New Strategic Direction for Alcohol and Drugs Phase 2

Second Update Report – June 2014

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Executive Summary

The cross-departmental strategy to reduce the harm related to substance misuse in Northern Ireland, known as the New Strategic Direction for Alcohol and Drugs (NSD) Phase 2, was launched in early 2012. This is the second annual report of progress against the outcomes and indicators set out in that document (the first report is available at the following link: http://www.dhsspsni.gov.uk/pdf_version_-_nsd_phase_2_update_report-_march_2013.pdf).

The report is structures as follows:

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

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

In terms of progress against the short-term outcomes within the NSD Phase 2, the majority of the 86 outcomes are on track for achievement within the timescale expected. 8 (9%) of the outcomes have been completed, 60 (70%) of the outcomes are classified as being on track for achievement, and in 18 (21%) of the outcomes progress is being made but with some delay. At this stage, no outcomes are identified as being not on track for achievement.

We will continue to monitor progress against the outcomes and indicators on an ongoing basis, and update annually. We will also seek to identify and address emerging issues. For example, we have initiated actions on prescription drug misuse and progress against these have been included in this year's report.

1. Background to the NSD Phase 2

Introduction

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

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

Update

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

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

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

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

NSD Phase 2 – Consultation

1.6 The NSD Phase 2 was issued for public consultation on 04 March 2011 and the process ran until 31 May 2011. 105 individuals and organisations were involved in the consultation. Direct consultation was also undertaken with children and young people through the Participation Network and the development of a young person's version of the consultation document.

NSD Phase 2 – Final Document

1.7 Following the consultation, the NSD Phase 2 was revised and refined to take on board the issues raised. The final document was then approved by the Northern Ireland Executive in December 2011 and launched by the Health Minister on 26 January 2012. The full document is available online at: http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_phase_2__2011-2016_

2. NSD Phase 2 – the Revised Approach

The Five Pillars

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

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

Themes

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

Values and Principles

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

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

Overall Aim

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

Long-term objectives

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

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

Key Priorities

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

KEY PRIORITY	UPDATE
Developing a Regional Commissioning Framework	The Alcohol and Drug Services Commissioning Framework, which covers all tiers of service, was issued for consultation on March 2013. The document will be finalised in the near future, but is currently being used to inform the next process of tendering and commissioning. A further consultation on Tier 4 inpatient detoxification was launched in October 2013 and proposal are now being finalised.
Targeting those at risk and/or vulnerable	The strategy, and its implementation, continues to target those at risk and/or vulnerable – this is on the basis of local needs assessment and prioritisation.
Alcohol and drug-related crime including anti-social behaviour and tackling underage drinking	Key links have been made between NSD Phase 2, the Community Safety Strategy, the Strategic Framework for Reducing Offending, and alcohol licensing. At the local level, we continue to promote joined up work between DACTs, PCSPs, and local councils.
Reduced availability of illicit drugs	Key links have made between NSD Phase 2, the Organised Crime Task Force, the Community Safety Strategy, and the Strategic Framework for Reducing Offending. At the local level, we continue to promote joined up work between DACTs, PCSPs, and local councils.
Addressing community issues	DACTs and ISFs remain in place to bring forward issues from local communities, and put in place action and programmes to address these. Policing and Community Safety Partnerships (PCSPs) also play a role in identifying problems within communities and seeking local solutions to local problems. The Alcohol and Drug Services Commissioning Framework looked at the role of Community Support Services, and specifications are being developed to support commissioning of services on a more consistent basis across the region.
Promoting good practice in respect of alcohol and drug-related education and prevention	The Alcohol and Drug Services Commissioning Framework sets out the evidence base for what works in alcohol and drug education and prevention, and a range of services will be commissioned in light of this work.
Harm Reduction approaches	We are continuing to support and develop substitute prescribing, needle and syringe exchange, naloxone, and other harm reduction approaches.
Workforce Development	Workforce development is a key part of the commissioning framework, and will support its roll out once finalised.

Emerging Issues

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

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

3. Update on NSD Phase 2 Indicators

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

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

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

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

Prevalence

Alcohol

Adults (Adult Drinking Patterns Survey)

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

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

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

Drugs

Adults – 15-64 (Drug Prevalence Survey)

Indicator	2002/03	2006/07	2010/2011
Lifetime use of any illegal drugs	20%	28%	27%
Last year use of any illegal drugs	6%	9%	7%
Last month use of any illegal drugs	3%	4%	3%

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

Indicator	2003	2007	2010
lifetime use of any drugs or solvents	23%	19%	15%
last year use of any drugs or solvents	18%	13%	11%
last month use of any drugs or solvents	12%	7%	7%

Treatment

Census of Drug and Alcohol Treatment Services in Northern Ireland

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

Northern Ireland Drug Misuse Database

Indicator	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13
Individuals presented to treatment services for drug misuse	1,666	1,464	1,984	1,755	2,008	2,593	2,999	2,824
First Main Drug of Misuse	Cannabis	Cannabis	Cannabis	Cannabis	Cannabis	Cannabis	Cannabis	Cannabis

Second Main Drug of Misuse	Benzodia zepines	Benzodia zepines	Benzodia zepines	Benzodia zepines	Benzodia zepines	Benzodia zepines	Benzodia zepines	Benzodia zepines

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

Hospital Admissions

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

Deaths

Indicator	2005	2006	2007	2008	2009	2010	2011	2012[(p)]
Alcohol-related deaths	246	248	283	276	283	284	252	270
Drug-related deaths	84	91	86	89	84	92	102	110
Deaths due to drug misuse	42	49	48	53	46	63	58	75

Data for 2012 are provisional

Blood Borne Viruses

Indicator	2005	2006	2007	2008	2009	2010	2011	2012[(p)]
New diagnoses of Hepatitis C	134	135	114	132	112	106	113	133
Reports of both acute and chronic Hepatitis B	88	78	116	106	90	106	107	111

Data for 2012 are provisional. Figures for earlier years have been revised.

Needle Exchange

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

Source: 2005/06 to 2009/10 – Public Health Information and Research Branch.
2010/11 to 2012/13 – Health and Social Care Board.

Crime

Indicator	06/07	07/08	08/09	09/10	10/11	11/12	12/13
Drug Offences	2,411	2,720	2,974	3,146	3,482	3,780	4,378
Drug seizure incidents	2,590	2,968	3,198	3,319	3,564	3,920	4,474

Year	2008	2009	2010	2011	2012	2013
No. Drink/Drug-driving related offence	4,700	4,645	3,994	3,889	3,590	3,168

