Setting Direction Together

To change the culture and patterns of alcohol and drug use in Belfast in order to reduce damaging trends over the next ten years.

26th, 27th & 28th September 2012, Mossley Mill, Newtownabbey.

Belfast Strategic Partnership
supported by
Belfast Health Development Unit

Contents

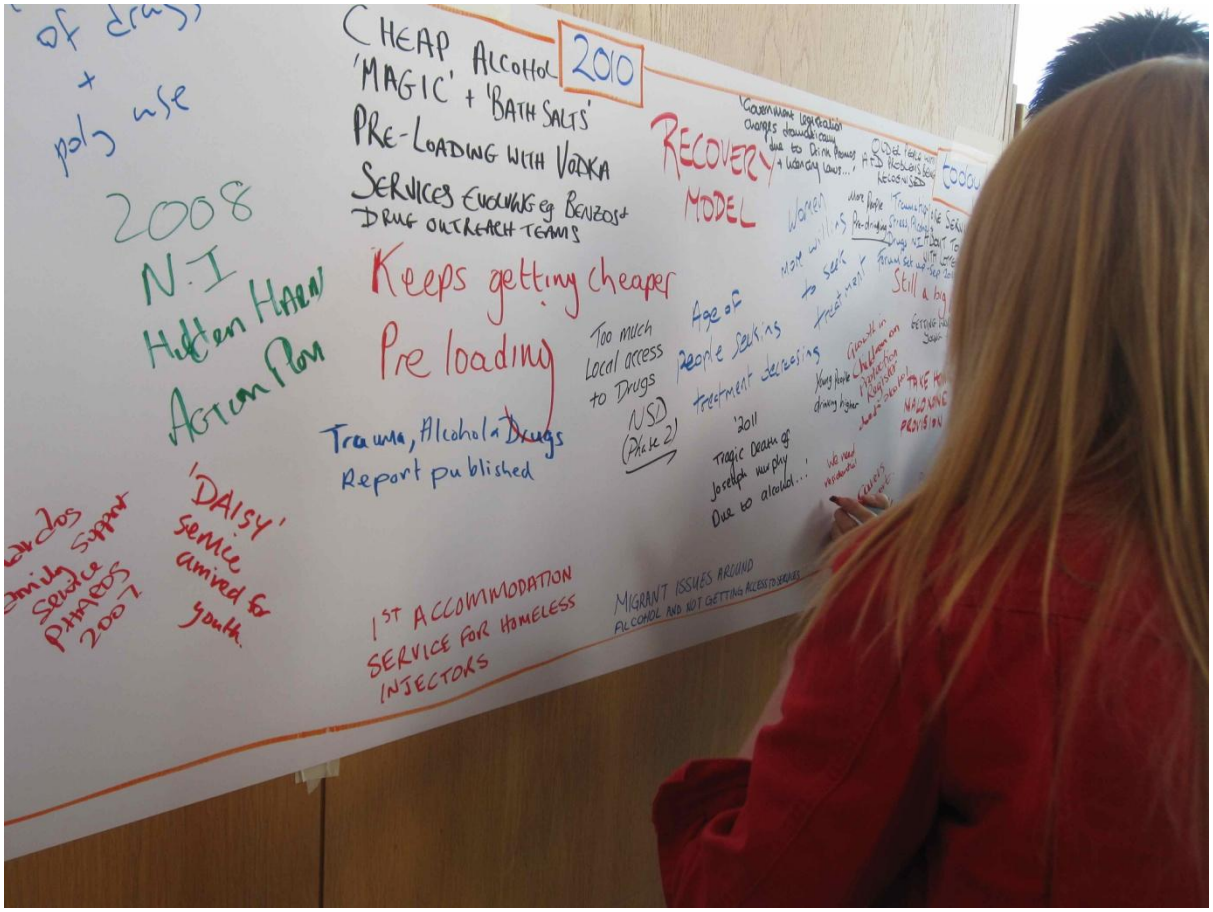
Introduction

This is the narrative report of the Future Search Workshop held at Mossley Mill on September 26, 27, and 28, 2012. As a narrative report it is made up from the contents of the flip chart pages compiled by the participants as well as the comments made during "whole group" discussions which took place at the end of each workshop session. The report follows the chronological flow of the event, starting with an examination of the past, through to looking at the present, the creation of preferred scenarios for the future, the common ground that participants want to see happen, and the next steps to move the common ground to action. Eighty participants signed up to attend the event. They were allocated to one of eight stakeholder groups including senior managers, client voice, advocates for at risk groups, commissioners, community perspective, service providers, youth perspective, and criminal justice/community safety.

Session One: Focus on the Past – Participants Create Timelines

***Purpose**: To develop a shared picture of our world, our experiences, our histories and our values. We will decide what this means for our work in this meeting*

Participants worked alone to fill in key events and memories onto three timelines, one from a global perspective, one from a personal perspective, and one from the perspective of alcohol and drugs in Belfast, all from the 1980's and before up to the present day. We have not written up the content of each of the timelines but this photo gives an indication of what they were like.



Session Two: Establish a Framework for a Shared Conversation – Participants Analyse Timelines

In their mixed groups, participants looked at the information on the timelines to tell a story about the people in the room, about how global society has changed in the recent past, about the recent past of alcohol and drugs in Belfast, and about all three timelines together and how they connected to or differed from each other.

Personal TimeLine – Group 4 (1980's, 90's up to 2000)

Themes – life changing and life shaping events
Hatches, matches and dispatches/departures
Story of survivors (death is there but outweighed by a lot more of birth, life and determination to survive some very difficult lives for some people)
Inspiration and influence – trans-Atlantic USA and Latin America, mentors here (now models, including trauma, PTSD)
Community:

- Faith encounters
- Cross-community work/contact
- Immigration/emigration
- Community activism

Politics – Ceasefire not registered at all
90's – heroin – scare of injecting

Personal Timeline – Group 1 (2000 to present day)

Colourful – people – creative
Changing evolving
Circle of life and death
Journeys – personal and professional and cross-over
Success and failure
Wealth of experience European and international – global context of work practice
Personal/tragedy/joys
Personal/family/friends use re alcohol and drugs
Rollercoaster – wheeee!
Progressing in learning – further education
Less change towards end of timeline? Recession?? Less opportunity
Life's focus changes to children i.e. son got married
Returning to previous career
We have:

- Huge life experience to frame the work we are involved in
- Personal trauma – fuelling empathy, compassion, non-judgemental practice, etc
- Great diversity to truly make a difference to the culture of misuse
- True resilience – less negativity re debt, funding, etc
- Limited to who we have in the room – disclosure? Lack of service users?
- This in turn can limit empathy/compassion!

- Capacity to manage / accept change within the rollercoaster journey

Framed by "still trying to make a difference"

Global Timeline – Group 3

Global Events

Rise of capitalist model economically and socially (no such thing as society/Loadsamoney to global banking crisis)
Rise of means of mass communication and mass travel (internet, mobile phones, holidays)
Individualism and weakening of social cohesion
Global and local conflict (end of Cold War, Peace Process, Troubles)

Implications for the work we have to do

Work to change cultural perceptions (to drink, to freedom) (seat belt wearing, smoking ban, etc)
Resilience and erosion
Trans generational post-traumatic stress
Alcohol policy (pricing, marketing, costs/taxation)

Global Timeline – Group 6

Global – political

End of Cold War → Resolution of old conflicts
↓
Alignment of nations – EU, USA/Russia/China
↓
Development of new global definition of conflict – terror

Local – political

Security crisis/conflict
↓
Peace Process/resolution?
↓
More localised control
↓
More free society – stability
↓
Attitudinal change – less division? → Multicultural

Economic

Open markets develop
↓
Economic growth → boom society
↓
Leads to economic failures
↓
Greater economic threat → affecting confidence, opportunity

Social
Greater availability and choice
↓
Social interaction increase (technology, mobility)
↓
Complex lives, accepted as norm
↓
Greater social legislation, drinking hours, smoking
↓
Global information access
↓
Celebrity culture

Alcohol and Drugs in Belfast Timeline – Group 8 (1980's – 1999)

Going out not so easy
Change in culture
- No preloading
- No post drinking

Stay in own communities – at homes, shebeens and local clubs
Women less likely to be seen drunk
Heroin emerging in Holylands – Holylands seen as "safe" area
City centre not safe to drink in/socialise. Pockets in city centre
Drug culture mid 80's
- Cross community element
- Acceptable/tolerance of drug use

Licensing laws mid 90's – sale of alcohol – supermarkets
Role of paramilitaries pre/post ceasefires
- Punishment shootings/beatings
- "Agreed" markets

Being "plastered" is exception
Abstinence focused treatment
Prescription drugs 90's →
Club culture
Greater availability of money to drink
Children learning from parents and peers
Alcohol unlikely to be in homes, predominated in pubs/clubs/off-licence
Buying alcohol with good/groceries uncommon
Limited range of alcohol products
- No culture of shots
- More likely to have or stick to beers

Acceptability of underage drinking
Emergence of street drinking in 80's
People becoming homeless due to drinking

Alcohol and Drugs in Belfast Timeline – Group 7 (2000 – 2010 – today)

Increased drug use
Supermarket sales – 2000
1998 on – large scale drug trade
Cannabis and cocaine only
Gang warfare – feuds (2001)
Limited community responses
Pubs open longer/supermarkets sell alcohol
Prescribed medication
2005 New Strategic Direction "NSD" Strategy → Hidden Harm Action Plan NI
EDACT

- funding to deliver services
- community and voluntary
- increase in services
- closer collaborative work between stat and comm

