



Department of  
**Health, Social Services  
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

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MÁNNYSTRIE O

**Poustie, Resydènter Heisin  
an Fowk Siccar**

# **New Strategic Direction for Alcohol and Drugs**

## **Phase 2**

### **2011-2016**

**A Consultation Document**

***January 2011***

# Contents

<i>Chapters</i>	<b>Page</b>
1. <b>Introduction</b>	1
2. <b>Background to the Development and Delivery of the NSD</b>	3
3. <b>Current Position</b>	8
4. <b>Addressing Alcohol and Drug Misuse in Northern Ireland</b>	18
5. <b>The New Strategic Direction for Alcohol and Drugs – Phase 2</b>	21
6. <b>Key Priorities</b>	30
7. <b>Outcomes</b>	33
<i>Annexes</i>	
A <b>Outcomes</b>	36
B <b>Equality Impact Assessment</b>	47
C <b>How to Respond to the Consultation Paper</b>	49
D <b>Consultation Questions</b>	51
E <b>Terms of Reference &amp; Memberships of Groups</b>	54

## 1. Introduction

- 1.1 Alcohol and drug misuse, and their related harms, cost our society hundreds of millions of pounds every year. However, this financial burden can never truly describe the full impact that substance misuse has on many vulnerable individuals (including children and young people), families, and communities in Northern Ireland.
- 1.2 Alcohol and drug misuse have therefore been significant public health and social issues in Northern Ireland over the last number of years, and continue to be a key priority.
- 1.3 In 2005 the Department of Health, Social Services, and Public Safety (DHSSPS) led the development of a cross-sectoral strategy that sought to reduce the harm related to both alcohol and drug misuse in Northern Ireland. DHSSPS launched this strategy, entitled the New Strategic Direction for Alcohol and Drugs (NSD), in 2006.
- 1.4 Originally, the NSD had a five-year life span. However, following discussion at the NSD Steering Group (the group which oversees the ongoing development and delivery of the NSD), it was agreed that, despite significant progress, 5 years allows a limited amount of time for a public health strategy to be embedded and to change long-term behaviours.
- 1.5 Accordingly, the Department agreed that, rather than undertaking a full new strategy development process, the existing NSD would be reviewed, revised, and extended until 2016. This decision was taken to ensure a consistent approach on the issue over a ten-year period, and to ensure that resources continue to be directed at front-line services, programmes, and interventions. It would also allow the NSD to pick up on emerging issues,

and re-direct effort to where it is most needed / or to where new issues are emerging.

Question 1: Do you agree with the approach being proposed by the NSD Steering Group, to reviewing, revising and extending the NSD to 2016?

1.6 In order to facilitate this process, the Department produced a report detailing progress against the indicators and outcomes contained in the NSD by the end of November 2009. This report is available at:

[http://www.dhsspsni.gov.uk/nsd\\_update\\_report - april 2010.pdf](http://www.dhsspsni.gov.uk/nsd_update_report_-_april_2010.pdf).

Question 2: Are you aware of any relevant information not contained in the Update Report that would inform the revision and extension of the NSD?

## **2. Background to the Development and Delivery of the NSD**

### **NSD Development**

- 2.1 Since 1986, there has been a number of Government initiatives to develop and implement strategic responses to these issues. Initially there were separate strategies for the two issues, however in May 2001 the Model for the Joint Implementation of the Drug and Alcohol Strategies (JIM) was launched.
- 2.2 In 2004, following a review of the two strategies and of the JIM, it was agreed that a New Strategic Direction for Alcohol and Drugs (NSD) would be developed to tackle the harm related to these issues in Northern Ireland. The Department began work to develop the NSD in April 2005 and followed a six-stage approach to produce a fully integrated, inclusive and co-ordinated strategic direction for addressing alcohol and drug misuse in Northern Ireland over the next five years. The intention was to combine a clear regional vision with local and community aspirations.
- 2.3 There was a comprehensive and inclusive engagement and consultation element to the original NSD's development. DHSSPS established ten special interest groups to look at specific issues such as workforce development, young people, and service users. In addition, a range of bi-lateral discussions, seminars, workshops and meetings were held to give key stakeholders the opportunity to shape the development of the NSD.
- 2.4 Following a formal public consultation during February/March 2006, DHSSPS published the original NSD in May 2006, and its implementation began in October 2006.

## **NSD Implementation**

- 2.5 The Health Minister established the overarching NSD Steering Group in 2006. Dr Andrew McCormick, the Department of Health, Social Services, and Public Safety's Permanent Secretary, originally chaired the Steering Group; however, the Chief Medical Officer, Dr Michael McBride, has now taken over this role. The Health Minister has also attended relevant meetings. The primary role of the Steering Group is to oversee and drive forward work to achieve the outcomes contained in the NSD. It also considers and recommends action in relation to relevant issues raised by members, and those teams and groups who report to it.
- 2.6 Membership of the Steering Group includes relevant professionals, statutory bodies and agencies, government departments, and voluntary/community sector representatives. The current membership of the Steering Group is attached at **Annex E** for information, along with its Terms of Reference.

### *Advisory Groups*

- 2.7 The Department established four advisory groups to provide advice and policy guidance on specific priorities contained within the NSD, and to inform the work of the NSD Steering Group. These Groups were:
- Children, Young People and Families;
  - Treatment and Support (*see paragraph 2.14*);
  - Binge Drinking (*now Alcohol*); and
  - Law and Criminal Justice.
- 2.8 The function of each group is to provide advice that draws on expertise in relation to the individual groups' strategic priorities and needs of specific strategic areas. Each group advises, commends and provides informative feedback on the NSD and its outcomes and on relevant issues related to its own specific remit. The Advisory Groups' Terms of Reference is set out at **Annex E** for information.

2.9 In addition, DHSSPS established a Liaison Group, consisting of the chairs of each advisory group along with the senior co-ordinators from the Public Health Agency and representatives from the Public Health Information and Research Branch and the Health Development Policy Branch in the DHSSPS. This group meets on a regular basis, and helps to monitor overall progress against the NSD's targets and outcomes, and integrates and co-ordinates relevant issues.

#### *Local Delivery*

2.10 From the outset, the NSD clearly recognised that local assessment of needs, and the development and delivery of services, programmes and initiatives to meet these needs, was paramount to the effectively addressing this issue. In support of this, the local Drug and Alcohol Co-Ordination Teams (DACTs), which operate in each of the former Health and Social Service Board areas, have developed local action plans – which match and reflect NSD priorities, and support the implementation of the NSD. In order to deliver on these Local Action Plans, the DACTs tendered for the services they required in their respective areas, and all local organisations are able to bid to provide these services.

2.11 The DACTs have established local delivery structures to oversee the implementation of their local action plans.

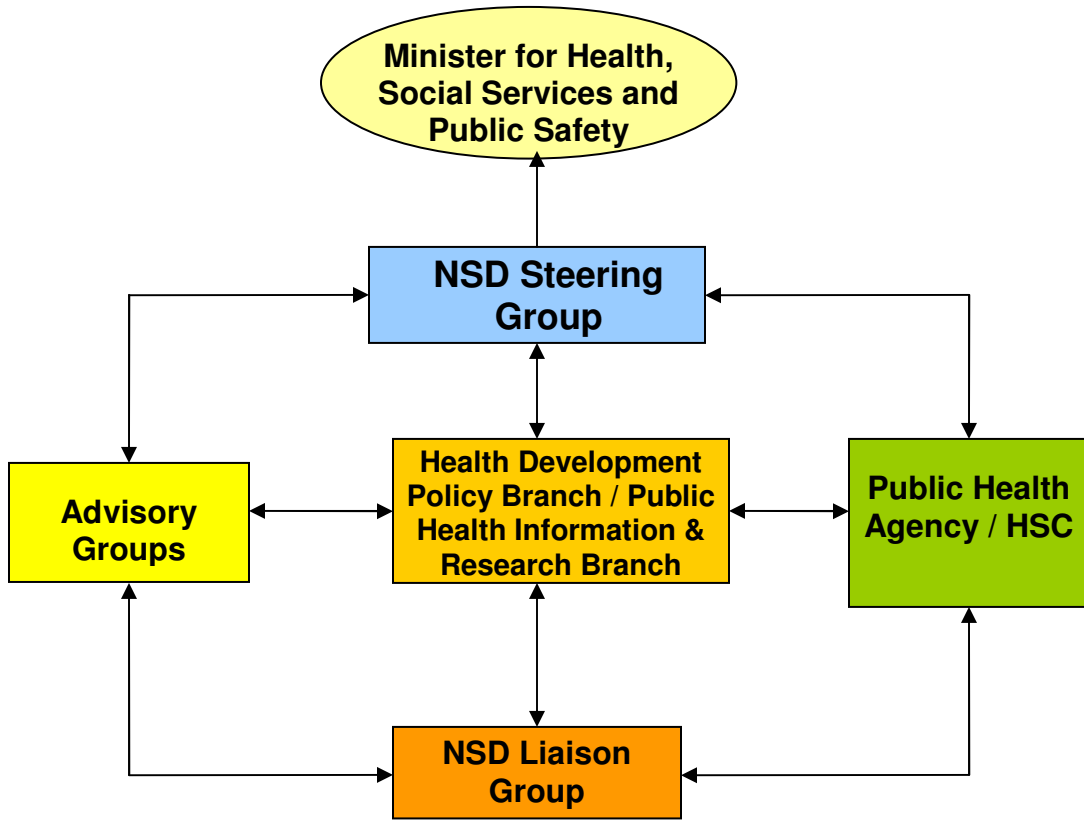
#### *Community Involvement*

2.12 The development of the NSD was informed throughout the process by the voluntary and community sector. This was facilitated through focus group discussions, members of the steering groups, and representation on the NSD Development Team. It was felt that it was essential that such involvement should be continued into the new structures of the NSD, and through the establishment of independent sector forums (ISF) in the local DACT areas. This has led to significant voluntary and community sector

involvement on the advisory groups, and the overarching NSD Steering Group, which has the four ISF chairs as full members.

*Revised Overall Structure*

- 2.13 Given the Review of Public Administration changes to the Health and Social Care settings, a slightly revised structure has been developed and is set out below. It is proposed that this structure is used to oversee the ongoing work of the NSD.
- 2.14 As part of the changes to the Health and Social Care system and the taking forward of the Bamford Review, it has been proposed that the work of the Treatment and Support Advisory Group will be carried out by the Substance Misuse Group established as part of the work to take forward the Bamford Review. This group will report to the NSD Steering Group through its chair.
- 2.15 The following diagram sets out the overall structure that oversees the ongoing implementation of the NSD.



