Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

New Strategic Direction for Alcohol and Drugs Phase 2

4th Update Report – July 2016

Contents

Executive Summary

The cross-departmental strategy to reduce the harm related to substance misuse, known as the New Strategic Direction for Alcohol and Drugs (NSD) Phase 2, was launched in 2012. This is the fourth* annual report of progress against the outcomes and indicators set out in that document. As with last year's update, this annual report includes progress against the medium and long term outcomes included in the NSD Phase 2. This should help focus action over the next years of the strategy's delivery. (*the previous three update reports are also available online: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports).

The report is structured as follows:

- **Chapter 1** sets out the background to the development of the strategy;
- **Chapter 2** summarises the revised approach taken in the NSD Phase 2;
- **Chapter 3** provides an update on the key indicators available since the last report;
- **Chapter 4** shows progress on the outcomes in the NSD Phase 2; and
- **Chapter 5** provides a summary and concluding comments

Overall, further progress has been made in the fourth year of the NSD Phase 2's implementation. Since the original strategy was published in 2006, we have seen some encouraging signs in relation to reductions in the levels of binge drinking and the percentage of young people who drink and get drunk. Prevalence of illegal drug misuse has largely plateaued and we are continuing to see more people access treatment and support services for alcohol and drug misuse. However, levels of alcohol and drug related hospital admissions and deaths are still high, and there is ongoing concern about the misuse of prescription drugs and particularly New Psychoactive Substances.

In terms of progress against the outcomes within the NSD Phase 2, the majority of the 141 outcomes are on track for achievement within the timescale expected. 18 (12.8%) of the outcomes have been fully completed, 104 (74%) of the outcomes are classed as being on track for achievement, and 18 (12.8%) of the outcomes progress is being made but with some delay. At this stage, only one outcome is

currently regarded as not being on track for achievement and that relates to research in respect of prescription drug misuse. We will continue to monitor progress against the outcomes and indicators on an ongoing basis, and update annually.

1. Background to the NSD Phase 2

Introduction

1.1 Alcohol and drug misuse, and their related harms, cost our society hundreds of millions of pounds every year. However, this financial burden can never describe the impact that substance misuse has on individuals, families and communities here. Alcohol and drug misuse therefore continue to be recognised as significant public health and social issues.

New Strategic Direction for Alcohol and Drugs (NSD)

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

NSD Phase 2

1.3 In 2010, an update document was published to consider how effective the NSD was in terms of delivering on its aims and objectives. This document looked particularly at the progress against the NSD's key priorities, completion of the NSD outcomes and progress against its indicators.

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

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

allowed the NSD Phase 2 to reflect new trends and re-direct effort to where it is most needed or to where new issues/concerns are emerging.

NSD Phase 2 – Final Document

1.6 Following a consultation, the NSD Phase 2 was revised and refined to take on board the issues raised. The final document was then approved by the former Executive and launched by the then Health Minister in January 2012. The full NSD Phase 2 document is available online at: https://www.health-ni.gov.uk/sites/default/files/publications/DoH/alcohol-and-drug-new-strategic-direction-phase-2-2011-16.pdf

2. NSD Phase 2 – the Revised Approach

The Five Pillars

2.1 The NSD Phase 2 identifies five supporting pillars, and these pillars provide the conceptual and practical base for the NSD. The five pillars are:

- Prevention and Early Intervention.
- Treatment and Support.
- Law and Criminal Justice.
- Harm Reduction.
- Monitoring, Evaluation and Research.

Themes

2.2 Two broad themes, “Children, Young People and Families” and “Adults and the General Public”, are also identified to enable an integrated and co-ordinated approach to tackle the issue. In delivering on the NSD, organisations are encouraged to focus on specific sub-groups within these themes.

Values and Principles

2.3 The values set out in the NSD Phase 2 are the basic tenets on which the strategy, and its implementation, is built. These values are:

- Positive, Person Centred, Non-Judgmental and Empowering;
- Balanced Approach;
- Shared responsibility;
- Equity and Inclusion;
- Partnership and Working Together;
- Evaluation, Evidence and Good Practice-based;
- Consultation, Engagement, Transparency;
- Addressing Local Need;
- Community-based;
- Long-Term Focus;
- Value for Money and Invest to Save;
- Built on Existing Work; and
- Access to information.

Overall Aim

2.4 The overall aim of the NSD Phase 2 is to: "*reduce the level of alcohol and drug-related harm"*.

Long-Term Objectives

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

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

Key Priorities

2.6 Although the NSD Phase 2 seeks to address a wide range of issues, a number of Key Priorities were identified. These form the cornerstone of work over the life of the Strategy and reflect those issues that have been identified to be of crucial importance through the Review and the extensive pre-consultation exercise. The Key Priorities, and some very high level updates on progress against these, are set out in the following table:

KEY PRIORITY	UPDATE
Developing a Regional Commissioning Framework	The Alcohol and Drug Services Commissioning Framework, which covers all tiers of service, was issued for consultation on March 2013. The document will be finalised in the near future, but has already been used to inform the current process of tendering and commissioning. Agreement has been reached on the reconfiguration of Tier 4 addiction services and the new model should be operational soon. Further work is now being undertaken to consider Tier 3 addiction services.
Targeting those at risk and/or vulnerable	The strategy, and its implementation, continues to target those at risk and/or vulnerable – this is on the basis of local needs assessment and prioritisation.
Alcohol and drug-related crime including anti-social behaviour and tackling underage drinking	Key links have been made between NSD Phase 2, the Community Safety Strategy, the Strategic Framework for Reducing Offending and alcohol licensing. At the local level, we continue to promote joined up work between Drug and Alcohol Co-ordination Teams (DACTs), Policing and Community Safety Partnerships (PCSPs), and local councils.
Reduced availability of illicit drugs	Key links have made between NSD Phase 2, the Organised Crime Task Force, the Community Safety Strategy, and the Strategic Framework for Reducing Offending. At the local level, we continue to promote joined up work between DACTs, PCSPs, the PSNI and local councils. We have also been working with the Home Office to identify and reduce access to new substances of concern. The Department has lobbied for a general ban on the sale of New Psychoactive Substances at the UK level, and this resulted in the passing of the UK-Wide Psychoactive Substances Act in January 2016.
Addressing community issues	DACTs, the new Connection services, and Independent Sector Forums (ISFs) continue to bring forward issues from local communities, and put in place action and programmes to address these. Community Planning in local Councils and PCSPs also play a role in identifying problems within communities and seeking local solutions to local problems.
Promoting good practice in respect of alcohol and drug-related education and prevention	The Alcohol and Drug Services Commissioning Framework sets out the evidence base for what works in alcohol and drug education and prevention, and a range of services has been commissioned in light of this work.
Harm Reduction approaches	We are continuing to support and develop Substitute Prescribing, Needle and Syringe Exchange, Naloxone Provision, and other Harm Reduction approaches.

Workforce Development	Workforce development is a key part of the Commissioning Framework, and its roll-out is now being supported.

Emerging Issues

2.7 The NSD Phase 2 recognised that, since publication of the original NSD, a number of issues had emerged. These issues were identified, noted and considered by the NSD Steering Group and the relevant Advisory Groups. This process was also informed by the ISFs, the Advisory Council on the Misuse of Drugs, the British-Irish Council Drug Misuse Sectoral Group, and recent research. These emerging issues include:

- prescription or over-the-counter drugs;
- new psychoactive substances;
- families and hidden harm;
- recovery;
- mental health, suicide, drug and alcohol misuse, sexual violence and abuse, and domestic violence;
- a population approach to alcohol misuse;
- local funding; and
- the Review of Public Administration.

3. Update on NSD Phase 2 Indicators

3.1. To measure the extent to which the overall aim of reducing alcohol and drug-related harm is being met, the NSD Phase 2 established a set of Indicators that can be used for this purpose. These are set out below:

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

3.2. Progress against these indicators is reported as the information becomes available. It should be noted that for the majority of these indicators we are seeking a reduction in the figures. However, in respect of some of the areas – particularly those presenting for treatment and public confidence – an increase in the numbers is actually positive as it means more people are seeking help for their misuse and this should lead to long-term reduction in related harm. When reporting against these indicators, where possible and appropriate, figures will be broken down by Section 75 groups and particularly in terms of age, gender and geographical area.

3.3. The tables below set out data information that has been published since the last report:

Prevalence

Alcohol

Adults (Adult Drinking Patterns Survey)

Indicator	2005	2008	2011	2013
Prevalence	73%	72%	74%	73%
Drinkers who exceed daily Limit	82%	81%	78%	77%
Drinkers who drink above sensible levels	29%	24%	23%	24%
Problem Drinking	10%	10%	9%	11%
Drinkers who binge drink	38%	32%	30%	31%

Young People - 11-16 (Young Persons Behaviour and Attitude Survey)

Indicator	2003	2007	2010	2013
Ever taken an alcoholic drink	60%	55%	46%	38%
Drink in the week prior	N/A	19%	13%	7%
Drink and been drunk	34%	30%	24%	14%

Drugs

Adults – 15-64 (Drug Prevalence Survey)

Indicator	2002/03	2006/07	2010/11	2014/15
Lifetime use of any illegal drugs	20%	28%	27%	28%
Last year use of any illegal drugs	6%	9%	7%	6%
Last month use of any illegal drugs	3%	4%	3%	3%

Young People – 11-16 (Young Persons Behaviour and Attitude Survey)

Indicator	2003	2007	2010	2013
Lifetime use of any drugs or solvents	23%	19%	15%	10%
Last year use of any drugs or solvents	18%	13%	11%	7%
Last month use of any drugs or solvents	12%	7%	7%	4%

Treatment

Census of Drug and Alcohol Treatment Services

Indicator	2005	2007	2010	2012	2014
In treatment for alcohol and/or drug misuse	5,064	5,583	5,846	5,916	8,553
In treatment for alcohol-only misuse	3,074	3,476	3,328	3,111	3,891
In treatment for drug-only misuse	1,030	1,118	1,294	1,514	2,617
In treatment for both alcohol and drug misuse	960	989	1,224	1,291	2,045

NI Drug Misuse Database

Indicator	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Individuals presented to treatment services for drug misuse	1,464	1,984	1,755	2,008	2,593	2,999	2,824	2,574	2,262

*A compliance exercise was carried out in 2011 which partially would explain an increase in the number of forms completed and returned at this time.

Cannabis was the main drug of misuse for all years, while benzodiazepines was the second most commonly drug of misuse for all years

Hospital Admissions (HIB)

Indicator	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Alcohol-Only Emergency Admissions	7,127	7,322	8,267	8,462	8,603	8,652	9,393	10,274	10,486	11,420
Drug-only related admissions	3,160	2,948	3,951	3,880	3,424	3,649	3,256	3,315	3,360	3,270
Alcohol and Drug related admissions	1,498	1,308	1,497	1,473	1,663	1,663	1,644	1,556	1,431	1,429

Deaths (DMB)

Indicator	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Alcohol-related deaths	246	248	283	276	283	284	252	270	236	238
Drug-related deaths	84	91	86	89	84	92	102	110	115	110
Deaths due to drug misuse	42	49	48	53	46	63	58	75	78	88

Blood Borne Viruses (HIB)

Indicator	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
New diagnoses of Hepatitis C	134	135	114	132	112	106	113	133	124	134	143
Reports of both acute and chronic Hepatitis B	87	74	116	105	89	104	106	110	114	127	91
HIV	57	57	60	91	69	86	82	95	95	94	n/a

Data for 2015 are provisional. Figures for earlier years have been revised.

Needle Exchange (PHA Needle Exchange report)

Indicator	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Visits to participating pharmacies	8,797	9,997	8,267	13,389	15,828	17,712	20,204	21,220	22,742	26,713

Source: 2005/06 to 2009/10 – Public Health Information and Research Branch.
2010/11 to 2014/15 – Health and Social Care Board.

Crime (NIPB and PSNI)

Indicator	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Drug Offences	2,413	2,721	2,974	3,146	3,485	3,780	4,378	4,732	4,048
Drug seizure incidents	2,590	2,968	3,198	3,319	3,564	3,920	4,474	4,825	5,104

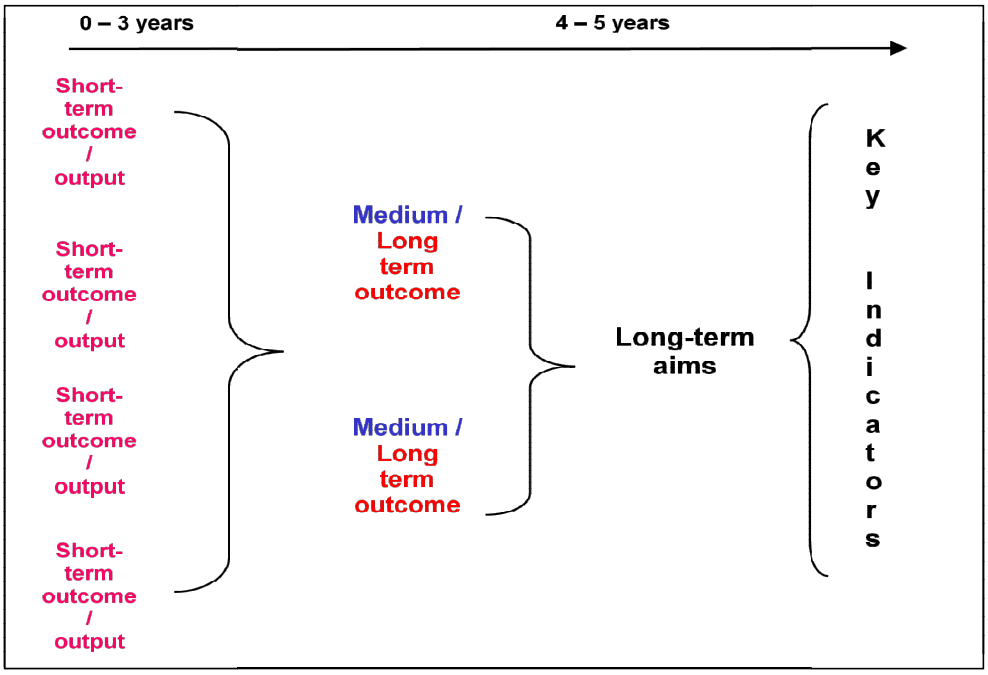
Year	2008	2009	2010	2011	2012	2013	2014	2015
No. of persons detected for a drink/drug-driving related offence	4,017	3,986	3,448	3,294	2,967	2,710	2,694	2,733

All figures have been revised since last update.

Figures are provisional and are subject to change.

4. Progress on Outcomes

4.1 In order to deliver the overarching long-term aims of the NSD, a series of outcomes were developed. Following the logic model approach, a number of long-term outcomes were initially agreed, and then a number of regional and local short and medium-term outcomes and outputs were put in place subsequently to support the delivery of these long-term aims and to provide the focus for activities and future work[1].



4.2 The outcomes and the overall success or otherwise of achieving the long-term aim of the NSD Phase 2 are measured by the Key Indicators in Chapter 3. The outcomes were structured in a manner that not only demonstrated their sequential nature across the five years of the NSD, but also their relationship with the Themes, Long-Term Aims and Key Priorities.

4.3 The outcomes are grouped within the themes based on certain issues or topics as follows:

- Adults and the General Public - 1 (Treatment and Support)
- Adults and the General Public - 2 (Prevention and Early Intervention)
- Children, Young People and Families - 1 (Treatment and Support)
- Children, Young People and Families - 2 (Prevention and Early Intervention)

[1] Short term means within 3 years, and medium to long-term within 4 - 5 years

- Community Safety and Anti-Social Behaviour
- Monitoring, Evaluation and Research
- Workforce Development

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

4.5 The outcomes are set out in the following table – along with an indication of progress against these deliverables using a **red** (not on target for achievement), **amber** (on target for achievement but with some delay), or **green** (on target for achievement) designation. Outcomes that have been completed are outlined in **blue**.

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

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
1. Targeted local prevention programmes in place.		The draft Commissioning Framework (Outcome 29) sets out the range of prevention initiatives that should be commissioned. The five HSCT-based Community Alcohol and Drugs Information and Networking Services (CADINS) commenced on 01 July 2015 and became branded as the DACT Connections service. These services work at local level alongside key community and statutory stakeholders and under the guidance of the local DACT to develop drug and/or alcohol related information, education and awareness-raising events and initiatives.	The effectiveness of the new services to be monitored.
2. Reduction in the proportion of adults who have used drugs in the last year.		The proportion of adults using any illegal drug in the last year fell from 9.4% in 2006/07 to 6.6% in 2010/11 and 5.9% in 2014/15.	New figures will be published in 2015/16.
3. Reduction in the proportion of adults who have misused prescription drugs in the last year.		At this stage we have no definite figures on the proportion of adults who *misused* prescription drugs in the last year. However, last year use of sedatives and tranquillisers was similar at 11.0% in 2010/11 and 10.3% at 2014/15 while last year use of anti-depressants rose from 12.0% in 2010/11 to 14.0% in 2014/15. Use of other opiates, which contains a number of prescription medicines, rose from 6.4% in 2010/11 to 10.0% in 2014/15.	New figures will be published in 2015/16. Prescription Drug Misuse Action Plan issued for implementation in late 2013 and an update on this work is included in this report.
4. Reduction in the proportion of adults who binge drink.		The proportion of adult drinkers who binge drink has fallen from 38% in 2005 to 31% in 2013.	
5. Increase in the proportion of adults who drink sensibly.		The proportion of adult drinkers who drink within the sensible weekly guidelines has risen from 74% in 2005 to 77% in 2013 (prior to the New CMO Guidelines issues in January 2016).	
6. Legislation in place to prevent and address substance misuse.		A range of legislation is in place to reduce the supply, availability and accessibility of alcohol and drugs (*see Outcomes 19 and 21*). In addition consideration is being given to strengthening this further through proposals such as minimum unit pricing for alcohol (see 19) and further legislation to tackle new psychoactive substances (see 21). DoH and DOJ have worked closely with the Home Office as the Psychoactive Substances Bill was progressed through Westminster.	Continue to consider the legislative base and bring forward proposals to strengthen these regulations based on evidence of effectiveness.