Troubles

- Cessation
- Prescription drugs
- Benzo programme

2007 smoking ban
2009 –
legal highs impact
Black market prescription drugs
Night time economy
Binge culture
Age groups
Gender groups (LGBT) — different experiences
BME groups — access to services, language barriers
Groups on the fringe — culture – drinking seen differently
Young people pre-loading — binge drinking
Older: wine, stress relief, isolation, habit
Services developed to respond to different / multiple issues
Overlap –

- Mental health
- Hidden harm
- Suicide
- Self-harm
- Young people

Impact on family
Family and youth services developed
Polydrug use
Evaluation and reports
Steroid use
Increase in intravenous drug use

All Timelines – Group 5

<u>World events</u>
History repeating itself
Influence of the media
Advancement of technology
New media
Negative media
More focus in UK and NI
Negative perspective of NI
Changing trends of alcohol
Research chemicals
Change in cultural attitudes
Wars and disasters
More diverse communities
"Troubles" related events

<u>Personal Timeline</u>
Personal – birth, death, marriages, divorces and relationships
Suicide
Drug use and addiction
Careers/employment – CV – health to make a difference
Cross-community work
Travel and moving away
Personal tragedies
Financial events – house
Health events
Less focus on Troubles

<u>Alcohol and Drug Use in Belfast</u>
Availability of drugs – easy/local access
Closure of services vs. new services
Paramilitaries and drug trade
Equal focus on alcohol and drugs
Named deaths
Trends and patterns
Strategies/reports/plans/structures

All Timelines – Group 2

Political conflict → drugs
Recession → wealth → recession
Society → individualism
Increase in availability and consumption (drugs and alcohol)

Whole Group Discussion on Timelines

At the end of each set of reports by the small groups the participants take the opportunity to have a conversation across the room to deepen the insights among the whole group.

Life is more complex now – is it harder for folks to cope and solve problems?
We can't rely on the state. There are more problems in society just now, so more services are needed, but there is no money for them, and this leads to a vicious circle. How do we support people?

We need a different way of thinking away from "all for themselves" – we need collaboration of the state and community sectors.

There is a high level of positivity and resilience in the personal stories – how can we build this resilience into society to make our work stronger?

Looking at the big picture. There is no mention of temperance in the past here! Happened on both sides of the community and had a protective aspect/impact on society.

We got more right in the development of services that we got wrong. Lots of this was done in the voluntary/community sector. Innovation is the right thing to do and it needs built on. Use the experience in this room!

There is a lack of prevention – we need to not just treat the end problem. For example, the culture of preloading, especially in the recession.

The importance of looking at trauma, and post-traumatic stress disorder and alcohol and drugs in a Northern Ireland context.

Highlighting preloading again, and the links to violence and assaults.

There has been lots of change in service provision. There has been an increase in provision and in diversity of services. The voluntary/community sector has been able to be more reactive to new changes. How to best respond to changes in the landscape (both services providers and communities)?

We can see patterns, but things change, and now change is accelerating through global society and interactions and complexity. This means that we need to think about where we will be in 5/10/15 years' time, anticipate and then plan around that. By the time we catch up with changes, the change has moved on to something else.

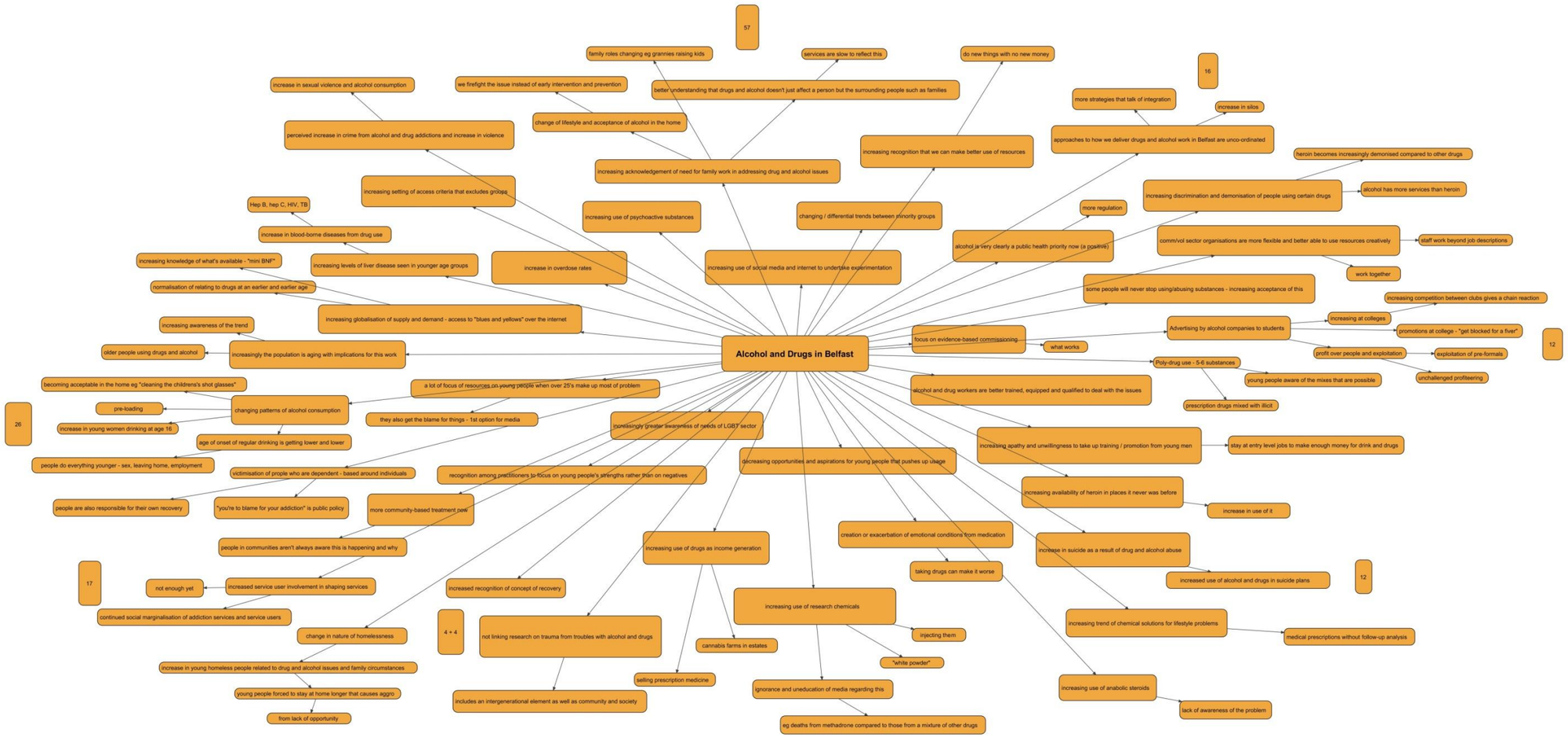
Enforcement – what about the private sector and those who sell alcohol to drunk people?
All drugs – which are really dangerous, and where should we focus to achieve maximum reduction in harm?

How do we change attitudes and create cultural changes? We need a complete change in our society away from "what we own" towards "what we are."

Session Three: Focus on the Present – Trends Affecting Alcohol and Drugs in Belfast

***Purpose**: To build a picture of all the key trends: social; economic; attitudes; legal; technology etc that impact the work we are trying to do*

Participants all contributed information to a mind map around the question: "What are the external trends affecting Alcohol and Drugs in Belfast that we all need to be aware of?" Links between the information on the mind map were identified, and then used sticky dots to highlight the trends that are most important to their particular stakeholder group.



Whole Group Discussion – Mind Map

- Lot of sticky dots on branch for increasing acknowledgement of need for family work
- User involvement is highlighted
- There is a lack of dots on emotional issues
- Some small branches have lots of dots
- Shocked at lack of dots on overdose
- The need for advocacy runs through lots of groups/clusters
- The three dots on social media are all from the youth perspective
- On highlighting the approach to delivery, the dots are mostly from youth and service users
- There was a difficulty as a service user in placing the dots – education isn't anywhere, nor is temperance (these may be linked)
- There is some overlap of the "family" line – lots of overlap and linkages with others
- The only dots on "some people will never stop" are from service users – have the other groups here not accepted that?
- Surprised that there is not more interest in training and skills of drugs and alcohol workers – what does this mean? Is it an issue of confidence in addressing the issue? It also ties in to education, of service providers as well as users.
- Is it about resources? This is tied closely with different/new ways of using resources
- Service providers are talking about recovery, research, etc – good to see their emphasis on knowing this
- There is nothing in criminal justice which is worrying. Also a remarkable lack of emphasis on enforcement of existing legislation. Enforcement is a very heavy stick to use to solve the problem, is the solution in other areas than PSNI, for example the license trade, personal responsibility, etc

- Highlight of liver disease and blood borne viruses as increasing problems – there is a problem of accommodation for people with these diseases, especially with young people ending up in nursing homes when they get very ill
- These things are all interlinked and interwoven
- The issues are wider than just families, its whole communities too
- There's a gap, about women who inject and increased use of substances by women, and the link to sex work
- Poverty
- Surprised at the emphasis on evidence-based work – does this show the confidence in people on the ground, and what they need to take to commissioners?