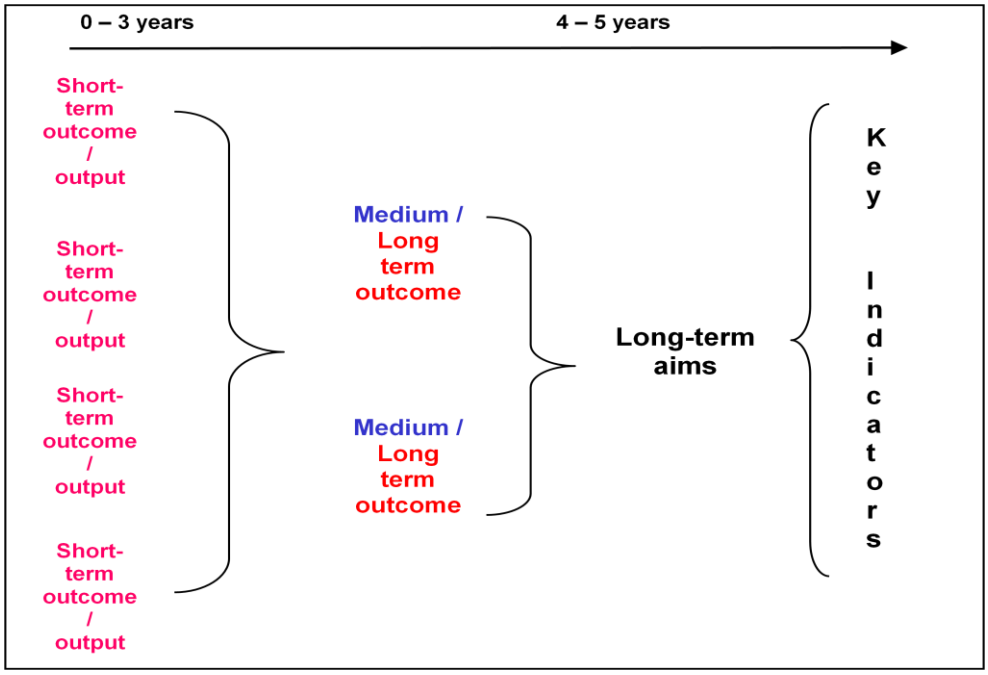
All figures have been revised since last update.

Figures are provisional and are subject to change.

Any person who is required to submit to an evidential test is counted as a drink/drug driving detection.

4. Progress on Outcomes

4.1 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 were initially developed. A number of regional and local short and medium-term outcomes and outputs have subsequently supported these and will provide the focus for activities and future work. *(Short term means within 3 years, and medium to long-term within 4 - 5 years).*



4.2 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 were structured in a manner that not only demonstrated their sequential nature across the five years of the NSD, but also their relationship with the Themes, Long-Term Aims and Key Priorities.

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

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

- Monitoring, Evaluation and Research
- Workforce Development

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

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

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

	Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
1.	An integrated and targeted programme undertaken to raise awareness of the health impact of drinking above the relevant guidelines – messaging must be clear and consistent.		The Commissioning Framework has indicated that DACTs should play a more active role in the development of a local integrated education and prevention plan. It is recommended that a service in each HSCT area will be commissioned to ensure that the outcomes listed here are addressed. A workshop was undertaken with the DACTs on the 17 September 2013 to inform the development of these services.	
2.	Improved understanding of the social norms associated with alcohol misuse, and work undertaken to challenge these and those factors driving the drinking culture; also work undertaken to challenge these norms			
3.	Local community support services reviewed and consideration given to increasing consistency across Northern Ireland.		A review of the community support services was undertaken as part of the Commissioning framework consultations. The findings have contributed to the redesign of tier 1 services which will come into effect under the new contracts.	
4.	Health professionals, particularly within Primary Pare and A&E, trained and encouraged to undertake brief alcohol advice/intervention programmes across Northern Ireland.		Primary Care currently receiving training in screening and brief interventions. Business case in development to enhance the number of substance misuse liaison nurses, a key role of which will be to undertake Alcohol Brief Interventions and train others to do likewise. Highlighted as Ministerial commissioning priority being taken forward by HSCB/PHA	Consideration is ongoing around local schemes to support GPs to deliver brief interventions to those clients who would most benefit.
5.	Review of the role and capacity of alcohol liaison nurses, and consideration given to ensuring they are available in all relevant HSC sites across Northern Ireland.		Business case in development to enhance the number of substance misuse liaison nurses. Role and function being standardised across the 5 HSCTs. Highlighted as Ministerial commissioning priority being taken forward by HSCB/PHA.	
6.	Proposals developed on how alcohol is: • Priced (including		**Pricing:** Research has been commissioned on a North/South basis to determine the potential impact of Minimum Unit Pricing for Alcohol. This will be published in 2014, and subsequently decisions	We will continue to give consideration to taking forward action on minimum unit pricing for alcohol.

consideration to minimum unit pricing); • promoted; • labelled; and • advertised.		will be made about our approach to this issue going forward. **Promotions:** DSD has worked with the alcohol industry on the development of a Responsible Retailing Code of Practice - www.responsibleretailingcodeni.org/. This code, which is overseen by an independent complaints panel, applies to the entire industry and will be run for an initial period of two years. DSD has introduced regulations to ban fixed price promotions such as 'all you can drink for £20' in pubs and registered clubs with effect from 01 January 2013. A recent consultation on proposed changes to licensing legislation included a proposal to make compliance with such codes to be a condition of holding an alcohol licence. Minister is currently considering the way forward. **Labelling:** Labelling of alcohol products is part of the UK-wide Responsibility Deal. The industry has committed that by December 2013 over 80% of products on shelves will have labels with clear unit content, alcohol guidelines and a warning about drinking when pregnant. We will monitor progress on this target closely and give consideration to taking a more robust regulatory approach if this commitment is not met. **Advertising:** Broadcast advertising is a reserved matter. We have continued to advocate, with the UK Government, for a strengthening of the code on alcohol advertising. We are also working with the industry, through the local Responsible Retailing Code of Practice and the Portman Group, to ensure that the self-regulation of alcohol advertising and promotion is as robust as possible. OFCOM Review...	
7. Workplace Alcohol and Drug Policy Guidance updated, disseminated and their usage supported and encouraged.		**Completed**. Reviewed guidelines placed on the NI Business Info Website (http://www.nibusinessinfo.co.uk/content/workplace-policies-smoking-drugs-and-alcohol). The PHA will promote the availability of these guidelines through their wider programme of health promotion in the workplace.	In the future we will update the guidelines as appropriate.
8. Information on emerging trends and drugs of misuse shared across UK and ROI Jurisdictions, particularly in relation to helping		The Department, and other key agencies such as DoJ and FSNI, feed into the ACMD and the British-Irish Council as appropriate.	

to inform the statutory role of the Advisory Council on the Misuse of Drugs (ACMD) in respect of the Misuse of Drugs Act.			
9. NI continues to contribute to the ACMD and inputs to UK-wide legislation in relation to the misuse of drugs, particularly in relation to emerging drugs of concern.		The Department continues to work with the ACMD, the Home Office, and the Department of Health, in relation to appropriate UK-wide legislation on these issues. The Minister has written to the Home Office advocating a more robust UK wide approach to "headshops", and a UK-wide review has been initiated for completion during 2014.	
10. All organisations promptly informed of changes to the drug and alcohol legislation.		Information is disseminated as appropriate by the Department through the PHA, the various advisory groups, the NSD Steering Group, and the DAMIS system.	
11. Parents, communities and key professionals provided with accurate and timely information in relation to emerging drugs, including legal highs.		Appropriate information is placed on the *Talk-to-Frank* Website, and other information sources such as NI Direct. CMO issues warning and advice letters as appropriate to health professionals within HSC. PHA also ensures that funded services provide up-to-date information to clients, young people, and their families.	
12. Group established to consider how the use of prescribed drugs can be addressed across Northern Ireland.		**Completed.** A group was established in 2012 to consider prescription drug misuse. Subsequently an action plan was developed and issued to key partners for. These actions are now included separately in this report.	Key Actions are included in this report.
13. Drink and drug driving (including prescription drugs) media campaigns continued and their impact assessed.		DOE's anti drink driving campaign, entitled *Hit Home* ran on television over the summer and Christmas periods in 2013. 'Hit Home' carries the strapline "Every drink increases your risk of crashing." Selected TV spots were chosen to air the Department's previous anti drink driving campaign, which carries the message 'Just One Drink Impairs Driving' and reinforces current activity. For most of 2013, the *Hit Home* anti drink drive message was also delivered on bus rear and bus shelter advertising. DOE, along with PSNI, supports Coca-Cola's Designated Driver campaign over the Christmas and New Year period, encouraging pub-goers to designate a driver who abstains from alcohol or to book a taxi home.	DOE is continuing to emphasise that driving is impaired from the very first drink. This supports the proposed future lower drink drive limit. It is anticipated that similar levels of anti-drink driving and anti-drug driving messages will continue to be delivered, as both remain road safety priorities for the Department.