7. Increase in number of workplaces implementing alcohol and drug policies.		There is currently no way of measuring the number of businesses who have effective alcohol and drug policies in place. Guidelines for workplaces are now available on https://www.nibusinessinfo.co.uk/content/dealing-alcohol-issues-workplace website, and are updated on a regular basis. The PHA promotes healthy workplaces, and the BIG Lottery Fund has funded a project to support workplaces to address alcohol.	
8. Reduction in the level of use of prescribed drugs.		Last year use of sedatives and tranquillisers rose from 9.2% in 2006/07 to 11% in 2010/11 and reduced slightly to 10% in 2014/15 and last year use of anti-depressants rose from 9.1% in 2006/07 to 12% in 2010/11 and further to 14% in 2014/15. Use of other opiates, which contains a number of prescription medicines, has fallen from 8.4% in 2006/07 to 6.4% in 2010/11 but increased again to 10% in 2014/15.	New figures will be published in 2015/16. Prescription Drug Misuse Action Plan issued for implementation in late 2013, and an update on this work is included in this report.
9. The committal screening process for all new prisoners refined by the NI Prison Service in partnership with the South Eastern HSC Trust to help ensure the early identification of drug and alcohol problems.		South Eastern Trust has revised the Healthcare Committal Process to establish an immediate healthcare screen at the point of committal and a further comprehensive healthcare screening within 48 hours following committal. Early identification of drug or alcohol problems are a key consideration in the Healthcare screening process. Where alcohol or drug problems have been identified, onward referrals are offered to the Healthcare Clinical Addictions Team, AD:EPT, Primary Healthcare or Mental Health Teams for support.	South Eastern Trust will review and monitor the training needs of Healthcare Staff in Committals to ensure early identification and response to drug or alcohol problems.
10. The rates of referral to Courses for Drink Drive Offenders increased.		Courses for Drink Drive Offenders (CDDOs) are a sentencing option for Courts here. Where an offender is disqualified for 12 months or more in respect of an alcohol-related driving offence, the court may order that the period of disqualification be reduced if the offender satisfactorily completes an approved CDDO course. Currently attendance is voluntary, costs are met by the offender and those successfully completing the course receive a reduction of up to 25% in the period of disqualification. The underlying aim of the scheme is to provide drink-drive offenders with expert training, in a group situation, about the problems associated with drink-driving, thus enabling them to develop future non-offending behaviour and thereby reduce re-offending.	DOE plans to introduce new legislation before the end of 2016 that will provide powers to establish a new drink drive regime here. The proposed changes include automatic referral onto a Course for Drink Drive Offenders, unless a District Judge decides that attendance would be inappropriate. Enrolment onto the course will remain voluntary but should lead to a change in the numbers participating in the course.

		In 2011 the number of persons convicted for drink-driving offences was 2,902 of which there were 1,329 referrals to CDDO representing a 46% referral rate. The most recently published figures for 2014 show a comparable referral rate of 52% (2,215 convictions of which there were 1,156 referrals).	
11. Reduction in the proportion of drivers who are breath tested returning positive results.		The PSNI conducted 28,160 preliminary breath tests in 2014/15 which was a decrease of 4% on the number carried out in 2013/14 (29,353). In total 466 people approached failed to complete a breath test in 2014/15 compared to 394 during 2013/14. The proportion of drivers who failed a preliminary breath test in 2014/15 was 9% which compares with 10% in 2013/14. The PSNI will continue to monitor levels in line with the new legislation when introduced.	It may take time for further reductions to be achieved – in fact the forthcoming change to drink driving regulations could lead to an initial increase in these figures.

	Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
12.	An integrated and targeted programme undertaken to raise awareness of the health impact of drinking above the relevant guidelines – messaging must be clear and consistent.		New Alcohol Guidelines were published by the 4 UK CMOs in January 2016. A consultation on the Guidelines ended in May 2016, and the guidelines, which are in place, will be considered in the light of this work. At a regional level, PHA alongside the 5 DACTs and their Connections Services will be working together to develop a NI-wide Alcohol Awareness Week which will focus on highlighting the CMO's new low-risk weekly alcohol guidelines and educating the general public (and specific target groups) about units and the negative consequences of drinking. A regional initiative around supporting Dry January and the benefits of abstaining from alcohol ran on social media throughout January 2016. At a local level, each of the DACT Connections services are tasked with developing local events and initiatives and with delivering awareness-raising sessions which address alcohol and which thereby challenge social norms and drinking culture.	
13.	Improved understanding of the social norms associated with alcohol misuse, and work undertaken to challenge these and those factors driving the drinking culture; also work undertaken to challenge these norms			
14.	Local community support services reviewed and consideration given to increasing consistency across the Region.		A review of the Community Support Services was undertaken as part of the Commissioning Framework consultations. The findings contributed to the re-design of Tier 1 addiction services which came into effect under the new contracts in place from 01 July 2015 (Five HSCT-based DACT Connections services now also in place).	
15.	Health professionals, particularly within Primary Care and A&E, trained and encouraged to undertake brief alcohol advice/intervention programmes.		A Regional Enhanced Service is in place to encourage the delivery and provision of screening and brief interventions in Primary Care. Programmes of training and awareness-raising have also been put in place. This has seen over 80,000 individuals screened over the last 2 years. An Alcohol Screening and Brief Intervention initiative with the Probation Board NI has been established and commenced in June 2015. Work is currently underway to develop a brief intervention pilot in N& E Belfast around alcohol for Health + Pharmacy trained community pharmacies. The pilot is expected to start in September 2016.	Step 2 services are now in place and can be accessed by GPs to deliver brief interventions to those clients who would most benefit. Evaluate the pilot and consider further roll-out.

16. Review of the role and capacity of alcohol liaison nurses, and consideration given to ensuring they are available in all relevant HSC sites.		Work has been undertaken to put in place proposals for the development of Substance Misuse Liaison Services. The regional service development proposal to enhance alcohol/substance misuse resources was endorsed by the HSCB/PHA in 2014. This sets out the aim to enhance existing baseline resources within Trusts with a focus upon the acute in-patient setting and within a '7 days per week' service model. Service development proposal was set out in two phases – to date, only funding (50%) for the initial phase has been confirmed: this additional investment was provided to Trusts in June 2015. New posts have recently come on-stream or are in process of being recruited. This will help enable service provision to shift from the current mainly Mon-Fri model to become 'seven-day' based.	The envisaged service model, and therefore full implementation of the 2nd phase, is dependent upon additional funding. This limits the level of service provision that can be achieved.
17. Proposals developed on how alcohol is: • Priced (including consideration to minimum unit pricing); • promoted; • labelled; and • advertised.		**Pricing:** The Court Case in respect of Minimum Unit Pricing for Alcohol in Scotland has been referred back to the Scottish Court of Session. The outcome of this case will have an impact on any decision to move forward in this area here. **Promotions:** DfC has worked with the alcohol industry on the development of a Responsible Retailing Code of Practice - www.responsibleretailingcodeni.org/. This code, which is overseen by an independent complaints panel, applies to the entire industry and will be run for an initial period of two years. DSD has introduced regulations to ban fixed price promotions such as 'all you can drink for £20' in pubs and registered clubs with effect from 01 January 2013. A consultation on proposed changes to licensing legislation included a proposal to make compliance with such codes to be a condition of holding an alcohol licence. **Labelling:** Labelling of alcohol products is part of the UK-wide Responsibility Deal. In March 2011, 92 companies made a commitment through the Public Health Responsibility Deal to "ensure that over 80% of products on shelf (by December 2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant."	

		This pledge was intended to increase people's awareness and understanding of units, the lower-risk drinking guidelines and the Chief Medical Officer's advice on drinking during pregnancy. A report by Campden BRI published in November 2014 showed that 79.3% of labels provided all three elements correctly (meeting the commitment); 92.8% provided correct pregnancy information; 87% provided correct unit content; and 82.8% provided correct lower-risk drinking guidelines. We are keen Industry continues to work to improve adherence to this pledge. **Advertising:** Broadcast advertising is a reserved matter. We have continued to advocate, with the UK Government, for a strengthening of the code on alcohol advertising. We are also working with the industry, through the local Responsible Retailing Code of Practice and the Portman Group, to ensure that the self-regulation of alcohol advertising and promotion is as robust as possible. Ofcom had tasked BCAP and the ASA to review the effectiveness of the current regulation of alcohol advertising in the light of the research, both as regards enforcement and whether it adequately reflects the changing circumstances of children's viewing. This has made some recommendations on how programmes are categorised and we are waiting to see the outcome of this on children's exposure to alcohol advertising.	
18. Workplace Alcohol and Drug Policy Guidance updated, disseminated and their usage supported and encouraged.		**Completed**. Reviewed guidelines placed on the NI Business Info Website (http://www.nibusinessinfo.co.uk/content/workplace-policies-smoking-drugs-and-alcohol). The PHA will promote the availability of these guidelines through their wider programme of health promotion in the workplace.	In the future, PHA will update the guidelines as appropriate.

19. Information on emerging trends and drugs of misuse shared across UK and ROI Jurisdictions, particularly in relation to helping to inform the statutory role of the Advisory Council on the Misuse of Drugs (ACMD) in respect of the Misuse of Drugs Act.		The Department, and other key agencies such as DoJ and Forensic Science NI (FSNI), feed into the ACMD and the British-Irish Council as appropriate.	
20. NI continues to contribute to the ACMD and inputs to UK-wide legislation in relation to the misuse of drugs, particularly in relation to emerging drugs of concern.		Key Stakeholders continue to work with the ACMD, the Home Office, and the Department of Health, in relation to appropriate UK-wide legislation on these issues. A key issue has been work by DoH and DoJ with the Home Office in support of the introduction of UK wide legislation to provide form a blanket ban of the sale of New Psychoactive Substance. This legislation received Royal Assent in January 2016 and was enforced from 26 May 2016. DoH and DoJ will continue to liaise with the Home Office on the implementation, monitoring and review of the Psychoactive Substances Act.	
21. All organisations promptly informed of changes to the drug and alcohol legislation.		Information is disseminated as appropriate by the Department through the PHA, the various advisory groups, the NSD Steering Group, and the DAMIS system.	DE will continue to attend the NSD steering group and process information through DAMIS
22. Parents, communities and key professionals provided with accurate and timely information in relation to emerging drugs, including legal highs.		Appropriate information is placed on the *Talk-to-Frank* Website, and other information sources such as NI Direct. The Chief Medical Officer (CMO) issues warning and advice letters as appropriate to health professionals within HSC and through DAMIS. PHA also ensures that funded services provide up-to-date information to clients, young people and their families.	DE will pass warnings / information to EA / schools on request from CMO and PHA
23. Group established to consider how the use of prescribed drugs can be addressed.		**Completed**. A group was established in 2012 to consider prescription drug misuse. Subsequently an action plan was developed and issued to key partners for implementation as appropriate. These actions are now included separately in this report.	Key Actions are included in this report. Work is ongoing to take forward this action plan.

24. Drink and drug driving (including prescription drugs) media campaigns continued and their impact assessed.		DOE's anti drink driving campaign, entitled *Hit Home* ran on television over the summer and Christmas periods in 2014. 'Hit Home' carries the strapline "Every drink increases your risk of crashing." Supporting the television campaign, the *Hit Home* anti drink drive message was also delivered on bus rear and bus shelter advertising. DOE, along with PSNI, supported Coca-Cola's 2014 Designated Driver campaign over the Christmas and New Year period, encouraging pub-goers to either designate a driver who abstains from alcohol or to book a taxi home. DOE has furthered this message via its online campaign '*Share the Road to Zero'*. Anti drink driving messages and links to *Hit Home* have been posted on emails and social media via the Facebook and Twitter pages for this campaign. In January 2015, similar messages were delivered regarding the DOE's anti drug driving message, with a link to the *Steps* campaign online. *'Steps'* carries the strapline "*What steps will you take to stop a drug driver from wrecking your life?*" and refers to both prescription and illicit drugs. In December 2015, DOE launched a new social media campaign to reinforce the message that the only safe level of alcohol when driving is no alcohol. With the proposed introduction of a lower drink drive limit, it was appropriate that the Department took the opportunity to anticipate the change in the law. The campaign is aimed at all drivers but particularly at young male drivers who are statistically at the core of this problem as they are more likely to be involved in a serious crash where alcohol is a factor. The new campaign stresses the impairing effects of alcohol on driving, even from the first drink. The message is designed to further increase the unacceptability of driving even after one drink, especially for young males. These messages will continue to be reinforced on the road safety social media channels 'Share the Road to Zero'. DOE also continued to support Coca-Cola's Designated Driver initiative over the Christmas 2015 period. DOJ and the PSNI continue to support the delivery targeted media campaigns in this area.	DOE continues to emphasise that driving is impaired from the very first drink. This supports the proposed future lower drink drive limit. Both anti-drink and anti-drug driving remain road safety priorities for DOE. Plans for 2016-17 will reflect this, but within a significantly reduced DOE budget.

25. Roadside drug screening devices in place when available.		The Crime and Courts Act 2013 created a new offence in England and Wales of driving with a specified controlled drug in the body above a specified limit. FSNI has now completed all project work regarding the detection of the 17 drugs and metabolites named in Section 5a of the UK Road traffic Act 1988 at the specified limits. Process re-engineering has produced additional capacity to deal with the potential increase in submissions to the Toxicology workstream. It is unlikely that PSNI will be seeking to purchase the current generation of roadside screening devices. Rather operational focus will remain with utilising Field Impairment Trained Officers to screen suspected drug drivers. It is envisaged that as the technology develops with increased screening capability for a range of drugs, PSNI and FSNI will revisit this issue	DOE has been prioritising drink drive legislation, as alcohol is a more significant issue in road casualties and our legislation on this is scheduled to be implemented before the end of 2016. DOE will closely monitor the effects of the new legislation in England and Wales, and the progress of convictions under the new law before the courts, as well as developments in Ireland. As a direct consequence of budgetary pressures, it is likely that for straightforward Driving Whilst Unfit cases, that where police can prove evidence of an Excess Alcohol offence, then no further toxicology analysis to prove the presence of drugs will be commissioned. Although FSNI can currently detect all 17 drugs and metabolites at the specified limits, this service will be further enhanced with investment in new equipment during Q1 of 2016. PSNI and FSNI will keep this issue under review pending introduction of the “per se” drugs offence in NI.

26. New roadside breath testing devices in place for drink drivers when available.		FSNI continues to work closely with the PSNI to ensure the new equipment fully meets the NI specification in relation to the reduced breath test limits. FSNI has obtained accreditation for the quantitative analysis of alcohol in both blood and urine at the proposed new limits. The Agency is building capacity within this work stream to mitigate against any delay in the type approval of the next generation roadside evidential breath testing equipment.	FSNI is currently engaged in technical discussions with CAST and the PSNI regarding the capability of the existing Lion 6000 intoxilisers for detections at the 20µg limit. This proposal is an interim measure prior to the type approval of replacement equipment.
27. The proportion of positive preliminary breath test results reduced.		The PSNI conducted 28,160 preliminary breath tests in 2014/15 which was a decrease of 4% on the number carried out in 2013/14 (29,353). In total 466 people approached failed to complete a breath test in 2014/15 compared to 394 during 2013/14. The proportion of drivers who failed a preliminary breath test in 2014/15 was 9% which compares with 10% in 2013/14.	
28. The Drink Drive (Blood Alcohol Concentration) Limit reduced.		The Road Traffic (Amendment) Bill passed Final Stage at the Assembly in January and received Royal Assent on 23 March 2016. The Act contains measures to tackle drink driving, introduce a Graduated Driver Licensing (GDL) programme and makes mandatory the wearing of helmets on quad bikes on public roads. New breath testing equipment is currently undergoing Type Approval within the Home Office Centre for Applied Science and Technology (CAST). In relation to the reduced breath test limits, FSNI is working closely with the PSNI to ensure that the new equipment fully meets the NI specification.	DOE issued a consultation paper (running from 21 March to 27 May 2016) on regulations needed to implement the new drink drive regime. This schedule, together with PSNI plans to acquire new evidential breath testing equipment, should enable a phased implementation of new police powers and new lower limits before the end of-2016. UKAS Accreditation for reduced limits of detection scheduled for mid-2014

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

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
29. Alcohol and drug users have access to appropriate and effective treatment and support services		The Alcohol and Drug Services Commissioning Framework, which covers all tiers of service, was issued for consultation on March 2013. The document will be finalised in the near future, but has already been used to inform the current process of tendering and commissioning. Agreement has been reached on the reconfiguration of Tier 4 services and the new model should be operational soon. The following service areas were commissioned; • Community Alcohol and Drugs Information and Networking Service *(now known as Connections Service)* • Drug and Alcohol Life-skills, Prevention and Harm Reduction programmes for vulnerable young people • Support, Care, Facilitation and Harm Reduction Services for People who are misusing Substances (Low Threshold Services) • Regional Workforce Development Programmes • Community-based services for young people who are identified as having substance misuse difficulties • Community-based intervention services for adults and family members affected by substance misuse. (*These services will include provision for those within the criminal justice system).* • Therapeutic services for children, young people and families affected by parental substance misuse	A review of Tier 3 services (community-based specialist Addiction) was undertaken over 2015/16: draft report completed awaiting approval. A range of service improvement recommendations are identified.
30. Integrated, cross-departmental and cross-sectoral planning for treatment and support services in place		The Bamford Substance Misuse Subgroup provides a cross-sectoral mechanism to plan appropriate treatment and support services – this group led the development of the draft Commissioning Framework. In addition, the Treatment and Support Advisory Committee is now in place and providing a strategic level input.	
31. Evidenced based alcohol and drug harm reduction approaches and activities promoted and expanded.		The PHA is working in partnership to expand the Needle and Syringe Exchange Scheme from 14 community pharmacies to 20. The commissioning process for the 6 remaining services is on-going. Naloxone programme has been further developed (See Naloxone section) PHA has worked in partnership with Council for the Homeless to	

		develop 2 harm reductions booklets aimed at people who use stimulants / synthetic cannabinoids. This is in response to information sent to DAMIS (Drug and Alcohol Monitoring and Information System) which indicates that these are the substances causing the most concerns at this time. 42,000 copies of these booklets have been printed and disseminated. New low threshold outreach services commissioned from 01 July 2015.	
32. Service users adequately and appropriately involved in planning and provision of treatment and support services.		Through the regional service User Network (commissioned from Council for the Homeless by PHA); service user representatives sit on all PHA/HSCB/DoH regional drug and alcohol groups, and also on all 5 local Drug and Alcohol Coordination Teams. Staffing issues within Council for the Homeless have impacted on work to support service users at local level, but new staff have recently taken up post and there is a renewed focus on this. The PHA held a Consultation Event on 19 May 2016 to hear views on priorities for future commissioning in this area.	Need to continue to build on work with service users to further integrate their input and involvement
33. Increase in the number of problem users who access treatment and support services, including harm reduction services.		There has been an increase in the number of users seeking treatment as well as demand for harm reduction services.	
34. Co-operative working relationships further developed between statutory, voluntary and community sectors that deliver services to alcohol and drug misusing offenders.		Informed by the new Commissioning Framework arrangements, co-operative working relationships continue to be developed with a range of service providers to deliver reparative placements for young offenders who misuse substances.	
35. Dismantling, disruption and frustration of organised gangs involved in supplying drugs.		Proactive intelligence led operations continue against organised crime gangs. In 2015/16, 28 gangs were dismantled and 96 were frustrated or disrupted	
36. The NI Prison Service in partnership with the South Eastern HSC Trust work closely with the Community Addiction Teams.		Good progress has been made to develop the interfaces between Prison Healthcare Staff and Addictions Teams. A bi-annual Substance Misuse Forum is in place which has reviewed the patient flow and transition process from the Prison Healthcare Addictions Team to Community Addition Teams. All Health & Social Care (HSC) Trusts are represented at this Forum which has resulted in the development of an Interface Protocol.	The Regional Protocol between Prison Healthcare and Community Addictions Team requires final approval and circulation in 2016/17.