Lines/Clusters highlighted by whole group in terms of dots and discussion

- Family focus
- Changing patterns of consumption
- Increase in service user involvement
- Increase in suicide role
- Uncoordinated service delivery
- Role of advertising

Session Four: Focus on the Present – How Trends Affect What We Do

***Purpose**: In Stakeholder Groups - To make connections among key trends and learn what people are doing now and want to in the future*

Group A – Criminal Justice/Community Safety

1. increase in crime and violence from drug and alcohol addictions
2. normalisation of drug and alcohol misuse
3. weakening of community and family structures

Improve partnership working

- Collaborative working
- Political buy-in

ID best practice models

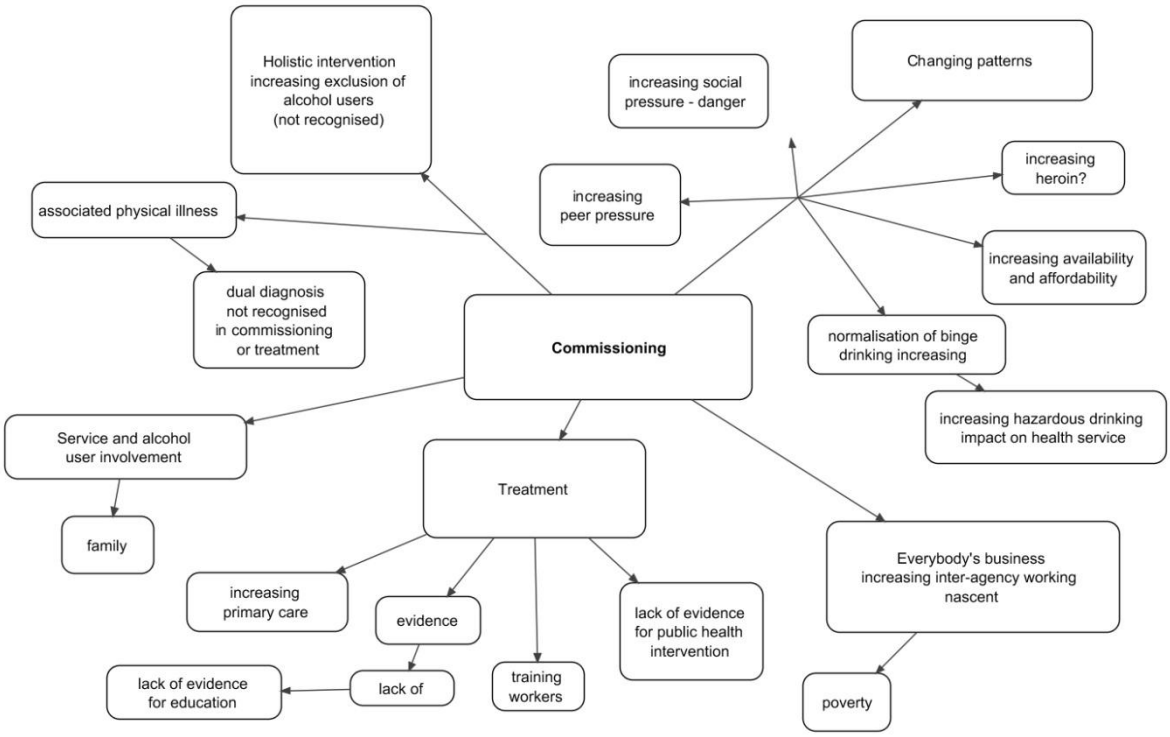
Working in partnership

- ROP
- Alcohol industry
- Get home safe
- Signposting
- Drug arrest referral
- NSD / CSS

Challenging attitudes and behaviour

- Each other
- Client group
- Families

Group B – Commissioners



Group C – Senior Managers

1. Constraints (trend)

↓

- Systems
- Performance management
- Complexity (no clear pathway) Relationships/loopholes overcome this (NOT the actual formal system)
- Awareness of services

2. Joined up working (trend)

- ↑positive joined up working (recognition that this is pivotal to service delivery)
- BSP – agreed priorities, community engagement

3. Early onset

- Early consumption
- Family breakdown
- ↑ levels of homelessness in young people
- Welfare reform (lack of opportunities & employment aspirations)
- Developmental/ability to change
- Availability/access to drugs and alcohol (evidence of some joined-up thinking – way to go)
- Vulnerability

4. Mental health/substance use/misuse

- Good mental health
- Mental unhealth

Inextricably linked

↓

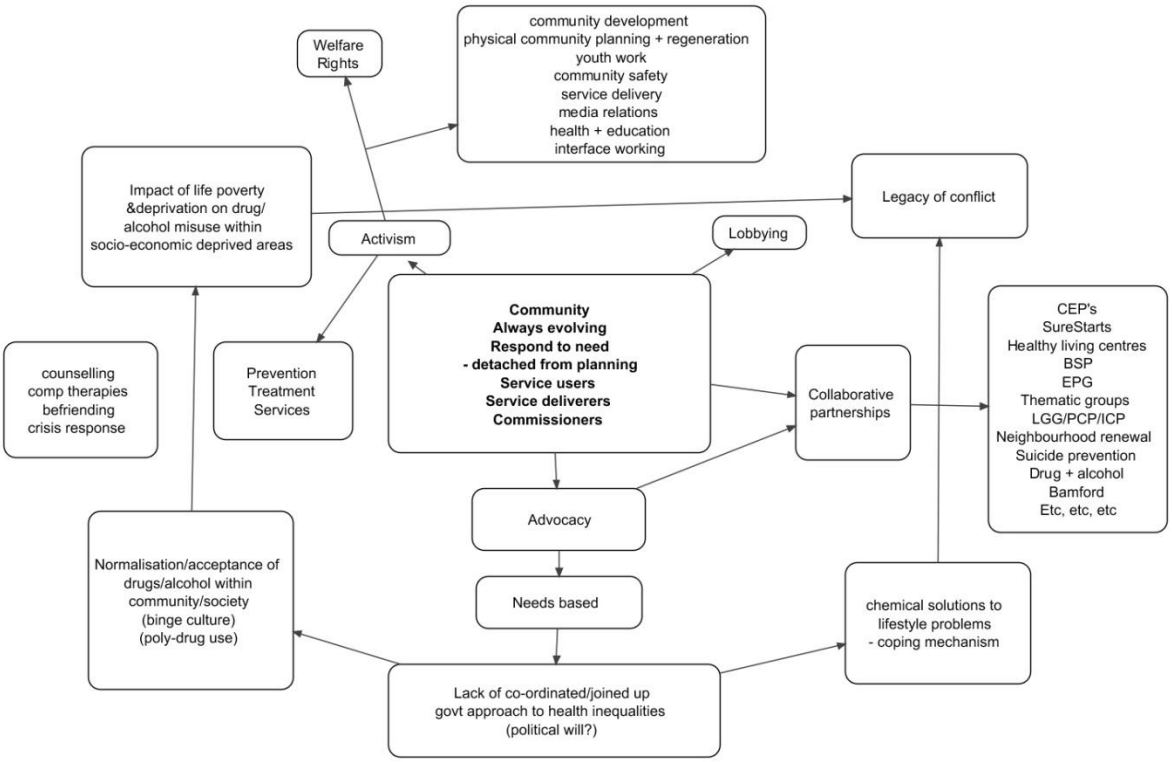
BSP – Priority – action plan in pipeline

MH ↙ ↘ D&A

Joint members

But need to move to joint service design/joint commissioning, especially for these two issues

Group D – Community Perspective

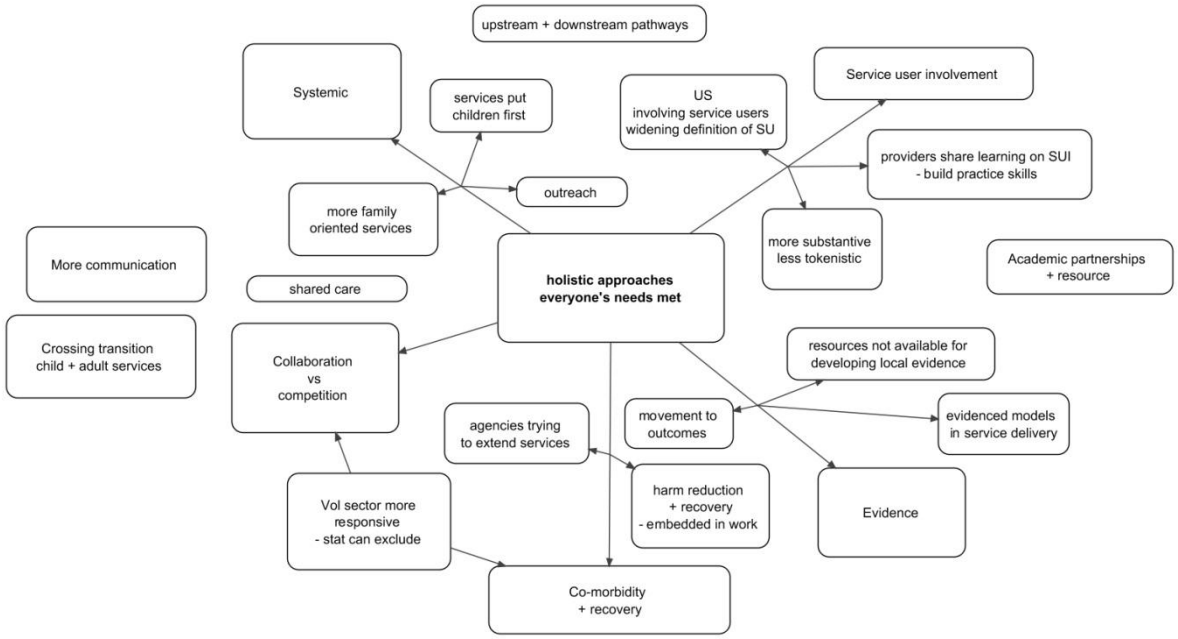


- Impact of life poverty and deprivation on drug/alcohol behaviour within socio-economic deprived areas
- Legacy of conflict
- Normalisation/acceptance of drugs and alcohol within community/society
- Chemical solutions to lifestyle problems – coping mechanism
- Lack of co-ordinated/joined up govt approach to health inequalities

<u>New actions</u>

1. Increased focus on locality planning
2. Services directed at need
3. Quicker response – less talking
4. More co-ordinated approach
5. Identification of best practice models and roll out within local approach