		DOE has also furthered this message via its online campaign 'Share the Road to Zero'. On emails, Facebook and Twitter for this campaign, anti drink driving messages and links to *Hit Home* have been posted. In the new year, similar messages will be delivered regarding the DOE's anti drug driving message, with a link to the *Steps* campaign online. *Steps* carries the strapline "What steps will you take to stop a drug driver from wrecking your life?" and refers to both prescription and illicit drugs.	
14. Roadside drug screening devices in place when available.		In 2013, the Department for Transport (DfT) sought views on regulations to specify particular drugs and their corresponding limits for a new offence of driving with a specified controlled drug in the body above a specified limit. The outcome of that consultation, together with the work of the Department for Transport's Scientific Review Panel which considered the drugs to be covered potentially by the new offence and subsequently tested by the screening device, will inform any final policy proposals for Northern Ireland. The Department of the Environment (DOE) had been advised that the Home Office had approved one drug screening device for use in police stations in potential drug driving cases. This device is limited to the detection of cannabis only. Given its limitation, coupled with the absence of Health Care Professionals in Custody suites, the PSNI has no plans to invest in this device at this time. For mobile drug screening devices, the Home Office issued a Guide to Type Approval in September 2013. The guide states that devices must be able to detect for cannabis and cocaine as the two most prevalent drugs amongst drug drivers. The police are expected to start operationally trialling devices that have been submitted by manufacturers for Type Approval. Type approval of the first devices is not, however, expected until mid 2014 at the earliest. It is envisaged that as the technology develops with increased screening capability for a range of drugs, PSNI and FSNI will develop a handling plan to deal with the potential increase in laboratory based analysis.	DOE continues to liaise with DfT throughout 2013 on drug driving developments on progress towards new regulations to address drug driving offences. PSNI and FSNI will liaise on the potential increase of laboratory based analysis as a direct result of roadside testing initiatives. Both organisations need to develop a joint Drugs Strategy for roadside detection and subsequent confirmation.

15. New roadside breath testing devices in place for drink drivers when available.		This issue continues to be progressed through the Ministerial Road Safety Group. A DOJ led Working Group has been established to consider a number of issues including the accreditation process of the appropriate equipment and the resource implications. The HO has issued specification requirements for the roadside evidential device to relevant providers and awaits replies. It is anticipated that selected devices will then be trialled in UK police services to test their effectiveness. New breath testing equipment is currently undergoing Type Approval within the Home Office Centre for Applied Science and Technology (CAST). In relation to the reduced breath test limits FSNI is working closely with the PSNI to ensure the new equipment fully meets the NI specification.	FSNI will continue to advise the PSNI in the Type Approval process. The technical lead will liaise with the CAST project manager for updates and assurance against the NI specification.
16. The proportion of positive preliminary breath test results reduced.		The PSNI's Operation Season's Greetings targeted drink drivers throughout the Christmas and New Year period. During the period 28/11/13 to 02/01/14 the number of Positive Breath Tests (PBTs) increased by 302 compared to last year (3882 versus 4184) whilst the number of positive results decreased from 273 to 258. Throughout the year enforcement operations continued, including the monitoring and enforcement of the road traffic collision breathalysing policy.	
17. The Drink Drive (Blood Alcohol Concentration) Limit reduced.		Drafting of the Road Traffic (Amendment) Bill is complete and includes provisions to lower the limits on blood alcohol levels for motorists and it will introduce other measures to tackle drink driving. The draft Bill was provided in 2013 to the Executive Committee for agreement to proceed. The DOJ will continue to work with the Department of the Environment on this issue and a working group has been established to consider the relevant operational issues. New breath testing equipment is currently undergoing Type Approval within the Home Office Centre for Applied Science and Technology (CAST). In relation to the reduced breath test limits, FSNI is working closely with the PSNI to ensure the new equipment fully meets the NI specification.	Subject to Executive Committee agreement, the Department (DOE) plans to introduce the Bill to the Assembly in the Spring of 2014. This schedule, together with PSNI plans to acquire new evidential breath testing equipment, should enable a phased implementation of new police powers and new lower limits commencing in mid-2015. UKAS Accreditation for reduced limits of detection scheduled for mid 2014

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

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
18. A Regional Addiction Services Commissioning Framework developed and implemented for Northern Ireland.		Draft framework completed and consultation completed. Revised framework to be published in the near future	
19. The Framework should ensure that services are supported and encouraged to adopt a "recovery and reintegration" approach to treatment and support.			
20. Local and regional Service User developments encouraged and supported.		**Completed.** Regional tender for a service user support service in place since May 2013. Subsequently, service users are key stakeholders on all appropriate regional policy and implementation groups.	We need to continue to promote service user engagement and participation.
21. Specific work in respect of identified vulnerable groups included in local action plans.		All appropriate services commissioned by the PHA will be expected to ensure that identified vulnerable groups can access services	
22. Pilot scheme for 'Take Home Naloxone' to be evaluated and consideration given to its roll-out.		Naloxone currently being distributed in all 5 Health and Social Care Trusts, as well as Prisons. Almost 300 kits have been distributed, and it has been administered to at least 7 people in overdose – potentially saving up to 7 lives.	Consideration needs to be given to making Naloxone available as widely as possible.
23. Provision of needle/syringe exchange scheme continued, and consideration given to expanding the scheme to areas with an identified need.		4 additional pharmacy-based sites have been identified in Dungannon, Newry, Downpatrick and Limavady. There has been a delay in procuring these new sites due to legal considerations. These sites will shortly be procured by HSCB. Local outreach schemes to be considered by local PHA offices.	
24. Learning from existing schemes/initiatives, work undertaken across Northern Ireland to reduce levels of prescribing, and support people to reduce/stop taking unnecessary prescriptions.		HSCB/PHA action plan on Prescribed Medication will outline how this will be addressed. This is due to be signed off by PHA/HSCB mid 2014.	