37. An interface protocol with Community Addiction Teams for a care pathway for prisoners leaving prison to return to the community developed by the NI Prison Service in partnership with the South Eastern HSC Trust		Update as above. A regional Forum which includes all Trusts regionally and Prison Healthcare Addictions Team have developed an Operational Protocol to ensure a planned Care Pathway for prisoners leaving prison and returning to the community.	As above
38. Discharge procedures, involving both in-prison health services and Voluntary & Community agencies to ensure prisoners have access to services and support across NI, further developed by the NI Prison Service in partnership with the South Eastern HSC Trust.		Discharge Procedures have been agreed regionally and reflected in the Regional Protocol. In addition, AD:EPT provide a through care service which provides support to prisoners up to six months post release.	As above
39. The NI Prison Service in partnership with the South Eastern HSC Trust aim to reduce the use of illicit and non-prescribed drugs in prison, and reduction in dangers associated with drug misuse, particularly the risk of transmitting blood borne viruses.		South Eastern Trust Prison Healthcare Services have prioritised work to address Medicines Management within a prison setting to include issues relating to prescribing, dispensing and administration of medicines RCGP training has been made available to GPs and Prison Healthcare staff. South Eastern Trust is now registered on the Regional Managed Clinical Network for Hepatitis B and C. Training has been provided to Prison Healthcare Clinicians in relation to screening and treatment for Hepatitis B and C. BBV Awareness sessions have been provided to prisoners and to staff working within the prison sites and includes harm reduction, advice and promotion of Hepatitis B immunisation. The NI Prison Service (NIPS) lead on work to reduce the available and use of illicit and non-prescribed drugs in prisons and undertake drug testing. South Eastern Trust and partner organisations, ADEPT/Start 360,	South Eastern Trust, in partnership with the Regional Network Group, is developing a Hepatitis Care Pathway specifically for Prison Health. BBV Awareness Sessions will continue to be developed. South Eastern Trust is supporting the NIPS and NICS officers in a review of the NIPS BBV Policy for its staff. South Eastern Trust will work in partnership with the NIPS to finalise a Joint Drugs Misuse Strategy.

		work in partnership with NIPS to address the issue of drug misuse. Work has commenced by South Eastern Trust and NIPS to draft a Joint Drugs Misuse Strategy.	
40. All pre-sentence report authors and supervising staff receive the appropriate tools to undertake accurate and consistent screening and assessment of adjudicated offenders as determined appropriate by the Probation Board.		All PBNI pre-sentence report authors and case managers are trained in PBNI's ACE (Assessment Case Management and Evaluation) tool. This is consistently applied at regular stated intervals and identifies risk of re-offending and/or risk of harm. PBNI staff have also been trained in brief interventions / screening tools and signposting to appropriate services related to the new Commissioning arrangements for front-line staff.	Follow-up training will take place in 2016-17 to review practice with the agreed assessment, screening and referral arrangements and also to update on developments i.e. new CMO drinking guidelines, Psychoactive Substance Act etc.
41. Drug testing for those offenders who volunteer or released from prison on a Life License		Whilst not funded to deliver this service, PBNI continues to provide the service and work with the Prison Service to explore the feasibility of extending the current drug testing arrangements with a view to consistent and cost-effective service provision across NI.	PBNI has been reviewing its drug-testing arrangements with a view to extending its provision throughout NI in 2016-17
42. A range of programmes developed to meet the priority needs of offenders (with particular emphasis on the Sentencing Framework).		During 2015-16, PBNI updated its internal Alcohol Management Programme to provide a Substance Misuse programme for addressing information, psychosocial and motivational issues.	
43. The Addressing Substance Related Offending (ASRO) programme for offenders rolled out.		**Completed:** ASRO is no longer available from NOMS and new arrangements are in place to assess the level of treatment intervention and refer, as necessary, to specialist services.	PBNI will continue to actively implement the new screening / assessment and referral Commissioning Framework arrangements of 2015.
44. PBNI funding provided through its Community Development Budget to secure the provision of substance misuse services in the community and voluntary sector.		**Completed:** PBNI provided funding of substance misuse services through Community Grant. This provision ended on 31 March 2015.	PBNI will continue to address local need through local partnership projects as funding becomes available. This will include but not solely relate to PCSPs.
45. Partnership work in place to deliver ASRO programmes to complement the P-ASRO programme for offenders.		**Completed:** ASRO is no longer available from NOMS and new arrangements are in place to assess the level of treatment intervention and refer, as necessary, to specialist services.	

46. Targeted treatment for prolific offenders with substance misuse related crime		PBNI continues to follow the screening / assessment and brief intervention model agreed with the PHA under the Commissioning Framework of 2015. Within this, PBNI addresses targeted treatment through PBNI staff delivering brief interventions, referral to PBNI's Substance Misuse Programme and onward referral to Level 2 / Level 3 Health provision using agreed processes as required. PBNI continues to play a full role as a key partner in the Reducing Offending in Partnership project with the services detailed above identifying level of need. The PSNI have established the Reducing Offending in Partnership project and these structures assist with the identification of substance misusing prolific offenders, who can in many cases secure speedier access to specialist services.	In line with the Joint Healthcare & Justice Strategy (currently out for consultation) PSNI and partner agencies are exploring referral pathways out of police custody.

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
47. A Regional Addiction Services Commissioning Framework developed and implemented. 48. The Framework should ensure that services are supported and encouraged to adopt a "recovery and reintegration" approach to treatment and support.		The Alcohol and Drug Services Commissioning Framework has been implemented through the procurement of a range of services across Tiers 1-3, development of Tier 4 service, provision of Substitute Misuse Liaison Service and development of CAMHS Drug and Alcohol Support.	A report against the framework will be published by 30 June 2016.
49. Local and regional Service User developments encouraged and supported.		**Completed.** Through the regional service User Network (commissioned from Council for the Homeless by PHA); service user representatives sit on all PHA/HSCB/DoH regional drug and alcohol groups, and also on all 5 local Drug and Alcohol Coordination Teams. Staffing issues within Council for the Homeless have impacted on work to support service users at local level, but new staff have recently taken up post and there is a renewed focus on this. The PHA held a Consultation Event on 19 May 2016 to hear views on priorities for future commissioning in this area.	We need to continue to promote service user engagement and participation.
50. Specific work in respect of identified vulnerable groups included in local action plans.		All appropriate services commissioned by the PHA are required to ensure that identified vulnerable groups can access services.	
51. Pilot scheme for 'Take Home Naloxone' to be evaluated and consideration given to its roll-out.		We are expanding the Naloxone programme in response to the evaluation findings and also in response to new legislation which widens access to the potentially lifesaving drug. Our focus now will be on working with Low Threshold Services to set up systems so they can supply Naloxone, and also to begin work with Community Pharmacy needle exchanges so in future they will be able to supply Naloxone to their clients / anyone who comes into contact with someone at risk. Naloxone training needs assessment completed to inform a business case for commissioning further Naloxone training.	Programme expanded to Low Threshold Services and Needle Exchange Pharmacies to ensure much wider access to Naloxone. Training to be commissioned.
52. Provision of needle/syringe exchange scheme continued, and consideration given to expanding		6 additional pharmacy-based sites have been identified in Dungannon, Newtownards, Lisburn, Newry, Downpatrick and Limavady. The commissioning process commenced in Spring 2015,	

the scheme to areas with an identified need.		but due to concerns about the suitability of the premises of the pharmacies identified through this process, service commencement has been delayed. PHA funded Low Threshold Services in 4 out of the 5 Trust areas are providing a Needle Exchange Outreach Service. Safer injecting / needle exchange training for Low Threshold Service staff and Needle Exchange Pharmacy staff has been commissioned.	
53. Learning from existing schemes/initiatives, work undertaken to reduce levels of prescribing, and support people to reduce/stop taking unnecessary prescriptions.		HSCB/PHA action plan on Prescribed Medication will outline how this will be addressed. This plan was agreed by PHA/HSCB in 2014.	
54. Services in place to assist clients with a common employability barrier, (eg history of drug/alcohol misuse, homelessness and ex-prisoners/ex-offenders) to enter employment.		Current LEMIS ran until 31 March 2015. The Department of Employment & Learning funds three LEMIS projects under priority 2 Social Inclusion T08 IP 1(a) and 1(b) of the first call of the NIESF Programme 2014-2020. The current funding allocation to these projects is £11.94 million over the three-year period from April 2015 to March 2018. DEL will also continue deliver of the Community Family Support Programme (CFSP) programme through the NI European Social Fund (ESF) Programme with a budget allocation of £8.15m over the three-year period from April 2015 to March 2018. The aim of the new ESF programme is to combat poverty and enhance social inclusion by reducing economic inactivity, and to increase the skills base of those currently in work and future potential participants in the workforce. Applications for funding have been assessed and currently, funding of approximately £111 million has been offered to 67 projects over the next three financial years. This fund will support 67 projects which will include initiatives for people who are unemployed or economically inactive, and families with a high level of need, which may include individuals with substance abuse issues to develop their capacity to reach full potential in terms of education, training, health, social and economic issues.	

55. Education and training for professionals, carers and families in relation to substance misuse problems in older people supported.		**Completed:** PHA produced a resource on this issue during 2013/14	
56. Consideration given to extending arrest referral schemes to other areas across NI.		**Completed:** Following an evaluation of the three pilot arrest referral schemes one Trust area ceased service provision. As a result of the severe financial constraints, the DOJ issued letters to the two remaining projects to indicate that funding would end in the 2014/15 financial year.	
57. Consideration given to how the current arrest referral schemes could be altered to address alcohol related offending, and depending on the outcome, consider the introduction of a pilot alcohol arrest referral project.		**Completed:** As above	
58. A continuum of treatment and support opportunities between custody and release of offenders back into the community for young and adult offenders developed – linked to the Joint Agency Offender Management Process.		NIPS and the NIPB lead on the Offender Management Process. South Eastern Trust Prison Healthcare staff will contribute as appropriate to ensure that discharge arrangements for any continuing health care are in place. South Eastern Trust has worked closely with the Health and Social Care Board (HSCB), the Public Health Agency (PHA), Health and Social Care Trusts, as well as Voluntary Sector Agencies, to plan for a seamless transition from custody to community for prisoners with healthcare needs.	The joint Health and Criminal Justice Strategy implementation process will provide a further focus and drive to improve interface working across Criminal Justice and Health. The Protocol developed by the Regional Substitute Prescribing Group requires final approval and circulation in 2016/17.
59. The NI Prison Service in partnership with the South Eastern HSC Trust further develop services to ensure appropriate interventions are in place for prisoners, including for those with opiate dependency.		South Eastern Trust completed a Health Needs Analysis on Addictions and Mental Health needs within NI Prisons in 2015/16. South Eastern Trust has shared the Health Needs Analysis with our Commissioners to inform further development of Addictions Services. South Eastern Trust has an established pathway in place for prisoners with Opiate Dependency and on Substitution Therapy. South Eastern Trust commissions Psycho-Social Services from Start360 as part of the Trust's Addictions Services.	Action Plan to be developed based on the recommendations from the 2015/16 Health Needs Analysis within the resources available. Further integrate the Start360 and Prison Healthcare Addition Team processes and pathways.

60. Accreditation sought for the "Prisoners – Addressing Substance Related Offending" (P-ASRO) programme, or other appropriate programmes, delivered in prisons.		A range of programmes have been developed to meet the priority needs of offenders including targeted treatment for offenders with substance misuse related offences. NIPS continue to work in partnership with the South Eastern Trust and AD:EPT (Alcohol and Drugs: Empowering People through Therapy) who provide a range of programmes to offenders including the Building Skills for Recovery (BSR) programme.	P-ASRO has been replaced by Building Skills for Recovery (BSR), an evidenced based structured psychosocial treatment programme accredited by the Correctional Services Accreditation and Advisory Panel.
61. The NI Prison Service in partnership with the South Eastern HSC Trust will have undertaken work to reduce the risk of drug-related death in prisons, and particularly on release from prison.		Information is provided to prisoners at induction re: substance misuse and how to access addiction services whilst in prison, taking into account the diversity of the prison population e.g. foreign nationals, offenders with literacy problems. NIPS support those at risk of self harm or suicide, including those who deliberately overdose, through the multi-disciplinary Supporting Prisoner At Risk (SPAR) programme. NIPS and the SEHSCT ensure lessons learned from Prisoner Ombudsman reports are incorporated into policy reviews to reduce the risk of deaths. Regular drug testing takes place and those who test positive for drug misuse are referred for assessment and/or treatment and procedures are in place for observed administration of medications. Pre-release sessions are available to offenders to discuss core harm issues of substance use following release from prison. Partnership working with the SEHSCT and voluntary and community agencies to ensure through care from prison to community is provided to offenders.	A substance abuse needs analysis and joint working on Substance Misuse Strategy is being taken forward as part of the Prison Reform Programme. Regional Substitute Prescribing Group needs to finalise and then circulate the Interface Protocol between Prison Services and HSC Trust Community Addiction Teams.
62. Education and information provided to parents of offenders regarding drugs and alcohol on a one to one basis and via the parent support groups.		Information is provided to prisoners at induction re: substance misuse and how to access addiction services whilst in prison, taking into account the diversity of the prison population e.g. foreign nationals, offenders with literacy problems. NIPS support those at risk of self harm or suicide, including those who deliberately overdose, through the multi-disciplinary Supporting Prisoner At Risk (SPAR) programme. NIPS and SEHSCT ensure lessons learned from Prisoner Ombudsman reports are incorporated into policy reviews to reduce the risk of deaths.	A substance misuse needs analysis and joint working on Substance Misuse Strategy is being taken forward as part of the Prison Reform Programme.

		Regular drug testing takes place and those who test positive for drug misuse are referred for assessment and/or treatment and procedures are in place for observed administration of medications. Pre-release sessions are available to offenders to discuss core harm issues of substance use following release from prison. Partnership working in place, with SEHSCT and voluntary and community agencies, to ensure through care from prison to community is provided to offenders. Education and information is provided through individual and group work programmes and through parent support groups where they are established across YJA regions.	Family education programme to commence in Woodlands to support families with children with challenging behaviour and likely to abuse drugs and/or alcohol.
63. The NI Prison Service and South Eastern HSC Trust work in partnership with Alcohol & Drugs: Empowering People through Therapy (AD:EPT) to deliver psychological and educational drug and alcohol programmes for all offenders.		AD:EPT deliver a range of psychological and educational drug and alcohol programmes in partnership with the NIPS and the South Eastern Trust Prison Healthcare Teams.	South Eastern Trust and NIPS will complete a joint Drugs Misuse Strategy.

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

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
64. Increase in the proportion of young people who see taking illicit drugs and getting drunk as socially unacceptable.		Consideration needs to be given to how best to measure this outcome.	Consider adding to Young People's Behaviour and Attitudes Survey.
65. Reduction in the availability and accessibility of alcohol to young people.		Range of measures in place to reduce the availability and accessibility of alcohol to young people (see outcome 19).	
66. Reduction in the proportion of young people who get drunk.		The proportion of young people who get drunk has fallen from 33% in 2003 to 14% in 2013.	
67. Reduction in the proportion of young people who drink on a regular basis.		Of those who drink – the proportion of young people who drink a few times a month or more regularly has fallen from 28% in 2003 to 21% in 2013.	
68. Reduction in the proportion of young people who take drugs on a regular basis.		Last Month use of drugs/solvents among young people has fallen from 12% in 2003 to 3.7% in 2013 according to the Young People's Behaviour and Attitudes Survey.	
69. Opportunities exist for young people to make a positive contribution, including through reparative placement, to the drugs and alcohol strategy.		YJA continue to identify and review reparative placements in organisations and community groups that are engaged in work to address the negative impact of drug and alcohol misuse.	

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
70. The "You, Your Child, and Alcohol" regional information campaign, aimed at reducing alcohol and drug misuse among young people (aged under 18), evaluated and consideration given to its future.		**Completed.** The "You, Your Child and Alcohol" was last run in Summer 2011. Overall, the campaign was well evaluated, with good awareness of the campaign and booklet and self-reported evidence that parents were more likely to talk to their children about alcohol and use the booklet for advice. It has been decided not to run another phase of the campaign at this stage. However, the steering group will share the learning from this campaign with interested stakeholders and use it to inform any future work in this area.	
71. Targeted education and awareness-raising among children, parents, and families on the risks of drug and alcohol misuse and how to prevent harm.		The Commissioning Framework indicated that DACTs should play a more active role in the development of a local integrated education and prevention plan. It was recommended that a service in each HSCT area will be commissioned to ensure that the outcomes listed here are addressed. The five HSCT-based Community Alcohol and Drugs Information and Networking Services (CADINS) commenced on 1 July 2015 and became branded as the DACT Connections service. These services work at local level alongside key community and statutory stakeholders and under the guidance of the local DACT to develop drug and/or alcohol related information, education and awareness-raising events and initiatives. A suite of life skills programmes has been developed for use with groups of young people identified as being at risk of substance misuse, with a complementary suite of harm reduction sessions that can be delivered in a way that is tailored to the needs of the young people. These three life skills programmes programmes are appropriate for 11-13 year olds, 14-15 year olds and 16-21 year olds, with the harm reduction sessions also tailored for the same age groups. Services are in place to deliver these programmes across the region	

72. Schools support the development of skills and knowledge that enable young people to resist social pressures to experiment with alcohol and drugs, including volatile substances, emerging drugs of concern, etc.		The school curriculum places a specific focus on the development of relevant "life skills" among pupils. In particular, through Personal Development and Mutual Understanding (PDMU) in primary schools pupils are provided with opportunities to develop strategies and skills for keeping themselves healthy and safe. Post-primary school pupils, through Learning for Life and Work, are provided with opportunities to investigate the effects on the body of legal and illegal substances and the risks and consequences of their misuse. In August 2015 the Council for the Curriculum, Examinations and Assessment (CCEA) published revised guidance on drugs and alcohol. The guidance is available to schools via the C2k Equella library and the DE and CCEA websites. There is also a KS3 'Drugs Awareness' Fronter room on C2k.	
73. Young People's Drinking Action Plan implemented.		**Completed.** The key actions from the Young People's Drinking Action plan have been incorporated within the NSD Phase 2, and progress is being made against these actions.	
74. Successful implementation of new liquor licensing regulations and laws.		Following the publication of the outcome report on the consultation on proposed changes to the law, the DSD Minister had intended to bring forward legislation before Assembly Elections in May 2016. Unfortunately due to competing priorities the legislation was not introduced to the Assembly.	This issue will be considered by the new Minister in the Department for Communities after the election in May.
75. Improved co-operation and co-ordination to address alcohol and drug misuse and mental health, suicide and self-harm, and sexual health, at both the strategic and operational level.		At the strategic level, there is a greater acknowledgement of the links between these issues within all relevant strategies. At the operational level, it is envisaged that the Substance Misuse Liaison posts will have a key role in linking with/addressing self-harm and associated mental health issues. In addition, commissioners for mental health, sexual health and alcohol and drugs met to discuss possible areas for collaboration. It was agreed that some procurement of programmes for young people would be subject specific but that work would be taken forward to look at generic work for young people. The One Stop Shop and the Strengthening Families initiative are examples of such work. Substance misuse training is promoted within the Mental Health field and likewise substance misuse services are encouraged to avail of mental health training, in particular ASSIST, Safe Talk and Mental Health First Aid.	This will continue to be built upon through ongoing policy development and implementation.