Group E – Service Providers



Group F – Advocates for At Risk Groups

<u>Increasing trend</u>

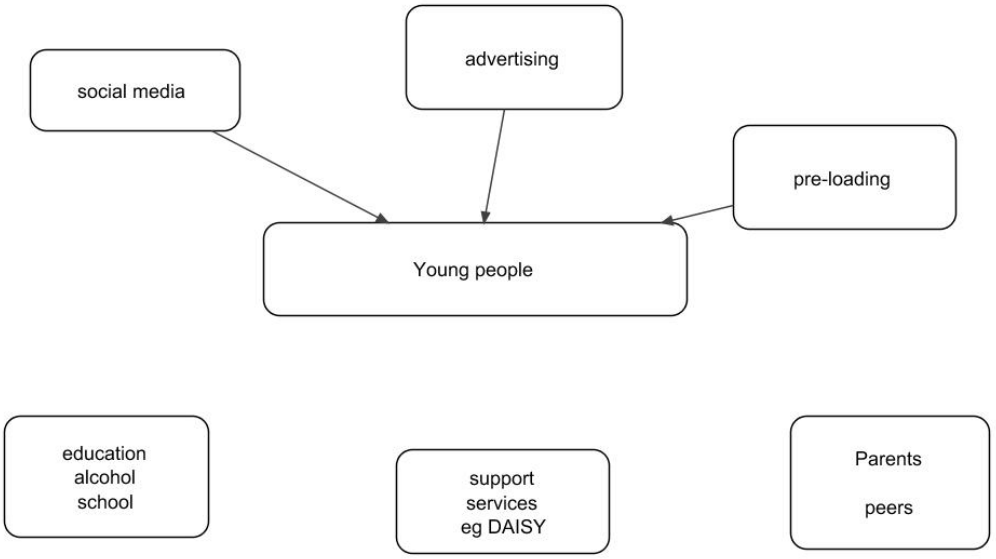
1. Macro vs micro level and lack of holistic understanding. Potential for silos. Hierarchy of age groups. At risk / vulnerable – who decides? Frustration as advocate – commit to change
2. Increasing trends of overdose (prescription and illegal) and self harm
3. Normalisation of abuse / misuse. Substances to deal with stressors
4. Changing trends in those presenting to services (younger) (chronic) (homeless) nature and consequences
5. Use of media / new media – access influence
6. Travellers cultural attitude to substances – suicide / women's specify
7. Access to services for at risk groups
8. Increasing use amongst all pops
9. Concern of increasingly prescriptive criteria re mental health – at issue

<u>Doing Right Now</u>

1. Information, advocacy, promotion of services
2. Delivery of services
3. Services not engaging with (chronic) users. Increasingly challenged. People can be worked with
4. Embedding of harm reduction practices for most at risk groups / services
5. Whole family approach → hidden harm and co-morbidity
6. Open door → how can we verify? Data monitoring / audit. Promote services
7. Recognition of partners / experts / signposting. Better networking
8. Raising awareness of needs amongst vulnerable groups. Engagement with strategic groups → challenge barriers / power imbalances in C/V/Stat sectors

- Do we need to review structures? DACTS/ISFs/Service users
- Travellers as peer role-models across health
- Pathways (workable and timely) smoother for service users/pros. Discourages sibs
- Developing new resources
- Greater awareness of service/skills/expertise available → accountability for this
- We should know how to work/engage. Or do we? Encouraging best practice models via service users
- Recognition of different ways of working – not one size fits all
- Social exclusion/community buy-in and support chronic use. Comm develop approaches? Structure and integrity/cohesion of communities. Multi-faceted
- What is "hard to reach" → pops vs. services
- Cross-departmental buy-in

Group G – Youth Perspective



1. Social media and advertising
2. Suicide – young people
3. Alcohol and drugs – pre-loading

<u>TV programmes</u>

Advertising "promotions"
Alcopops
Theme – fit in
↓
"Fresher's week"
↑
Education (schools)

home measures vs pub measures
pre-loading
drugs
drinking games
"peer pressure"
↑ ↑ ↑
Support services (for young people)

↑ ↑
Parents

<u>Suicide</u>

Increase in number overdosing and feeling suicidal while intoxicated
Self-harming
Coming down makes u more suicidal

Debt/paramilitaries – if can't cope suicide is an option
Impact on friends

- Some do same
- Some put you off

Social media
Use drug/alcohol service sites to increase connectivity with S.U.
Promote service – faceless contact can be less threatening
Engagement and reduce DNAs – text message reminders
Better organised and informed – pre-internet
Increased pressure from marketing – drink promos – invites to venues and order online sites
Belfast based topix forum disguises dealing
Connecting service users – own sites
Can be +ve and -ve

Key Actions
Create opportunities for young people:

- Jobs
- Forums
- Lobbying

Greater linkage between agencies and centres to support youth
Young people can decide their own futures – "nothing without us is for us"
Talk to us in the way we choose
Train us to help

Group H – Service Users

Service user involvement
EM/power
Best practice ignored in NI!
Marginalisation
Keep people alive
Service user involvement
Service user involvement
Treatment trends ↓ alcohol
other drugs
injecting
BBD's
Back to the future
Trauma and the family
Lack of integration
In the box
What happens if you fall outside?
Nothing about us without us
Meaningful service user involvement
Remove barriers
Record user experience

Models
Employment
Realistic expectations
Family support
Respite

Whole Group Discussion on How Trends Affect What We Do

Interesting now people are in stakeholder groups – can talk to people more easily.
Plea to commissioners – can you genuinely listen? There is a need to be holistic and talk to all departments. We need to go to talk to peoples ourselves, not wait for them to come to us. The voluntary sector puts more energy into "selling ourselves."

Criminal justice organisations – reiterate "nothing for us without us". Use of drug profile – goes straight to user – provision of services should be informed by users, and inform them.

Emphasis on evidence-base.

Issue of defining communities – important to have a clear definition when designing services. All have different definitions, eg within the health service. Also need to remember that there is a difference between the community sector and the voluntary sector, this can lead to conflict, especially at a local level.

Back to the mind map – the youth perspective and service users highlight the same things on the map, they have the same voice. What will happen to the map?

Looking at the experience of services, people tend to have care in the community (where there are no/few places of safety) and are sent back into unsafe places while trying to change, which leads to uncomfortable stories which are avoidable. We need real structured family support, eg the value of respite is not appreciated by funders. This shows the human interlinking issues and pictures. The question is "how can we keep someone alive long enough to make a change" – we all need to understand this.

Cheered by the role of service users in design of services. Also need to broaden out to hear the voice of all drinkers (not just those who are brave enough to admit their problem), including those who function in the world. It's everyone's issue, we're all "using" alcohol

Regarding evidence-based practice, the community/voluntary sector can see it as a stick to stop innovation. Many organisations produce reports, outputs, and outcomes, and this data is held centrally by funders and statutory bodies. Should they use all this data to analyse it and tell the community/voluntary sector what works and what doesn't?

There are no evidence based models in UK/Ireland for LGBT populations and what works with them.

Session Five: Focus on the Present – "Prouds and Sorries"

***Purpose**: Taking responsibility for what we are doing and not doing*

Group A – Criminal Justice/Community Safety

Proud
ROP (Reducing Offering Partnership)
DoJ and PSNI – drug arrest referral
PSNI – more accepted
NI Drinks Industry, responsible promotion of alcohol
PSNI – programme with service users – addressing behaviour / attitudes
YJA – supporting parents and young people
YJA – relationships developed with voluntary sector (FASA / DAISY, etc)
PSNI / BCC – joint enforcement work to address licensing and underage drinking
Engagement with community

Sorry
Part of denial of extend and nature of substance misuse
Unable to get a wet day centre for street drinkers in Belfast (PSNI)
Unable to intervene at earlier stage (restricted by remit)
Not engaging / visible enough in difficult policing areas
Alcohol industry take so long to start engaging with problem
Getting best value spending and money
Sorry that if an issue does not fit the 5 year strategy it is unlikely to get funded

Group B – Commissioners

Proud
BSP – facilitating new learning
Harm reduction – drug arrest referral team
Addiction team – range of support – community based
Commissioning/tendering – transparency and planning. Needs to be more x-agency/dept, build on progress to date
Legislation

Sorry
Service user involvement (power and control) – comm & service development
Legislation/regulation for alcohol takes too long
Comm sector – value of
Commissioning – too embedded in one area
Slow to react and change
Carers and families

Group C – Senior Managers

Proud
This event
BDACT
BSP – wide agenda
We are proud of a wide range of services and staff
BLF Impact of alcohol
Level of expertise/knowledge of staff in the field
Good working relationships with providers across the board
We are proud of the commitment/passion
We have expertise but are not experts and are willing to learn
We are proud of local innovations and responses which have been designed in NI (no need for external experts)

Sorry
We are sorry that we are "here" again
I'm sorry that council was not good enough with engaging with the community
I'm sorry that the DACT hasn't co-ordinated as well as it could have
I'm sorry that enough progress wasn't made when resources were available
We are sorry that our focus on budget and performance management restricts our service delivery/how we can respond

Group D – Community

Proud
As community activists, achievements in face of limited resources and the innovation/creativity within the community sector (going the extra mile)
Service users – employable opportunities. To be job creators (service users → deliverers)
Response to need rather than policy – REAL LIFE!
Courage to speak out and articulate need
Ability to challenge statutory/govt/CVS, and associated risk
Journey of our organisations (growth, governance, QA, professionalism)

Sorry → seems to be the hardest word!
To be dependent – not self-sustaining – YET!
For not having the resources to evidence our practice – we just know they are needed to work
For not having more cohesion within communities
Sorry for allowing commissioning/funding to fracture relationships within and between service delivery organisations
And for always having to justify our representation on groups