25. Services in place to assist clients with a common employability barrier, (e.g. history of drug/alcohol misuse, homelessness and ex-prisoners/ex-offenders) and NEETs Young People to enter employment.		DEL's Local Employment Intermediary Service (LEMIS) is a community employment initiative designed to help the "hardest to reach" overcome those issues that may be preventing them from finding and keeping a job. During the period April 2011 to April 2014, 887 clients with a common employability barrier have been supported by LEMIS with 87 (9.8%) entering full-time permanent employment and 7 individuals entering part time employment.	In July 2013, as part of the Pathways to Success Strategy, NEETs clients (young people aged 16-24 not in education, employment or training) were added to the common employability barrier grouping to enable all NEETS young people throughout NI to avail of LEMIS. Providers continue to work with clients with a history of drug/alcohol misuse in partnership with other organisations in the community. Providers continue to work with clients with a history of drug/alcohol misuse in partnership with other organisations in the community.
26. Education and training for professionals, carers and families in relation to substance misuse problems in older people supported.		**Completed:** PHA produced a resource on this issue during 2013/14	
27. Consideration given to extending arrest referral schemes to other areas across NI.		The DOJ continues to liaise with the PSNI on their review of custody healthcare provision and its potential impact on extending arrest referral schemes to other areas.	Joint working on a Joint Healthcare and Criminal Justice Strategy, including consideration of people in custody is being currently being taken forward.
28. 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.		The DOJ continues to liaise with the PSNI on their review of custody healthcare provision and its potential impact on the need to alter existing arrest referral schemes.	As for above
29. A continuum of treatment and support opportunities between custody and release of offenders		NIPS continue to work in partnership with the South Eastern Health and Social Care Trust (SEHSCT) to ensure that discharge structures are in place to provide the appropriate continuum of treatment and	As for above.

back into the community for young and adult offenders developed – linked to the Joint Agency Offender Management Process.		support to prisoners returning to the community, following release from Prison or those on home leave. In partnership with the SEHSCT, NIPS continue to work with the Northern Ireland Health and Social Care Board and Trusts as well as voluntary sector agencies to achieve close integration and a seamless transition from custody to community and vice versa.	
30. The NI Prison Service in partnership with the South Eastern HSC Trust further develop services to ensure appropriate interventions are in place for prisoners, including for those with opiate dependency.		NIPS continue to work in partnership with the SEHSCT to minimise the abuse of drugs and to educate and support those prisoners who have addiction issues. NIPS are committed to providing an appropriate regime to support those who remain free from drugs and systems are in place for those who test positive for drug abuse/misuse. Work is ongoing to develop a pilot drug rehabilitation unit at Maghaberry.	As for above. Work is taking place to produce a Joint Substance Misuse Strategy, to be taken forward as part of the Prison Reform Programme.
31. Accreditation sought for the "Prisoners - Addressing Substance Related Offending" (P-ASRO) programme, or other appropriate programmes, delivered in prisons.		NIPS continue to work in partnership with the SEHSCT and AD:EPT (Alcohol and Drugs: Empowering People through Therapy) who provide a range of programmes to offenders including the P-ASRO programme. P-ASRO is soon to be replaced by Building Skills for Recovery (BSR), an evidenced based structured psychosocial treatment programme accredited by the Correctional Services Accreditation and Advisory Panel.	The Drug Rehabilitation Unit at Maghaberry Prison will open in June.
32. The NI Prison Service in partnership with the South Eastern HSC Trust will have undertaken work to reduce the risk of drug-related death in prisons, and particularly on release from prison.		Information is provided to prisoners at induction regarding substance misuse on how to access addiction services whilst in prison, taking into account the diversity of the prison population, e.g. foreign nationals, offenders with literacy problems. NIPS support those at risk of self-harm or suicide, including those who deliberately overdose, through the multi-disciplinary Supporting Prisoner At Risk (SPAR) programme. NIPS and the SEHSCT ensure lessons learned from Prisoner Ombudsman reports are incorporated into policy reviews to reduce the risk of deaths. Regular drug testing takes place and those who test positive for drug misuse are referred for assessment and/or treatment. Procedures	A substance abuse needs analysis and joint working on Substance Misuse Strategy is being taken forward as part of the Prison Reform Programme.

		are also in place for the observed administration of medications. Pre-release sessions are available to offenders to discuss core harm issues of substance use following release from prison. Partnership working with the SEHSCT and Voluntary and Community Agencies to ensure through-care from prison to community is provided to offenders.	
33. Education and information provided to parents of offenders regarding drugs and alcohol on a one to one basis and via the parent support groups.		Education and information to parents of young offenders is provided on a one-to-one basis and through parent support groups.	
34. The NI Prison Service and the South Eastern HSC Trust work in partnership with Alcohol & Drugs: Empowering People through Therapy (AD:EPT) to deliver psychological and educational drug and alcohol programmes for all offenders.		The AD:EPT project delivers a range of psychological and educational drug and alcohol programmes in partnership with the Northern Ireland Prison Service and the SEHSCT.	Joint working on a Substance Misuse Strategy is being taken forward as part of the prison reform programme.

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

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
35. The "You, Your Child, and Alcohol" regional information campaign, aimed at reducing alcohol and drug misuse among young people (aged under 18), evaluated and consideration given to its future.		**Completed.** The "You, Your Child and Alcohol" was last run in Summer 2011. Overall, the campaign evaluated well with good awareness of the campaign and booklet. Self-reported evidence indicated that parents were more likely to talk to their children about alcohol issues, and use the booklet for advice. It has been decided not to run another phase of the campaign at this stage. However, the steering group are happy to share the learning from this campaign with interested stakeholders – and to use it to inform any future work in this area.	
36. Targeted education and awareness-raising among children, parents, and families on the risks of drug and alcohol misuse and how to prevent harm.		Targeted education and awareness-raising among children, parents, and families on the risks of drug and alcohol misuse and how to prevent harm are currently being provided in each DACT area. The Commissioning Framework has indicated that DACTs should play a more active role in the development of a local integrated education and prevention plan. It is recommended that a service in each HSCT area will be commissioned to ensure that the outcomes listed here are addressed. A workshop was undertaken with the DACTs on the 17 September 2013 to inform the development of these services	
37. Schools support the development of skills and knowledge that enable young people to resist social pressures to experiment with alcohol and drugs, including volatile substances, emerging drugs of concern, etc.		The school curriculum places a specific focus on the development of relevant "life skills" among pupils. In particular, through Personal Development and Mutual Understanding (PDMU) in primary schools pupils are provided with opportunities to develop strategies and skills for keeping themselves healthy and safe. Post-primary school pupils, through Learning for Life and Work, are provided with opportunities to investigate the effects on the body of legal and illegal substances and the risks and consequences of their misuse.	DE is working with the Council for Curriculum, Examinations and Assessment to schedule an update of DE's guidance on drugs and alcohol.
38. Young People's Drinking Action Plan implemented.		**Completed.** The key actions from the Young People's Drinking Action Plan have been incorporated within the NSD Phase 2, and progress is being made against these actions.	

39. Successful implementation of new liquor licensing regulations and laws.		The outcome report of the recent DSD public consultation on proposed changes to the law regulating the sale and supply of alcohol in Northern Ireland was published on 18 December 2013. Minister McCausland is giving careful consideration to the way forward. He has indicated that not all the proposed restrictions on the availability of alcohol in supermarkets are likely to be beneficial and that only a modest increase in opening hours for licensed premises is likely to be introduced to assist the economy, tourism and hospitality sector.	
40. Improved co-operation and co-ordination to address alcohol and drug misuse and mental health, suicide and self-harm, and sexual health, at both the strategic and operational level.		At the strategic level, there is a greater acknowledgement of the links between these issues within all relevant strategies. At the operational level, it is envisaged that the substance misuse liaison posts will have a key role in linking with/addressing self-harm and associated mental health issues. Commissioners for mental health, sexual health and alcohol and drugs met to discuss possible areas for collaboration. It was agreed that some procurement of programmes for young people would be subject specific but that work would be taken forward to look at generic work for young people. The One Stop Shop and the Strengthening Families initiative are examples of such work. Substance misuse training is promoted within the Mental Health field and likewise substance misuse services are encouraged to avail of mental health training, in particular ASSIST, Safe Talk and Mental Health First Aid.	This will continue to be built upon through ongoing policy development and implementation.
41. A One-Stop-Shop service, informed by the evaluation of the pilot project, available in areas of identified need to those young people affected by substance misuse, but also addressing issues such as suicide and self-harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping skills.		Eight One Stop shops are now in place. All are developing referral pathways for young people into a wide range of services to address the key issues as per target. A network of services has been established and meets quarterly to share practice, address concerns, and improve consistency across the region. Two networking practice events have been held for all staff. An application is in progress to evaluate the One Stop Shop initiative over three years.	