Question 3: Do you agree the proposed revised implementation structure is fit for purpose to deliver the NSD Phase 2?

### 3. Current Position

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

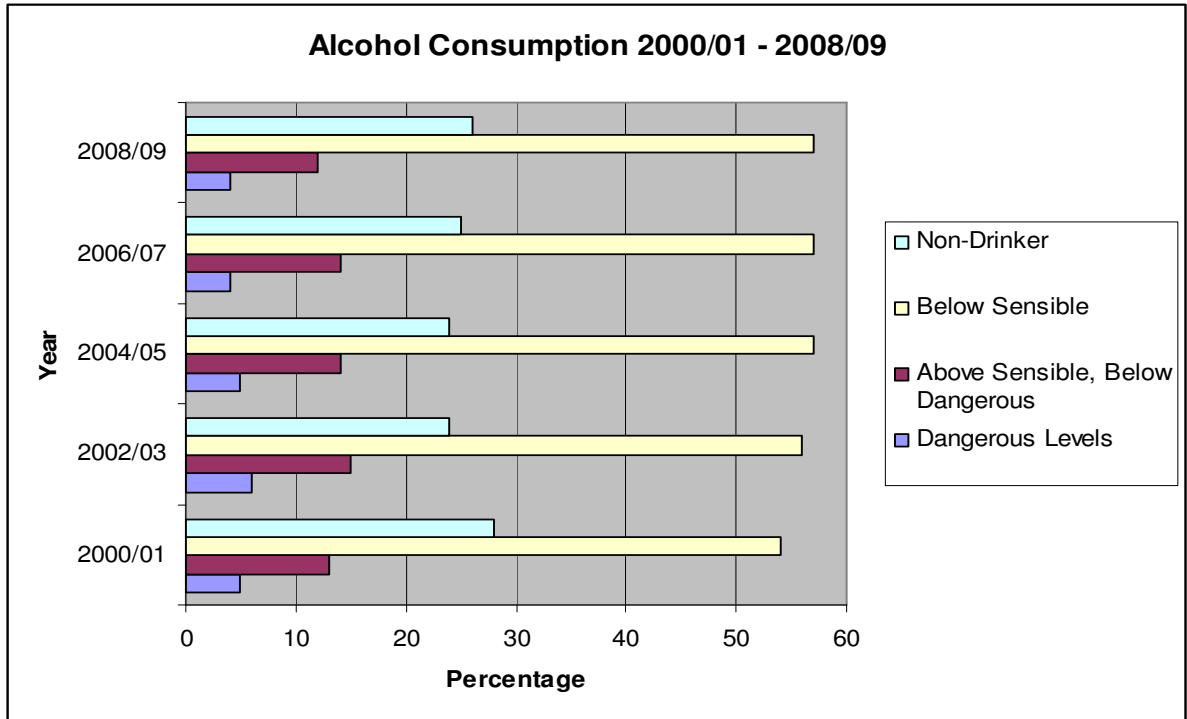
[http://www.dhsspsni.gov.uk/nsd\\_update\\_report - april 2010.pdf](http://www.dhsspsni.gov.uk/nsd_update_report_-_april_2010.pdf)

#### *Alcohol*

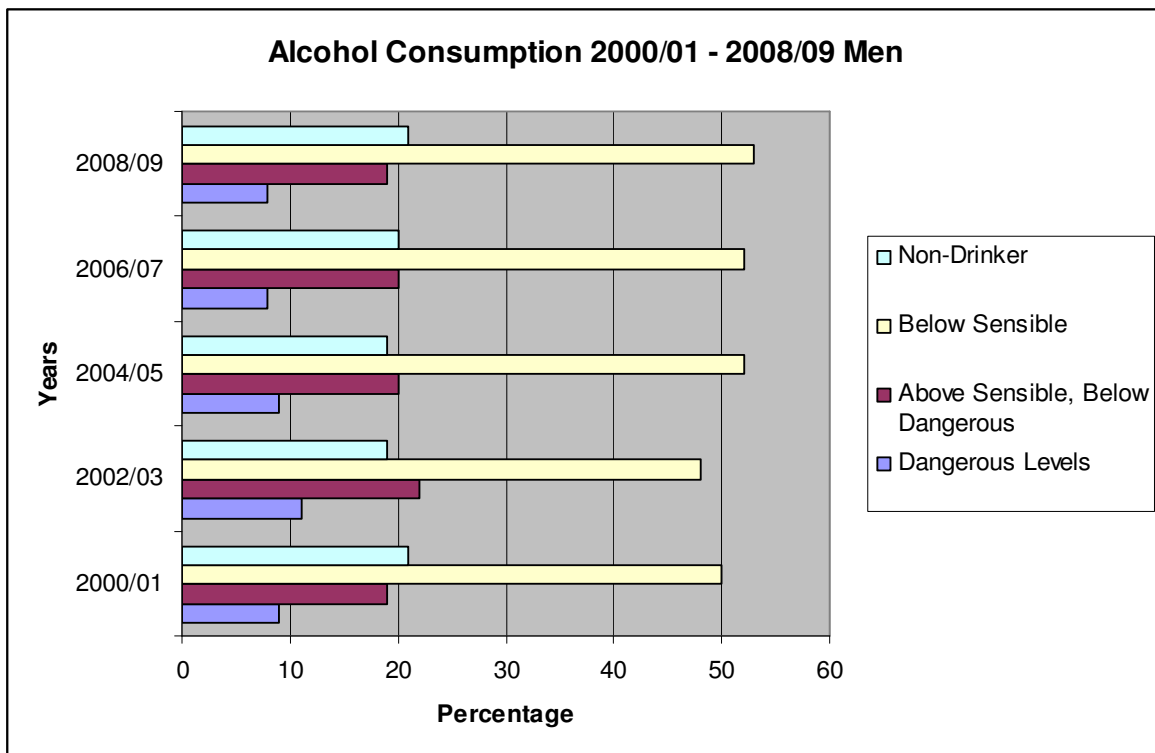
3.2 An estimate undertaken in 1998 placed the social cost of alcohol related harm in Northern Ireland at £770m. A further piece of work published by the Department in 2010 estimated that the cost of alcohol misuse could be as much as £900 million each year.

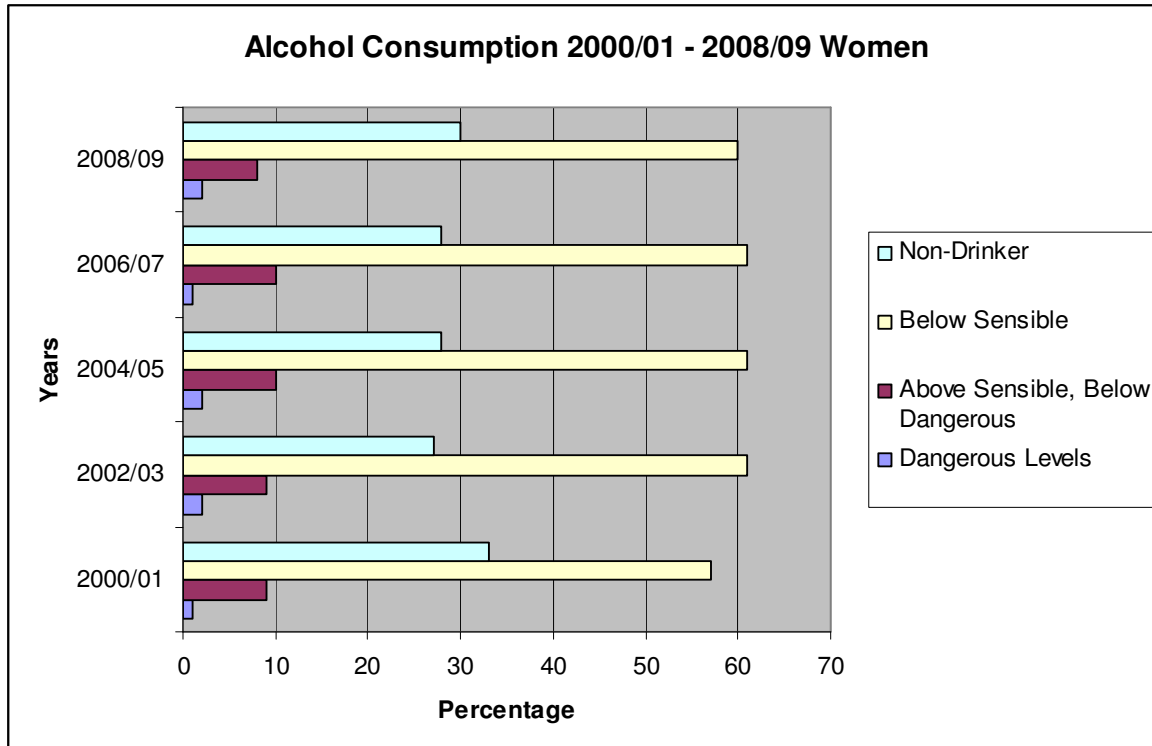
[http://www.dhsspsni.gov.uk/social\\_costs\\_of\\_alcohol\\_misuse\\_200809.pdf](http://www.dhsspsni.gov.uk/social_costs_of_alcohol_misuse_200809.pdf)

3.3 According to the Continuous Household Survey, alcohol consumption has remained relatively constant since 2000/02. Although, in recent years we have seen a slight decrease in the proportion of people drinking above sensible levels and at dangerous levels.



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





3.5 The Adult Drinking Patterns Survey highlights that almost three quarters of survey respondents in both 2008 (72%) and 2005 (73%) drank alcohol. A higher proportion of males than females stated that they drank alcohol in both years of the survey (74% compared to 70% in 2008 and 77% compared to 70% in 2005).

3.6 In addition, just over four fifths of respondents who had consumed alcohol in the week prior to the survey exceeded the recommended daily limits in both 2008 (81%) and 2005 (82%). In both years of the survey, approximately four fifths of both males (79% in 2008 and 81% in 2005) and females (83% in 2008 and 83% in 2005) exceeded the recommended daily drinking limits in the week prior to the survey.

3.7 In terms of hazardous drinking, of those who consumed alcohol in the week prior to the survey, just over three quarters (76%) of respondents in 2008

consumed alcohol within sensible weekly limits compared to 71% in 2005. This is a statistically significant increase since 2005.