Group E – Service Providers

Proud
Being more responsive to changing client needs and circumstances
Of surviving! In face of adversity
Of dedicated and improving staff quality
Of keeping people alive
Of making a difference
Of being innovative
Of being professional
Of leading the way
Of influencing future workers
Of taking risks
Of lobbying and influencing policy and practice
Spotting service gaps and addressing them

Sorry
We haven't been better at collaboration
We haven't been better at educating communities about alcohol and drugs
We haven't got to help people sooner
We haven't been better at lobbying together for resources
We're afraid to be political (small p)
We have been selfish about own survival
We have compromised at times
We haven't always met client needs

Group F – Advocates for At Risk Groups

Proud
Innovation and achievements with high risk groups
Getting the voice of our service users heard
Raised issue of singular themes eg trauma, hidden harm, OD, travellers, LGBT, etc
Pushing powers that be to listen and respond

Sorry
Promoting our egs of innovation
We haven't pushed the system enough towards SVI
We can be single issue focused
We haven't managed to convince others that hold power

Group G – Youth Perspective

Proud
More young people are making decisions in services
Needle exchange scheme – helping drug addicts – prevents disease (public health)
Young people open up to me about issues (privilege!)
Helping children and their families understand how drugs and alcohol affect their family life
To help children have fun
I have completed the assist course which gives me the tools to help others who are feeling suicidal
I'm proud that my voice is listened to
Proud of achievements that young people make
Proud of services – FASA, DAISY, PHAROS
Proud that there are more youth volunteers
Never lost the passion to change young people's lives
Proud of the support from organisations we work in
Proud that we have a vision
Being young

Sorry
Sorry for abusing prescription drugs that GP's give out so easily
Sorry for every person I've worked with that have lost their lives
I'm sorry that some children are suffering in silence who live with alcohol and drug misuse
Sorry for the choices I have made
Sorry for hurting family members
Sorry for wasting emergency services' time
Sorry I don't have enough skills to always help
I'm sorry that I have not involved young people more
I'm sorry that I don't take enough care of myself
I'm sorry that I have neglected the ones that love me most
I'm sorry we cannot rate these as they are all equally important

Group H – Service Users

Proud
Surviving
Navigating the web of organisations / policies / funders and burnout

Sorry
Lost opportunities
School of hard knocks
Impact on partners, family, community

Whole Group Discussion on "Prouds and Sorries"

One big thing to mention – we're not defined by the organisations we represent, we're people "in" organisations, and we need to remember this! Remember it's about the people in the organisations and groups, and try to avoid a pack mentality. We can achieve more if we build relationships with people in different organisations.

Very refreshing to hear from commissioning group, and hear honest feedback, not usual excuses, giving us the right foundations to work on. Most of the right people are here and there's lots of energy. Honesty's very refreshing.

Most important opportunity to effect change in strategy is Bamford, BUT service users are ignored. Work has been done on how to get them involved, hope to start process today.

From commissioning group perspective, we spend 99% of our time talking about ill health rather than prevention. We need to change the system to allow staff to help prevent ill-health. Restrictions are there on speech and decision-making, because of the bureaucracy. There is an ongoing discussion on how to change health and social care from the medical model to a bias towards prevention.

Rhetoric of transforming care should be about prevention, early intervention, community care, etc. "The community's expectations aren't keeping up with our (commissioning bodies) aspirations" We need to find a way to get past that and have a real honest conversation, away from panic reactions.

The community sector have a lot of energy, commitment, skill, resources, access to partnership – they should take hold of the authority this gives them and go "this is what needs to happen, this is the direction we need to go". Take the power, make it happen! How are you going to take power?

A lot of similarities here in what we're expressing, whoever you are here, there's a desire to move forward. How to do this, getting energy and ideas together?

Still ignoring the big elephants in the room:

- We don't have the resources to do that much
- Have to go in earlier
- Have to work with more people
- Have to work for longer
- How to achieve this with existing resources (either financial or in the way we live)?
- We start out from a position of limitations

In reality, people with the purse-strings need input, to eliminate competition, how to actually have a collective process and engagement? We have to find an answer to that – has to be actually collectively over a period of time, not just in this workshop.

Highlight conflict between and within community groups due to funding. Highlight work of community groups in drugs and alcohol issues without direct specific funding. There has always been partnership working going on. Community workers have always been

firefighting. Community activists are here for passion, not money or resources, they want to stop people in their communities from hurting – we all want to make things better in Belfast.

More government/statutory involvement seems to lead to less involvement from service users – there are also issues of the language being used being excluding. Best look/view of a service and the experience of it comes from a service user – sometimes we forget this.

We have to be realistic – we have a finite and decreasing budget. We need to have honesty over what's up for discussion / inclusion or not. Remember we're coming to the end of a funding stream, a lot of it is already committed. Next time there may well be less funding available, certainly in the near future. There is difficulty in getting an effective co-ordinated approach funded.

Alcohol and drugs from a community perspective – setting the context here in the face of the biggest welfare reform – alcohol and drugs are a crutch in a lot of communities to deal with these issues. How to tackle legal drugs in the community, especially drugs prescribed by GP's, and alcohol.

Service users' voices should be at the forefront of this process, and ongoing.

Session Six: In Mixed Groups – Focus on the Future: Desired Future Scenarios

***Purpose**: To imagine a future you believe in and are willing to work toward*

Participants worked in mixed groups to imagine themselves 10 years into the future, on 27 September 2022. The Belfast of their dreams is now a reality. The culture and patterns of Alcohol and Drug use are transformed. The groups visualised what this would look like using the following prompts:

1. What life is like in Belfast
2. The culture and patterns of Alcohol and Drug use in Belfast
3. Policies, structures and services that are in place
4. How stakeholders in the city set direction together.

They presented this vision back to the whole group, noting on their flipchart the main barriers they had to remove to clear the way to where they are in 2022.

Session Seven: Focus on the Future – Discovering Common Ground

***Purpose**: To establish those elements and key features desired by everyone here on which to set direction together on Alcohol and Drug use in Belfast*

In their mixed groups, participants prepared a list of common ground elements that reflected what they believed everyone in the room wanted now and in the future. This included values, norms, structures, programmes, services, and procedures.

They then joined with another group and compared their common ground lists, merging them into one list. If they disagreed about an item, they put it on the Not Agreed list.

The whole group then organised and talked over the common ground for as long as it took to come to agreement. Items that were not accepted by all were moved to the Not Agreed list.

Families
Child centred approach
Systematic approach working with families/communities within life context
Early years approach – is vital
Comprehensive family support system – accessible and one door (greater investment in early intervention)
Family focussed alcohol and drug services
Engagement with families
Hidden harm – services for children and families

Dual Diagnosis
Dual diagnosis – approach
Stigma prevention
"Record" → towards recognition – action
Mental health issues and addiction to be worked with together – not used as an excuse for non-engagement

Joint Commissioning
Single partnership (power sharing) – tied into community planning
Minimising bureaucracy as a barrier
Joined up working, covering services, education, prevention, commissioning, planning, delivery, information systems
Confidence and trust that what is agreed here is represented in outward plan and leadership between/across sectors to implement it
Transition services and their management (no wrong door) – commitment!
All services recognise and address alcohol related problems
Healthy organisations – stability, quality services and systems, skills, professional workforce

Early Intervention

Early intervention/prevention – not just y.p. focus
Move to early intervention care in the community enabling people to take responsibility (social model)
Early identification/intervention – across all issues/ages
Education in all settings
Early intervention across all areas including trauma
A holistic – from pre-birth →
Effective
Education, prevention and early intervention (individuals and communities)

Child Centred

Early years/child centred approach
Fun for children (individual or groups)

Harm Reduction

Address issue of street drinking
Focus is on harm reduction/minimisation
Greater access to and retention in housing, addiction, mental health services for those with most complicated and chaotic issues
Development of peer ↔ peer services/supports/networks, eg peer ↔ peer needle exchange
Services for vulnerable with needs eg wet hostels
Targeting of identified vulnerable groups, egs include: PTSD, trauma, LGBT, BME, homeless, older people, etc
Hard to reach/engage groups (eg ex-combatants/prisoners) but with known high level issues and key for targeting and involving in planning and service design

Safer City

Safer city – reducing crime and the harm it does
Alcohol free alternatives in night economy
Better opportunities for all ages:

- Jobs
- Education

Address poverty
Low cost family based activities (café culture)
Integrated vibrant multicultural city
Non-alcohol focused socialising opportunities for all
Creating a different cultural environment
Drugs-smoking like with alcohol
New laws
Joined up government policy/greater accountability to local people

Access to Services

Working outside traditional delivery to meet needs – timely, flexible, responsive
Individually tailored programmes of care eg “one stop shop” include BME and sex workers
More productive integrated working and communication

A continuum of services and pathways across stat and vol sectors = prevention, intervention, recovery, relapse
Services are not there when people come out of prison – services commencing inside followed through to outside
Joint assessment/clear pathway/joint up working
Real joined up services to start immediately – network this
Client gets to the right service/support by the shortest route
Systemic approach (co-ordinated) focused on clients' needs (PCP)
Virtual referral hub (holistic)
Collaboration – working together integrated across disciplines, across agencies and VS with communities, users, families sharing information
Recognise good practice
One stop shops – resources/facilities shared
Needs/risk assessed – holistic
Case managed approach – standardised assessment – MD care plan
Comprehensive service pathways and entry points
Dedicated health and social care issues, ie, current provision of respite (detox), personal care, specific budgets, physical health intervention, "not suitable for client groups"
Recurrent funding
Taking good practice BHSCT – regionally
Integration of at risk group providers
Specific – joint health/housing – accommodation provision
Housing and health and education and employment and community safety co-ordinated around individual and family needs (chronic needs of individual) = safety net. Sustaining people in communities