42. Greater information-sharing between PSNI, the Youth Justice Agency (YJA) and PBNI regarding the identification of children who offend and who are known to be using alcohol and drugs either in the commissioning of offences or to gain money to purchase drugs or alcohol.		Criminal Justice organisations continued close working with all partners to ensure the appropriate and timely sharing of information relating to young people. Ongoing communication with Reducing Offending Units and Youth Diversion Officers highlighted relevant information and issues relating to substance misusing offenders. The Youth Justice Agency has joined with the PSNI, PBNI, NI Prison Service and DOJ to form - 'Reducing Offending in Partnership' (ROP). It is aimed at making communities safer by reducing crime and re-offending, at the same time improving public confidence in the criminal justice system. ROP has been extended across all police districts and of the 371 individuals currently being managed under the scheme, 65 are young people under the age of 18. The Youth Engagement Project is a partnership between the Youth Justice Agency, Public Prosecution Service and the PSNI. The aim is to speed up the process of diversionary disposals whilst ensuring all young people are also offered support and services (including those with alcohol/drugs issues) when needed.	
43. Opportunities in Youth Conferences for young people involved in substance related offending to hear first hand experiences from those who have experienced dependency but have addressed it.		Established relationships are maintained and developed with Drug and / or Alcohol workers who have personal experience of dependency to attend Youth Conferences as appropriate. Youth Conference Coordinators take every opportunity to involve people, with relevant experiences, in youth conferences to derive the most benefit and impact in order to reduce the likelihood of the young person committing further offences. For some specific cases this involves the participation in the conference of peer educators. However, this is more commonly dealt with in the plan that comes out of the conference process rather than during the conference itself and follows an assessment (RIAT) resulting in referral to a specialist service.	
44. Education and awareness sessions provided to young people who, though the criminal justice system, are subject to statutory supervision in the		Appropriately tailored education and awareness sessions are provided to young people who have been assessed and are subject to statutory supervision. The Youth Justice Agency in Omagh recently worked with the PHA	

community and are assessed as Tier 1.		to deliver a targeted education/early intervention programme to a group of young people currently involved with the Agency. This was an accredited Open College Network (OCN) programme in Drug & Alcohol Misuse Awareness. All young people admitted to Woodlands receive Tier 1 education and awareness sessions.	

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

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
45. Development of a framework of Treatment and Support Services for those aged under 18.		The framework of Treatment and Support Services for those aged under 18 has been developed and forms part of the PHA commissioning framework for substance misuse services. Consultation on this Framework is complete and the procurement process for new services is underway. Specifications will help improve regional consistency in service provision.	
46. Family support services available across Northern Ireland, and treatment services supported and encouraged to take a family orientated approach to provision where appropriate – reflecting the "Think Child, Think Parent, Think Family" strategy.		Family support services are now available in each DACT area. All treatment services are encouraged to take a family approach where appropriate; work around Hidden Harm includes a protocol and planned training associated with the protocol which will support this.	
47. The Regional Hidden Harm Action Plan implemented.		Implementation of the action plan is ongoing, with some areas of work having been significantly developed in line with the emerging evidence base. A workshop was held in Mid-March 2014 to re-draft the action plan, taking account of the revised structures in Northern Ireland. The following priority was agreed in the PHA/HSCB Commissioning Framework. "Commission treatment and support services for young people affected by parental substance misuse and their families, including intensive support for those families most affected, and ensure these services are linked to Family Support Hubs";	Implementation of the reviewed plan
48. The Regional Initial Assessment Tool embedded within the Youth Justice Agency, and work taken forward to roll it out to other key sectors.		Within the YJA, staff will be trained to deliver RIAT and the YJA will continue to review the assessment tool to ensure needs are identified. RIAT is the assessment tool used by YJA Practitioners to determine the appropriate level service required for young people for whom drugs and /or alcohol misuse is a matter of concern.	Work with key stakeholders to support any future roll out will continue. The Youth Justice Agency will contribute to the upcoming PHA review of RIAT.

49. Within the custodial setting of Woodlands, young people assessed (and follow up action and support provided) regarding their drug and alcohol misuse, with appropriate screening and management systems in place to minimise risk to those young people who are admitted to custody under the influence of substances.		All young people admitted to Woodlands are assessed for drug and alcohol misuse to ensure that the appropriate services are in place. Close monitoring is provided. Young people admitted to Woodlands JJC are screened and if necessary assessed by JJC medical personnel. Those assessed as being under the influence of, or intoxicated through drug and/or alcohol misuse are kept under observation on the Woodlands medical wing until such times as they are further assessed as fit and well enough to be discharged from the medical wing and admitted to the Centre proper. RIAT assessments in Woodlands JJC are carried out by YJA Practitioners with training and experience in using the tool.	
50. 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.		Work to establish appropriate protocols between the relevant organisations at times of transition continues. The Youth Justice Agency and the Northern Ireland Prison Service developed agreed protocols for the transition of young people from Woodlands to Hydebank and these were signed off in January 2014	

Community Safety and Anti-Social Behaviour

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
51. Existing relationships between Community Safety Partnerships (now PCSPs), District Policing Partnerships and DACTs developed in respect of addressing alcohol and drug related anti-social behaviour.		PCSP managers are aware of the need to develop these relationships in order to assist in addressing alcohol and drug related anti-social behaviour.	The DOJ will continue to engage with PCSP managers to reinforce those key messages.
52. Assess the level alcohol plays in Sexual Violence and Domestic Violence; further work will flow from that assessment.		Consideration of how best to assess the level alcohol plays in Sexual Violence and Domestic Violence is ongoing.	
53. Community Safety Strategy recognises the role of alcohol and drug misuse.		**Completed.** The Community Safety Strategy includes the theme of alcohol and drug misuse. A recent update on progress towards delivering the related outcomes has been provided to the Minister for Justice and the Justice Committee.	
54. Protocol developed to improve information sharing between PSNI, Health Trusts, Ambulance Service and others regarding alcohol related incidents, including hospital admissions and ambulance calls to inform local action planning.		The PSNI and Belfast Health and Social Care Trust initiative in the Royal Victoria Hospital's Accident and Emergency Department, that leads to the sharing of information regarding incidents of violent (alcohol) related crime, is now firmly embedded and informs intelligence reports used by police to target resources across Belfast, including Licensed premises. A data sharing protocol has also established with SEHSCT to enable data sharing between the PSNI and the Ulster Hospital.	The Joint Health Justice strategy action plan places urgency on the development of information sharing agreement across the interface between Justice and Health.
55. Promotion of schemes at a local level that tackle anti-social behaviour linked to alcohol misuse (and underage drinking).		The DOJ, through PCSPs and other Criminal Justice organisations, continue to encourage the development of local initiatives to tackle anti-social behaviour linked to alcohol misuse.	The DOJ will continue to engage with PCSP managers to reinforce this key message.
56. Cross-Government approach taken to addressing issues related to Alcohol and the Night-Time Economy Seminar.		DHSSPS and DOJ continue to work with others around the Night Time Economy. The Survey has been carried out and the proposed published report is being prepared.	