- 3.8 One feature often ascribed to Northern Ireland drinking is that of 'binge drinking'. This is a colloquial expression describing the consumption of several drinks/units in a single or prolonged session. It is also true that the bulk of drinking takes place on Fridays, Saturdays and Sundays. According to the Adult Drinking Patterns Survey, in 2008 almost one-third (32%) of respondents engaged in at least one binge drinking session during the week prior to the survey. This was a significant decrease since 2005 (38%) in the proportion of adults who binge drink.
- 3.9 A higher proportion of males (35%) than females (29%) were classified as binge drinkers in the 2008 survey; in 2005, males (43%) were also more likely than females (33%) to binge drink. The percentage of male binge drinkers decreased between 2005 and 2008 whereas there was no significant difference in the proportions of female binge drinkers.
- 3.10 There also remains a concern about the high proportion of young people who have drunk alcohol and particularly with the proportion of young people reporting having been drunk. The Young Persons' Behaviour and Attitudes Survey found the proportion of respondents aged 11-16 who said that they had ever taken an alcoholic drink (not just a taste or a sip) decreased from 59.9% in 2003 to 55.1% in 2007.
- 3.11 The Young Persons' Behaviour and Attitudes Survey also highlights that the proportion of young people (aged 11-16) who reported getting drunk in 2007 was 30.0%, down from baseline of 32.9% in 2003; this is a statistically significant decrease.

### *Drug Misuse*

- 3.12 Drug use, compared to alcohol, can vary in respect of scale, pattern and intensity. Drug use in Northern Ireland over the last 20 years has reflected the changing nature of illicit drug use. The other point about drug misuse, as with alcohol misuse, is that people inevitably make comparisons with other countries and regions. In Northern Ireland, this has been particularly the case with opiate misuse, and more recently with cocaine use. In fact, Northern Ireland's pattern of drug use has probably mirrored that in Great Britain and the Republic of Ireland in terms of recreational use, but has not seen the same intensity of problem drug use, especially in respect of heroin and crack cocaine.
- 3.13 Figures provided by prevalence surveys and treatment services show that cannabis remains the main drug of choice, and the most commonly reported on by treatment services. In the early 1990s, an emerging 'rave' or club scene was observed and commented on, and Ecstasy, LSD and speed became drugs that were of some concern, especially among young people. At the same time, there was a growing acknowledgement of localised heroin use in certain parts of Northern Ireland, and public concern about such use in these areas was noticeable. Particular note should also be taken of the prevalence of blood borne viruses among the injecting drug user population.
- 3.14 This Northern Ireland trend seemed to grow slowly into the early 21<sup>st</sup> century. Since then the rise in drug use among young people seems to have slowed, and there has not been an explosion in opiate use as was seen in Dublin and parts of Great Britain at the end of the 1990s. However cannabis use is still of some concern and it would also appear that there has been an increase in the use of cocaine as exemplified by increased seizures, treatment referral figures and anecdotal evidence.

3.15 Another aspect or feature of drug use in Northern Ireland is the misuse of 'over-the-counter' (OTC) medicines and prescribed drugs, often, but not solely, by older people. In addition, volatile substance misuse remains a perennial issue, especially among young people. The Drug Prevalence Survey 2006/07 showed 20.2% of all adults (aged 15-64 years) in Northern Ireland had used sedatives and tranquillisers at some point in their lifetime, and 21.0% had used anti-depressants. Last year prevalence was 9.2% for sedatives and tranquillisers and 9.1% for anti-depressants while last month prevalence for these drugs was 7.1% and 7.5% respectively. (Comparative figures for Ireland are as follows: lifetime prevalence of 10.5% for sedatives and tranquillisers and 9.2% for anti-depressants; last year prevalence of 4.7% and 4.3% respectively; and last month prevalence 3.0% and 3.1% respectively.) More information can be obtained here:

[http://www.dhsspsni.gov.uk/drug\\_prevalence\\_survey\\_2006-07\\_bulletin\\_6.pdf](http://www.dhsspsni.gov.uk/drug_prevalence_survey_2006-07_bulletin_6.pdf)

3.16 The Drug Prevalence Survey highlighted that in Northern Ireland, lifetime use of any illegal drugs increased from 20.0% in 2002/03 to 28.0% in 2006/07 among all adults aged 15-64 years. There were increases since 2002/03 in lifetime use of any illegal drugs among males (from 26.7% to 33.9%) and females (from 13.5% to 22.1%).

3.17 Last year use of any illegal drugs increased from 6.4% in 2002/03 to 9.4% in 2006/07 among all adults aged 15-64 years. There were increases since 2002/03 in last year use of any illegal drugs among males (from 9.7% to 13.7%) and females (from 3.1% to 5.2%).

3.18 There was no significant difference in last month use of any illegal drugs among all adults aged 15-64 years since the previous survey (3.4% in 2002/03 and 3.6% in 2006/07). The only significant increase since 2002/03 in last month use of any illegal drugs was found among females (from 1.1% to 2.4%).

3.19 The most recent prevalence figures over a range of drugs are set out in the tables below:

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

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

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

Note: All figures are rounded to the nearest decimal place

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

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

\*\*\* Poppers ie amyl or butyl nitrite.

3.20 The Young Persons' Behaviour and Attitudes Survey contains information on drug misuse among 11-16 year olds in Northern Ireland. Among all respondents, lifetime use of any drugs or solvents decreased from 23.0% in 2003 to 18.9% in 2007. Since 2003, lifetime use of any drugs or solvents decreased among male pupils (from 26.1% to 19.3%), with no significant difference in lifetime prevalence among female pupils (20.0% in 2003 and 18.8% in 2007).

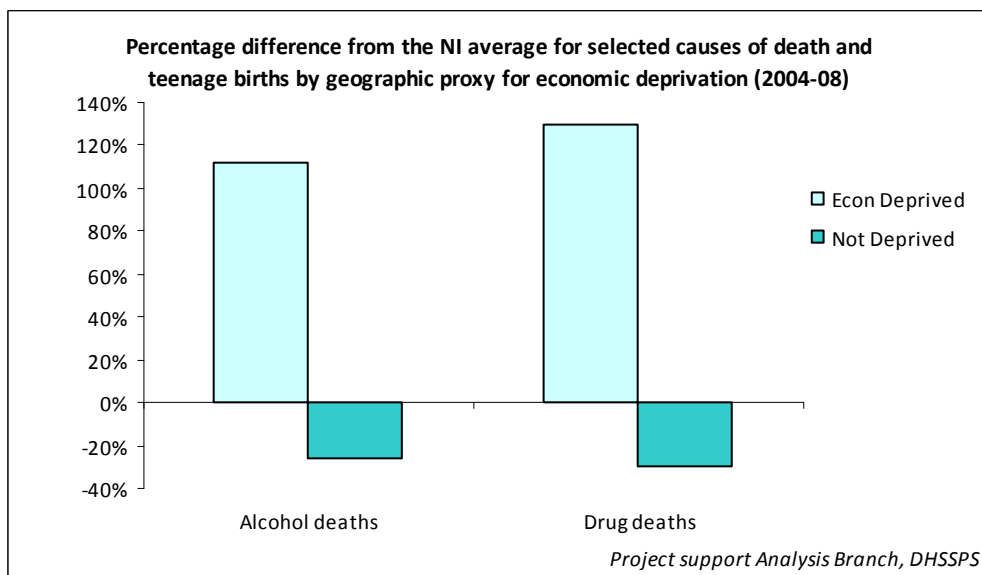
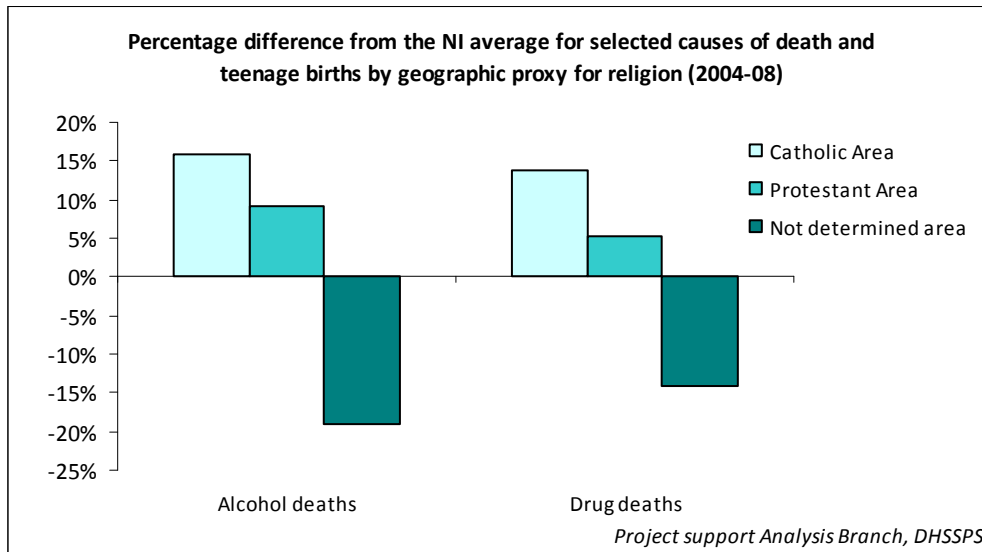
3.21 Among all respondents, last year use of any drugs or solvents decreased from 17.9% in 2003 to 13.4% in 2007. Since 2003, last year use of any drugs or solvents decreased among male pupils (from 20.2% to 13.7%) and among female pupils (from 15.7% to 13.4%).

3.22 Among all respondents, last month use of any drugs or solvents decreased from 11.5% in 2003 to 7.5% in 2007. Since 2003, last month use of any

drugs or solvents decreased among male pupils (from 13.1% to 8.0%) and among female pupils (from 10% to 7%).

### Religion and Disadvantage

3.23 The following graphs show the percentage deviation from the NI average for selected causes of death by geographic proxy for religion and economic deprivation for the period 2004-2008. These particularly highlight the impact of deprivation the rates of alcohol and drug related deaths.



Question 4: Are you aware of any other statistics not included in this document or the NSD Update Report that would help inform the revision and extension of the NSD?

## 4. Addressing Alcohol and Drug Misuse in Northern Ireland

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

### *Treatment*

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

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

4.4 These services collectively provide a full range of treatment options – detoxification, rehabilitation, substitute prescribing and therapeutic counselling. They also provide a counselling and education service for young people through a partnership with a local voluntary organisation.