76. A One-Stop-Shop service, informed by the evaluation of the pilot project, available in areas of identified need to those young people affected by substance misuse, but also addressing issues such as suicide and self-harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping skills.		Eight One Stop shops are now in place. All are developing referral pathways for young people into a wide range of services to address the key issues as per target. A network of services has been established and meets quarterly to share practice, address concerns, and improve consistency across the region. Annual networking practice events are held for both staff and service users. The evaluation of the One Stop Shop initiative is currently being undertaken.	
77. Greater information-sharing between PSNI, the Youth Justice Agency (YJA) and PBNI regarding the identification of children who offend and who are known to be using alcohol and drugs either in the commissioning of offences or to gain money to purchase drugs or alcohol.		There are ongoing programmes of work focused on interventions for children and young people and Criminal Justice organisations continue to work closely with all partners to ensure the appropriate and timely sharing of information relating to young people. Ongoing communication with Reducing Offending Units and Youth Diversion Officers highlight relevant information and issues relating to substance misusing offenders. PSNI has embarked upon a Vulnerability Pilot within Derry, City and Strabane with partners and young people are a cohort of this group. Youth Engagement Clinics continue to operate across the region and both YJA and PBNI continue to participate in the delivery of the 'Reducing Offending in Partnership' (ROP) initiative which focuses on making communities safer by reducing crime and re-offending as well as improving public confidence in the criminal justice system. The Prevent & Deter strand is now implemented in all police districts, focusing on young people at risk of offending.	
78. Opportunities in Youth Conferences for young people involved in substance related offending to hear first hand experiences from those who have experienced dependency but have addressed it.		Youth Conference Coordinators take every opportunity to involve those who have personal experience of substance related dependency, with relevant experiences, in youth conferences to derive the most benefit and impact in order to reduce the likelihood of re-offending.	Woodlands will provide opportunities for children and young people to hear first-hand experiences of those who have/are addressing drug and alcohol misuse.

79. Education and awareness sessions provided to young people who, though the criminal justice system, are subject to statutory supervision in the community and are assessed as Tier 1.		Appropriately tailored education and awareness sessions are provided to young people assessed and subject to statutory supervision. The Drugs and Alcohol Intervention Service for Youth (DAISY) service is available and provides information and education to all young people admitted to Woodlands Juvenile Justice Centre.	

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

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
80. All organisations with a responsibility for young people have an alcohol and drug policy in place.		We continue to work across Government and sectors to ensure that all appropriate organisations have alcohol and drug policies in place. PBNI continues to implement and monitor its Substance Misuse Strategy and YJA will continue to maintain and review their current Drug & Alcohol Policy.	
81. Improved identification and signposting of young people who have alcohol and drug related issues, and ongoing monitoring of the Regional Initial Assessment Tool.		RIAT is currently being updated to reflect changing patterns of drug use. The Workforce Development contract now includes promotion and delivery of RIAT to relevant front line workers. YJA staff are trained to deliver RIAT throughout YJA and will continue to review the assessment tool to ensure needs are identified.	RIAT will be used to inform referrals to young people's substance misuse treatment services.
82. Children and young people have access to early interventions and appropriate support services directly related to their alcohol and drug use.		A range of new service for young people have been commissioned as of 1 July 2015. In addition, the One-Stop-Shops provide early intervention for a range of issues. Whilst the YJA small grants scheme has been discontinued due to financial constraints, YJA will continue to assess the level of treatment intervention and refer, as necessary, to specialist services.	
83. Increase in the number of young people and parents accessing treatment and support services.		The PHA has provided funding to develop DAMMHS services in the Western, Northern and Southern areas. A care pathway is being developed to ensure the Stepped Care processes operate smoothly between Youth Treatment Services and DAMMHS. Criminal Justice Agencies will continue existing assessment process to ensure appropriate onward referrals are made based on identified need.	
84. Protocols agreed with the Child and Adolescent Mental Health Service (CAMHS) across NI ensure a consistent approach to referrals by the Criminal Justice agencies where concerns about potential self-harm are raised.		Community CAMHS Service is now established on the Woodlands JJC site providing an in-reach service. Whilst discussions regarding protocols with other Health Trusts continue to be taken forward through the Children & Young People Strategic Partnership's Offending Subgroup, YJA will continue to operate referral pathways under the agreed protocols with the Western Trust.	

85. Relationships with a wide range of community and voluntary drug and alcohol treatment providers maintained and YJA making appropriate referrals.		YJA will continue to maintain established relationships with a wide range of drug and alcohol treatment providers at regional and local levels to ensure appropriate referrals are made.	

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
86. Development of a framework of Treatment and Support Services for those aged under 18.		**Completed:** The framework of Treatment and Support Services for those aged under 18 was developed and forms part of the PHA commissioning framework for substance misuse services, A procurement process for new services was developed to help improve regional consistency in service provision. The tender process to appoint new service providers to deliver these services is now complete.	
87. Family support services available, and treatment services supported and encouraged to take a family orientated approach to provision where appropriate – reflecting the "Think Child, Think Parent, Think Family" strategy.		Family support services are now available in each DACT area. All treatment services are encouraged to take a family approach where appropriate; work around Hidden Harm includes a protocol and planned training associated with the protocol which will support this. A need for training to support the implementation of the Regional Joint Service Agreement (Hidden Harm protocol) has been identified. Training to support the implementation is now in place.	
88. The Regional Hidden Harm Action Plan implemented.		The Regional Hidden Harm Action Plan has been reviewed and implementation of the action plan is almost complete. The RHHQAG is currently considering revised structures in order to better oversee the implementation of the remaining actions. The following priority was agreed in the PHA/HSCB Commissioning Framework. "Commission treatment and support services for young people affected by parental substance misuse and their families, including intensive support for those families most affected, and ensure these services are linked to Family Support Hubs". The tender process to appoint service providers to deliver this service is complete and services are now in place across the region.	Implementation of the reviewed plan
89. The Regional Initial Assessment Tool embedded within the Youth Justice Agency, and work taken forward to roll it out to other key sectors.		The RIAT assessment tool will continue to be used by YJA Practitioners to determine the appropriate service required for young people for who drugs and /or alcohol misuse is a matter of concern. Training in RIAT is currently being provided across the region through the Workforce Development service provider.	Feedback from practitioners within the YJA and the HSCTs will continue to inform the updating of the tool and work will then be undertaken to roll the tool out more widely.

90. Within the custodial setting of Woodlands, young people assessed (and follow up action and support provided) regarding their drug and alcohol misuse, with appropriate screening and management systems in place to minimise risk to those young people who are admitted to custody under the influence of substances.		All young people admitted to Woodlands JJC are assessed for drug and alcohol misuse to ensure that the appropriate services and monitoring is provided. RIAT assessments in Woodlands JJC are carried out by YJA Practitioners with training and experience in using the tool. Assessments are also carried out by the Drugs and Alcohol Intervention Service for Youth (DAISY) worker who is based in the JJC one day per week and appropriate interventions offered. This service continues following release if necessary.	
91. Accurate sharing of information of alcohol and drugs risks at times of transition with the Criminal Justice system e.g. transfer to adult Probation Services or transfer to Hydebank Wood.		**Competed:** The Youth Justice Agency and the NI Prison Service have developed agreed protocols for the transition of young people from Woodlands to Hydebank – these were agreed in January 2014.	

Community Safety and Anti-Social Behaviour

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
92. The working relationship between the criminal justice sector, the health service and other stakeholders further developed to ensure an integrated approach to tackling alcohol and drug offending behaviour improves.		The current consultation on a joint Healthcare and Criminal Justice Strategy outlines the proposed substantial programme of work that seeks to ensure that resources are better aligned to need, enhance access to services, improve continuity of care, develop our workforces and the way we collaborate, increase diversion of vulnerable people and improve health protection and health promotion. South Eastern Trust continue to work in partnership with HSCB, other Trusts, the NIPS and Voluntary Sector Agencies to achieve close integration to improve transition from custody to community and vice versa.	Future work will be guided by the outcome of the current consultation. Regional Substitute Prescribing Group needs to finalise and then circulate the Interface Protocol between Prison Services and HSC Trust Community Addiction Teams
93. Increase in the level of public confidence in how alcohol and drug-related issues, and their impact at community level, are addressed.		Respondents to the 2015 Omnibus survey expressed higher levels of confidence in the PSNI's work to tackle alcohol and/or drug related issues across the region than that of any other organisation, with 69.5% having either some, a lot or total confidence. Taking everything into account, 52.7% of respondents expressed some, a lot or total confidence that enough is being done to tackle alcohol and/or drug related issues across the region.	Measure future levels.
94. Implementation of Strategies to tackle sexual violence and domestic violence.		The 'Stopping Domestic and Sexual Violence and Abuse Strategy in Northern Ireland' was launched by on 15 March 2016.	
95. Community Safety Strategy fully implemented.		CSS has been published with progress against the thematic action plans continuing to be reported to the overarching Regional Steering Group and the Justice Committee.	

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
96. Existing relationships between Community Safety Partnerships (now PCSPs), District Policing Partnerships and DACTs developed in respect of addressing alcohol and drug related anti-social behaviour.		The Department has continued to encourage the ongoing development of existing relationships between PCSPs and local DACTs in address locally identified issues relating to substance misuse.	
97. Assess the level alcohol plays in Sexual Violence and Domestic Violence; further work will flow from that assessment.		Consideration of how best to assess the level alcohol plays in Sexual Violence and Domestic Violence is ongoing.	
98. Community Safety Strategy recognises the role of alcohol and drug misuse.		**Completed.** The Community Safety Strategy includes the theme of alcohol and drug misuse. A recent update on progress towards delivering the related outcomes has been provided to the Minister for Justice and the Justice Committee.	
99. Protocol developed to improve information sharing between PSNI, Health Trusts, Ambulance Service and others regarding alcohol related incidents, including hospital admissions and ambulance calls to inform local action planning.		The PSNI and Belfast Health and Social Care Trust initiative in the Royal Victoria Hospital's Accident and Emergency Department that leads to the sharing of information regarding incidents of violent (alcohol) related crime is now firmly embedded and informs intelligence reports used by police to target resources across Belfast, including licensed premises. A data-sharing protocol has also been established with South Eastern Health & Social Care Trust to enable data-sharing between the PSNI and the Ulster Hospital.	Information sharing across partner agencies has been included in the Joint Healthcare and Justice Strategy (out for consultation)
100. Promotion of schemes at a local level that tackle anti-social behaviour linked to alcohol misuse (and underage drinking).		DOJ, through PCSPs and other Criminal Justice organisations, continue to encourage the development of local initiatives to tackle anti-social behaviour linked to alcohol misuse.	DOJ will continue to engage with PCSP managers to reinforce this key message.
101. Cross-Government approach taken to addressing issues related to Alcohol and the Night-Time Economy Seminar.		DoH & DOJ continue to be informed by the findings from the 2011/12 and 2012/13 Crime Survey published in October 2014.	
102. Work with the Alcohol Industry and Pubs of Ulster on rolling out the Purple Flag accreditation.		DOJ will continue to support purple flag accreditation operated by the Association of Town and City Management.	

103. The Organised Crime Task Force Drugs Expert Group sharing information and intelligence, and monitoring and overseeing joint action by its partner organisations, to ensure ongoing disruption of the drugs market, and help reduce the availability for drugs.		The Organised Crime Task Force Drugs Expert Group continues to meet to share information and intelligence, and lead joint action, as appropriate. PSNI, UK Border Force, HMRC and other law enforcement partners continue to use intelligence to disrupt importation of drugs. Operations continue to be run to deal with both high level suppliers as well as street level dealing. The Organised Crime Task Force continued to make a number of significant interventions against organised crime gangs in 2015/16. 28 were dismantled, and 96 were frustrated or disrupted.	

Supporting Outcomes – Monitoring, Evaluation and Research

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
104. Improved response and dissemination of information in respect of emerging substance misuse trends.		DAMIS in place since 2012.	
105. More detailed and relevant information in respect of alcohol and drug misuse available.		Ongoing publication of relevant information for NI and a greater sharing of relevant information from UK, RoI, EU and globally.	
106. Progress in respect of aims of NSD Phase 2 described accurately and reported on.		Annual reports published each year.	
107. PBNI considered how best to deliver its Alcohol Management Programme and implement appropriate delivery arrangements.		PBNI has updated and will continue to deliver its Alcohol Management Programme.	
108. Data gathered by PBNI on the impact of the ASRO programme and contributed to any local or national evaluation on the effectiveness of this programme.		**Completed:** The ASRO programme is no longer available from NOMS.	
109. The delivery of drugs and alcohol programmes, delivered with young people in the community, evaluated by YJA.		YJA has developed an evaluation tool for existing Tier 2 programmes for young people with drugs and/or alcohol issues.	Programme evaluation has been scheduled for 2016.
110. NSD Phase 2 reviewed and evaluated, and consideration given to the need for the development of a successor strategy.		Annual reports published each year.	Consideration needs to be given to the timing of a full review and evaluation of the NSD Phase 2 prior to commissioning the development of a successor strategy. It will be important to align this work with

			budget periods and also the commissioning cycles used by the HSCB and PHA and the wider public sector to ensure it is implemented in a timely manner

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
111. The Regional Impact Measurement Tool (IMT) continues to be completed for all initiatives funded as part of the New Strategic Direction.		Tools have been revised in line with the service specifications issued and and now part of PHA contracts.	
112. Consideration given to developing one overarching monitoring system including Drug Misuse Database (DMD), Substitute Prescribing and Needle Exchange; and also an Alcohol Misuse Database established.		Work has been completed on revising the reporting mechanism around substitute prescribing, and a template report designed to provide annual and quarterly information at both Trust and regional level. Reports are now being issued. Work is underway to improve electronic reporting under the DMD and for this to be expanded to also include alcohol.	
113. A rolling research programme developed and updated on an annual basis.		Research has been undertaken on the potential impact of minimum unit pricing for alcohol and on alcohol harm to others.	There is very limited funding for DoH funded research.
114. Available statistics and research information published.		All information produced by DoH is available online.	
115. A local "Drug and Alcohol Monitoring and Information System" (DAMIS) in respect of alcohol and drug trends and developments in place which reports to the NSD Steering Group.		**Completed.** The DAMIS is in place and operational. We will continue to monitor its usage and the revise the scheme as required. A local incident response protocol developed by PHA and agreed with the DACTs is now in place.	
116. The NI Prison Service in partnership with the South Eastern HSC Trust will have undertaken a review of the Prison Strategy to tackle alcohol and drug issues among prisoners.		The South Eastern Trust and NIPS refreshed its joint substance misuse policy in 2012. Development of a Drugs Misuse Strategy has commenced. The NIPS drugs strategy delivers three strands; reducing supply, reducing demand, reducing harm. Working in partnership with the SEHSCT is integral to ensure the delivery of the Strategy. The SEHSCT and NIPS are engaged in ongoing joint working arrangements	NIPS and South Eastern Trust will complete a joint Drugs Misuse Strategy.

		to address issues around the abuse of prescribed medication and the abuse of illicit substances.	
117. Improved quality and scope of data on drink and drug driving, including provision of separate data on drink and drugs present in road fatalities and separate trend data on fatal and serious injury collisions.		In 2011, the consumption of drugs or alcohol by driver or rider accounted for 10.9% of killed or seriously injured casualties (96 people), the most common causation factor. From 01 April 2010, separate data is available on the collision causation factors 'Impaired by alcohol' and 'Impaired by drugs'. It should be noted, however, that disclosure control is applied to data in line with the requirements of the Code of Practice for Official Statistics. Where this applies, data are merged or suppressed in published reports in order to ensure that the identity of individuals or any private information relating to them is not revealed. Separate analysis is now carried out for drugs and alcohol in blood samples taken from Road Traffic Collision fatalities and those suspected to be driving whilst unfit through drugs.	Work will continue to shorten existing timescales in forensic analysis to avoid undue delay. This analysis is potentially jeopardised by the budgetary constraints that will result in curtailment of drugs analysis where the excess alcohol offence is already proven. This will not apply to fatal or life-changing RTC investigations.
118. Improve public understanding about the road safety risks of excessive alcohol consumption on buses		In 2012-13, DOE engaged with stakeholders around the issue of alcohol consumption on buses. This culminated in a consultation which concluded that DOE should implement a multi-stranded approach designed to improve understanding of the risks, make providers more responsible and engage with other departments as part of the wider strategic approach to dealing with issues relating to alcohol. Since June 2014, it has been a licensing requirement that bus providers inform passengers about not drinking on buses. In Summer 2014, DOE began a wide ranging communication exercise aimed at informing bus operators and the public about the risks of excessive alcohol consumption on buses. The Tennents Vital event was used as a launch board of the communication plan. Appraisal of this exercise showed that whilst it made little impact on levels of consumption, people seemed to be better behaved.	Consideration of any further required actions is being progressed by DOJ, DOH and DOE.
119. Results of the Night-Time Economy module of the NI Crime Survey published.		Findings from the 2011/12 and 2012/13 NI Crime Surveys on alcohol and the night-time economy were published in October 2014.	