57. Work with the Alcohol Industry and Pubs of Ulster on rolling out the Purple Flag accreditation.		Departments continue to work with representatives of the Association of Town Centre Managers and the Alcohol industry in their work to encourage towns and cities to seek accreditation through membership of the Purple Flag steering group.	
58. The Organised Crime Task Force Drugs Expert Group sharing information and intelligence, and monitoring and overseeing joint action by its partner organisations, to ensure ongoing disruption of the drugs market, and help reduce the availability for drugs.		The Organised Crime Task Force Drugs Expert Group continues to meet to share information and intelligence, and lead joint action, as appropriate. PSNI, UK Border Force, HMRC and other law enforcement partners continue to use intelligence to disrupt importation of drugs. Operations continue to be run to deal with both high level suppliers as well as street level dealing.	

Supporting Outcomes – Monitoring, Evaluation and Research

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
59. The Regional Impact Measurement Tool (IMT) continues to be completed for all initiatives funded as part of the New Strategic Direction.		Workshops were undertaken in November 2013 to review the current tools. This information will inform the development of revised tools for the procurement of services to support Phase 2 of the NSD.	Consideration need to be given to how the IMT fits with the commissioning framework.
60. Consideration given to developing one overarching monitoring system including Drug Misuse Database (DMD), Substitute Prescribing and Needle Exchange; also an Alcohol Misuse Database established.		Discussions are ongoing but have been delayed by the need to reflect what is in the alcohol and drug services commissioning framework.	
61. A rolling research programme developed and updated on an annual basis.		Research is being undertaken on the potential impact of minimum unit pricing for alcohol.	
62. Available statistics and research information published.		All information produced by DHSSPS is available online at: http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm.	
63. A local "Drug and Alcohol Monitoring and Information System" (DAMIS) in respect of alcohol and drug trends and developments in place which reports to the NSD Steering Group.		**Completed.** The DAMIS is in place and operational. We will continue to monitor its usage and the revise the scheme as required.	DAMIS is revised and updated as appropriate.
64. The NI Prison Service in partnership with the South Eastern HSC Trust will have		The SEHSCT and NIPS refreshed its joint substance misuse policy in 2012. A joint review of the Substance Misuse Strategy has now commenced.	Work will continue to strengthen NIPS drugs strategy in partnership with its key stakeholders, including PSNI and

undertaken a review of the Prison Strategy to tackle alcohol and drug issues among prisoners.		The NIPS drugs strategy delivers three strands; reducing supply, reducing demand, reducing harm. Working in partnership with the SEHSCT is integral to ensure the delivery of the Strategy. The SEHSCT and NIPS are engaged in ongoing joint working arrangements to address issues around the abuse of prescribed medication and the abuse of illicit substances.	SEHSCT
65. Improved quality and scope of data on drink and drug driving, including provision of separate data on drink and drugs present in road fatalities and separate trend data on fatal and serious injury collisions.		In 2011, the consumption of drugs or alcohol by driver or rider accounted for 10.9% of killed or seriously injured casualties (96 people), the most common causation factor. From 01 April 2010, separate data is available on the collision causation factors '*Impaired by alcohol*' and '*Impaired by drugs*'. It should be noted, however, that disclosure control is applied to data in line with the requirements of the Code of Practice for Official Statistics. Where this applies data is merged or suppressed in published reports in order to ensure that the identity of individuals or any private information relating to them is not revealed Separate analysis is now carried out for drugs and alcohol in blood samples taken from Road Traffic Collision fatalities and those suspected to be driving whilst unfit through drugs.	Work will continue to shorten existing timescales in forensic analysis to avoid undue delay.
66. Improve public understanding about the road safety risks of excessive alcohol consumption on buses		In 2012-13 the DoE engaged with stakeholders around the issue of alcohol consumption on buses. This culminated in a consultation which concluded that DoE should implement a multi-stranded approach designed to improve understanding of the risks, make providers more responsible and engage with other departments as part of the wider strategic approach to dealing with issues relating to alcohol.	Work will be undertaken to improve knowledge and understanding of this issue. Bus providers will be required to inform passengers about not drinking on buses. Engagement will take place with DOJ and DHSSPS to better address this matter as part of a strategic approach to alcohol issues.
67. Results of the Night-Time Economy module of the NI Crime Survey published.		The NI Crime Survey findings on alcohol and the night time economy for 2009/10 and 2010/11 were published in June 2012 and circulated to all stakeholders. A further Survey is due for publication in early 2014.	The fieldwork for the years 2011-12 and 2012-13, part of the NI Crime Survey findings on Alcohol and the Night-time Economy, has now been completed, and is due for publication during the summer of 2014.

Supporting Outcomes – Workforce Development

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
68. Effectiveness of workforce development initiatives reviewed.		Workforce development services funded by the PHA are monitored on a quarterly basis to ensure courses are meeting identified needs.	
69. Informed by this review, workforce development initiatives are better co-ordinated, and front-facing workforce better equipped to provide early effective intervention.		Commissioning framework has prioritised the development of a range of courses. Regional programmes scheduled to be in place by 1st of October. Existing contracts may be extended should this deadline fail to be met.	
70. Improved awareness and opportunities for Criminal Justice Organisations to avail of training programmes.		All training courses are open to criminal justice organisations. The awareness of, and opportunities for, appropriate staff training programmes continues to be improved.	
71. Organisations work together to share information and secure a greater understanding on the composition and impacts of legal highs (or any other new drug).		DAMIS provides an opportunity for organisations to share information about new and emerging drugs of concern. Training courses have been developed to inform services about the risks associated with such substances. DOJ, DHSSPS,PHA and PSNI continue to work together to implement the Drug and Alcohol Monitoring Information System (DAMIS) and this assists with raising the awareness of new psychoactive substances and the current drug situation among key staff.	
72. Dissemination of the Drugs and Alcohol National Occupational Standards (DANOS) for all sectors in Northern Ireland.		DANOS Standards have recently been updated and these have now been disseminated to all appropriate sectors and organisations.	
73. Training in respect of Hepatitis C and other blood borne viruses for those working with Injecting Drug Users continues to be delivered.		Training is available in these areas.	
74. YJA ensures that service delivery staff have the skills and knowledge to deliver alcohol and drugs interventions at Tier 2.		Practitioners are appropriately trained to deliver Drug and Alcohol interventions / programmes. Programme manuals for YJA Practitioners and Workbooks for young people have been designed and provided across the YJA.	