4.5 Many people also choose to access self-help organisations for support and advice. Various self-help groups cater for those with specific issues in alcohol and drug misuse and their families and carers.

*Education and Prevention*

- 4.6 A great deal of positive prevention work is carried out in Northern Ireland targeting a wide range of groups and delivered by a wide spectrum of statutory and non-statutory organisations and agencies.
- 4.7 A significant portion of this work has been carried out within the formal education and youth setting, i.e. schools and clubs. There has also been an increasing emphasis on developing and promoting prevention work in the community and neighbourhood setting, with a greater emphasis on informal and outreach approaches, especially in respect of 'hard-to-reach' groups and areas typically described as disadvantaged. Increasingly such work has been guided by known good practice.

*Criminal Justice*

- 4.8 The criminal justice system has made a major contribution to addressing alcohol and drug misuse in Northern Ireland. The Police Service for Northern Ireland (PSNI) is actively tackling the issue of the organised crime gangs and their involvement with illicit drugs. As the link between the misuse of alcohol with serious violent crime and instances of anti-social behaviour is well established, the PSNI, and others, have developed regional and local alcohol initiatives. They have been contributing to prevention efforts through education and support to local communities in an effort to address both of these issues. The Probation Board for Northern Ireland (PBNI) and the Northern Ireland Prison Service (NIPS) also play a major role in both prevention and support and the issue of 'at risk' and vulnerable groups is one which the Youth Justice Agency has also given a high priority to.
- 4.9 In addition, the criminal justice system and the health service continue to work closely to develop a partnership approach to tackling offenders who have illicit drug problems. Community Addiction Teams have seen referrals

from criminal justice projects, people who have never had any previous contact with treatment services. There are also schemes and projects involving the NIPS, the PBNI and the PSNI.

## The New Strategic Direction for Alcohol & Drugs – Phase 2

5.1 The following chapter sets out the revised and updated approach that we propose taking forward in the NSD Phase 2. This is built on the original process, essentially following a ‘logic model’ approach. Through this approach, the emphasis has been from the outset on the development of long-term outcomes with the subsequent development of short and medium outcomes in order to deliver these long-term outcomes. This has also involved the development of outputs or activities. Together these deliver the overall long-term aims which themselves are set within the overarching long-term aim of reducing the level of alcohol and drug-related harm in Northern Ireland.

### *Aim of NSD Phase 2*

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

5.3 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 and/or their carers and the wider community;
- increase awareness 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

Question 5: Do you agree the Overarching Aim of NSD Phase 2 is appropriate, and are the associated long-term objectives appropriate to deliver the overall Aim? Are there others we should consider, or you feel are important?

*Key Indicators*

5.4 To measure the extent to which the overall aim of reducing alcohol and drug-related harm is met, we have established a set of Indicators that can be used for this purpose. Progress is against these indicators as they become available. The Key Indicators identified for alcohol and drugs are:

Alcohol	Drugs
<ul style="list-style-type: none"> <li>• Numbers presenting to treatment</li> <li>• Related hospital admissions</li> <li>• Alcohol-related deaths</li> <li>• Binge drinking prevalence</li> <li>• Prevalence</li> <li>• Personal Expenditure on alcohol</li> <li>• Alcohol-related crime</li> <li>• Drink/Drug driving (including prescription drugs)</li> <li>• Public perceptions of alcohol as a social problem</li> </ul>	<ul style="list-style-type: none"> <li>• Numbers presenting to treatment</li> <li>• Related hospital admissions</li> <li>• Drug-related deaths</li> <li>• Blood Borne Viruses among Injecting Drug Users</li> <li>• Prevalence</li> <li>• Drug-related crime</li> <li>• Drink/Drug driving (including prescription drugs)</li> <li>• Disruption of drug supply markets</li> <li>• Public perceptions of drugs as a social problem</li> </ul>

5.5 Where appropriate figures will be broken down in terms of age, gender, and geographical area.

Question 6: Do these indicators provide a relevant range of information that can be used to assess progress against the overarching aim, and long-term objectives, of NSD Phase 2? Are there other indicators we should/could use?

### *Values and Principles*

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

<b>Value</b>	<b>Description</b>
<b>Positive, Person Centred, Non-Judgmental and Empowering</b>	Each person has individual circumstances, experiences and needs. By developing and delivering services that seek to extenuate the positive and are congruent, respectful and relevant to each person, people can be empowered to make healthier choices. Everyone should feel able to engage freely with services without feeling prejudiced, isolated, stereotyped or stigmatised.
<b>Balanced Approach</b>	The needs and rights of the individual to make health-related choices should be balanced with the need to protect families, communities and societies from any adverse effects of such choices.
<b>Shared Responsibility</b>	Substance misuse is complex and multi-faceted. Effectively preventing and addressing this issue will require a co-ordinated approach, and a shared responsibility and commitment, across Government Departments, Sectors, Professions, Communities, and Individuals.
<b>Equity and Inclusion</b>	Each person has equal worth and rights regardless of differences in race, gender, age, ability, religious belief, political affiliation, cultural outlook, origin, sexual orientation, citizenship, nature, lifestyle, or geographical location.

Question 7: Do you agree with these values? Are there any other values that should be included, or you feel are important?

### *Principles*

5.7 The NSD Phase 2 also sets out a number of principles that must be adhered to as it is taken forward. These principles are:

<b>Principle</b>	<b>Description</b>
<b>Partnership and Working Together</b>	Effective partnership has a far greater potential to impact on the complex area of substance misuse rather than fragmented actions carried on in isolation. This Strategy will seek to ensure joint action at every level of implementation and encourage seamless service between sectors.
<b>Evaluation, Evidence and Good Practice Based</b>	A commitment to taking action informed by evidence about what the problems, 'what works' and by information on cost-effectiveness. The Strategy will also seek to improve the evidence base, and will ensure that appropriate evaluation and reviews are undertaken to ensure all programmes and initiatives are effective.
<b>Consultation, Engagement, and Transparency</b>	Support for, and commitment to, continued consultation, engagement and communication with key stakeholders at every level.
<b>Addressing Local Need</b>	Local needs should be identified and the appropriate resources effectively used by local stakeholders and organisations. Any local action must take into consideration with plans already developed.
<b>Community Based</b>	Alcohol and drug misuse is a community issue. The importance of the community dimension is recognised, and we acknowledge the work carried out by, and within, the community in addressing this issue, and will continue to support good practice in this area.
<b>Long-Term Focus</b>	There is no simple or immediate solution to the complex issue of substance misuse. A sustained, long-term strategic approach, with measured shorter-term milestones, must therefore be taken.
<b>Value for Money</b>	Work must be taken forward in a way that maximises impacts and their cost-effectiveness
<b>Built on Existing Work</b>	It is recognised that there is much good work already underway, particularly in relation to the NSD, Hidden Harm, and Young People's Drinking. This Strategy, and its implementation, should seek to build on this good work where possible.
<b>Access to information</b>	Organisations should be obligated to release data, both at a regional and local level, and subject to any confidentiality issues, that would assist with an assessment of the current drug / alcohol situation.

Question 8: Do you agree with these principles? Are there any other principles that should be included, or you feel are important?

### *The Five Pillars*

5.8 In developing the NSD, five supporting pillars were identified, and these pillars provide the conceptual and practical base for the NSD. The five pillars are:

Pillar	Rationale
<b>Prevention and Early Intervention</b>	<p>Prevention and Early Intervention is largely concerned with encouraging and developing ways to support and empower individuals, families and communities in the acquisition of knowledge, attitudes and skills.</p> <p>A particular focus should be placed on the importance of early intervention (especially young children and families), and the adoption of targeted, as well as universal types of prevention which will lead to the reduction of risks factors and the development of protective factors associated with the prevention of alcohol and drug-related harm.</p> <p>Interventions must be tailored to particular settings such as the school, community and workplace. In this respect, the importance of formal and informal education and community-based approaches is acknowledged.</p>
<b>Harm Reduction</b>	<p>Harm reduction refers to policies, strategies and programmes designed to reduce the harmful consequences of substance misuse. A defining feature of harm reduction is the focus on the prevention of alcohol and drug-related harm for those users who are unable or unwilling to stop using substances. This includes reducing the harm at the individual, family and community levels.</p> <p>Harm reduction is not about condoning alcohol and/or drug use, but it should be seen as those policies, programmes and approaches that aim to prevent anticipated harm and reduce actual harm.</p>
<b>Treatment and Support</b>	<p>A comprehensive range of treatment, rehabilitation and aftercare services for individuals and families affected by alcohol and drug use should be in place.</p> <p>There is also a need to acknowledge the wide range of substances which is misused, including prescribed and 'over the counter' preparations as well as 'illicit' drugs. Particular importance needs to be placed on the continuity of care, and the need to develop greater linkages across agencies and the Health and Social Care system.</p> <p>Similarly, people should be able to access a comprehensive range of community-orientated, evidence-based treatment and support services responsive to client needs.</p>
<b>Law and Criminal Justice</b>	<p>The NSD will continue to stress the importance of addressing those issues that fall within the domain of the law and criminal justice. As well as continuing those efforts aimed at reducing the supply of illicit drugs and irresponsible sale (particularly underage sales) of alcohol, the NSD will continue to support those justice and correctional initiatives that aim to reduce the level of harm associated with alcohol and drug use, such as the increased emphasis on diversion to treatment.</p>
<b>Monitoring, Evaluation and</b>	<p>It will be essential that the resources available to deliver the NSD be properly targeted at activities and programmes that have been</p>

<p><b>Research</b></p>	<p>shown by previous research and evaluation to be effective. This does not devalue the need for innovation. Arrangements for evaluation will be an integral part of all current and future services funded as part of the NSD.</p> <p>It is recognised that it is of vital importance at both regional and local levels to monitor and evaluate processes, outputs and outcomes in order to inform the overall implementation of the NSD and ultimately measure its success.</p> <p>Where appropriate, existing systems and surveys will help to set baselines and monitor progress and changes, however it may be necessary to develop new monitoring systems or build on existing ones to provide additional information required.</p> <p>In addition, well-designed and targeted research projects can address gaps in knowledge and seek to explore specific topics and issues in detail.</p>
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Question 9: Are the revised five Pillars still relevant? Do you agree with these Pillars? Are there any other areas that should be included as a Pillar?