Supporting Outcomes – Workforce Development

Medium/Long Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
120. Development of a training framework, which ensures that skill development (an individual's development of competency as defined by the occupational standards), is evidenced to a quality standard that is recognised throughout the UK.		Commissioning Framework has prioritised the development of a range of courses. Regional programmes scheduled to be in place by 01 October 2015.	
121. Dissemination of DANOS.		**Completed:** DANOS has been updated on a 4-Nations basis.	
122. Improved competence and capacity of the alcohol and drug misuse, and wider, workforce.		This will continue to be monitored as appropriate	

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
123. Effectiveness of workforce development initiatives reviewed.		Workforce development services funded by the PHA are monitored on a quarterly basis to ensure courses are meeting identified needs.	
124. Informed by this review, workforce development initiatives are better co-ordinated, and front-facing workforce better equipped to provide early effective intervention.		Commissioning framework has prioritised the development of a range of courses. Regional programmes are now in place and reviewed on a quarterly basis.	
125. Improved awareness and opportunities for Criminal Justice Organisations to avail of training programmes.		All training courses are open to criminal justice organisations. The awareness of and opportunities for appropriate staff training programmes continues to be improved. Alcohol Screening and Brief Intervention Training for PBNI staff undertaken in June 2015.	An evaluation has been built into the initiative and is being undertaken by the PHA.
126. Organisations work together to share information and secure a greater understanding on the composition and impacts of legal highs (or any other new drug).		DAMIS provides an opportunity for organisations to share information about new and emerging drugs of concern. Training courses have been developed to inform services about the risks associated with such substances. Quarterly reports are produced for DAMIS stakeholder groups outlining the concerns that have been reported to DAMIS and measures that have been taken. DoJ continues to be a key contributor to DAMIS that ensures greater awareness of new psychoactive substances amongst key Criminal Justice staff.	
127. Dissemination of the Drugs and Alcohol National Occupational Standards (DANOS) for all sectors.		Completed: DANOS information is available to all services.	
128. Training in respect of Hepatitis C and other blood borne viruses for those working with Injecting Drug Users continues to be delivered.		Training is available in these areas.	
129. YJA ensures that service delivery staff have the skills and knowledge to deliver alcohol and drugs interventions at Tier 2.		Practitioners are appropriately trained to deliver Drug and Alcohol interventions / programmes. Programme manuals for YJA Practitioners and Workbooks for young people have been designed and provided across the YJA.	

		Awareness sessions on these programmes have been provided across the Youth Justice Services directorate. A range of individual and group work interventions and education programmes are delivered in Woodlands in addition to the YJA Drug and Alcohol Programme. YJA practitioners also avail of training provided by organisations such as ASCERT to keep their skills and knowledge base up to date.	
130. YJA ensures that medical staff within Woodlands Juvenile Justice Centre have access to updated information about new drugs and their effects in order to manage any presenting risk and to inform an ongoing treatment plan within custody.		Information and training is delivered on new psychoactive substances and their effects. Provision of this training to both existing and new staff ensures they have access to up to date information about new and emerging drugs and their effects. This allows treatment plans to be more relevant and effective Information from DAMIS on a range of drugs, legal and illegal and the related alerts/warnings is made available to all YJA practice staff. Woodlands open clinic also provides staff with the opportunity to access up to date information on a range of legal and illegal drugs / substances.	

Prescription Drug Misuse

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
131. Collate and disseminate information on the current level of prescribing and misuse.		Fact Sheet on Prescription Drug Information disseminated as appropriate. This will be updated over time.	
132. Consideration given to research calls in this area.		Limited funding means that no progress has been made in respect of identifying possible research areas. This will be reconsidered in future.	Need to consider further mechanisms to deliver research given pressure on finance and the need to ensure that the majority of resources are aimed at the front line.
133. Awareness raised among health professionals		DoH, with support from HSCB and PHA, held a workshop on prescription drug misuse in Spring 2014. This brought together commissioners and policy makers, highlighted the issue of PDM, and identified opportunities for further work in this area. DoH is leading on this area and PHA/HSCB will provide ongoing support for this action as required. A workshop with Northern area LCG members is currently in development. Further work in this area is on-going as needed and is outlined in the Prescribed Drug Misuse Action Plan.	
134. Workforce development on prescription drug misuse is a key element of the Alcohol and Drug Services Commissioning Framework.		The Public Health Agency commissioned a range of training courses in 2015, including half- and one-day courses specifically on prescription drug misuse running several times a year. Key messages will continue to be incorporated into existing training events by HSCB as appropriate e.g. NICPLD and NIMDTA training events and DOIC practice based learning events.	
135. Awareness Raising among the public and prescription drug misusers		Community Alcohol and Drugs Information Network Services (CADINS) were commissioned by the Public Health Agency. These services will support Drug and Alcohol Coordination Teams to address substance misuse including prescription drug misuse and are now in place from 01 July 2015. At a regional level, PHA alongside the 5 DACTs and their Connections Services (CADINS) will be working together to develop a NI-wide event/initiative focusing on Medicines Misuse which will be	

		developed and delivered in partnership with the HSCB. This will include the production of an information/awareness-raising booklet alongside a PR and social media plan. A regional seminar on Polydrug Misuse (which featured speakers/sessions on prescribed medication misuse) was held in September 2016 and was targeted at professionals working with those using/misusing prescribed meds informing their practice and encouraging discussion and debate.	
136. Schemes to support appropriate reductions in prescribing levels		HSCB continues to work to promote existing resources during prescribing visits and as described in *Raising awareness among professionals* above (133). Practices are encouraged to focus activity on the prescribing of drugs of misuse through prescribing LES, HSCB practice support pharmacists and as part of practices annual governance activity. Outlying GPs in terms of prescribing are identified via a 'Top 30 quarterly report' and 'Basket of Indicators' report for targeted visits. A letter has been sent from HSCB Head of Pharmacy and Medicines Management to these top 30 practices advising that their prescribing is significantly above the norm and that this will continue to be monitored. No additional funding is available for GPs at present to undertake additional work in this area. HSCB Benzodiazepine Resource Pack has been produced for practitioners. Further work in this area is ongoing as needed and is outlined in the Prescribed Drug Misuse Action plan. Currently there are a number of posts specifically funded by HSCB within the Mental Health POC. A number of posts are also funded by PHA. However, there is currently no consistency or equity across the region in terms of these posts/services. The commissioning of specialist Prescribed Drug Misuse Practitioners has been identified as a regional priority within the Public Health Agency / Health and Social Care Board Alcohol and Drugs Commissioning Framework Consultation document. To date however, no funding has been identified to secure additional posts in order to address the equity issue. Furthermore, the PHA and HSCB will need to assess the best model of provision across the region for addressing the issue and will need to have in place services which can address the needs of those misusing prescribed medication	

		obtained illegally as well as that obtained via general practice. A review of Tier 3 Addiction services is currently taking place to undertake a stocktake of current (wte) resources and to better understand the main functions being undertaken by the teams. However, it is not expected at this stage to look specifically at prescribed medication services. Other sources of funding for prescribed medication services such as LCGs etc should also be considered.	
137. Reduced OTC medication misuse		A joint letter from HSCB, DoH and Pharmaceutical Society to Community Pharmacists was issued in June 2015 outlining the issues and the professional position regarding this issue to community pharmacists and pharmacy staff.	
138. Continuation of seizures and operations to disrupt the illicit markets in prescription drug misuse, and internet purchases		Support for this issue to have a raised profile within PSNI, Home Office, Border Force, HMRC and other OCTF partners. Work continues to disrupt importation of drugs including prescription medication via the internet. At present, it is not illegal to import prescription medication for personal use unless it contravenes other legislation such as abortion medicines. Seizures of quantities of drugs, where it is believed there is an intention to supply, continue to be made. Ongoing involvement in Operation Pangea. This is a global enforcement campaign on illicit/counterfeit prescription or over-the-counter drugs. It targets the product as well as attempting to disrupt the supply chain by closing down websites.	
139. Alcohol and Drug Services Commissioning Framework should consider the consistency of approaches across NI.		A review of Tier 3 services provided by Statutory Addiction services is currently taking place.	
140. Harm reduction measures and messages available as appropriate.		Provision of clean needles for those who inject. Targeted harm reduction messages issued to those deemed at risk. Access to Substitute Prescribing where appropriate. Guidance in relation to harm reduction specifically around poly-drug	

		use has been issued by the PHA due to concerns raised through DAMIS.	
141. Substance Misuse Liaison Posts consider and support those with prescription drug misuse.		This area will be addressed when the Substance Misuse Liaison Networks are established in each HSCT.	

5. Conclusions

5.1. Progress continues to be made against the overall aims, objectives and key priorities set out NSD Phase 2. This builds on the work taken forward through the original NSD.

5.2. Progress has also been made in a range of indicators (as set out in Chapter 3), with many encouraging signs. However, there is still much work to be done and we will continue to report progress against these indicators on an annual basis.

5.3. There are 141 outcomes set out in the NSD Phase 2, to be taken forward by a range of Government Departments, agencies, the community and voluntary sector, and others.

5.4. In the fourth year, progress continues to be made on a number of these outcomes. 18 (12.8%) of the outcomes have been completed. Progress against 104 (74%) of these outcomes is classified having **green** status – i.e. progress is being made as expected and is on track for achievement. 18 (12.8%) of the outcomes are classified as having an **amber** status – progress is being made but there has been delay in completing these due to a number of issues. At this stage, 1 (less than 1%) outcome is identified as being **red** – not on track for achievement. We will continue to monitor achievement of these outcomes as we move forward, and report on an annual basis.

Annex A

Section 1 - Numbers Presenting to Treatment

Source: Census of Drug and Alcohol Treatment Services in NI 1 March 2005, 1 March 2007, 1 March 2010, 1 March 2012 and 1 September 2014

Background

A comprehensive range of statutory and non-statutory treatment services were approached to participate in a Census on five occasions (1 March 2005, 2007, 2010, 2012 & 2014) to establish the number of persons in treatment for drug and/or alcohol misuse. It should be noted that the figures reported from each census reflect the number of persons in treatment at these particular points in time. They cannot be used to derive the numbers in treatment over the course of a year.

The report of the findings of the 2014 census can be accessed on-line at:

https://www.health-ni.gov.uk/publications/census-drug-and-alcohol-treatment-services-northern-ireland-2014

Information on the 2014 census follows:

Summary

Alcohol-only Misuse

- In 2014, a total of 3,831 individuals were in treatment for alcohol-only misuse compared with 3,111 individuals in 2012, an increase of 23%.
- Almost three-fifths (59%) of those in treatment for alcohol-only misuse were male and two-fifths were female.
- The vast majority (92%) of individuals in treatment for alcohol-only misuse were aged 18 years and over.

Drug-only Misuse

- In 2014, 2,617 individuals were in treatment for drug-only misuse compared with 1,514 individuals in 2012, an increase of 73%.
- Two-thirds of those in treatment for drug-only misuse were male and one-third were female.
- A high proportion (87%) in treatment for drug-only misuse were aged 18 years and over.

Alcohol and Drug Misuse

- In 2014, 2,045 individuals were in treatment for both alcohol and drug misuse, compared with 1,291 individuals in 2012, an increase of 58%
- Two-thirds (67%) of those in treatment for both alcohol and drug misuse were male and one third were female.
- The vast majority (84%) of individuals in treatment for both alcohol and drug misuse were aged 18 years.

Alcohol and/or Drug Misuse

- In 2014, 8,553 individuals were in treatment for alcohol and/or drug misuse compared with 5,916 individuals in 2012.

- Around three-fifths (63%) of those in treatment for alcohol and/or drug misuse were male and 37% were female.

- Almost all individuals (90%) in treatment for alcohol and/or drug misuse were aged 18 years and over.

	1 March 2005		1 March 2007		1 March 2010		1 March 2012		1 Sept 2014	
	No.	%	No.	%	No.	%	No.	%	No.	%
All	**5,064**	**100**	**5,583**	***100***	**5,846**	***100***	**5,916**	***100***	**8,553**	***100***
Gender										
Male	3,292	65	3,686	66	4,244	73	4,066	69	5,377	63
Female	1,772	35	1,897	34	1,602	27	1,850	31	3,176	37
Age										
Under 18	271	5	847	15	644	11	398	7	862	10
18 or over	4,793	95	4,736	85	5,202	89	5,518	93	7,691	90
Type										
Drugs only	1,030	20	1,118	20	1,294	22	1,514	26	3,891	45
Alcohol only	3,074	61	3,476	62	3,328	57	3,111	53	2,617	31
Drugs and alcohol	960	19	989	18	1,224	21	1,291	22	2,045	24

Statistics from the NI Drug Misuse Database: 2005/06 – 2014/15

Background

The NI Drug Misuse Database (DMD) was established in April 2000 and holds information provided by statutory and non-statutory treatment services on people presenting with problem drug misuse. Client participation in the DMD is voluntary and they must give informed consent to their details being held on the database.

The annual statistical bulletins reporting on the 12-month period ending 31 March can be accessed at:
https://www.health-ni.gov.uk/publications/statistics-northern-ireland-drug-misuse-database-200102-201314

Summary

Drug Misuse

- In 2014/15, 2,262 individuals were presented to treatment services for drug misuse compared with 2,574 individuals in 2013/14, a decrease of 12%.

- In 2014/15, the majority of those presenting to treatment services for drug misuse were male (80%).

- Around one third of males (32%) presented for treatment in 2014/15 were aged between 18 and 25, compared with 23% of females.

Main Drug of Misuse

- Since 2005/06, the main drug of misuse for individuals presenting to treatment services for drug misuse was cannabis, followed by benzodiazepines.

Section 2 – Hospital Admissions

Source: Hospital Inpatient System (HIS), DOH

Background

HIS holds information on the number of emergency admissions to hospitals (as an inpatient) for alcohol and/or drug-related conditions. Data is presented for all alcohol related diagnoses in any position.

An emergency admission is a type of admission method that occurs when the admission is unpredictable and at short notice because of clinical need. An emergency admission can be via (1) A&E Departments, (2) GPs, after a request for immediate admission, (3) Bed Bureaux, (4) Consultant Outpatient Clinics, (5) Domiciliary Visits, or (6) other. Deaths and discharges are used as an approximation of admissions.

Summary

Alcohol-Only Emergency Admissions

- The number of emergency admissions to hospital for alcohol-only related conditions has risen year-on-year from 8,462 in 2008/09 to 11,420 in 2014/15. This represents a 35% increase. (Table A.1)

- In 2014/15, seven tenths (70%) of those admitted in an emergency were male and 30% were female. (Table A.1)

- In 2014/15, over half (52%) of those who were admitted for alcohol-only emergencies were aged between 45-64 years with 21% aged 65 and above, and 15% aged 35-44 years. (Table A.1)

Drug-Only Emergency Admissions

- In 2014/15 there were 3,270 emergency admissions to hospital for drug-only related conditions which was a 3% reduction on the 3,360 in 2013/14. (Table A.2)

- In 2014/15, 51% of those admitted in an emergency were female and 49% were male. (Table A.2)

- Over a fifth of those in the age categories of 18-24 year olds and 25-34 year olds (both 22%), and a fifth of 45-64 year olds (20%) were admitted for treatment. (Table A.2)

Alcohol and Drug Emergency Admissions

- The number of emergency admissions for alcohol and drug related conditions were 1,429 in 2014/15. This was similar to the 1,431 in previous years (Table A.3)

- In 2014/15, 58% of those admitted were male and 42% were female. (Table A.3)

- Around one third of those admitted (31%) in 2014/15 were aged 45-64 years, while 24% were aged 25-34 years and 22% were aged between 35-44 years (Table A.3)

Table A.1 Alcohol-only related admissions* to hospital (2008/09 – 2014/15)

	2008/09		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**8,462**	**100**	**8,603**	**100**	**8,652**	**100**	**9,393**	**100**	**10,274**	**100**	**10,486**	**100**	**11,420**	**100**
Gender														
Male	6,359	75	6,360	74	6,284	73	6,835	73	7,440	72	7,526	72	7,977	70
Female	2,103	25	2,243	26	2,369	27	2,559	27	2,834	28	2,960	28	3,443	30
Age														
Under 18	183	2	181	2	136	2	127	1	133	1	119	1	140	1
18-24	358	4	326	4	354	4	399	4	383	4	361	3	396	3
25-34	723	9	709	8	738	9	789	8	796	8	837	8	841	7
35-44	1,911	23	1,842	21	1,605	19	1,693	18	1,839	18	1,591	15	1,701	15
45-64	4,106	49	4,274	50	4,438	51	4,728	50	5,200	51	5,536	53	5,955	52
65+	1,181	14	1,271	15	1,381	16	1,657	18	1,923	19	2,042	19	2,387	21

* Deaths and discharges are used as an approximation of admissions. These figures should not be used to denote individuals as a person may be admitted to hospital more than once a year or across a number of years.

Codes used to identify alcohol-related admissions in any diagnostic position 2008/09**:

ICD-10 code	Description	ICD-10 code	Description
F10	Mental and behavioural disorders due to use of alcohol	K73	Chronic hepatitis, not elsewhere classified
G31.2	Degeneration of the nervous system due to alcohol	K74	Fibrosis and cirrhosis of liver (Excluding K74.3-K74.5 – Biliary cirrhosis)
G62.1	Alcoholic polyneuropathy	K86.0	Alcohol induced chronic pancreatitis
I42.6	Alcoholic cardiomyopathy	X45	Accidental poisoning by and exposure to alcohol
K29.2	Alcoholic gastritis	X65	Intentional self-poisoning by and exposure to alcohol
K70	Alcoholic liver disease	Y15	Poisoning by and exposure to alcohol, undetermined intent

Codes used to identify alcohol-related admissions in any diagnostic position 2009/10 onwards**:

ICD-10 code	Description	ICD-10 code	Description
F100	Acute intoxication	K703	Alcoholic cirrhosis of liver
F101	Harmful use	K704	Alcoholic hepatic failure
F102	Dependence syndrome	K709	Alcoholic liver disease, unspecified
F103	Withdrawal state	K730	Chronic persistent hepatitis, not elsewhere classified
F104	Withdrawal state with delirium	K731	Chronic lobular hepatitis, not elsewhere classified
F105	Psychotic disorder	K732	Chronic active hepatitis, not elsewhere classified
F106	Amnesic syndrome	K738	Other chronic hepatitis, not elsewhere classified
F107	Residual and late-onset psychotic disorder	K739	Chronic hepatitis, unspecified
F108	Other mental and behavioural disorders	K740	Hepatic fibrosis
F109	Unspecified mental and behavioural disorder	K741	Hepatic sclerosis
G312	Degeneration of nervous system due to alcohol	K742	Hepatic fibrosis and hepatic sclerosis
G621	Alcoholic polyneuropathy	K746	Other and unspecified cirrhosis of liver
I426	Alcohol cardiomyopathy	K860	Other diseases of pancreas
K292	Alcohol gastritis	X45	Accidental poisoning by and exposure to alcohol
K700	Alcoholic fatty liver	X65	Intentional self-poisoning by and exposure to alcohol
K701	Alcoholic hepatitis	Y15	Poisoning by and exposure to alcohol, undetermined intent
K702	Alcoholic fibrosis and sclerosis and sclerosis of liver		

** It is not appropriate to provide a breakdown of primary or secondary diagnoses for the admissions as it is unlikely that alcohol would be recorded as the main reason for admission; the code for alcohol would be recorded as a secondary diagnosis due to the fact that it is a contributing factor to the primary admission.