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

Prescription Drug Misuse

Short Term Outcomes/Outputs	RAG Status	Update on Progress	Future Steps (if appropriate)
76. Collate and disseminate information on the current level of prescribing and misuse.		HSCB and PHA are considering this outcome and will implement appropriately as part of the overall prescription drug misuse action plan. Information on prescription drug misuse will continue to be part of the drug prevalence survey and the DMD.	
77. Consideration given to research calls in this area.		PHA to consider what research can be supported in this area.	
78. Awareness raised among health professionals		The Department, with support of the PHA/HSCB, is developing a range of specific prescription drug misuse workshops to share information and best practice and improve consistency across NI. Following on from the workshops, consider the development of audits or guidelines that can be disseminated to professionals	
79. Workforce development on prescription drug misuse is a key element of the Alcohol and Drug Services Commissioning Framework.		This area will be addressed through the procurement of future services including workforce training in 2014 by the PHA.	
80. Awareness Raising among the public and prescription drug misusers		Support and dissemination of the MRG campaign in relation to the use of substances not prescribed for you. Prevention and Education section of the Alcohol and Drug Services Commissioning Framework will reference issues around prescription drug misuse. Engage community pharmacies in campaigns to raise awareness of the issues associated with prescription and OTC medicines including the display of promotional materials, provision of information and advice in the pharmacy and outreach to local communities.	
81. Schemes to support appropriate reductions in prescribing levels		Use of annual prescribing visits to promote and support appropriate prescribing practices. Supported the update and dissemination of the HSCB Benzodiazepine Resource Pack. The forthcoming PHA/HSCB regional addiction services commissioning framework should support Local initiatives and the rollout of the Prescribed Drug Misuse Practitioners.	

		Consideration of further work in due course with pain clinics etc	
82. Reduced OTC medication misuse		Raise awareness of OTC misuse with pharmacists and GPs, including implication of opioid prescribing decisions. Investigate use of in-pharmacy information for patients.	
83. Continuation of seizures and operations to disrupt the illicit markets in prescription drug misuse, and internet purchases		Support for this issue to have a raised profile within PSNI, Home Office Border Force, HMRC and other OCTF partners. Work continues to disrupt importation of drugs including prescription medication via the internet. At present it is not illegal to import prescription medication for personal use unless it contravenes other legislation such as abortion medicines. Seizures of quantities of drugs where it is believed there is an intention to supply, continue to be made. Ongoing involvement in Operation Pangea. This is a global enforcement campaign on illicit/counterfeit prescription or over-the-counter drugs. It targets the product as well as attempting to disrupt the supply chain by closing down websites.	
84. Alcohol and Drug Services Commissioning Framework should consider the consistency of approaches across NI.		Further consideration given to emerging evidence around the treatment of prescription drug misuse.	
85. Harm reduction measures and messages available as appropriate.		Provision of clean needles for those who inject. Targeted harm reduction messages issued those at risk. Access to substitute prescribing where appropriate. Guidance in relation to harm reduction specifically around poly drug use has been issued by the PHA due to concerns raised through DAMIS.	
86. Substance Misuse Liaison Posts across Northern Ireland consider and support those with prescription drug misuse.		This area will be addressed when the substance misuse liaison networks are established in each HSCT.	

5. Conclusions

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

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

5.3. There are 86 short-term outcomes set out in the NSD Phase 2, to be taken forward by a range of Government Departments, agencies, the community and voluntary sector, and others.

5.4. In the second year, progress continues to be made on a number of these outcomes. 8 (9%) of the outcomes have been completed. Progress against 60 (70%) of these outcomes is classified having green status – i.e. progress is being made as expected and is on track for achievement. 18 (21%) of the outcomes are classified as having an amber status – progress is being made but there has been delay in completing these due to a number of issues. At this stage, no outcomes are identified as being red – not on track for achievement. We will continue to monitor achievement of these outcomes as we move forward, and report on an annual basis.

Annex A

Section 1 - Numbers Presenting to Treatment

Source: Census of Drug and Alcohol Treatment Services in Northern Ireland: 1 March 2005, 1 March 2007, 1 March 2010 & 1 March 2012

Background

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

The reports of the findings of the 2005, 2007, 2010 & 2012 censuses can be accessed on-line at http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm

Information on the 2012 census follows:

Summary

Alcohol-only Misuse

- In 2012, a total of 3,111 individuals were in treatment for alcohol-only misuse compared with 3,328 individuals in 2010, a decrease of 7%.
- Two-thirds of those in treatment for alcohol-only misuse were male and 34% were female.
- The vast majority (97%) of individuals in treatment for alcohol-only misuse were aged 18 years and over.

Drug-only Misuse

- In 2012, 1,514 individuals were in treatment for drug-only misuse compared with 1,294 individuals in 2010, an increase of 17%.
- Over two-thirds (69%) of those in treatment for drug-only misuse were male and 31% were female.
- Almost all individuals (94%) in treatment for drug-only misuse were aged 18 years and over.

Alcohol and Drug Misuse

- In 2012, 1,291 individuals were in treatment for both alcohol and drug misuse, compared with 1,224 individuals in 2010, an increase of 5%
- Three-quarters of those in treatment for both alcohol and drug misuse were male and 25% were female.
- In total, 84% of individuals in treatment for both alcohol and drug misuse were aged 18 years.

Alcohol and/or Drug Misuse

- In 2012, 5,916 individuals were in treatment for alcohol and/or drug misuse compared with 5,846 individuals in 2010.

- Over two-thirds (69%) of those in treatment for alcohol and/or drug misuse were male and 31% were female.

- Almost all individuals (93%) in treatment for alcohol and/or drug misuse were aged 18 years and over.

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

Statistics from the Northern Ireland Drug Misuse Database: 2005/06 – 2012/13

Background

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

The annual statistical bulletins reporting on the 12-month period ending 31 March can be accessed at:
http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm

Summary

Drug Misuse

- In 2012/13, 2,824 individuals were presented to treatment services for drug misuse compared with 2,999 individuals in 2011/12, a decrease of 6%.

- In 2012/13, the majority of those presenting to treatment services for drug misuse were male (77%).

- Over one third of males (37%) presented for treatment were aged between 18 and 25, compared with18% of females.

Main Drug of Misuse

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

Section 2 – Hospital Admissions

Source: Hospital Inpatient System (HIS), DHSSPS

Background

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

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

Summary

Alcohol-Only Emergency Admissions

- The number of emergency admissions to hospital for alcohol-only related conditions has risen year-on-year from 7,322 in 2005/06 to 10,274 in 2012/13. This represents a 40% increase. (Table A.1)

- In 2012/13, just under three quarters (72%) of those admitted in an emergency were male and 28% were female. (Table A.1)

- In 2012/13, over half of those who were admitted for alcohol-only emergencies were aged between 45-64 years with 19% aged 65 and above, and 18% aged 35-44 years. (Table A.1)

Drug-Only Emergency Admissions

- In 2012/13 there were 3,315 emergency admissions to hospital for drug-only related conditions compared with 3,256 in 2011/12. This was an increase of 2%. (Table A.2)

- In 2012/13, half of those admitted in an emergency were female and half were male. (Table A.2)

- Over a fifth of those in the age categories of 18-24 year olds (22%), 25-34 year olds (21%) and 45-64 year olds (21%) were admitted for treatment. (Table A.2)

Alcohol and Drug Emergency Admissions

- The number of emergency admissions for alcohol and drug related conditions was 1,556 in 2012/13. This was a decrease of 5% from the previous year. (Table A.3)

- In 2012/13, 56% of those admitted were male and 44% were female. (Table A.3)

- Around one third of those admitted (30%) in 2012/13 were aged 45-64 years, while 26% were aged 35-44 years and 22% were aged between 25-34 years (Table A.3)

Table A.1 Alcohol-only related admissions* to hospital (2006/07 – 2012/13)