*Themes*

5.9 The NSD identified two themes, “Children, Young People, and Families” and “Adults and the General Public”, which has enabled the development of an integrated and co-ordinated approach to tackle the issue.

Question 10: Are the two Themes still relevant? Do you agree with these Themes? Are there any other areas that should be included as a Theme?

*Emerging Issues*

5.10 Since the publication of the original NSD, a number of issues has emerged that should now have a greater prominence in the NSD Phase 2. These emerging issues have been raised through discussion at the NSD Steering Group and the relevant Advisory Groups, through key information sources like the Independent Sector Forums, the Advisory Council on the Misuse of Drugs, the British-Irish Council Drug Misuse Sectoral Group, recent research, and subsequently highlighted in the NSD Update Report.

## 5.11 These emerging issues include:

Issue	Rational
<b>Prescription or Over-The-Counter Drugs</b>	<p>Information sources, prevalence surveys, and discussions at both the regional and local level have continued to demonstrate the high levels of prescription and over-the-counter drug use in Northern Ireland.</p> <p>There appear to be issues around the level of prescribing in Northern Ireland, as well as the illicit use of prescription and over-the-counter drugs. The buying of prescription drugs on the internet has also emerged as a problem.</p> <p>A range of key outcomes has therefore been developed in relation to raising awareness of this issue, preventing further misuse, and providing appropriate advice, professional training, treatment and support.</p>
<b>Emerging Drugs of Concern / “Legal Highs”</b>	<p>There has been increased awareness of the issue and availability of so-called “legal high” products in Northern Ireland. In some cases, “legal highs” are sold to people trying to buy illicit drugs, in other case these products are being actively promoted and sold across Northern Ireland.</p> <p>A range of key outcomes has been developed in relation to uncovering the scale of the issue, raising awareness of the dangers of these products, preventing misuse, and providing appropriate advice, professional training, treatment and support. We will also work with colleagues across the UK jurisdictions in relation to the legal status of these products – in order to prevent harm.</p>
<b>Families and Hidden Harm</b>	<p>In the first phase of the NSD’s implementation, there was a significant emphasis on prevention and education work with children and young people, and progress has been made in this area.</p> <p>However, effectively engaging with families and parents/carers is a much more difficult task, and has not been tackled with the same consistency or focused approach. The revised NSD therefore contains a greater emphasis on engaging with parents and carers, both in terms of prevention and education, and treatment and support.</p> <p>In addition, there needs to be a continued focus on preventing and addressing Hidden Harm – through the implementation of the PHA’s Hidden Harm Action Plan. Therefore, Hidden Harm will be a key priority throughout the NSD Phase 2.</p>
<b>Recovery</b>	<p>Across the UK there has been an increased emphasis placed on helping those affected by alcohol and drug misuse to work towards recovery.</p>

	<p>Scotland recently defined recovery as “a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society. Furthermore, it incorporates the principle that recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment.”</p> <p>In practice, recovery will mean different things at different times to each individual person with problem drug use. For an individual, 'the process of recovery' might mean developing the skills to prevent relapse into further illegal drug taking, rebuilding broken relationships, or actively engaging in meaningful activities. Milestones could be as simple as gaining weight, re-establishing relationships with friends, or building self-esteem. It is critical that recovery is sustained.</p>
<b>Mental Health, Suicide, and Drugs and Alcohol Misuse</b>	<p>There has been increasing recognition of the association between poor mental health, suicide and self-harm, and alcohol and drug misuse. Indeed, many of the risk and protective factors for these issues are the same. Therefore, through the NSD Phase 2 we are seeking to improve further the co-ordination of work on these issues at both a strategic and an operational level.</p>
<b>Cocaine</b>	<p>There has been increasing concern about the prevalence and misuse of cocaine in Northern Ireland. Prevalence surveys and information for local service providers indicate that while most levels of drug misuse are plateauing, there is an increase in the misuse of cocaine. Therefore, within the outcomes contained in Annex A, a specific focus should be taken on preventing and addressing cocaine misuse.</p>
<b>Alcohol</b>	<p>Previously the NSD focused on reducing specific behavioral patterns of alcohol misuse, such as “binge drinking”. The NSD Phase 2 has a much greater focus on reducing the health and community harms, including anti-social behaviour and serious violent crime, all which are related to alcohol misuse. Therefore, a range of outcomes has been developed to begin to prevent, address and treat Northern Ireland’s increasingly unhealthy relationship with alcohol. Through the development of the Young People’s Drinking Action Plan, there is a greater emphasis on addressing issues such as the advertising, marketing, labelling and pricing of alcohol. Addressing underage drinking and improving alcohol education are also included.</p>
<b>Links with Sexual Violence and Abuse, and Domestic Violence</b>	<p>In June 2008, DHSSPS and DoJ published a five-year Strategy ‘<i>Tackling Sexual Violence and Abuse</i>’. The Strategy highlights a number of risk factors in relation to the vulnerability of certain groups of people to sexual violence and abuse, including drug and alcohol use.</p> <p>A research study on Drug Facilitated Sexual Assault carried out between 1999 and 2005 examined cases where toxicology requests were made for forensic analysis and were entered into the Forensic Science Northern Ireland database. The research</p>

	<p>found that as the number of requests increased each year, more cases were shown to involve alcohol and this trend appeared to increase throughout the study period. In addition, the number of cases where high or very high alcohol levels were found also increased over the research period. The study found that the number of cases involving prescription drugs doubled within the years studied.</p> <p>Domestic Violence and abuse is a serious problem. It has a devastating impact on victims and their families. Each year in Northern Ireland, around 7 people are killed and over 700 families have to be re-housed because of violence in the home. In October 2005 the Department in conjunction with the Department of Justice responded to the issues in publishing an inter-agency Domestic Violence Strategy "Tackling Violence at Home".</p> <p>Although the relationship between substance use and domestic and sexual violence is complex, there are clear indications that alcohol use, particularly heavy drinking and binge drinking, not only complicates the extent and nature of violence against women, particularly among intimate partners, it also increases the likelihood of re-assault and reduces the likelihood of perpetrators of domestic violence completing treatment. It should also be noted that the trauma suffered by victims can lead them into a spiral of using prescription medication, drugs and alcohol in an attempt to alleviate their circumstances.</p>
<b>Local Funding</b>	<p>To date, two tendering rounds have been completed by the legacy Health and Social Services Boards in support of DACT Action Plans. The learning from both these tendering rounds should be built into any future decisions in relation to the local funding processes.</p>
<b>Review of Public Administration</b>	<p>The delivery structures for the NSD Phase 2, at both the local and regional level, should take account of the RPA changes that have been completed to date, and prepare for those changes still being planned.</p> <p>With the establishment of the Public Health Agency and the Health and Social Care Board, we would like to see a more consistent approach taken to prevention, education, workforce development, treatment and support across Northern Ireland.</p>

Question 11: Do you agree that these are the key emerging issues for alcohol and drug misuse since the publication of the NSD? Are there other issues that you feel need to have a stronger emphasis in the NSD Phase 2?

## Key Priorities

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

Key Priority	Description
<b>Developing a Regional Commissioning Framework for treatment</b>	There is support in Northern Ireland to consider this issue in more detail and develop a strategic framework that would both cover service delivery and the development of local needs-based plans.
<b>Targeting those at risk and vulnerable</b>	<p>Although it is an issue which is typically associated with ‘at risk’ young people, within the context of the NSD vulnerability refers to both young people and adults. The following groups have been described as potentially vulnerable in respect of alcohol and drug misuse, although the list is not exhaustive:</p> <ul style="list-style-type: none"> <li>• Homeless, including rough sleepers.</li> <li>• Refugees and asylum seekers.</li> <li>• Ethnic minorities.</li> <li>• People living with domestic violence.</li> <li>• Sex workers.</li> <li>• Ex-offenders.</li> <li>• Vulnerable young people including - <ul style="list-style-type: none"> <li>○ Children of alcohol/drug using parents (<i>Hidden Harm</i>).</li> <li>○ Looked-after children.</li> <li>○ Young homeless.</li> <li>○ Young offenders.</li> <li>○ School excludees.</li> </ul> </li> <li>• Older people drinking hazardously, dangerously or dependant on alcohol and/or addicted to/misusing drugs.</li> <li>• People with mental health problems.</li> <li>• People with learning disabilities</li> <li>• Street drinkers.</li> <li>• Those excluded from communities because of their alcohol and/or drug use.</li> </ul>

<b>Key Priority</b>	<b>Description</b>
<b>Alcohol and drug-related crime including anti-social behaviour and tackling underage drinking</b>	There is increasing public concern about those types of crime associated with and exacerbated by alcohol and/or drugs. The misuse of alcohol has been associated with a range of anti-social behaviours including noise, nuisance, litter, criminal damage and verbal or physical abuse. Serious violent crime statistics also show that alcohol is a major contributory factor. Both these types of incidents have been associated with the 'night-time economy' in urban centres, but are also recognised as a problem in rural and/or residential areas. The impact of alcohol-related crime on public services such as police, fire, ambulance and transport, and on the public, is acknowledged. Activities that aim to address these issues, especially within the community setting, are to be encouraged. One of the issues to be tackled is the availability of alcohol to those underage, which is a contributory factor leading to anti-social behaviour within communities.
<b>Reduced availability of illicit drugs</b>	Continued emphasis will be placed on those efforts and activities within the law and criminal justice sector that aim to reduce the availability of drugs, with particular attention being paid to the complex supply chain involved.
<b>Addressing community issues</b>	The importance of the community sector in respect of addressing alcohol and drug misuse is recognised, and particular emphasis needs to be placed on supporting community-based activities, especially strengthening community capacity to respond to alcohol and drug issues through identified outcomes.
<b>Promoting good practice in respect of alcohol and drug-related education and prevention</b>	<p>In developing or implementing education and prevention programmes, regardless of the target group or setting, due attention must be made to ensure that they are following sound conceptual principles and that they are following acknowledged and, where possible, evidenced good practice.</p> <p>In addition, cognisance should be taken of emerging patterns and trends of misuse (including new substances) – and approaches developed to address these.</p>

Key Priority	Description
<b>Harm Reduction approaches</b>	The overall aim of the NSD is to reduce alcohol and drug-related harm. Continuing support should therefore be given to further developing appropriate harm reduction approaches and strategies, which reduce the harmful consequences of substance misuse, with, particularly, a closer look at such approaches in respect of alcohol misuse.
<b>Workforce Development</b>	A broad range of workers has a key role to play in addressing substance misuse, and reducing substance misuse should be regarded as a core business to many services. It is clear that the successful implementation of the NSD will require colleagues in related sectors to recognise the significant contribution they can make to addressing drug and alcohol issues. Although numbers in the workforce are important, the competence of those staff has the most crucial relationship to achievement of the NSD aims. In particular, all those working with vulnerable individuals need to have a basic substance misuse knowledge and understanding. Therefore, a priority will be given to the development of agreed and appropriate competences across all sectors and access to supportive training, and agreed protocols for inter-service working/co-operation.