Table A.2 Drug-only related admissions* to hospital (2008/09 – 2014/15)

	2008/09		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**3,880**	**100**	**3,424**	**100**	**3,649**	**100**	**3,256**	**100**	**3,315**	**100**	**3,360**	**100**	**3,270**	**100**
Gender														
Male	1,712	44	1,601	47	1,745	48	1,560	48	1,668	50	1,656	49	1,659	51
Female	2,168	56	1,823	53	1,904	52	1,698	52	1,647	50	1,704	51	1,611	49
Age														
Under 18	523	13	487	14	517	14	458	14	423	13	495	15	498	15
18-24	737	19	717	21	817	22	688	21	716	22	709	21	711	22
25-34	791	20	682	20	807	22	685	21	707	21	763	23	705	22
35-44	842	22	710	21	633	17	610	19	596	18	556	17	531	16
45-64	823	21	686	20	705	19	671	21	694	21	675	20	659	20
65+	164	4	142	4	170	5	144	4	179	5	162	5	166	5

* Deaths and discharges are used as an approximation of admissions. These figures should not be used to denote individuals as a person may be admitted to hospital more than once a year or across a number of years.

Codes used to identify drug-related admissions in any diagnostic position 2008/09 onwards**:

ICD-10 code	Description
F11-F16, F19	Mental and behavioural disorders due to drug use (excluding tobacco and volatile solvents)
X40-X44	Accidental poisoning by drugs, medicaments and biological substances
X60-X64	Intentional self-poisoning by drugs, medicaments, and biological substances
X85	Assault by drugs, medicaments and biological substances
Y10-Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent

** It is not appropriate to provide a breakdown of primary or secondary diagnoses for the admissions as it is unlikely that drugs would be recorded as the main reason for admission; the code for drugs would be recorded as a secondary diagnosis due to the fact that it is a contributing factor to the primary admission.

Table A3 Alcohol and Drug related admissions* to hospital (2008/09 – 2014/15)

	2008/09		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**1,473**	**100**	**1,478**	**100**	**1,663**	**100**	**1,644**	**100**	**1,556**	**100**	**1,431**	**100**	**1,429**	**100**
Gender														
Male	823	56	835	56	980	59	917	56	867	56	813	57	824	58
Female	650	44	643	44	683	41	727	44	689	44	618	43	605	42
Age														
Under 18	66	4	81	5	79	5	59	4	56	4	51	4	56	4
18-24	263	18	297	20	299	18	319	19	260	17	278	19	249	17
25-34	307	21	278	19	410	25	377	23	340	22	307	21	345	24
35-44	389	26	418	28	425	26	392	24	411	26	336	23	310	22
45-64	436	30	380	26	426	26	479	29	460	30	435	30	448	31
65+	12	1	24	2	24	1	18	1	29	2	24	2	21	1

* Deaths and discharges are used as an approximation of admissions. These figures should not be used to denote individuals as a person may be admitted to hospital more than once a year or across a number of years.

Codes used to identify alcohol-related admissions in any diagnostic position 2008/09**:

ICD-10 code	Description	ICD-10 code	Description
F10	Mental and behavioural disorders due to use of alcohol	K86.0	Alcohol induced chronic pancreatitis
F11-F16, F19	Mental and behavioural disorders due to drug use (excluding tobacco and volatile solvents)	X40-X44	Accidental poisoning by drugs, medicaments and biological substances
G31.2	Degeneration of the nervous system due to alcohol	X45	Accidental poisoning by and exposure to alcohol
G62.1	Alcoholic polyneuropathy	X60-X64	Intentional self-poisoning by drugs, medicaments, and biological substances
I42.6	Alcoholic cardiomyopathy	X65	Intentional self-poisoning by and exposure to alcohol
K29.2	Alcoholic gastritis	X85	Assault by drugs, medicaments and biological substances
K70	Alcoholic liver disease	Y10-Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent
K73	Chronic hepatitis, not elsewhere classified	Y15	Poisoning by and exposure to alcohol, undetermined intent
K74	Fibrosis and cirrhosis of liver (Excluding K74.3-K74.5 – Biliary cirrhosis)		

Codes used to identify alcohol-related admissions in any diagnostic position 2009/10 onwards**:

ICD-10 code	Description	ICD-10 code	Description
F11	Mental and behavioural disorders due to use of opioids	K731	Chronic lobular hepatitis, not elsewhere classified
F12	Mental and behavioural disorders due to use of cannabinoids	K732	Chronic active hepatitis, not elsewhere classified
F13	Mental and behavioural disorders due to use of sedatives or hypnotics	K738	Other chronic hepatitis, not elsewhere classified
F14	Mental and behavioural disorders due to use of cocaine	K739	Chronic hepatitis, unspecified
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine	K740	Hepatic fibrosis
F16	Mental and behavioural disorders due to use of hallucinogens	K741	Hepatic sclerosis
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	K742	Hepatic fibrosis and hepatic sclerosis
F100	Acute intoxication	K746	Other and unspecified cirrhosis of liver
F101	Harmful use	K860	Other diseases of pancreas
F102	Dependence syndrome	X40	Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
F103	Withdrawal state	X41	Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified
F104	Withdrawal state with delirium	X42	Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
F105	Psychotic disorder	X43	Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system
F106	Amnesic syndrome	X44	Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
F107	Residual and late-onset psychotic disorder	X45	Accidental poisoning by and exposure to alcohol
F108	Other mental and behavioural disorders	X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
F109	Unspecified mental and behavioural disorder	X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic

			drugs, not elsewhere classified
G312	Degeneration of nervous system due to alcohol	X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
G621	Alcoholic polyneuropathy	X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
I426	Alcohol cardiomyopathy	X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
K292	Alcohol gastritis	X65	Intentional self-poisoning by and exposure to alcohol
K700	Alcoholic fatty liver	X85	Assault by drugs, medicaments and biological substances
K701	Alcoholic hepatitis	Y10	Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent
K702	Alcoholic fibrosis and sclerosis and sclerosis of liver	Y11	Poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent
K703	Alcoholic cirrhosis of liver	Y12	Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent
K704	Alcoholic hepatic failure	Y13	Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent
K709	Alcoholic liver disease, unspecified	Y14	Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent
K730	Chronic persistent hepatitis, not elsewhere classified	Y15	Poisoning by and exposure to alcohol, undetermined intent

** It is not appropriate to provide a breakdown of primary or secondary diagnoses for the admissions as it is unlikely that alcohol or drugs would be recorded as the main reason for admission; the code for alcohol or drugs would be recorded as a secondary diagnosis due to the fact that it is a contributing factor to the primary admission.

Section 3 - Alcohol/Drug-related Deaths

Source: Demography and Methodology Branch (DMB), NISRA

Background

DMB supports government and the wider society by improving the official demographic and geographic statistics base for the region through the provision of reliable, fit for purpose statistics and research tools. With regard to death statistics, the figures have been compiled from returns to local registrars. The results are based on analysis of all alcohol and drug-related deaths registered within each calendar year according to the National Statistics Definition.

Summary

Alcohol-related Deaths

- In 2014, there were 238 alcohol-related deaths which was similar to the 236 deaths in 2013. (Table B.1)
- In 2014, over two-thirds (69%) of alcohol-related deaths were among males. (Table B.1)
- Since 2008, there have been 1,839 alcohol-related deaths recorded. In 2014, almost two-thirds (64%) of those who died were aged between 45 and 64. (Table B.1)
- In each of the years from 2005 to 2014, the most common underlying cause of death among all alcohol-related deaths was 'Alcoholic liver disease'. In 2014, this was 63%.

Drug-related Deaths

- In 2014, there were 110 drug-related deaths which compares with the 115 deaths in 2013. (Table B.2)
- Approximately two-thirds (65%) of drug-related deaths were among males in 2014. (Table B.2)
- The highest proportion of drug-related deaths in 2014 belonged to the 35-44 age category. (Table B.2)
- From 2009 to 2014, the most common underlying cause of death among all drug-related deaths was 'Poisoning by drugs, medicaments and biological substances, undetermined intent'. This accounted for 57% of deaths in 2014.

Deaths due to Drug Misuse

- In 2014, 80% of drug-related deaths were due to drug misuse which was identical to the proportion in 2012 (Table B.3)
- In 2014, two-thirds (66%) of deaths due to drug misuse were among males which compares with the 68% in 2013. (Table B.3)
- The largest proportion of deaths due to drug misuse in 2014 was among 25-44 years (28%) (Table B.3).
- In 2014, the most common cause of death for drug misuse was poisoning by drugs, medicaments and biological substances, undetermined intent. This accounted for 57% of deaths by drug misuse.

Other Source: National Programme on Substance Abuse Deaths (Np-SAD)
'Drug-related deaths in the UK: Annual report 2009'

Background

Information on drug-related deaths is also available from the National Programme on Substance Abuse Deaths (np-SAD) which is managed within the overall structure of the International Centre for Drug Policy (ICDP) within the Division of Mental Health, St George's University of London. It should be noted that the np-SAD case definition differs from the National Statistics definition – this will therefore account for the variations in numbers of drug-related deaths presented from the two sources.

Alcohol-related Deaths

Definition

The National Statistics definition of alcohol-related deaths only includes those regarded as being directly due to alcohol consumption and are coded according to the International Classification of Diseases, Tenth Revision (ICD-10) for 2001 onwards. The definition does not include other diseases where alcohol has been shown to make some contribution to increased risk. Apart from deaths due to poisoning with alcohol (accidental, intentional or undetermined), the definition excludes any other external causes of deaths such as road traffic deaths and other accidents and violence.

ICD-10 code	Description
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of the nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K73	Chronic hepatitis, not elsewhere classified
K74	Fibrosis and cirrhosis of liver (Excluding K74.3-K74.5 – Biliary cirrhosis)
K86.0	Alcohol induced chronic pancreatitis
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent

Table B.1 Alcohol-related deaths (2008 - 2014) according to National Statistics Definition

	2008		2009		2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**276**	**100**	**283**	**100**	**284**	**100**	**252**	**100**	**270**	**100**	**236**	**100**	**238**	**100**
Gender														
Male	185	67	187	66	191	67	177	70	178	66	172	73	164	69
Female	91	33	96	34	93	33	75	30	92	34	64	27	74	31
Age														
Under 25	0	0	0	0	0	0	0	0	1	0	0	0	4	2
25-34	6	2	9	3	12	4	6	2	5	2	7	3	28	12
35-44	34	12	44	16	33	12	52	21	52	19	26	11	76	32
45-54	102	37	98	35	104	37	76	30	82	30	82	35	77	32
55-64	75	27	80	28	80	28	69	27	81	30	71	30	37	16
65 and over	59	21	52	19	55	19	49	19	49	18	50	21	16	7

Percentages in the above table may not sum to 100 due to rounding.

Drug-related Deaths

Definition

The National Statistics definition of drug-related deaths only includes those where the underlying cause of death is regarded as resulting from drug-related poisoning and are coded according to the International Classification of Diseases, Tenth Revision (ICD-10) for 2001 onwards. The definition includes accidents and suicides involving drug poisoning, as well as poisonings due to drug abuse and drug dependence, but not other adverse effects of drugs. The range of substances includes legal and illegal drugs, prescription drugs and over-the-counter medications. The definition excludes poisoning with non-medicinal substances such as household, agricultural or industrial chemicals.

ICD-10 code	Description
F11-F16, F18-F19	Mental and behavioural disorders due to drug use (excluding tobacco)
X40-X44	Accidental poisoning by drugs, medicaments and biological substances
X60-X64	Intentional self-poisoning by drugs, medicaments, and biological substances
X85	Assault by drugs, medicaments and biological substances
Y10-Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent

Table B.2 Drug-related deaths (2008 - 2014) according to National Statistics Definition

	2008		2009		2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**89**	**100**	**84**	**100**	**92**	**100**	**102**	**100**	**110**	**100**	**115**	**100**	**110**	**100**
Gender														
Male	60	67	48	57	66	72	65	64	76	69	71	62	71	65
Female	29	33	36	43	26	28	37	36	34	31	44	38	39	35
Age														
Under 25	8	9	10	12	15	16	18	18	13	12	11	10	18	16
25-34	22	25	13	15	25	27	33	32	30	27	21	18	29	26
35-44	26	29	31	37	19	21	21	21	29	26	41	36	30	27
45-54	15	17	19	23	20	22	18	18	22	20	25	22	17	15
55-64	12	13	7	8	4	4	10	10	12	11	13	11	11	10
65 and over	6	7	4	5	9	10	2	2	4	4	4	3	5	5

Percentages in the above table may not sum to 100 due to rounding.

Table B.3 Deaths due to drug misuse (2008 – 2014) according to National Statistics Definition

	2008		2009		2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**53**	**100**	**46**	**100**	**63**	**100**	**58**	**100**	**75**	**100**	**79**	**100**	**88**	**100**
Gender														
Male	41	77	30	65	50	79	40	69	57	76	54	68	58	66
Female	12	23	16	35	13	21	18	31	18	24	25	32	30	34
Age														
Under 25	3	6	6	13	12	19	11	19	9	12	4	5	14	16
25-34	17	32	9	20	19	30	17	29	20	27	16	20	25	28
35-44	16	30	20	43	12	19	12	21	23	31	31	39	25	28
45-54	7	13	8	17	12	19	7	12	15	20	19	24	14	16
55-64	6	11	2	4	4	6	9	16	6	8	8	10	8	9
65 and over	4	8	1	2	4	6	2	3	2	3	1	1	2	2

Percentages in the above table may not sum to 100 due to rounding.

Section 4 – Alcohol/Drug Prevalence

4. 1 Alcohol Prevalence among Adults (18-75 years)

Source: Adult Drinking Patterns Survey (2005, 2008, 2011 & 2013)

Background

The Adult Drinking Patterns survey was carried out in 2005, 2008, 2011 and 2013 by the Central Survey Unit (CSU) of NISRA on behalf of DOH.

Further information on alcohol can be accessed on-line at:

https://www.health-ni.gov.uk/articles/adult-drinking-patterns-survey

Summary

Consumption

- In 2013, almost three quarters of survey respondents drank alcohol (73%).
- In 2013, a higher proportion of males than females stated that they drank alcohol (76% compared with 70%).
- Younger adults (18-29 years) were more likely to drink alcohol than older adults (60-75 years) in all years (82% and 58% respectively).

Recommended Daily Limits

Definition: The current recommended daily drinking limits state that drinking 4 or more units of alcohol a day for males and 3 or more units a day for females increases alcohol related health risks.

- Around four fifths of respondents who had consumed alcohol in the week prior to the survey exceeded the recommended daily limit (65% in 2013).
- In 2013, approximately four fifths of both males (71%) and females (58%) exceeded the recommended daily drinking limits in the week prior to the survey.

Hazardous Drinking

Definition: Levels of alcohol consumption can be banded into weekly guidelines for sensible drinking. On a weekly basis, males drinking 21 units or less are considered to be within sensible limits, those drinking between 22 and 50 are considered to be above sensible but below dangerous levels and those drinking 51 units and above are drinking at dangerous levels. For females, within sensible limits is 14 units per week, above sensible but below dangerous levels is between 15 and 35 units and dangerous levels are 36 units and above.

- Of those who consumed alcohol in the week prior to the survey, just over three quarters (77%) of respondents in 2013 consumed alcohol within sensible limits. The proportion of respondents who consumed alcohol at above sensible but below dangerous weekly was 19%.
- In all years, a higher proportion of females than males stayed within their respective sensible weekly limits (81% of females compared with 74% of males in 2013).
- The highest proportion of females that drank at dangerous levels occurred among 18-29 year olds (5%) whereas for males it occurred among 45-59 year olds (7%).

Problem Drinking

- CAGE question analysis (clinical interview questions) indicated that approximately one tenth of those surveyed in 2013 (11%) had a problem with alcohol.

- Males were more likely than females to have a problem with alcohol. In 2013, this represented 13% of males and 11% of females.

4.2 Binge Drinking

A binge is defined as consuming 10 or more units of alcohol in one session for males and 7 or more units of alcohol for females.

- In 2013, 31% of respondents engaged in at least one binge drinking session during the week prior to the survey.

- A higher proportion of males (35%) than females (27%) were classified as binge drinkers in the 2013 survey.

- Younger adults (18-29 year olds) (50%) were more likely to binge drink than older adults (60-75 year olds) (11%).

Other Source: Continuous Household Survey (CHS) - Alcohol module (2004/05, 2006/07, 2008/09, 2009/10 & 2010/11)

Information on alcohol consumption among adults aged 18 years and over is also available from the CHS and results can be accessed online at the following address: www.csu.nisra.gov.uk

4.3 Alcohol Prevalence among Young People (11-16 years)

Source: Young Persons' Behaviour and Attitudes Survey (2003, 2007, 2010 and 2013)

Background

The Young Persons' Behaviour and Attitudes Survey (YPBAS) is a post-primary school-based survey conducted by the Central Survey Unit (CSU) of NISRA on behalf of a consortium of government departments and public bodies. The secondary analysis of the alcohol and drugs modules of the 2003 & 2007 surveys can be accessed on-line at the following address: http://www.csu.nisra.gov.uk/survey.asp96.htm

Summary

Lifetime Prevalence

- The proportion of respondents aged 11-16 who said that they had ever taken an alcoholic drink was 38% in 2013.

- Since 2003, lifetime prevalence of alcohol significantly decreased for both males (from 61% in 2003 to 44% in 2013) and females (from 59% in 2003 to 32% in 2013).

- The likelihood of ever having taken an alcoholic drink was found to increase with age.

*Last Week Prevalence**

- In 2013, 7% of all pupils had drunk alcohol in the week prior to the survey, compared with almost one fifth (19%) in 2007.

- In 2013, 8% of males and 7% of females had drunk alcohol in the week before the survey, compared with 18% of males and 20% of females in 2007.

- Between 2007 and 2013, older pupils were more likely to have drunk alcohol during the week prior to the survey than younger pupils.

*No comparable information is available from the 2003 YPBAS

Drunkenness

- Of those who had ever drunk alcohol, almost two-fifths of respondents (38%) reported to having been drunk on at least one occasion.

- In 2013, similar proportions of males and females reported to have been drunk on at least one occasion (35.8% of females and 39.1% of males).

- Older pupils were more likely to report ever having been drunk than younger pupils in all four timeframes.

4.4 Drug Prevalence among Adults (15-64 years)

Source: All Ireland Drug Prevalence Survey (2002/03, 2006/07 & 2010/11)

Background

The survey was carried out by the Central Survey Unit (CSU) of NISRA according to standards set by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Results relating to drug prevalence are presented on a lifetime, last year (recent), and last month (current) basis in Bulletin 1. More detailed information on the survey and all of the bulletins produced can be accessed online at the following address: https://www.health-ni.gov.uk/articles/drug-prevalence-survey.