Service Users
Increased S.U. involvement at all levels of decision-making within services and task groups
Service users have input into all services and it's listened to
User involvement in decisions/service planning/delivery/review

Legislation
Restrictions on alcohol sales and advertising
Debate initiated to include alcohol free supermarkets/more regulation on sale and advertising
Availability/affordability of alcohol:

- Promotions
- Supermarkets
- Advertising

Real exploration of legislation eg decriminalisation/act of "war" on drugs has failed
Minimum pricing (as a package)
Decriminalisation – taking out of the "hands" of the criminals – included in debate
Banning advertising and promotion but "young" people are smart and will know ways to beat the system
Open discussion about decriminalisation issue
Effective legislation re alcohol advertising, sales, enforcement, etc
Criminalise dealers and decriminalise users – honest debate

Tighter control of legal drugs and increase alternative (non-drug based) treatment in primary care

Schools and Youth Organisations

Teachers are not comfortable in dealing with issues around substance/alcohol misuse – they don't have knowledge/understanding of issues – no experience
Change behaviours of young people in schools – making informed decisions
Update DE drugs guidance (from 1996) – BELB are committed to the young people in schools and youth orgs
Programmes in schools – a better approach needed!
Address attitudes to alcohol amongst young people

Session Eight: Focus on the Future – Create Common Ground Statements

***Purpose**: Create statements that reflect the will of everyone present*

Participants worked in self-selecting groups to write a few sentences on a single sheet of paper describing this group's common ground vision. They wrote a statement that they believed

a. every person in the room would agree with; and
b. would be understood by all stakeholders who were not in the room.

Families
We will commit to a holistic shared care and supportive systemic approach to engaging and working with families.

Dual Diagnosis
We will start with individuals with needs – with multi-faceted needs – recognising individuals have a range of needs. Focus on the individuals and their needs.

Joint Commissioning
We commit to genuine collaboration and partnership working, minimising bureaucracy and deliver joined up services (multiple entry points) (link to community planning and population planning).

We commit to developing trust and equality between statutory and voluntary and community organisations that will foster sustainability.

Early Intervention
We will develop a framework for effective early intervention in alcohol and drug misuse.
This framework will apply to all organisations and communities. This framework will mean that people get information, advice and appropriate support at the right time, which will reduce alcohol and drug related harm.

Child Centred
We commit to deliver a "child and young people centred" focus to all of our work (child as determined in law).

Info Research Evidence
We will develop policies, interventions and services that are based on identified need (informed by users) informed by outcome-focused research (evidence) where impact is measured and contributing to our knowledge-base on what works.

Harm Reduction
We will ensure that we assertively target groups who are known to be in need or at risk, and in designing and providing accessible services for these groups, we will ensure that their specific needs are met holistically with a focus on harm reduction and reducing risk.

Safer City

We will develop a vibrant, multi-cultural city for those who live, work and socialise across Belfast where people feel safe. This will be characterised by widely available, affordable, family friendly activities, providing a range of alcohol-free alternatives in the night-time economy.

We will provide/champion increased personal and social responsibility and incentives to industry to encourage change.

Access to Services

We will ensure that people that need support have easy and timely access to services that are systemic and appropriate for their needs. There will be a clear route in and out of services. Services will be integrated in a shared careplan that follows the person. There will be common and shared systems across services.

Service Users

Service users will have full participation in all decisions at all levels regarding substance abuse issues.

We will respect self-determination by service users regarding treatment plans/pathways.

Legislation

We will champion the debate on developing legislation surrounding the availability of alcohol and drugs.

Schools and Youth Organisations

We will work with key stakeholders to ensure teachers and youth workers have the capacity and skills to deliver/co-deliver age-appropriate drugs and/or alcohol programmes using a lifeskills approach.

We will enable young people (early years to 25 years) to make informed decisions about drugs and alcohol by giving them the opportunity to develop those skills and by providing a continuum of support.

Session Nine: Focus on the Future – Taking the Next Steps Together

***Purpose**: To agree what success looks like for this common ground statement and to decide on what next steps you will take going forward*

Participants worked again in self-selecting groups, in three rounds, to capture what success would look like for the Common Ground statements, and described some of the initial steps that would need to be taken to achieve that success, including measurements, who else needs to be involved, and how they will be engaged.

Families
(We will commit to a holistic shared care and supportive systemic approach to engaging and working with families)

Local framework to support families living with a loved one affected by drugs and alcohol
Communication point

- Referral
- Early identification
- Quick access/local approach
- More public access to contact numbers for organisations

Drink Think (Derry model)
RISE Foundation Family Programme → training support around issues such as enabling
Pharos (Barnardos)
DAMHS – extend remit to family
Psycho-social support for families

- Stress management/personal development
- Therapeutic (holistic)
- Travel access
- Training support

DAISY (y.p.)
ASCERT – brief intervention (adult)
Build on what is good and do more of it

Limitations
Accessibility for families, outreach – flexible, choice, more pressures
Family – too much to do at once eg AA, CAT, Therapy
Service user (family) need to feel safe to talk, trust, open up and be real about difficulties experienced
Non judgemental approach
People need to talk – s.u. view
Families need to be consulted about all issues affecting them including professional response at all stages of intervention
F.S. Services need to be co-ordinated to avoid duplication
Shared approach – whether its child, parent or other family member –
Wrap-around service

Sharing skills and expertise.
Families skills

Next Steps
Communication point of referral
Build on current models of good practice in Belfast (eg, Pharos, DAISY, ASCERT, DAMMHS)
Explore other models and how they work eg Derry model – "Drink Think"
Local framework to support families
Make services more accessible and appropriate for families (consult with families on what is best for them)
Create safe environment to develop open trusting relationships with families
Non judgemental approach
Co-ordinate services to avoid duplication and overloading
Wrap-around services
Expert workforce – share skills

Dual Diagnosis
(We will start with individuals with needs – with multi-faceted needs – recognising individuals have a range of needs. Focus on the individuals and their needs)

A model of shared care approach is implemented across adolescent and adult services
Public sector will/could extend their adolescent services up to 25 years old in line with current voluntary sector provision

Co-morbid presentation
Better understanding of the micro/macro approach in a holistic dual diagnosis and treatment
Multi-skilled practitioners
Multi-disciplinary

Risk Management
We say: We recognise people's lives are complicated and they have a range of needs – that we find a way of working that sustain the supportive relationship while bringing in specialist skills so that there is always that connecting support
The first assessment – support/complexity of someone's life problems
Therapeutic alliance maintained by a skilled professional 1-1 treatment → history

Ideas here
Tick-box pro-forma – here is your problem – you got trauma go over there – at the end of that you should be fixed
Individuals owning their care plan
Comprehensive client-based evolving forms to shape intervention
To develop a shared understanding of emotional and psychological issues. To recognise people's lives are complicated and they have a range of needs, that we find a way of working that sustains collaborative, integrated supportive relationships while incorporating specialist skills.

Outcome

Shared care plans, service user included – responsibility issue MoU. A care plan should identify roles and responsibilities supported by a MoU, named who does what – so the person only has to tell their story once
One-stop in a seamless way
Common assessment shared between agencies
Shared practice and training, for example, shadowing
Do this action within a timeframe
Shared practice sharing
Working across the disciplines of alcohol, drugs, suicide, trauma, across all levels
The right people having the conversation with the "client"
Have to look at the practical needs of people, ie, their food, housing, clothing for their children, as well as psychological etc
Key worker role in all services
Macro and micro approach
A model of shared care approach is implemented across adolescent and adult service
Public sector could / will extend their adolescent services for up to 25 years old in line with current voluntary sector provision
A trans-generational service
A transition plan where the young person is moved seamlessly – with comprehensive preparation, service linkage established and continuum of care

Joint Commissioning

(We commit to genuine collaboration and partnership working, minimising bureaucracy and to deliver joined up services with multiple entry points and linking to community planning and population planning
We commit to developing trust and equality between statutory and voluntary and community organisations that will foster sustainability)

Transparent and open and collaborative partnership between commissioners and service providers
Flexibility to adapt to improve outcomes

Sub-group:

- BDACT
- PHA
- HSCB
- BHSCT
- City Council
- V/C sector
- BRO
- NIHE
- Service users

Next Steps

Commissioning bodies to consider feasibility of Joint Commissioning Process – pilot
Better assessment of need

Clear and transparent commissioning process
3-5 year funding commitment
Full cost recovery
Shared reporting/monitoring re outcomes/targets
Infrastructure to support this

Success
Belfast Strategic Partnership will develop a 10 year strategy which provides a framework for joint commissioning
Shared outcomes
Measured
Milestones/actions achieved, i.e. service delivery, agreed KPI's, QAF standards

Early intervention
(We will develop a framework for effective early intervention in alcohol and drug misuse
This framework will apply to all organisations and communities
This framework will mean that people get information, advice and appropriate support at the right time, which will reduce alcohol and drug related harm)

Framework must be psycho-social
Framework will empower communities and individuals
A & D discussion "normalised" rather than "stigmatised"
Identifying specific groups/communities/communities of interest and targeting health inequalities
Self-awareness and self "management" of alcohol and drugs as part of health and wellbeing

Next Steps
Mapping "audiences" and "participants" in the process, eg, health and care professionals, workplaces, communities, etc
Identifying content of framework and materials, information and training to be included – what works?
Develop information and communication campaign for framework
Develop evaluation mechanisms
Who will lead it, who will fund it?
Create early intervention "champions" who will keep area live in different settings

Success
Reduced levels of A&D related harm – psychological and physical
Fewer people at top of Bamford Triangle
Cultural change from fatalism to empowerment and action
Development of core effective info, education and brief intervention tools with consistent messages

Child Centred

(We commit to deliver a "child and young people centred" focus to all of our work – child as determined in law)

Success

Better outcomes for children is everyone's responsibility (Children and Young People Strategy)
People/agencies know and adhere to relevant legislation – Children (NI) Order – "Welfare of the child is paramount", 5P's
Fully implement the UNCRC
Commissioning needs to have evidence of above
Children's champion with power and authority to ensure that all depts/orgs are adhering to legislation and what they do is child-centred
People are confident and competent around child protection issues – all of them
Parents / families feel empowered and supported
Eradicate child poverty
Right support, right time, right place, delivered by right person

Next Steps

What is already out there and working well? (health visiting, school nursing) – securing ed resources
Develop clear seamless support pathway for children
Menu of service provision – universal to targeted
Debate how we increase aspirations of children/families? Put children on the agenda?