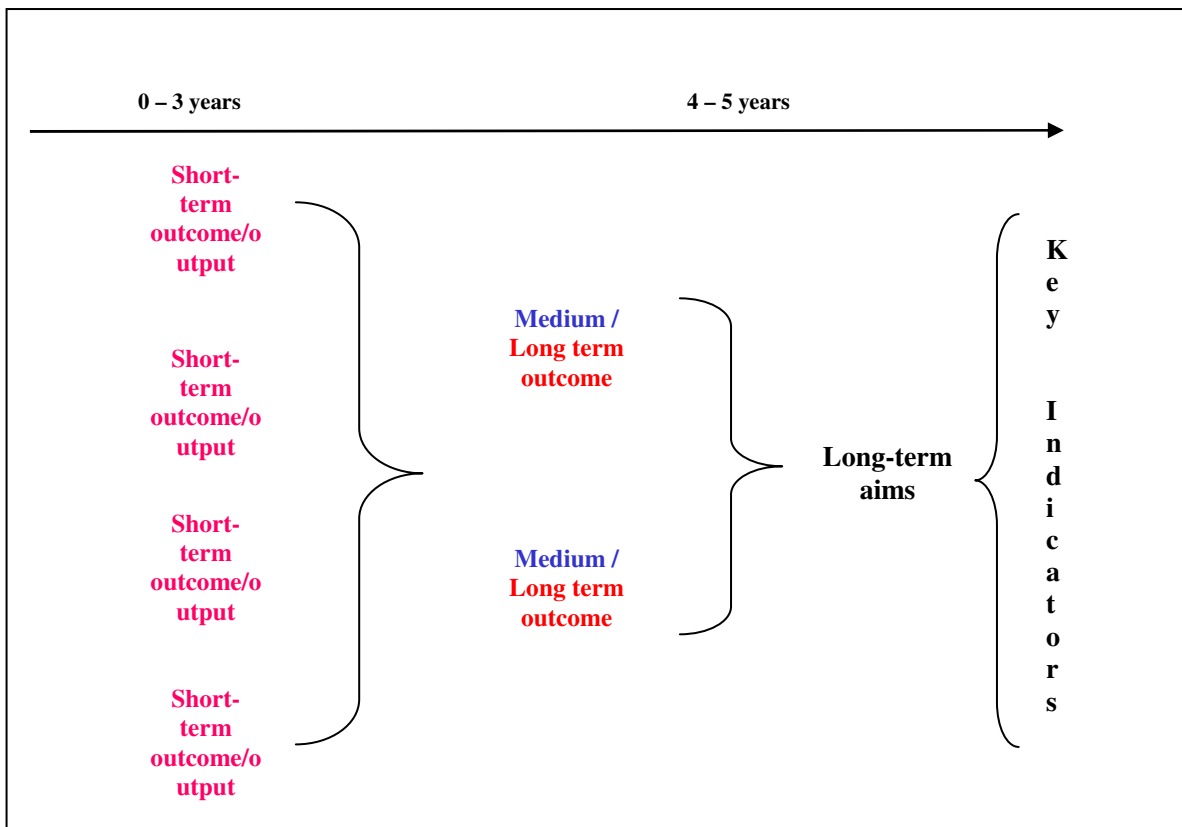
Question 12: Do you agree that these should be the Key Priorities for the NSD Phase 2? Are there other issues that you feel should be a Key Priority?

## 6. Outcomes

7.1 In order to deliver the overarching long-term aims of the NSD, a series of outcomes has been developed. Following the logic model approach a number of long-term outcomes was initially developed. A number of regional and local short and medium-term outcomes and outputs has subsequently supported these. These will provide the focus for activities and future work.

*(By short term, this means within 3 years, and medium to long-term within 4 - 5 years)*

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



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

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

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

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

## **Funding**

7.6 DHSSPS currently allocates around £8 million to the HSC for the implementation of the NSD each year. Given the commitments to ongoing outcomes contained in the NSD Phase 1 document, and the ongoing demand for such services, this revised document should be delivered within that funding (subject to the outcome of the ongoing budgetary and Comprehensive Spending Review process).

7.7 It should be noted that many other departments and delivery partners also invest in initiatives that help address this issue – the updated NSD recommends making the most effective use of existing resources whilst

investigating possibilities for gaining additional funding from a variety of sources.

## Annex A - Outcomes

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

0 – 3 Years	4 – 5 YEARS
Short Term Outcomes/Outputs	Medium Term / Long Term Outcomes
1. A five-year integrated population wide campaign undertaken to raise awareness of health impacts of drinking above the relevant guidelines.	<ul style="list-style-type: none"> <li>• Targeted local prevention and harm reduction programmes in place.</li> <li>• Reduction in the proportion of adults who have used drugs in the past year.</li> <li>• Reduction in the proportion of misusing prescription drugs in the past year.</li> <li>• Reduction in the proportion of adults who binge drink.</li> <li>• Increase in the proportion of adults who drink sensibly and responsibly.</li> <li>• Reduction in the proportion of drivers who are breath tested returning positive results.</li> <li>• Improved response and dissemination of information in respect of emerging substance misuse trends.</li> <li>• Increase in number of workplaces implementing alcohol and drug policies.</li> <li>• The current penalties and blood / alcohol limits associated with drink-driving considered with a view to strengthening them to reflect EU levels.</li> </ul>
2. Local community support services further developed.	
3. Good practice guidelines supporting and informing community-based initiatives and activities disseminated across Northern Ireland.	
4. Health professionals, and other relevant stakeholders, trained in undertaking brief alcohol advice/intervention programmes across Northern Ireland.	
5. Proposals developed on how alcohol is: <ul style="list-style-type: none"> <li>• priced (including minimum unit pricing)</li> <li>• promoted;</li> <li>• labelled; and</li> <li>• advertised.</li> </ul>	
6. Further development of local Service User Groups encouraged and supported.	
7. Information on emerging trends and drugs of misuse shared across UK and ROI Jurisdictions, particularly in relation to helping to inform the ACMD's statutory role in respect of the Misuse of Drugs Act.	
8. Further consideration given to the Misuse of Drugs Act - particularly in relation to emerging drugs of concern.	
9. All organisations promptly informed of changes to the drug and alcohol legislation.	

<p>10. Parents, communities and key professionals provided with accurate and timely information in relation to emerging drugs, including legal highs.</p>	<ul style="list-style-type: none"> <li>• Refined committal screening process for all new prisoners helps ensure the early identification of drug and alcohol problems.</li> </ul>
<p>11. Awareness/information campaign developed highlighting the harm related to the misuse of prescription drugs.</p>	
<p>12. Drink and drug driving (including prescription drugs) media campaigns continued and their impact assessed.</p>	
<p>13. Roadside drug screening devices in place when available.</p>	
<p>14. New roadside breath testing devices in place for drink drivers when available.</p>	
<p>15. To lower the proportion of positive preliminary breath test results</p>	
<p>16. Consideration given to a reduction in the drink drive (Blood Alcohol Concentration) Limit</p>	

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

**0 – 3 Years**

**4 – 5 YEARS**

Short Term Outcomes/Outputs	Medium Term / Long Term Outcomes
1. A Regional Addiction Services Commissioning Framework developed for Northern Ireland.	<ul style="list-style-type: none"> <li>Alcohol and drug users have access to appropriate and effective treatment and support services</li> </ul>
2. Services supported and encouraged to adopt a “recovery” approach to treatment and support services.	<ul style="list-style-type: none"> <li>Integrated, cross-departmental and cross-sectoral planning for treatment and support services in place.</li> </ul>
3. Protocols for the involvement of key stakeholders, including service users, developed and included in the Commissioning Framework.	<ul style="list-style-type: none"> <li>Evidenced based harm reduction approaches and activities in respect of alcohol and drug misuse promoted and expanded appropriately.</li> </ul>
4. Specific work in respect of identified vulnerable groups included in local action plans.	<ul style="list-style-type: none"> <li>Service users adequately and appropriately involved in planning and provision of treatment and support services.</li> </ul>
5. Improved co-ordination of harm reduction services, including ongoing monitoring, review and development of the needle and syringe exchange scheme and the substitute prescribing scheme.	<ul style="list-style-type: none"> <li>A body of legislation that will meet the needs of the Northern Ireland community to tackle alcohol and illicit drugs issues.</li> </ul>
6. Pilot scheme for ‘Take home Naloxone’ available for individuals identified as being at risk of opiate overdose.	<ul style="list-style-type: none"> <li>Increase in the number of problem users who access treatment and support services, including harm reduction services.</li> </ul>
7. Provision of needle and syringe exchange scheme continued, and consideration given to expanding the scheme to areas with an identified need.	<ul style="list-style-type: none"> <li>The establishment of co-operative working relationships between statutory, voluntary and community sectors that will deliver services to alcohol and drug misusing offenders continuing.</li> </ul>
8. Learning from existing schemes/initiatives, work undertaken across Northern Ireland to reduce levels of prescribing and support people to reduce/end unnecessary prescriptions.	

