Implementation Teams might be the successors to the unwieldy 6 Working Groups and myriad of sub committees. Stakeholders need to be involved in re-design but Chart 6.2 offers one option to consider. Importantly the Implementation Teams are overseen by Hub Operations who should provide a development worker as well as secretariat for each Team. Each Team Leader or Chair must have sufficient time to lead and manage in association with the development worker and secretariat. The Head of Operations works with each Implementation Team. DACTs should be represented on each Team but in a cost-effective way.

This approach should improve efficiency, communications, etc. and encourage committed senior players to become Chairs and champions for their arena knowing they will be fully supported and that work will be progressed between meetings.

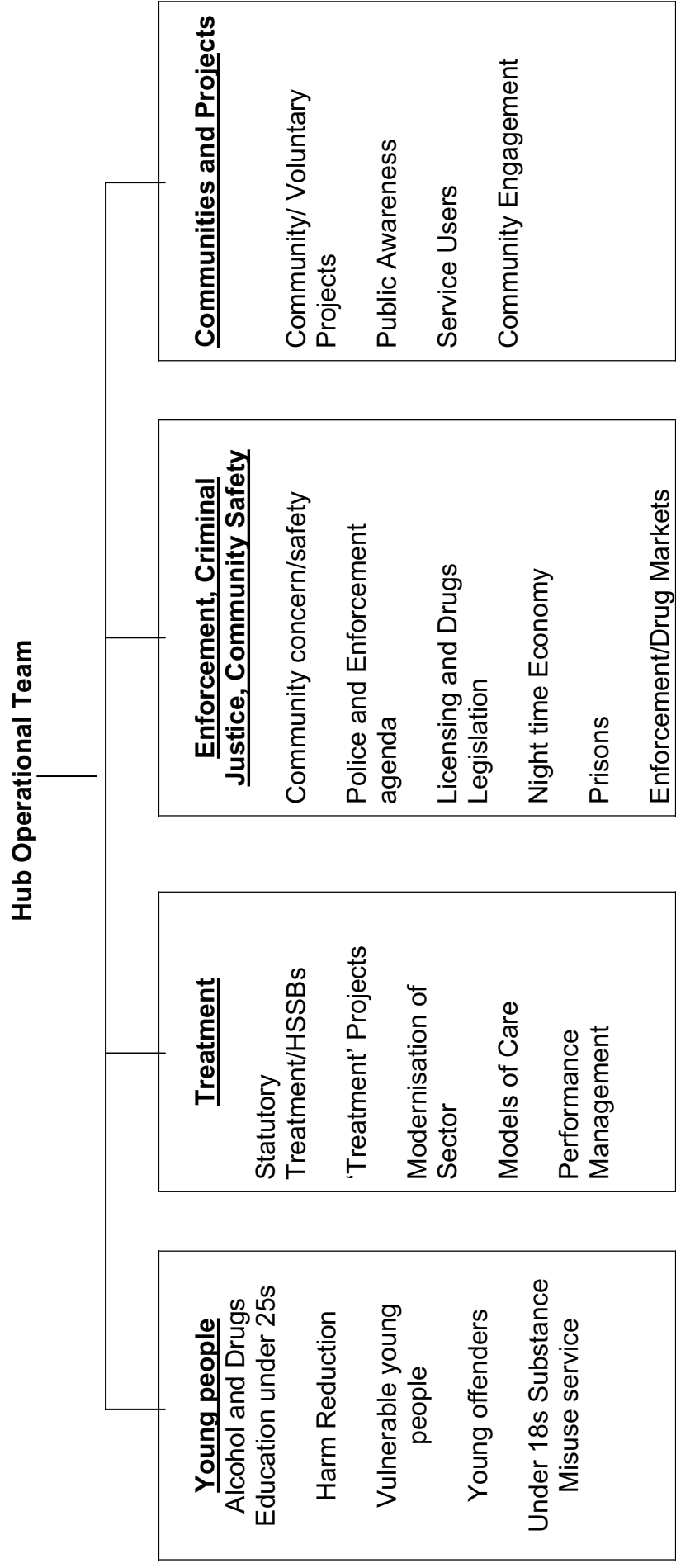
The reasons for introducing a Young Persons Implementation Team have already been rehearsed in Section 5. There is a real opportunity here for incorporating the alcohol and drugs agenda and resource delivery into a wider young person's portfolio of work especially if the revised strategic goals drive this. Similarly the Treatment portfolio has been outlined. Within this Implementation Team those projects which align with statutory treatment (e.g. Prescribing Service, Youth Counselling, Dual Diagnosis) should also be included. The priorities of modernisation, performance management and consistency apply equally to these 'projects'.

In terms of Enforcement, Criminal Justice and Community Safety this Implementation Team needs to embrace new partnerships and attempt to produce a more integrative approach particularly with PSNI. Despite not being NIO business the liquor licensing agenda needs locating here as does scrutiny of all other related legislation (e.g. Misuse of Drugs Act).

The old Communities Working Group had a difficult and far too abstract agenda. A Communities and Projects Implementation Team should have a more concrete and deliverable work plan which involves nurturing the plethora of community and voluntary projects and ensuring they develop satisfactory governance and organizational standards, overseeing public awareness programmes and promoting inclusivity with service users and community locality level stakeholders.

Clearly these Teams' work and domains will overlap and this reality must be largely managed by the Regional Hub rather than the creation of multiple sub-committees.