Summary

Lifetime Prevalence

- Lifetime use of any illegal drugs among all adults aged 15-64 years was similar in 2010/11 (27.3%) and 2014/15 (27.7%).

- Proportions were also similar for males and females during this period. This was 32.3% of males in 2010/11 compared with 35.1% of males in 2014/15. The proportions for females were also similar at 22.4% in 2010/11 and 20.4% in 2014/15.

- Lifetime use of any illegal drugs among young adults aged 15-34 years was lower in 2010/11 (36.9%) than 2010/11 (34.0%).

Last Year Prevalence

- Last year use of any illegal drugs among all adults was similar at 6.6% in 2010/11 and 5.9% in 2014/15.

- Last year use of any illegal drugs among males was similar at 9.2% in 2010/11 and 8.9% in 2014/15. This was also true for females at 3.9% in 2010/11 and 3.1% in 2014/15.

- Last year use of any illegal drugs among young adults aged 15-34 years was similar at 11.8% in 2010/11 and 10.8% in 2014/15. For older adults aged 35-64 years, last year use of any illegal drugs was also similar at 2.7% in 2010/01 and 2.6% in 2014/15.

Last Month Prevalence

- There was no significant difference in last month use of any illegal drugs among all adults aged 15-64 years between 2010/11 and 2014/15 (3.3% in 2010/11 and 2.9% in 2014/15).

- Last month use of any illegal drugs among females was identical at 1.6% in both 2010/11 and 2014/15. This was also true for males at 5.1% and 4.2% respectively.

4.5 Problem Prevalence

Source: Estimating the Prevalence of Problem Opiate and Problem Cocaine Use (2006) – No update available

Background

This research was commissioned by DOH and used the capture-recapture method, an established method for estimating the size of covert populations. The report provides prevalence estimates for problem drug use (defined as use of opiates and/or cocaine) in 2004 and can be accessed online at the following address: https://www.health-ni.gov.uk/articles/drug-prevalence-survey. At this point in time, there are no plans to repeat this research.

Summary

- In 2004, it was estimated that there were 1,395 problem opiate users (1.28 per thousand of the population aged 15-64 years).

- The number of problem opiate and/or cocaine users in 2004 was estimated to be 3,303, which corresponds to 3.03 per thousand of the population.

4.6 Drug Prevalence among Young People (11-16 years)

Source: Young Persons' Behaviour and Attitudes Survey (2003, 2007, 2010 and 2013)

Prevalence rates of illegal drug use for age 11-16

	Lifetime (%)	Last year (%)	Last month (%)
Any illegal drug	10.5	6.5	3.7
Cannabis	4.8	3.4	2.0
Solvents	4.6	2.5	1.2
Legal highs	1.9	1.1	0.6
Cocaine	1.1	0.6	0.4
Ecstasy	1.1	0.6	0.2
Speed	1.0	0.8	0.4
Tranquillisers	1.0	0.6	0.3
Poppers	1.0	0.4	0.2
LSD	0.9	0.6	0.3
Anabolic steroids	0.8	0.4	0.2
Mephedrone	0.7	0.6	0.4
Magic Mushrooms	0.7	0.4	0.2
Heroin	0.6	0.4	0.2
Crack	0.6	0.3	0.2

Summary

Lifetime Prevalence

- Among all respondents, lifetime use of any drugs or solvents decreased from 19% in 2007 to 15% in 2010 and 10% in 2013.

- Lifetime use of any drugs or solvents decreased among male pupils from 19% in 2007 to 17% in 2010 and 13% in 2013, with lifetime prevalence among female pupils also decreasing from 19% in 2007 to 13% in 2010 and 7% in 2013.

- Generally older pupils were more likely to report ever using drugs or solvents than younger pupils.

- Lifetime use of cannabis decreased from 9% in 2007 to 7% in 2010 and 5% in 2013. In relation to solvents, the proportions were similar in 2007 and 2010 at 8% and 7% respectively but were significantly lower at 5% in 2013.

- Among males, lifetime use of cannabis was the same in 2007 and 2010 at 10% but was 7% in 2013. Lifetime use of speed among males was 2% in 2007, 2010 and 2013.

- Among females, lifetime use of cannabis decreased from 8% in 2007 to 5% in 2010 and 3% in 2013.

- Lifetime prevalence for solvents was 4% for females in 2013.

Last Year Prevalence

- Among all respondents, last year use of any drugs or solvents decreased from 13% in 2007 to 11% in 2010 and to 8% in 2013.

- Last year use of any drugs or solvents for male pupils decreased from 13% in 2010 to 9% in 2013. In relation to female pupils the proportion decreased from 9% in 2010 to 4% in 2013.

- In general, older pupils were more likely to report using any drugs or solvents in the last year than younger pupils.

- For all pupils, use of solvents was 4% in both 2007 and 2010 and 2% in 2013.

- Last year use of cannabis halved between 2010 and 2013 at 6% and 3% respectively.

- Among males, the proportion of pupils who used cannabis was 7% in both 2007 and 2010, reducing to 5% in 2013.

- Among females, last year use of cannabis decreased from 6% in 2007 to 4% in 2010 and 2% in 2013.

Last Month Prevalence

- Among all respondents, last month use of any drugs or solvents was 7% in both 2007 and 2010 and 4% in 2013.

- Last month use of any drugs or solvents for males was 8% in 2007 and 2010 and 5% in 2013. The corresponding figures for females were 7%, 6% and 2% respectively.

- Pupils in Year 12 were more likely to use drugs than pupils in Year 8.

- Last month use of cannabis continues to decrease – 4% in 2007, 3% in 2010 and 2% in 2013.

- The proportion of males who had used cannabis was 4% in both 2007 and 2010 and 3% in 2013.

- Among females, last month use of cannabis was 3% in 2007, 2% in 2010 and 1% in 2013.

Section 5 - Blood Borne Viruses among Injecting Drug Users

5.1 Viral Infections

Source: Unlinked Anonymous Prevalence Monitoring Programme - Survey of Injecting Drug Users (IDUs) (No Update available);
Shooting Up - Infections among injecting drug users in the UK 2011

Background

Injecting drug users (IDUs) are vulnerable to a wide range of infections, including blood borne viruses such as HIV, Hepatitis B and Hepatitis C. The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) survey of injecting drug users monitors HIV, Hepatitis B and Hepatitis C infection levels in those injectors in contact with specialist services such as needle exchanges, or on treatment programmes such as methadone maintenance. It is a voluntary survey where those injectors who agree to participate provide an anonymous saliva sample and complete a brief behavioural questionnaire. The following information summarises data presented in the 'Shooting Up' report produced by the Health Protection Agency on the extent and trends over time of Hepatitis B and C infections among IDUs up to the end of 2008. Figures on new diagnoses of HIV infection are not reported at regional level. Further information about the UAPMP can be found on the Health Protection Agency (since 1 April 2013, HPA is part of Public Health England) website: http://www.hpa.org.uk

Summary

- The sharing of needles and syringes is a key route by which blood borne infections may be transmitted among IDUs and approximately one-fifth of IDUs continue to share. Combining data for the years 2007 and 2008, 19% (17 of 89) of IDUs participating in the UAPMP survey who had injected in the four weeks prior to the survey, reported sharing needles and syringes during this time. This compares with 21% (18 of 84) when the data for the years 2006 and 2007 was combined and 21% (19 of 90) for 2005 and 2006 combined.

Hepatitis C

- Since the introduction of diagnostic tests in 1990, laboratories have reported a total of 2,156 diagnoses of Hepatitis C up to and including the year 2015.

- In 2015, there were 143 new diagnoses of Hepatitis C reported, compared with 134 in 2014.

- Of the current and former IDUs participating in the UAPMP survey, Hepatitis C prevalence for the years 2007 and 2008 combined was 31% (97 of 317). The corresponding prevalence rate for 2005 and 2006 data combined was 29% (90 of 312) and 29% (95 of 329) for 2006 and 2007 data combined.

- Among current IDUs participating in the UAPMP survey, Hepatitis C prevalence for the years 2005 and 2006 combined was 25% (23 of 92 samples). Hepatitis C prevalence among current IDUs for subsequent years is no longer reported at regional level.

- Less than one in ten (7.6%, 23 of 302) survey participants in 2007/08 reported not having been tested for Hepatitis C and almost one third (31.8%, 27 of 85) of IDUs infected with Hepatitis C were unaware of their infection. This compares to 9%, (27 of 307) of participating IDUs in 2006/07 who reported not having been tested for Hepatitis C and just over one quarter (23 of 83) of those infected were unaware of their infection. Similarly in 2005/06, 9% of survey participants (25 of 292) reported not having been tested and just over one quarter (29%, 23 of 80) of IDUs infected with Hepatitis C were unaware of their infection.

Hepatitis B

- The total number of reports of both acute and chronic Hepatitis B was 91 in 2015, compared with 127 in 2014.

- Of the current and former IDUs participating in the UAPMP survey, Hepatitis B prevalence for the years 2007 and 2008 combined was 5.7% (18 of 316 samples). This compares to 8% (25 of 312 samples) for the years 2005 and 2006 combined and 6% (21 of 329 samples) for 2006 and 2007 combined.

HIV

- Of the current and former IDUs participating in the UAPMP survey, HIV prevalence for the years 2007 and 2008 combined was 2.2% (7 of 317 samples). This compares to 1.9% (6 of 312 samples) for the years 2005 and 2006 combined and 1.8% (6 of 329 samples) for 2006 and 2007 combined.

- The number of people living with HIV has increased to 809 in 2014, compared with 738 in 2013, an increase of nearly 10%.

5.2 Viral Testing and Vaccination

Source: Statistics from the NI Drug Misuse Database: 1 April 2005 - 31 March 2006; 1 April 2006 - 31 March 2007; 1 April 2007 - 31 March 2008; 1 April 2008 - 31 March 2009; 1 April 2009 - 31 March 2010; 1 April 2010 - 31 March 2011; 1 April 2011 - 31 March 2012; 1 April 2012 – 31 March 2013, 1 April 2013 – 31 March 2014, 1 April 2014 – 31 March 2015

Background

In addition to drugs misused, the Drug Misuse Database (DMD) also collects information on injecting behaviour and virus testing. However, this data from the DMD has been supplemented by the introduction of the study of anonymous testing of IDUs in contributing agencies, which has been outlined in ***Section 5.1***. This study should provide robust data on levels of infection in the injecting drug-using population.

Summary

- From 2005/06 to 2014/15, approximately nine-in-ten individuals who had presented to treatment services had never been tested for HIV, Hepatitis B or C.
- Over nine-in-ten individuals presenting for treatment since 2005/06 had not had any injections of the Hepatitis B vaccination course. Less than one-in-twenty had completed all 3 injections.

5.3 Needle and Syringe Exchange Scheme

Source: Statistics from the NI Needle and Syringe Exchange Scheme: 1 April 2005 – 31 March 2006; 1 April 2006 – 31 March 2007; 1 April 2007 – 31 March 2008; 1 April 2008 - 31 March 2009; 1 April 2009 - 31 March 2010

Background

Needle and Syringe Exchange Schemes (NSES) are a service for injecting drug users (IDUs), targeted as a harm reduction measure to help limit the spread of blood borne viruses such as Hepatitis B and C and HIV. The NSES began operation in pharmacies from April 2001 and data are currently collected by the Health and Social Care Board.

Summary

- During 20014/15, there were 26,713 visits to participating pharmacies by users of the scheme. This is an increase of 17% (3971 visits) on the 2013/14 figure (22,742). The corresponding number of visits for the years 2010/11, 2011/12 and 2012/13 were 17,712, 20,204 and 21,220 respectively.

- Since 2005/06, over four fifths of visits to participating pharmacies were made by males.

- Around half of all visits were made by clients aged 31 and over in each of the years since 2005/06. Please note that this proportion is worked out on those that have an age field completed. Since 2010/11, less than 1% of the total visits have not completed the age field.

Section 6 – Personal Expenditure on Alcohol

Source: Expenditure and Food Survey (EFS) (2006 and 2007) (Re-named Living Costs and Food Survey – Information on expenditure on alcohol no longer available separately)

Background

The EFS is a continuous survey which collects information on household expenditure, income and food consumption. In addition to each participating household completing a questionnaire on the above topics, each person aged 16 and over in that household is asked to maintain a detailed diary for 14 consecutive days following the interview, recording full details of all expenditure (including expenditure on alcohol) during that period. The information recorded in this diary is used to calculate weekly personal expenditure.

Summary

- Over half of survey respondents aged 18 years and over in both 2006 (54%) and 2007 (51%) did not have any weekly expenditure on alcohol (Table C.1). Almost all respondents under the age of 18 (99% in 2006 and 98% in 2007) did not spend any money on alcohol in a typical week (Table C.2).

- Over one third of all respondents aged 18 years and over spent between £0.01 and £20.00 on alcohol per week in both 2006 (34%) and 2007 (37%) (Table C.1).

- Excluding those who spent £0 a week on alcohol, the average personal weekly expenditure for all respondents aged 16 and over was £15.10 in 2006 and £15.60 in 2007 (Table C.3).

- On average, males spent more money per week on alcohol than females in both 2006 (£18.20 compared with £11.80) and 2007 (£18.00 compared with £13.00) (Table C.3).

- Of those who spent more than £0 per week on alcohol, the average weekly personal expenditure on alcohol was highest among those aged 18-24 years in both 2006 (£18.80) and 2007 (£20.80) (Table C.3).

Table C.1 Weekly expenditure on alcohol by all persons aged 18 years and over (2006 and 2007)

All persons aged 18 years and over *Base = 100%*	**Year**	
	2006	**2007**
£0.00	54	51
£0.01 - £10.00	24	22
£10.01 - £20.00	10	14
£20.01 - £30.00	6	5
£30.01 - £40.00	2	3
£40.01 - £50.00	1	1
£50.01 and over	2	2
n =	**1126**	**1125**

Table C.2 Weekly expenditure on alcohol by all persons under 18 years of age (2006 and 2007)

All persons under 18 years of age Base = 100%	Year	
	2006	**2007**
£0.00	99	98
£0.01 - £10.00	0	1
£10.01 - £20.00	0	1
£20.01 - £30.00	0	0
£30.01 - £40.00	0	0
£40.01 - £50.00	0	0
£50.01 and over	0	0
n =	**409**	**439**

Table C.3 Average weekly expenditure on alcohol by all persons aged 16 years and over who spent more than £0 on alcohol (2006 and 2007)

	Year					
	2006			**2007**		
	Male	***Female***	***Total***	***Male***	***Female***	***Total***
Under 18 years	£10.10	£0.0	£10.10	£12.80	£6.30	£8.30
18 – 24 years	£22.80	£16.10	£18.80	£22.90	£18.00	£20.80
24 – 44 years	£18.00	£11.30	£14.80	£15.90	£12.30	£14.10
45 – 64 years	£19.00	£9.70	£14.50	£20.30	£13.80	£17.00
65 years and over	£13.50	£10.50	£12.40	£10.90	£7.80	£9.30
Total	**£18.20**	**£11.80**	**£15.10**	**£18.00**	**£13.00**	**£15.60**

Section 7 – Alcohol / Drug-related Crime

Source: NI Policing Board (NIPB) and the Police Service of Northern Ireland (PSNI)

Summary

The relationship between the consumption of alcohol, drugs and crime is well established. It has been suggested that the consumption of alcohol and the use of illicit drugs is a contributing factor in a large percentage of all crime. The misuse of both drugs and alcohol are of increasing concern to the police and public alike.

An analysis of persons arrested and brought to Police Custody suites revealed that 46% of those arrested declared that they had consumed alcohol recently before arrest. This rose to 77% for persons arrested between 22:00 and 06:00 on Fri/Sat, Sat/Sun and Sun/Mon. In over half of the arrests for assault-related offences, alcohol had been consumed prior to arrest.

Police operations have continued over recent years to focus on prevention and enforcement. South Belfast contains the majority of the night time economy and the last few years have seen a number of enforcement and new initiatives designed to ensure compliance with licensing laws and improvements to customer safety. The PSNI continue to work on initiatives at local level such as 'Vulnerability Awareness Training' for workers in the NTE and a working group has been formed to better coordinate PSNI responses to alcohol and harm.

The existence of data sharing arrangements between the PSNI and two of Belfast's Emergency Departments has helped the PSNI to further understand the size of the alcohol / crime link.

Enforcement operations continue to be conducted as appropriate. These have included operations to ensure compliance with licensing conditions such as licencing hours and the testing of 'drink promotions' in support of the Responsible Retail Code.

7. 1 Recorded Crime

Source: PSNI –Statistics Branch

'PSNI Annual Statistical Report: Recorded Crime and Crime Outcomes '

Background

PSNI collate crime statistics in accordance with the National Crime Recording Standard. Copies of the reports produced can be accessed online at the following address: https://www.psni.police.uk/inside-psni/Statistics/

Drug Offences

- From 2006/07 to 2013/14, the total number of drug offences recorded year-on-year has increased (2,413 in 2006/07, 2,721 in 2007/08, 2,974 in 2008/09, 3,146 in 2009/10, 3,485 in 2010/11, 3,780 in 2011/12, 4,378 in 2012/13, 4,732 in 2013/14) In 2014/15, the number had reduced to 4,048.

- Since 2006/07, approximately four fifths of drug offences recorded were non-trafficking offences (80% in 2006/07, 81% in 2007/08, 80% in 2008/09, 79% in 2009/10, 78% in 2010/11, 78% in 2011/12, 80% in 2012/13, 80% in 2013/14 and 83% in 2014/15).

Crimes where alcohol is a contributing factor

During 2012/13, PSNI established a baseline relating to those crimes where alcohol was a contributory factor. This identified that alcohol was a contributory factor in 20 per cent of all crimes recorded, while for offences of violence against the person, alcohol was a contributory factor in 47 per cent of crimes of this nature. Figures for 2014/15 indicate that alcohol is contributory factor in 19 per cent of all crimes recorded, slightly less than the 20 per cent identified in 2013/14. For offences of violence against the person, the proportion in which alcohol was a contributory factor has fallen from 45 per cent in 2013/14 to 43 per cent in 2014/15.

Section 8 – Drink/Drug Driving

8.1 Detections in NI

Source: PSNI Roads Policing Development Branch

Background

Statistics on drink/drug-driving detections are collated by the PSNI Roads Policing Development Branch who receive the figures from District Command Units and the Urban and Rural Road Policing Command Units. The numbers of drink/drug driving detections are held on the Drink/Drive Register which is usually retained in each PSNI Enquiry Office and contains details of returns submitted by various ranks of the PSNI and Administrative Support Staff.

PSNI advised that drug-driving detection statistics are no longer available. They have revised previous figures to give drink-driving detections statistics only. Only aggregated information on the number of drink-driving detections is available at NI level and cannot be broken down by gender and/or age.