<p>9. Progress to work scheme delivered to help address the employability needs of problem substance users developed.</p>	<ul style="list-style-type: none"> <li>• Support for families of alcohol and drug offenders who are affected by alcohol and drug misuse further developed.</li> </ul>
<p>10. Support and promotion of workplace alcohol and drugs policies developed, and consideration given to updating the regional guidance.</p>	<ul style="list-style-type: none"> <li>• Organised gangs involved in supplying drugs to Northern Ireland disrupted.</li> </ul>
<p>11. Education and training for professionals, carers and families in relation to substance misuse problems in older people supported.</p>	<ul style="list-style-type: none"> <li>• The Criminal Justice Sector (including the NI Prison Service) continues to work with the Community Addiction Teams across NI.</li> </ul>
<p>12. Information and education campaign in respect of blood borne viruses targeting IDUs together with supporting information for professionals.</p>	<ul style="list-style-type: none"> <li>• An interface protocol developed between the Prison Service and Community Addiction Teams that would lead to a care pathway for prisoners leaving to return to the community.</li> </ul>
<p>13. Consideration given to extending arrest referral schemes to other areas across NI.</p>	<ul style="list-style-type: none"> <li>• Further developed discharge procedures, involving both in-prison health services and community and voluntary agencies, ensure prisoners have access to services and support across NI</li> </ul>
<p>14. 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.</p>	<ul style="list-style-type: none"> <li>• Reduction in 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.</li> </ul>
<p>15. 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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<p>16. Services further developed and available to prisoners that ensure appropriate interventions in place, including for those with opiate dependency.</p>	<ul style="list-style-type: none"> <li>• Drug testing for those offenders who volunteer or released from prison on a Life License.</li> </ul>

<p>17. Accreditation sought for the “Prison Addressing Substance Related Offending” programme or other appropriate programmes delivered in prisons.</p>	<ul style="list-style-type: none"> <li>• A range of programmes developed to meet the priority needs of offenders (with particular emphasis on the Sentencing Framework).</li> <li>• The ASRO programme for offenders rolled out across Northern Ireland.</li> <li>• PBNI provide funding through their Community Development Budget to secure the provision of substance misuse services in the community and voluntary sector.</li> <li>• Partnership work in place to deliver ASRO programmes to complement the P-ASRO programme for offenders.</li> <li>• Targeted treatment for prolific offenders with substance misuse related crime.</li> </ul>
<p>18. Work undertaken to reduce the risk of drug-related death in prisons, and particularly on release from prison.</p>	
<p>19. Education and information provided to parents regarding drugs and alcohol on a one to one basis and via the parents support group.</p>	
<p>20. Partnership work in place to deliver psychological and educational drug and alcohol programmes for all offenders.</p>	

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

**0 – 3 Years**

**4 – 5 YEARS**

Short Term Outcomes/Outputs	Medium Term / Long Term Outcomes
21. The current regional campaign, supported by local activities and initiatives, aimed at reducing alcohol and drug misuse among young people (aged under 18) evaluated and consideration given to its future.	<ul style="list-style-type: none"> <li>• Increase in the proportion of young people who see taking illicit drugs and getting drunk as socially unacceptable.</li> </ul>
22. Targeted education and awareness-raising among children and parents of the risks of drug and alcohol misuse	<ul style="list-style-type: none"> <li>• Reduction in the availability and accessibility of alcohol to young people.</li> </ul>
23. Families supported to be better informed about how to prevent the impact of alcohol and drug misuse.	<ul style="list-style-type: none"> <li>• Reduction in the proportion of young people who get drunk.</li> </ul>
24. Through the school setting, young people to have the skills and knowledge to enable them to resist social pressures to experiment with alcohol and drugs, including volatile substances, emerging drugs, etc.	<ul style="list-style-type: none"> <li>• Reduction in the proportion of young people who drink on a regular basis.</li> </ul>
25. Work undertaken to encourage further parental responsibility, and potential involvement in prevention and support programmes.	<ul style="list-style-type: none"> <li>• Reduction in the proportion of young people who take drugs on a regular basis.</li> </ul>
26. Young People’s Drinking Action Plan implemented.	<ul style="list-style-type: none"> <li>• Opportunities exist for young people to make a positive contribution, including through reparative placement, to the drugs and alcohol strategy e.g. using peer education to advise others of the risks etc.</li> </ul>
27. Successful implementation of new liquor licensing regulations and laws.	
28. 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.	
29. A One-Stop-Shop service, informed by the evaluation of the pilot project, available across Northern Ireland to those young people (and their families) affected by substance misuse, but also addressing related issues such as suicide and self-harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping with school / employment	
30. Guidance on the operation of Test Purchasing reviewed after it has been operation for 1 year.	
31. Greater information sharing between PSNI, the Youth Justice	

<p>Agency (YJA) and PBNI etc 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.</p>	
<p>32. More opportunities created through Youth Conferences, for young people involved in alcohol or drugs related offending to hear first hand experiences from adults who have experienced dependency but have addressed it.</p>	
<p>33. 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.</p>	

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

**0 – 3 Years**

**4 – 5 YEARS**

Short Term Outcomes/Outputs	Medium Term / Long Term Outcomes
34. Treatment and Support Services for those aged under 18 made a key element of the addiction services commissioning framework.	<ul style="list-style-type: none"> <li>All organisations with a responsibility for young people have a policy in respect of reducing alcohol and drug related harm.</li> </ul>
35. Through the commissioning framework, appropriate youth intervention services provided across Northern Ireland.	
36. Family support services available across Northern Ireland, and treatment services supported and encouraged to take a family orientated approach to provision where appropriate – reflecting the strategy of “Think Child, Think Parent, Think Family”.	<ul style="list-style-type: none"> <li>Improved identification and signposting of young people who have alcohol and drug related issues, and ongoing monitoring of the Regional Initial Assessment Tool.</li> </ul>
37. The Regional Hidden Harm Action Plan implemented	<ul style="list-style-type: none"> <li>Children and young people have access to early interventions and appropriate support services directly related to their alcohol and drug use.</li> </ul>
38. The Regional Initial Assessment Tool embedded within the Youth Justice Agency, and work taken forward to encourage its use in key sectors.	
39. Within the custodial setting of Woodlands, young people assessed regarding their drug and alcohol misuse, with appropriate screening and management systems in place to minimise risk to those young people who admitted to custody under the influence of substances.	<ul style="list-style-type: none"> <li>Increase in the number of young people and parents accessing treatment and support services increased.</li> </ul>
40. 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.	<ul style="list-style-type: none"> <li>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.</li> <li>Relationships with a wide range of community and voluntary drug and alcohol treatment providers maintained and YJA making appropriate referrals.</li> </ul>

**Anti-Social Behaviour**

**0 – 3 Years**

**4 – 5 YEARS**

Short Term Outcomes/Outputs	Medium Term / Long Term Outcomes
41. Existing relationships between CSPs, DPPs and DACTs developed in respect of addressing alcohol and drug related anti-social behaviour.	<ul style="list-style-type: none"> <li>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.</li> </ul>
42. 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.	<ul style="list-style-type: none"> <li>Increase in the level of public confidence in how alcohol and drug-related issues, and their impact at community level are addressed.</li> </ul>
43. Promotion of schemes at a local level that tackle anti-social behaviour linked to alcohol misuse (and underage drinking).	
44. Consideration given to the outcomes of the Alcohol and the Night Time Economy Seminar – and development of an action plan.	
45. Work with the Alcohol industry and Pubs of Ulster on the possible introduction of Purple Flag accreditation into NI	
46. The OCTF Drugs Expert Group sharing information and intelligence, and monitoring and overseeing joint action by its partner organisations, to ensure ongoing disruption of the drugs market, and help reduce the availability for drugs.	

**Supporting Outcomes – Monitoring, Evaluation and Research**

**0 – 3 Years**

**4 – 5 YEARS**

<b>Short Term Outcomes/Outputs</b>	<b>Medium Term / Long Term Outcomes</b>
47. The Regional Impact Measurement Tool continuing to be completed for all initiatives funded as part of the New Strategic Direction.	<ul style="list-style-type: none"> <li>Improved response and dissemination of information in respect of emerging substance misuse trends.</li> </ul>
48. The Regional Impact Measurement Tool considered and further developed	<ul style="list-style-type: none"> <li>More detailed and relevant information in respect of alcohol and drug misuse available.</li> </ul>
49. Existing monitoring systems (DMD, Substitute Prescribing and Needle Exchange) maintained and an alcohol misuse database established.	<ul style="list-style-type: none"> <li>Progress in respect of aims of New Strategic Direction described accurately and reported on.</li> </ul>
50. A rolling research programme developed and updated on an annual basis.	<ul style="list-style-type: none"> <li>PBNI considered how best to deliver their Alcohol Management Programme and implement appropriate delivery arrangements.</li> </ul>
51. Available statistics and research information published.	
52. A local “Early Warning System” in respect of alcohol and drug trends and developments in place which reports to the NSD Steering Group.	<ul style="list-style-type: none"> <li>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.</li> </ul>
53. Review of Prison strategy to tackle alcohol and drug issues among prisoners undertaken.	
54. Improved quality and scope of data on drink and drug driving, including consideration given to the provision of separate data on drink and drugs present in road fatalities and the provision of separate trend data on fatal and serious injury collisions	<ul style="list-style-type: none"> <li>The delivery of drugs and alcohol programmes, delivered with young people in the community, evaluated by YJA.</li> </ul>
55. Results of the Night-time Economy module of the NI Crime Survey published	

**Supporting Outcomes – Workforce Development**

**0 – 3 Years**

**4 – 5 YEARS**

Short Term Outcomes/Outputs	Medium Term / Long Term Outcomes
56. Workforce development co-ordination improved.	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Dissemination of DANOS across Northern Ireland.</li> <li>• Improved competence and capacity of the alcohol and drug misuse, and wider, workforce.</li> </ul>
57. Improved awareness and opportunity for Criminal Justice Organisations to avail of training programmes.	
58. Organisations work together to share information and secure a greater understanding on the composition and impacts of legal highs (or any other new drug)	
59. The development of Drugs and Alcohol National Occupational Standards (DANOS) appropriate for all sectors in Northern Ireland.	
60. Training in respect of Hepatitis C and other blood borne viruses for those working with IDUs continues delivered.	
61. YJA ensure that service delivery staff have the skills and knowledge to deliver alcohol and drugs interventions at tier 2	
62. YJA ensure that medical staff within Woodlands have access to updated information about new drugs and their effects in order to manage any presenting risk and to inform an ongoing treatment plan within custody	

Question 13: Do you agree with the outcomes set out in Annex A. Are there other areas that should be considered or specific outcomes that should be added?

**Annex B****Equality Impact Assessment****EQUALITY CONSIDERATIONS NORTHERN IRELAND ACT 1998**

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

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

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

*(b) between men and women generally;*

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

*(d) between persons with dependants and persons without.*

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

**POLICY AIM AND GROUPS AFFECTED**

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

As part of the consultation, the Department welcomes your views on this screening decision, particularly in relation to the following question:

Question 14: Do you feel that the New Strategic Direction’s proposals are addressing adequately those categories of people within the remit of Section 75?

The Department will consider all responses before finally deciding whether an Equality Impact Assessment is necessary.