Chart 6.2: Regional Implementation Teams



6.6.3 DACTs role

The DACTs were already in place before the current strategic and joint implementation arrangements and had, quite understandably, already developed local agendas and ways of working. Their role was reviewed and in 2003 revised terms of reference were eventually introduced. These in fact integrate both specific local activities and important regional support and delivery processes.

Criticisms of DACTs found during the overall consultation suggest they are too little connected to the regional strategy and pursue their own priorities and agendas as witnessed by their quite distinctive portfolios. Their accountability to DAST and the regional apparatus is said by many to be ambiguous, the more so since DACTs have become sited and line managed in HSSBs. The DACTs understandably defend their ground and the stakeholders consultation, as we have seen, provides a wide ranging negative critique of the regional apparatus be it communication, coordination, funding, monitoring or leadership.

This is unfortunate 'history' and is one of the reasons this Section recommends utilising universal *principles* rather than historical preferences to configure the next strategic framework and also that revised strategic goals must be meaningful to local community stakeholders.

The recommended overall revised structure should allow DACTs to feel more valued and be more efficient and effective if they can 'forgive and forget' the recent past where it has felt alienating. If funding principles become more transparent and needs led, if support with needs assessment, monitoring and evaluation is uplifted, if JIM structures are less bureaucratic and if DAST can be properly resourced to be more efficient with delivery of essential information, then the experience of the DACTs should be far more positive.

The principle most breached by current arrangements is accountability. The lines are fuzzy with DAST and in turn with DAISG. If there is to be a robust unbroken line of accountability in the future then some suitable and hopefully universally agreed new arrangements are required. One possibility is that DACTs become accountable by being line managed by a restructured DAST – an option previously rejected. Another possibility is to actually harness the HSSBs to deliver accountability for instance by senior HSSB officers joining the revised DAISG, by creating binding service level agreements with HSSBs/DACTs or actually allocating 'project' funding on the basis of performance against a specification which ensures the regional agenda is appropriately implemented (without losing sight of local needs). Further consultation with HSSBs is required but it must be said that the CEOs of the Boards, during this consultation, were not impressed with current arrangements.

The DACTs will need time to consider how they might operate within the suggested revisions if they are taken up. This might be encouraged to

produce possible organisational and terms of reference templates which allow them to:

- Identify current terms of reference which remain 'best fit'.
- Identify 'best practice' to be protected and enhanced.
- Operate to the same principles which must guide the whole system.
- Utilise the new systems to audit their contribution in a more comprehensive and accessible way.
- Work to local targets which mirror those set regionally in the new strategic framework.

6.6.4 In conclusion

This Section has outlined how revised alcohol and drugs strategies and joint implementation might be better configured given the poor performance of recent years measured against critical objectives and general efficiency. The approach suggested is systemic and integrative and has purposefully identified principles to practice. Thus whatever location, scale of reinvestment or particular delivery arrangements are decided on, the principles remain critical and if practiced should overcome many of the current difficulties.

The DHSSPS has recently become the senior funding department for the whole programme and sees it as continuing to rest within *Investing for Health*. The Review has recognised the benefits and support this has brought to the programme but has also identified the risks of so doing in marginalising non health priorities. The proposed revised system is designed to embrace the genuinely cross-cutting nature of the alcohol and drug programme wherever it is located but **only** if implemented fully and without compromising its integrity.

The additional investment required to implant the revised system is around £350,000 a year for 3 years to deploy more senior officers and running costs to DAST. This equates to the current round of cuts which have this year taken £350,000 and in 2005-06 £700,000 from the programme budget.

As vital as this 'additional' investment is, the most important resource is the workforce involved. The Review has focused on their rights to work in a system fit for purpose and their responsibilities to utilise the principles and terms of reference which can create and maintain such a system.

Recent population surveys (e.g. Omnibus, 2005) have shown that the citizens of Northern Ireland irrespective of age, gender, religion or residence are very concerned about alcohol and drug related problems and most do not believe government is doing enough. Furthermore there is little recognition of what has recently been delivered. This should be salutary for public servants. A challenge is set to ensure that in 2009 concern will be reduced, confidence increased and that Northern Ireland's alcohol and drug problems are being better managed.

ACRONYMS

CAMHS	Children and Adolescent Mental Health Services
CATs	Community Addiction Teams
CCGAAD	Central Coordinating Group for Action Against Drugs
DACT	Drug and Alcohol Coordination Team
DAT/DAAT	Drug (and Alcohol) Action Team (in England)
DAIRU	Drug and Alcohol Information and Research Unit
DAISG	Drug and Alcohol Implementation Steering Group
DAMSSG	Drug and Alcohol Ministerial Strategic Steering Group
DANOS	Drug and Alcohol National Occupational Standards
DAST	Drug and Alcohol Strategy Team
DCLS	Department of Culture, Leisure and Sport
DCU	District Command Unit (locality division of PSNI)
DENI	Department of Education, Northern Ireland
DHSSPS	Department of Health, Social Services and Public Safety
DMD	Drug Misuse Database
DSD	Department of Social Development
HSSBs	Health and Social Services Boards
'IMERS'	Information, Monitoring, Evaluation, Research and Surveillance
JIM	Joint Implementation Model
LLR	Liquor Licensing Review
NI	Northern Ireland
NIO	Northern Ireland Office
NIDAC	Northern Ireland Drug and Alcohol Campaign
NIPS	Northern Ireland Prison Service
NISRA	Northern Ireland Statistics and Research Agency
PSNI	Police Service Northern Ireland
QuADs	Quality Assurance for Alcohol and Drug Services
'RES'	A monitoring form completed by projects funded by DAST
SMART	Service Management and Re-assessment Tool
YOCs	Young Offender Centres (custodial)