Who Involved

Dept of Ed
DEL
DHSSPS – BSP
Voluntary
Service Providers
Parents – children
Communities
DSD
NICCY

How to Engage

Power has to come out to the people – active listening
Use existing good models that are used day and daily be services and orgs
Article 12 UNCRC
Voice of the child

Info Research Evidence

(We will develop policies, interventions and services that are based on identified need (informed by users) informed by outcome-focused research (evidence) where impact is measured and contributing to our knowledge-base on what works)

Success

Available info and research (UK and Int) reviewed and used

Local research prioritised and commissioned/funded to address gaps in knowledge

Better system/processes for collecting, analysing, using and sharing the info we collect and research we do/have

Quantitative and qualitative info and research – given equal weight

Focus on outcome and impact measurement

What success looks like is agreed

Robust and consistent data on client profiles and the services they receive

Services are designed and delivered which are effective and evidence-based

Innovative services are designed and delivered within a system/process built in at the start → throughout to collect evidence of impact and effectiveness

There will be dedicated capacity/resource within both commissioning and delivery orgs to undertake all of the above

There will be a framework and standards outlining requirements and expectations (and if you're not there yet a process/support mechanism will be in place to help you get there)

If all of this is in place we will all be able to target better, respond better to changing and emerging needs, know local need, and what works at a local level. Therefore, policies and interventions etc etc will be informed/guided by all of this

How

BDACT/BSP need to lead/champion

Framework/standards need developed – common language, systems, etc

Inc. process both when designing/deciding and when endorsing these

1st key – mapping/identifying what and how we currently collect info / "do" research and use info – if we do?

Sources of funding identified to help us to do this / partnership approach with research orgs to guide us / help us

Use of IT both for recording info and sharing info at central points

Levels of sharing, client/ind, info – generalised

Standardised client info systems and assessment → CAF

Dedicated budget within service delivery for eval/impact assessment (20%?)

Research focussed on those who have received the service rather than those funded to deliver it

Accountability for public funds – needs to be owned by all ie commissioners and deliverers

Up-skilling re how to monitor, evaluate and budget manage/record spend better = programme of training. Work with other orgs to identify and address skills gaps

Willingness and capacity to share models and skills built in / encouraged around best practice and good recording and eval models

Follow-up post receipt of services/completion of programme = basic requirement – 3 mths, 6 mths min. Client satisfaction questionnaire

PHA/DSD-BRO/BHSCT/BCC/Bfs team. As a starting point these Bfs-based orgs need to agree a process/system for collating and sharing info in a consistent way and use what you're getting
DMD – needs to include alcohol and be online → CAF?
RIMT needs either scrapped or completely overhauled

How
Specific research around – returnees – revolving door issue
Social support given equal weight as therapy – accessibility. And resourced – money for taxis, money for food, food and clothing parcels! Basic needs and the specific d&a needs – providers/services need to be able to respond to both

Harm Reduction
(We will ensure that we assertively target groups who are known to be in need or at risk, and in designing and providing accessible services for these groups, we will ensure that their specific needs are met holistically with a focus on harm reduction and reducing risk)

Success
Timely/access re detox provision
Widespread naloxone provision to people at risk of opiate overdose and their representatives
Peer to peer needle exchange
Dedicated accommodation service for IDUs
"Patient" advocates who, along with the person, will help them map their treatment episode and physically help them through that journey → very holistic/systemic
"Wet" day centre for street drinkers
Safer consumption rooms
Reconfig of treatment services to a greater focus that is evidence based on harm reduction low threshold, outreach and comm based services
A recognition that service users are a v broad group including children affected by parents who use alcohol and/or drugs
Commissioning process allows greater flexibility re outcomes in dealing with those most vulnerable
All/more services recognise that they have a responsibility to provide interventions to those who are most difficult to "treat" or do not change behaviour significantly
Focus on our motivation to help these people rather than their motivation to change
Helping sex workers:

- Access services – healthcare/drug addiction/domestic violence/assault
- And exit – innovation, incentives

The sex industry
BME – failed asylum seekers – accessing timely healthcare and treatment

Next Steps
Lobbying, negotiation, legislative review
Education and training
Engage with vol + comm sector to identify those most in need/most risky
Innovation – flexibility encouraged and embraced

Working safely outside the traditional box and being supported to do so

Safer City

(We will develop a vibrant, multi-cultural city for those who live, work and socialise across Belfast where people feel safe. This will be characterised by widely available, affordable, family friendly activities, providing a range of alcohol-free alternatives in the night-time economy

We will provide/champion increased personal and social responsibility and incentives to industry to encourage change)

Success

Multiple social enterprise companies (CIC) developing local economies across Belfast (self-start)
Change in attitudes
Reduce harm where alcohol and drugs are misused
Community development approach/development programme
No. of people (industry) aware of law/legal issues re: serving alcohol

How Do We Measure Success (Long Term)?

Reduction in crime, violent crime, hate crime (measured by statistics)
Recorded through info sharing
Record and evaluate alternative activities (surveys)
Number of people visiting Belfast
No of local regeneration/social economy initiatives across Belfast involving and engaging with planning
No of local people visiting city centre

Next Steps

Identify what is family friendly – set baseline
Investigate financial incentives to set up family friendly activities (businesses)
Using BDACT to encourage community to address drugs
Link in with local business and communities
Develop regeneration projects in partnership with range of stakeholders
Investigate New York approach
Pilot project for self start
What will people participate in as alternative to alcohol/drugs
Wet centre
Link in with legislation
Pilot project – community safety → community development approach
Develop self-regulation approach to serving alcohol across Belfast inc training staff in handling issue and giving more responsibility to staff to control
Define success
Engage with diff stakeholders eg local community
Develop alcohol free events in bars/clubs etc for U-18's

Access to Services

(We will ensure that people that need support have easy and timely access to services that are systemic and appropriate for their needs
There will be a clear route in and out of services
Services will be integrated in a shared careplan that follows the person
There will be common and shared systems across services)

Success

Cultural shift in acceptance of Voluntary Sector within statutory organisation – validated/qualified/experiences with services
Timely access to appropriate services for all groups – one size not fitting all
Accessing right people at right time
Knowledge of who is accessing services
Identify who is not – why not
Virtual hub/directory:

- Updated
- Who, where, what
- Appropriate / user friendly

Person centred (jargon) / shared care – needs led
Smooth points of entry and exit. Not dependent solely on GP referral but other areas of good practice
Clear accountability along the pathway
Meaningful monitoring/measurements
Breakdown of hierarchy of current structures

Next steps

Scoping IT systems
Identify what's working well (good practice models), build on these
Leadership with organisations to drive meaningful dialogue
Moving jargon
Systemic needs assessment tool
Recognised case co-ord that is and can be delivered by a validated organisation

Service Users

(Service users will have full participation in all decisions at all levels regarding substance abuse issues
We will respect self-determination by service users regarding treatment plans/pathways)

Key words

Safety
Capacity
Support
Appropriate
Levels of involvement
Tokenism/cronyism
Pathways
Unique contribution insight

Privilege access
Clear ground rules

Success
Outcomes – will have full input to service provision
Goals – no tokenism, agree goals
Goal / mission – to improve the quality and effectiveness of the planning and delivery of services and improve quality of outcomes

Next Steps
Protocols
SMART outcomes
Models
Define service users:

- Children and young people
- Advocacy
- Family

Outcome
A perspective
Rep on Bamford
All service users, → start
A different way of working!

Legislation
(We will champion the debate on developing legislation surrounding the availability of alcohol and drugs)

Key Steps
We will lead the debate on minimum pricing, sale and availability of alcohol
We will lead the debate on regulation of drugs, including decriminalisation

Measure
We are recognised as the leaders of the debate
Regular events held

Short Term Objective (alcohol)
Encourage/engage with key stakeholders to inform current consultation(s) on alcohol (DSD) by 12 November 2012
Medium/Long Term Objectives (alcohol and drugs)
We will become a knowledge centre for sharing existing research and commission new research in this area
We will develop proposals for legislative change when engagement with stakeholders and evidence based research demonstrates the need
We will organise conferences on these key specific issues to present evidence case to influence the way forward/future direction

Schools and Youth Organisations

(*We will work with key stakeholders to ensure teachers and youth workers have the capacity and skills to deliver/co-deliver age-appropriate drugs and/or alcohol programmes using a lifeskills approach*

We will enable young people (early years to 25 years) to make informed decisions about drugs and alcohol by giving them the opportunity to develop those skills and by providing a continuum of support)

Actions

Recruiting and training teachers and youth staff about the knowledge of drugs and alcohol, on how it can impact on individuals, families and education

No DO'S and DON'TS, try to have a more on level approach to connect and help individuals/groups understand at their age level

Allow young people to open up and voice what they want from the programme, also no question is a silly or stupid question

More practical approach:

- Showing substances
- Personal experience stories (identified service user)
- Young people's thoughts and views projected through mind-maps and spider diagrams
- Day trips to rehab centres and deprived areas, to see first-hand the effects of prolonged drug and alcohol misuse. May help to change the views of young people
- Trained up service users – more of an impact!