## Annex C

### **How to Respond to the Consultation Paper**

The Department welcomes your responses and comments on any aspect of this document. They should reach the Department by **31 May 2011**.

A response can be submitted by letter, fax, e-mail or via the Department's website. Details are:

**NSD Phase 2 Consultation**  
**Health Development Policy Branch**  
**Department of Health, Social Services and Public Safety**  
**Room C4.22**  
**Castle Buildings**  
**BELFAST**  
**BT4 3SQ**  
Tel: (028) 9052 0540  
Fax: (028) 9052 8490  
E-mail: [HDPB@dhsspsni.gov.uk](mailto:HDPB@dhsspsni.gov.uk)  
Website: [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

Please ensure that responses are clearly marked '*A Response to the Consultation on Phase 2 of the New Strategic Direction for Alcohol and Drugs*'.

Additional copies of the document, free of charge, can be obtained by contacting the address above or from the 'Consultations' section of the Department's website.

Versions of this document, in other languages, large type, Braille and audiocassette may be made available on request.

### **Freedom of Information Act 2000 - Confidentiality of Consultations**

The Department will publish a summary of responses following completion of the consultation process. Your response, and all other responses to this consultation, including personal information, may be published or disclosed on request in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA).

The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely the Department in this case. This

right of access to information includes information provided in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential. If you do not want information about your identity to be made public, please include an explanation in your response.

If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- The Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department's functions and it would not otherwise be provided;
- The Department should not agree to hold information received from third parties 'in confidence' which is not confidential in nature; and
- Acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or the web site at: <http://www.informationcommissioner.gov.uk/>). For further information about this particular consultation, please contact the Health Development Policy Branch Drugs and Alcohol Strategy Team at the above address.

An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

## Annex D

### Consultation Questions

#### Approach to Extension of NSD

**Question 1:** Do you agree with the approach being proposed by the NSD Steering Group, to reviewing, revising and extending the NSD to 2016?

#### Appropriateness of Available Information

**Question 2:** Are you aware of any relevant information not contained in the Update Report that would inform the revision and extension of the NSD?

#### Revised Implementation Structure

**Question 3:** Do you feel the proposed revised implementation structure is fit for purpose to deliver the NSD Phase 2?

#### Statistical Information

**Question 4:** Are you aware of any other statistics not included in this document or the NSD Update Report that would help inform the revision and extension of the NSD?

#### Aim of NSD Phase 2

**Question 5:** Is the Overarching Aim of NSD Phase 2 appropriate, and are the associated long-term objectives appropriate to deliver the overall Aim? Are there others we should consider?

#### Indicators of Harm

**Question 6:** Do these indicators provide a relevant range of information that can be used to assess progress against the overarching aim, and long-term objectives, of the NSD Phase 2? Are there other indicators we should/could use?

## Values

**Question 7:** Do you agree with these values? Are there any other values that should be included, or you feel are important?

## Principles

**Question 8:** Do you agree with these principles? Are there any other principles that should be included, or you feel are important?

## Revised Pillars

**Question 9:** Are the revised five Pillars still relevant? Do you agree with these Pillars? Are there any other areas that should be included as a Pillar?

## Themes

**Question 10:** Are the two Themes still relevant? Do you agree with these Themes? Are there any other areas that should be included as a Theme?

## Emerging Issues

**Question 11:** Do you agree that these are the key emerging issues for alcohol and drug misuse since the publication of the NSD? Are there other issues that need to have a stronger emphasis in the NSD Phase 2?

## Key Priorities

**Question 12:** Do you agree that these should be the Key Priorities for the NSD Phase 2? Are there other issues that should be a Key Priority?

## Outcomes

**Question 13:** Do you agree with the outcomes set out in Annex A. Are there other areas that should be considered or specific outcomes that should be added?

## Equality

**Question 14:** Do you feel that the New Strategic Direction's proposals are addressing adequately those categories of people within the remit of Section 75?

## Annex E

## Terms of Reference and Membership of Groups

## NSD STEERING GROUP - Membership

<b>Dr Michael McBride</b>	(Chief Medical Officer, DHSSPS)
<b>Koulla Yiasouma</b>	(Children, Young People & Families Advisory Group Chair)
<b>Professor Ian Young</b>	(Alcohol Advisory Group Chair)
<b>Declan McGeown</b>	(Law & Criminal Justice Advisory Group Chair)
<b>Julie Smyth</b>	(NDACT Chair)
<b>Gary McMichael</b>	(EDACT Chair)
<b>Yvonne McWhirter</b>	(WDACT Chair)
<b>Kieran Devlin</b>	(SDACT Chair)
<b>Eugene O'Goan</b>	(Northern VCSN Chair)
<b>Anne Bill</b>	(Eastern ISF Chair)
<b>Jenny Irvine</b>	(Western ISF Chair)
<b>Craig Cook</b>	(Southern ISF Chair)
<b>John Spence</b>	(HM Revenue & Customs)
<b>Sharon Beattie</b>	(PSNI Strategic Partnership & Development)
<b>Owen O'Neill</b>	(Public Health Agency)
<b>Geraldine O'Hare</b>	(Probation Board NI)
<b>Linda Wilson</b>	(Dept of Education)
<b>Deirdre Kenny</b>	(DoE Road Safety)
<b>Dr Philip McClements</b>	(NI Prison Service)
<b>Mick Cory</b>	(Dept for Culture, Arts & Leisure)
<b>Liam Quinn</b>	(Dept of Social Development)
<b>Stephen Jackson</b>	(Dept for Employment & Learning)
<b>Nicola Carruthers</b>	(NI Drinks Industry Group)
<b>Kieron Moore</b>	(Public Health & Information Research Branch, DHSSPS)
<b>Gary Maxwell</b>	(Health Development Policy Branch, DHSSPS)
<b>Rob Phipps</b>	(Health Development Policy Branch, DHSSPS)

## **NSD STEERING GROUP – Terms of Reference**

### **Function**

As part of the NSD implementation process, a Steering Group will be set up.

Its function will be:

- to consider alcohol and drug-related issues and proposals brought to it by members and those teams and groups represented on it;
- to comment on and/or suggest proposed changes to the current strategic direction
- to monitor and provide an overview in respect of the NSD and its outcomes; and

### **Key Principles**

Within the NSDSG, there will be:

- Clear understanding of status, objectives, conduct and roles; and
- Openness in sharing information wherever possible.

The processes underpinning these principles are set out below.

### **Membership and Representation**

Appointments will be made based on achieving a balanced and representative grouping that reflects the issues involved, with members contributing based on their knowledge and background. However, where appropriate, members should be able to commit their organisations to certain actions.

### **Terms of Reference**

- To agree proposals on future policy issues and priorities to address alcohol and drug-related issues
- To agree on future public awareness programmes
- To agree on future research priorities and the implications of research results for policy.

- To agree on the development of the future strategic direction
- To monitor progress in implementation of the appropriate regional and local outcomes

*In practice, this will involve:*

- Discussion of relevant policy and strategic issues
- Observation, at a strategic level, of the implementation of the short, medium and long term outcomes contained in the NSD

## **Processes for Engagement**

- Meetings should take place at least 2 times a year
- Meetings will normally be chaired by Chief Medical Officer DHSSPS or, if unavailable, a DHSSPS senior official.
- HDPB officials will attend meetings in support of the NSD Steering Group.
- HDPB will provide a secretariat service to the Steering Group.
- Wherever possible, papers for meetings will be circulated to members one week in advance of each meeting.
- Minutes of meetings will record proceedings in a non-attributable format. These will be published on the website, as will the list of members. At the outset, these will record the processes for engagement.

## **NSD ADVISORY GROUPS - TERMS OF REFERENCE**

### **Function**

As part of the NSD implementation process, Advisory Groups will be set up to provide advice for the NSD Steering Group that draws on expertise in relation to the strategic priorities and needs of specific strategic areas. Each Advisory Group will bring together key stakeholders and experts in respect of the issue. The three current Advisory Groups are:

- Children, Young People and Families;
- Alcohol;
- Law and Criminal Justice.

The function of each Advisory Group will be to advise, comment, and provide formative feedback on the NSD and its outcomes and on those relevant issues related to their specific remit.

### **Key Principles**

Within each Advisory Group there will be:

- Clear understanding of status, objectives, conduct and roles; and
- Openness in sharing information wherever possible.

The processes underpinning these principles are set out below.

### **Membership and Representation**

Appointments will be made based on achieving a balanced and representative grouping that reflects the issues involved, with members contributing based on their knowledge and background. Each Advisory Group will have a common core membership consisting of:

- HDPB officials
- DACT representatives\*
- Voluntary & Community representatives

- PHA / HSCB representatives
- PHIRB

\* *where possible, DACT representatives to have an understanding/experience of the Advisory Group area of activity*

In addition each group will have members who will bring with them expertise, understanding and insights in respect of the particular issue. Further information on this and proposals on voluntary/community and key stakeholder representation will be in attached annexes.

At the discretion of the Advisory Group, representatives from other organisations may be co-opted or invited to attend particular meetings or for certain agenda items.

Any member unable to attend a meeting will be entitled to send a deputy, with prior agreement from secretariat.

### **Terms of Reference**

- To advise, at a strategic level, on the implementation of the NSD in respect of children, young people and families/ alcohol misuse / law and criminal justice / treatment and support
- To note progress in implementation of the appropriate regional outcomes
- To advise on future policy issues and priorities to address
- To advise on future public awareness programmes
- To advise on future research priorities and the implications of research results for policy.
- To consider and advise as appropriate on the development of the future strategic direction

*In practice, this will involve:*

- Observation, at a strategic level, of the implementation of the short-term outcomes contained in the NSD
- Discussion of relevant policy and strategic issues
- Bringing relevant issues to the attention of the NSDSG

## **Processes for Engagement**

- Meetings should take place at least 3 times a year
- Meetings will normally be chaired by an appropriate senior figure with expertise in the area of activity or, if unavailable, a HDPB/DOJCSU senior official.
- HDPB/DOJCSU officials will attend meetings, as appropriate, in support of the Groups.
- HDPB/DOJCSU will provide a secretariat service to the Groups.
- Wherever possible, papers for meetings will be circulated to members one week in advance of each meeting.
- Minutes of meetings will record proceedings in a non-attributable format. These will be published on the website, as will the list of members. At the outset, these will record the processes for engagement.
- Groups may invite presentations from individuals or representatives of organisations, as appropriate.

## **Areas of Activity**

Each Advisory Group will have its own specific areas of activity.