Summary

- Between 2008 to 2015, the number of drink-driving detections in decreased from 4,017 to 2,733; a decrease of 32% over this period (Table D.1)

At present, current recording and monitoring systems within the PSNI do not permit the calculation of the number of those who tested positive for alcohol/drugs as a proportion of those who were stopped and tested for drink/drug-driving. However, it is proposed that new technology will be introduced in the future which will automatically record the number of individuals tested for drink/drug-driving and the number of those who tested positive for alcohol/drugs.

8.2 Prosecutions and Convictions in NI

Source: Analytical Services Group, Department of Justice (DoJ)

Background

The figures that DoJ use in relation to court convictions are based on extracts from the Criminal Record Viewer (CRV). The CRV is held in Causeway and originated in PSNI, using data from the Courts and Tribunals Service. Causeway is an interconnected information system launched as a joint undertaking by the Criminal Justice Organisations.

Separate drink-driving and drug-driving prosecution and conviction statistics are not available. The offence referred to in the subsequent tables is one for which the court took its final decision. This is not necessarily the same as that for which the defendant was initially proceeded against. The decision recorded is that reached by the court and takes no account of any subsequent appeal to a higher court. If a number of defendants are jointly charged with a particular offence, each is recorded, as are any charges dealt with on separate occasions. Where proceedings involve more than one offence dealt with at the same time, the tables record only the principal offence. The basis for selection of the principal offence is laid down in rules issued by the Home Office. In summary these indicate that, where there is a finding of guilt, the principal offence is usually that for which the greatest penalty was imposed.

Summary

Convictions –

- The number of convictions for alcohol/drug related driving offences decreased from 1,952 in 2013 to 1,871 in 2014. (Table D.2)

- Over three quarters (79%) of all convictions for alcohol/drug related driving offences were among males in 2014. (Table D.2)

- A fifth of convictions for alcohol/drug related driving offences were among those under the age of 25 years in 2014. (Table D.2)

PLEASE NOTE:

It is not appropriate to measure police detections against persons proceeded against and convicted for the following reasons:

Offences that occur in previous years may not result in prosecutions or convictions for the year in which the crime is detected.

Counting rules for recorded crimes and prosecutions statistics differ in that, except in special circumstances, only the most serious offence (one crime) is recorded per victim.

If a number of offenders are subsequently charged for the same incident, each offender will be included in the prosecution and conviction figures.

The detection statistics document the offence as initially recorded. These may differ from the offence for which a suspect or suspects are subsequently proceeded against.

In cases where an offender has been charged or a summons has been issued, not all of these may be tried at court (for example, the Public Prosecution Service may not take forward proceedings).

8. 3 Injury Road Traffic Collisions due to Alcohol or Drugs (all road users)

Source: PSNI – Central Statistics Branch 'PSNI Annual Statistical Report: Injury Road Traffic Collisions and Casualties'

Background

PSNI collate statistics on all road traffic collisions (RTCs) on public roads where persons are injured (non-injury collisions are excluded). Copies of the reports produced can be accessed online at the following address:
http://www.psni.police.uk/index/updates/updates_statistics/updates_road_traffic_statistics.htm

Summary

- Between 2004 and 2015, 5%-7% of all injury road traffic collisions (for all road users) were as a result of alcohol consumption or drug taking. (Table D.3)

- Of all fatal collisions, almost 25% in 2011 were attributed to alcohol and drugs, whereas in 2015, this had decreased to 17% (Table D.3)

- Approximately one tenth of all serious collisions were attributed to drinking alcohol or taking drugs in each of the years from 2004 to 2015. (Table D.3)

- From 2004 to 2015, approximately 5% of all slight collisions were as a result of alcohol consumption or drug taking. (Table D.3)

- In 2004 and 2005, 9% of all injury collisions attributed to alcohol/drugs were fatal collisions, compared with 4% in 2015 (Table D.4)

- In each of the years from 2004 to 2011, approximately a quarter of all injury collisions attributed to alcohol/drugs were serious collisions. This figure had reduced to 18% in 2015. (Table D.4)

Detections in NI

Table D.1 Number of Persons detected for a drink/drug-driving related offence in NI (2008 - 2015).

Year	2008	2009	2010	2011	2012	2013	2014	2015
No. of persons detected for a drink/drug-driving related offence	4,017	3,986	3,448	3,294	2,967	2,710	2,694	2,733

All figures have been revised since last update.

Figures are provisional and are subject to change.

Convictions in NI

Table D.2 Convictions for Alcohol/Drug related driving offences in NI (2007-2014)

	2007		2008		2009		2010		2011		2012		2013		2014	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
All	3,377	*100*	2,775	*100*	2,694	*100*	2,476	*100*	2,351	*100*	2,217	*100*	1,952	*100*	1,871	*100*
Gender																
Male	2,915	*86*	2,415	*87*	2,273	*84*	2,044	*83*	1,949	*83*	1,787	*81*	1,592	*82*	1,479	*79*
Female	462	*14*	360	*13*	421	*16*	432	*17*	400	*17*	430	*19*	360	*18*	392	*21*
Other/not specified	0	*0*	0	*0*	0	*0*	0	*0*	2	*0*	0	*0*	0	*0*	0	*0*
Age[4]																
Under 18	23	*1*	26	*1*	17	*1*	20	*1*	14	*1*	10	*0*	6	*0*	7	*0*
18-21	391	*12*	325	*12*	314	*12*	255	*10*	252	*11*	217	*10*	197	*10*	152	*8*
22-24	352	*10*	326	*12*	302	*11*	272	*11*	225	*10*	215	*10*	190	*10*	193	*10*
25-29	489	*14*	471	*17*	404	*15*	373	*15*	360	*15*	328	*15*	308	*16*	271	*14*
30-34	441	*13*	319	*11*	281	*10*	287	*12*	292	*12*	247	*11*	242	*12*	238	*13*
35-39	417	*12*	312	*11*	303	*11*	279	*11*	282	*12*	236	*11*	198	*10*	208	*11*
40-44	380	*11*	293	*11*	299	*11*	274	*11*	238	*10*	243	*11*	206	*11*	197	*11*
45-59	727	*22*	548	*20*	614	*23*	584	*24*	549	*23*	555	*25*	469	*24*	470	*25*
60+	155	*5*	154	*6*	150	*6*	130	*5*	135	*6*	162	*7*	133	*7*	132	*7*
age not known	2	*0*	1	*0*	10	*0*	2	*0*	4	*0*	4	*0*	3	*0*	3	*0*

Source: Dept. Justice.

Note:

1. Data are collated on the principal offence rule; only the most serious offence for which an offender is convicted is included.

2. The figures provided relate to convictions for all classifications of the offence specified.

3. Figures for 2013 have been revised.

4. Age relates to the age at time of court conviction.

Injury Road Traffic Collisions

Table D.3 Injury Road Traffic Collisions attributed to alcohol/drugs[1] as a proportion of all Injury Collisions (2004-2015)

	Number of reported injury collisions (all road users)											
	Fatal Collision			Serious Collision			Slight Collision			Total Collision		
	All	No attributed to alcohol or drugs	% attributed to alcohol or drugs	Serious	No attributed to alcohol or drugs	% attributed to alcohol or drugs	Slight	No attributed to alcohol or drugs	% attributed to alcohol or drugs	Total	No attributed to alcohol or drugs	% attributed to alcohol or drugs
2004	128	31	24	895	89	10	4,610	238	5	5,633	358	6
2005	127	30	24	835	85	10	3,985	219	5	4,947	334	7
2006	110	18	16	904	95	11	4,614	248	5	5,628	361	6
2007	105	19	18	838	104	12	5,047	289	6	5,990	412	7
2008	98	20	20	814	105	13	5,311	257	5	6,223	382	6
2009	104	24	23	826	101	12	5,321	272	5	6,251	397	6
2010	51	13	25	726	80	11	4,889	218	4	5,666	311	5
2011	57	14	25	706	93	13	4,831	264	5	5,594	371	7
2012	45	7	16	669	68	10	5,061	260	5	5,775	335	6
2013	55	11	20	615	40	7	5,150	248	5	5,820	299	5
2014	74	18	24	577	45	8	5,434	246	5	6,085	309	5
2015	69	12	17	570	60	11	5,508	267	5	6,147	339	6

[1] Based on the principal causation factor

Table D.4 Injury Road Traffic of Collisions attributed to alcohol/drugs[1] (2004 – 2015)

Reported injury collisions attributed to alcohol/drugs (all road users)								
	Fatal Collision		Serious Collision		Slight Collision		Total	
Year	No.	%	No.	%	No.	%	No.	%
2004	31	9	89	25	238	66	358	100
2005	30	9	85	25	219	66	334	100
2006	18	5	95	26	248	69	361	100
2007	19	5	104	25	289	70	412	100
2008	20	5	105	27	257	67	382	100
2009	24	6	101	25	272	69	397	100
2010	13	4	80	26	218	70	311	100
2011	14	4	93	25	264	71	371	100
2012	7	2	68	20	260	78	335	100
2013	11	4	40	13	248	83	299	100
2014	18	6	45	15	246	80	309	100
2015	12	4	60	18	267	79	339	100

[1] Based on the principal causation factor. Figures have been revised from previous figures

Source: Statistics Branch, PSNI, Lisnasharragh

Section 9 – Disruption of Drug Supply Markets

Source: PSNI

Summary

- Success against crime gangs continues with 96 gangs frustrated or disrupted and 28 gangs dismantled in 2015/16. (Table E.1)

Table E.1 Frustrated, Disrupted and Dismantled Organised Crime Groups (2006/07 - 2015/16)

Year*	Frustrated	Disrupted	Dismantled
2006/07	6	4	2
2007/08	29	25	4
2008/09	41	17	5
2010/11	30	46	28
2011/12	27	53	18
2012/13	47	46	23
2013/14	49	50	16
2014/15	37	43	14
2015/16	96		28

* Figures for 2006/2007 reflect C1 Drug Squad activity only, which is directed at the 'top end' of the drug supply networks. The focus of the target has been further developed by PSNI as district command units adopt the strategy, targeting the 'supply networks' at local/community level and this is reflected in the 2007/08 and 2008/09 figures.

9.1 Drug Seizures and Arrests

Source: PSNI – Central Statistics Branch 'PSNI Annual Statistical Report: Drug Seizures and Arrests'

Background

PSNI reports statistics on the quantities of drugs seized and on the number of seizure incidents on a financial year basis. Copies of the reports produced can be accessed online at the following address:
https://www.psni.police.uk/inside-psni/Statistics/drug-seizure-statistics/

Summary

Seizures

- From 2006/07 to 2014/15, the total number of drug seizure incidents recorded year-on-year has increased (2,590 in 2006/07, 2,968 in 2007/08, 3,198 in 2008/09, 3,319 in 2009/10, 3,564 in 2010/11, 3,920 in 2011/12, 4,474 in 2012/13, 4,825 in 2013/14 and 5,104 in 2014/15).
- In each of the years since 2006/07, cannabis was the drug most commonly seized. From 2006/07 through to 2008/09, ecstasy (including the BZP derivative) and cocaine were the second and third most commonly seized illegal drugs respectively, however since 2009/10 cocaine seizures exceeded ecstasy seizures.
- In 2012/13, information was collected on benzodiazepines, of which there were 450 seizures. This increased to 471 seizures in 2013/14 and 656 seizures in 2014/15.

Arrests

- The number of persons arrested for drug-related offences has increased year-on-year since 2005/06 (1,440 in 2005/06, 1,726 in 2006/07; 1,896 in 2007/08; 2,014 in 2008/09, 2,250 in 2009/10, 2,435 in 2010/11, 2,543 in 2011/12, 2,784 in 2012/13, 2,867 in 2013/14 and 2,831 in 2014/15).

Section 10 – Public Perception of Alcohol/Drugs as a Social Problem

Source: NI Omnibus Survey – Alcohol and Drugs Module (2007 and 2008)

Background

The NI Omnibus Survey is a household based survey carried out among people aged 16 and over on a regular basis and is designed to provide a snapshot of their lifestyle and views on a wide range of issues.

Summary

Alcohol

- The percentage of survey respondents who said that alcohol misuse was a fairly or very big problem in their area increased from 38% in 2007 to 44% in 2008. Conversely, the percentage of those who said that alcohol misuse was not a very big problem in their area decreased from 35% in 2007 to 30% in 2008.

- The majority of survey respondents said that alcohol misuse was a fairly or very big problem in both 2007 (88%) in 2007 and 2008 (91%). This was a significant increase between the two years. Conversely, the percentage of those who said that alcohol misuse was not a very big problem decreased from 9% in 2007 to 5% in 2008.

- Just over half of survey respondents said that underage drinking was a fairly or very big problem in their area in both 2007 (51%) and 2008 (53%). Approximately a quarter of respondents said it was not a very big problem (27% in 2007 and 24% in 2008) and almost a fifth said that it was not a problem at all (18% in both 2007 and 2008).

- Just over one quarter of those surveyed said that 'street drinkers' were not a very big problem in their area in both 2007 (26%) and 2008 (28%). The percentage of respondents who said that they were a fairly or very big problem increased from 15% in 2007 to 19% in 2008 while the percentage of those who did not think they were a problem at all decreased from 58% in 2007 to 51% in 2008.

- Just under a quarter (24%) of survey respondents said that rowdy and drunken behaviour was a fairly or very big problem in their area in both 2007 and 2008. The percentage of respondents who said that it was not a very big problem increased from 36% in 2007 to 41% in 2008 while the percentage of those who did not think it was a problem at all decreased from 40% in 2007 to 35% in 2008.

- The percentage of survey respondents who said that alcohol misuse had a fairly or very big impact on family life in their area increased from 22% in 2007 to 27% in 2008. There was a decrease in the percentage of respondents who said that alcohol misuse did not have a very big impact on family life in their area (from 38% in 2007 to 35% in 2008) and in the percentage of those who said it had no impact at all (from 33% in 2007 to 28% in 2008).

- In both years of the survey, almost half of respondents felt that the situation with alcohol misuse in their area was about the same as it was 5 years ago (46% in 2007 and 48% in 2008), just under a third felt that it was a little or a lot worse (32% in 2007 and 29% in 2008) while less than a tenth felt that it was a little or a lot better (6% in 2007 and 7% in 2008).

Drugs

- In both years of the survey, respondents had similar views on drug misuse in their area. Over a fifth of survey respondents said that drug misuse was a fairly or very big problem in their area in both 2007 (23%) and 2008 (22%), less than a third said it was not a very big problem (28% in 2007 and 30% in 2008) and approximately a third said it was not a problem at all (33% in 207 and 31% in 2008).

- The majority of survey respondents said that drug misuse was a fairly or very big problem in both 2007 (85%) and 2008 (86%).

- In both years of the survey, respondents had similar views on young people taking drugs in their area. Over a quarter of survey respondents said that young people taking drugs was a fairly or very big problem in their area (29% in 2007 and 27% in 2008), not a very big problem (28% in 2007 and 29% in 2008) and not a problem at all (28% in 2007 and 26% in 2008).

- Approximately a fifth of those surveyed felt that drug dealing was a fairly or very big problem in their area in both 2007 (20%) and 2008 (19%), approximately a quarter felt it was not a very big problem (26% in 2007 and 25% in 2008) and approximately a third felt it was not a problem at all (35% in 2007 and 33% in 2008).

- In both years of the survey, respondents had similar views on cocaine use in their area. Almost a tenth of survey respondents felt that cocaine use was a fairly or very big problem in their area in 2007 (9%) and 2008 (9%), almost a fifth felt it was not a very big problem (19% in 2007 and 18% in 2008) and approximately two fifths felt it was not a problem at all (40% in 2007 and 37% in 2008). Approximately a third of respondents didn't know if cocaine use in their area was a problem in both 2007 (32%) and 2008 (36%)

- Over two fifths of survey respondents felt that injecting drug use (such as injecting heroin) was not a problem at all in their area in both 2007 (46%) and 2008 (43%). Less than one fifth said it was not a very big problem (18% in 2007 and 18% in 2008) and 4% in both 2007 and 2008 said it was a fairly or very big problem. Approximately a third of respondents didn't know if injecting drug use in their area was a problem in both 2007 (32%) and 2008 (35%)

- Less than a fifth of survey respondents said that drug misuse had a fairly or very big impact on family life in their area in both 2007 (17%) and 2008 (18%). The percentage of those who did not know if drug misuse had an impact on family life in their area increased from 16% in 2007 to 20% in 2008. Conversely, the percentage of those who said that drug misuse did not have a very big impact on family life in their area decreased from 28% in 2007 to 25% in 2008 and the percentage of respondents who said that drug misuse had no impact at all decreased from 40% in 2007 to 36% in 2008.

- In both years of the survey, just over two fifths of respondents felt that the situation with drug misuse in their area was about the same as it was 5 years ago (43% in 2007 and 42% in 2008), less than a third felt that it was a little or a lot worse (30% in 2007 and 28% in 2008) while approximately a twentieth felt that it was a little or a lot better (4% in 2007 and 5% in 2008).

Section 11 – Views on Alcohol and Drug Related Issues

Source: NI Omnibus Survey – September 2015

- Results from the September 2015 NI Omnibus Survey (NIOS) found that 36.6% of respondents agreed or strongly agreed with the statement 'I am concerned about alcohol related issues in my local area'. This compares to 43.9% of respondents who disagreed or strongly disagreed with the statement.

- Just over one third of respondents (35.5%) agreed or strongly agreed with the statement 'I am concerned about drug related issues in my local area' compared with 44.2% who disagreed or strongly disagreed.

- The most cited primary reason given for those reporting concern about alcohol related issues in the local area was 'underage drinking' (64.0%). The most cited secondary issue for respondents in relation to alcohol was 'drinking in public places' (32.0%). For drug related issues, 51.2% of respondents stated 'drug use/abuse' was the primary drug related issue in the local area. The most cited secondary issue for respondents in relation to drugs was 'drug dealing' (46.8%).

- Four fifths of respondents (82.0%) stated there was no change in the level of alcohol related issues in their local area in the last 12 months. A similar proportion of respondents (81.7%) stated there was no change in the level of drug related issues in their local area in the last 12 months.

- Of those respondents who reported having approached a body or representative in the last year, the PSNI was the most likely organisation to be approached for both an alcohol (61.4%) and a drug (42.3%) related issue in their local area.

- Just over 1 in 17 respondents (5.8%) had heard of the Assembly's New Strategic Direction for Alcohol and Drugs Phase 2, 2011-16.

- Taking everything into account, 52.7% of respondents expressed some, a lot, or total confidence that enough is being done to tackle alcohol and/or drug related issues.

- Respondents expressed higher levels of confidence in the PSNI's work to tackle alcohol and/or drug related issues across the region than that of any other organisation, with 69.5% of respondents having either some, a lot or total confidence.