Next Steps

Training – service users, outreach staff

Trained child protection

Funding avenues

Networking, i.e. DSD

Whole Group Discussion – Group Action Planning to Achieve Common Themes from

Desired Futures

Remember DSD consultation on changes to the law regulating the sale and supply of alcohol in Northern Ireland, it closes 12th November. We all need to respond to this, regardless of outputs (content and timing) from this workshop. Can BSP facilitate the set-up of a sub-committee/sub-group to look at the feasibility of this work?

From a service users perspective this is exciting, moving beyond the rhetoric. One outcome will be representation on Bamford (immediate response is that this is achievable). There would be "smarter" protocols for actions to ensure an effective service user network (broad church). We also recognise the level of support and facilitation needed to ensure all on the continuum of service users can be included.

Dual diagnosis – shared assessment to have the right people, shared care plan, identify and name rights and responsibilities. Only one time would be needed, no repetition.

Safer city – across all Belfast, not just city centre. We need right away to find out what all the different people want. We can encourage less harmful drug/alcohol/social use in the community.

Evidence/Research – refer to BSP to take it forward. Key organisations into task groups to take this better, creating better information systems. We should take the information back to BSP and support them.

Engagement with people who are hardest to reach/engage – reconfigure treatment services to be more reflective of the needs. More services recognise they do have a responsibility to help the hardest to reach.

Access – we need a cultural shift, so that stats accept the expertise of vol groups in planning and policy development. Identify and use "smooth points of entry and exit" – referral should not just be through GP's. Measurement and monitoring needs to be meaningful. We need a systemic needs assessment tool – we can look at good practice and work on this now.

Early intervention – we need a difference in the way drug and alcohol misuse is viewed → early intervention is possible leading to behavioural change (idea of a continuum to empower communities – make health professionals' tools available to communities and normalise this work, not stigmatise it). This is the key to making a difference!

Child Centred Focus – we need to refocus on what's already in place and implement it properly with everyone's buy-in, eg UN Convention on the Rights of the Child. What's working, how can we improve on that? We can improve outcomes for children (and families and communities). We must put children on the agenda for all policy and decisions in government!

Families – to have one point of communication and referral. There are existing good practice models in Belfast, we should build on them, and explore other models (Drink Think, Derry).

Develop a local framework for families and have more outreach services, creating more/better relationships between families and professionals. We should wrap around the family, not wrap around the service. Share resources.

Youth action – work more and train staff in drug and alcohol issues. Feed information into all organisations. Give young people a voice and listen to them. Share ex-users stories in person with young people, eg in schools. Identify service users and lead them to the services they need. Train users.

Regarding accessibility to services, especially for LGBT – there's no evidence at all for this group, we need to collect sexual orientation/gender identity information by all service providers to help target services to this group better.

Worried that we all leave here and go back to the world, and hope this doesn't get lost on a shelf. We should all meet again this time next year and hold each other accountable, so it doesn't all get lost!

Appendix 1: Future Search Agenda

Wednesday 26th September
12.30pm – light lunch available
1.30pm – start
Focus on the Past (highlights and milestones)
Focus on the Present (current trends)
6pm – finish

Thursday 27th September
8.30am – continental breakfast available
9.00am – start
Focus on the Present (stakeholders working together)
Focus on the Future (the future in ten years – focus on common ground/ priorities)
6pm – finish

Friday 28th September
8.30am – continental breakfast available
9.00am – start
Confirming Common Ground and Planning for the Future – Next Steps
3pm – finish

Appendix 2: Participant List

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Appendix 3: Stakeholder Groups

A. Criminal Justice/Community Safety
B. Commissioners
C. Service Providers
D. Advocates for At Risk Groups
E. Senior Managers
F. Community Perspective
G. Youth Perspective
H. Client Voice

Appendix 4: Framework for Future Search Conference

How this conference differs from typical participative meetings:

- The **WHOLE SYSTEM** participates - a cross section of as many interested parties as practical. That means more diversity and less hierarchy than is usual in a working meeting, and a chance for each person to be heard and to learn other ways of looking at the task in hand.

- Future scenarios - for an organisation, community or issue - are put into **HISTORICAL** and **GLOBAL** perspective. That means thinking globally together before acting locally. This feature enhances shared understanding and great commitment to act. It also increases the range of potential actions.

- People **SELF-MANAGE** their work, and use **DIALOGUE** - not "problem-solving" as the main tool. That means helping each other do the tasks and taking responsibility for our perceptions and actions.

- **COMMON GROUND** rather than "conflict-management" is the frame of reference. That means honouring our differences rather than having to reconcile them.

WORKING AGREEMENT
Conference Facilitators: Tara Haughian and Michael Donnelly

Conference Facilitators	**Participants**
Set time and tasks	Provide information and make meaning
Large group discussions	Manage their own small groups
Keep purpose front and centre	Future scenarios/action steps

GROUND RULES
- All ideas are valid
- Everything is written on flip charts
- Listen to each other
- Observe time frames
- Seek common ground and action
- Differences and problems are acknowledged – not "worked"
- Have fun

SELF-MANAGEMENT LEADERSHIP ROLES
Each small group manages its own discussion, data, time and reports. Here are useful roles for self-managing this work. **Leadership roles and other roles can be rotated.** Divide up the work as you wish:

- **DISCUSSION LEADER** - Assures that each person who wants to speak is heard within the time available.

- **TIMEKEEPER** - Keeps group aware of time left. Monitors feedback and signals time remaining to person talking.
- **RECORDER** - Writes group's output on flip charts, using speaker's words. Asks people to restate long ideas.
- **REPORTER** - Delivers feedback reports to large group in time allotted.

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Appendix 5: What is a Future Search

By Marvin Weisbord and Sandra Janoff. Ph.D.

Future Search is a unique planning meeting that is used worldwide by hundreds of communities and organisations. It meets two goals at the same time, (1) helping large diverse groups discover values, purposes and projects they hold in common; and (2) enabling people to create a desired future together and to start working towards it right away.

Future Search is especially helpful in uncertain, fast changing situations. Participants need no training or expertise. Conferences focus on a wide range of purposes in schools, hospitals, churches, communities, government agencies, voluntary networks, foundations, business firms and non-profits in every sector. Because Future Search is largely culture free, it has been adopted with success by people from all walks of life in North and South America, Africa, Australia, Europe and South Asia.

A Future Search usually involves 60-70 people— large enough to include many perspectives and small enough that the full group can be in dialogue at each step of the process. This makes possible a shared picture of the 'whole elephant'. (For larger groups, conferences may be run in parallel or in sequence). The optimal length is about 2 1/2 days, with a minimum of four half day sessions. When people stay engaged in a task for that long, they are more likely to make a notable shift in their trust of each other and in their capability for action. The task for us is always: **Setting Direction Together: To change the culture and patterns of alcohol and drug use in Belfast in order to reduce damaging trends over the next ten years**

HOW FUTURE SEARCH WORKS

The Conference is designed to principles that enable people to work together without having to defend or sell a particular agenda. This opens the door to creative new opportunities. The first principle involves 'getting the whole system in the room'. That means inviting people with a stake in the agenda who don't usually meet, thus, enlarging everybody's potential for learning and action. The second involves putting the focal issue in global perspective, helping each person to see a bigger picture than the one they usually consider. The third means treating problems and conflicts as information rather than action items, while searching for common ground and desirable futures. The fourth invites people to manage their own small groups in discussing and acting on what they learn.

THE FUTURE SEARCH AGENDA

There are five tasks. The first establishes a common history, the second, a map of world trends affecting the whole group. The third step calls for an assessment by stakeholders of what they are doing now that they are proud of and sorry about, an important step toward mutual understanding. Next, people devise ideal future scenarios, living their dreams as if they have already happened. Then all groups identify common ground themes - key features that appear in every scenario. The whole group confirms their common future, acknowledges differences and makes choices about how to use their energy. In the final segment, they sign up to work together on desired action plans and actions.

LETTING GO OF STEREOTYPES

Staging a Future Search means changing our assumptions about large, diverse groups. In these meetings we learn that most people can bridge lines of culture, class, gender, ethnicity, power status and hierarchy if they will work as peers on tasks of mutual concern. They can do this despite stereotypes, prejudices and 'isms' that lie deep in all of us.

They can do this despite scepticism and sometimes-gloomy predictions of what will or will not happen. Freed from impulse to put pressure on each other to solve intractable problems, people often find common ground none of them knew existed.

CHANGING OUR ASSUMPTIONS

For decades it was presumed the best way to bring a large group together was in the presence of an expert speaker or panelists who would answer peoples' questions. The belief that someone else has the knowledge we need is deep in us. So is the belief that if others tell us what to do we can do it. Future Search turns those assumptions upside down. Instead of speeches, we have working sessions among a wide range of parties who have information, authority to act, and a stake in the outcome, regardless of their status, skills or attitudes. In addition, we assume that complex planning issues require choices more than expertise and 'data'. We believe that people make different choices when they are in dialogue than they would make working alone or only with familiar faces.

RESOURCES

Future Search Network - a non-profit network of 400 colleagues makes Future Search conferences available worldwide to non profit and public organisations regardless of ability to pay. We also distribute books and videotapes and offer public workshops in the United States and abroad. We are glad to discuss your needs and potential applications of Future Search.

The text above is adapted from a longer document by Marvin Weisbord and Sandra Janoff, co-directors of Future Search Network. They are co-authors of FUTURE SEARCH: Getting the Whole System in the Room for Vision, Commitment and Action (Berrett-Koehler, 2010).

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