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**7,322**	***100***	**8,267**	***100***	**8,462**	**100**	**8,603**	**100**	**8,652**	**100**	**9,393**	**100**	**10,274**	**100**
Gender														
Male	5,371	73	6,214	75	6,359	75	6,360	74	6,284	73	6,835	73	7,440	72
Female	1,951	27	2,053	25	2,103	25	2,243	26	2,369	27	2,559	27	2,834	28
Age														
Under 18	155	2	167	2	183	2	181	2	136	2	127	1	133	1
18-24	289	4	342	4	358	4	326	4	354	4	399	4	383	4
25-34	620	8	758	9	723	9	709	8	738	9	789	8	796	8
35-44	1,778	24	1,910	23	1,911	23	1,842	21	1,605	19	1,693	18	1,839	18
45-64	3,509	48	3,955	48	4,106	49	4,274	50	4,438	51	4,728	50	5,200	51
65+	971	13	1,135	14	1,181	14	1,271	15	1,381	16	1,657	18	1,923	19

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

Codes used to identify alcohol-related admissions in any diagnostic position 2006/07 – 2008/09**:

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

Codes used to identify alcohol-related admissions in any diagnostic position 2009/10 – 2012/13**:

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

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

Table A.2 Drug-only related admissions* to hospital (2006/07 – 2012/13)

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**2,948**	**100**	**3,951**	**100**	**3,880**	**100**	**3,424**	**100**	**3,649**	**100**	**3,256**	**100**	**3,315**	**100**
Gender														
Male	1,290	44	1,693	43	1,712	44	1,601	47	1,745	48	1,560	48	1,668	50
Female	1,658	56	2,258	57	2,168	56	1,823	53	1,904	52	1,698	52	1,647	50
Age														
Under 18	416	14	516	13	523	13	487	14	517	14	458	14	423	13
18-24	549	19	769	19	737	19	717	21	817	22	688	21	716	22
25-34	647	22	834	21	791	20	682	20	807	22	685	21	707	21
35-44	658	22	900	23	842	22	710	21	633	17	610	19	596	18
45-64	549	19	784	20	823	21	686	20	705	19	671	21	694	21
65+	129	4	148	4	164	4	142	4	170	5	144	4	179	5

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

Codes used to identify drug-related admissions in any diagnostic position 2006/07 – 2012/13**:

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

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

Table A3 Alcohol and Drug related admissions* to hospital (2006/07 – 2012/13)

	2006/07		2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
All	**1,308**	**100**	**1,497**	**100**	**1,473**	**100**	**1,478**	**100**	**1,663**	**100**	**1,644**	**100**	**1,556**	**100**
Gender														
Male	729	56	852	57	823	56	835	56	980	59	917	56	867	56
Female	579	44	645	43	650	44	643	44	683	41	727	44	689	44
Age														
Under 18	72	6	72	5	66	4	81	5	79	5	59	4	56	4
18-24	247	19	312	21	263	18	297	20	299	18	319	19	260	17
25-34	293	22	292	20	307	21	278	19	410	25	377	23	340	22
35-44	345	26	429	29	389	26	418	28	425	26	392	24	411	26
45-64	328	25	376	25	436	30	380	26	426	26	479	29	460	30
65+	23	2	16	1	12	1	24	2	24	1	18	1	29	2

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

Codes used to identify alcohol-related admissions in any diagnostic position 2006/07 – 2008/09**:

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

K74	Fibrosis and cirrhosis of liver (Excluding K74.3-K74.5 – Biliary cirrhosis)		

Codes used to identify alcohol-related admissions in any diagnostic position 2009/10 – 2011/12**:

ICD-10 code	Description	ICD-10 code	Description
F11	Mental and behavioural disorders due to use of opioids	K731	Chronic lobular hepatitis, not elsewhere classified
F12	Mental and behavioural disorders due to use of cannabinoids	K732	Chronic active hepatitis, not elsewhere classified
F13	Mental and behavioural disorders due to use of sedatives or hypnotics	K738	Other chronic hepatitis, not elsewhere classified
F14	Mental and behavioural disorders due to use of cocaine	K739	Chronic hepatitis, unspecified
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine	K740	Hepatic fibrosis
F16	Mental and behavioural disorders due to use of hallucinogens	K741	Hepatic sclerosis
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	K742	Hepatic fibrosis and hepatic sclerosis
F100	Acute intoxication	K746	Other and unspecified cirrhosis of liver
F101	Harmful use	K860	Other diseases of pancreas
F102	Dependence syndrome	X40	Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
F103	Withdrawal state	X41	Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified
F104	Withdrawal state with delirium	X42	Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
F105	Psychotic disorder	X43	Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system
F106	Amnesic syndrome	X44	Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
F107	Residual and late-onset psychotic disorder	X45	Accidental poisoning by and exposure to alcohol
F108	Other mental and behavioural disorders	X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
F109	Unspecified mental and behavioural disorder	X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified
G312	Degeneration of nervous system due to alcohol	X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
G621	Alcoholic polyneuropathy	X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
I426	Alcohol cardiomyopathy	X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
K292	Alcohol gastritis	X65	Intentional self-poisoning by and exposure to alcohol
K700	Alcoholic fatty liver	X85	Assault by drugs, medicaments and biological substances
K701	Alcoholic hepatitis	Y10	Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent
K702	Alcoholic fibrosis and sclerosis and sclerosis of liver	Y11	Poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent
K703	Alcoholic cirrhosis of liver	Y12	Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent
K704	Alcoholic hepatic failure	Y13	Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent
K709	Alcoholic liver disease, unspecified	Y14	Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent
K730	Chronic persistent hepatitis, not elsewhere classified	Y15	Poisoning by and exposure to alcohol, undetermined intent

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

Section 3 - Alcohol/Drug-related Deaths

Source: Demography and Methodology Branch (DMB), NISRA

Background

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

Summary

Alcohol-related Deaths

- In 2012, there were 270 alcohol-related deaths which was similar to the 252 deaths in 2011. (Table B.1)
- In 2012, two-thirds of alcohol-related deaths were among males. (Table B.1)
- Since 2006, there have been 1,896 alcohol-related deaths recorded. In 2012, three-fifths of those who died were aged between 45 and 64. (Table B.1)
- In each of the years from 2005 to 2012, the most common underlying cause of death among all alcohol-related deaths was 'Alcoholic liver disease'. In 2012, this was 56.3%.

Drug-related Deaths

- In 2012, there were 110 drug-related deaths which compares with the 102 deaths in 2011. (Table B.2)
- Over two-thirds (69%) of drug-related deaths were among males. (Table B.2)
- The highest proportion of drug-related deaths in 2012 belonged to the 35-44 age category. (Table B.2)
- In each of the years from 2005 to 2008, the most common underlying cause of death among all drug-related deaths was 'Intentional self-poisoning by drugs, medicaments and biological substances'. From 2009 to 2011, the most common underlying cause of death among all drug-related deaths was 'Poisoning by drugs, medicaments and biological substances, undetermined intent'. In 2012, the most common underlying cause of death (17.3%) among all drug-related deaths was 'Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent.'

Deaths due to Drug Misuse

- In 2012, 68% of drug-related deaths were due to drug misuse compared with 57% in 2011. (Table B.3)
- In 2012, over three-quarters (76%) of deaths due to drug misuse were among males compared with 59% in 2011. (Table B.3)
- The largest proportion of deaths due to drug misuse in 2012 was among 35-44 years (Table B.3)
- In 2005, 2007, 2008 and 2009, the most common underlying cause of death among deaths due to drug misuse was 'Accidental poisoning by drugs, medicaments and

biological substances', while in 2006 it was 'Intentional self-poisoning by drugs, medicaments and biological substances'. In 2010 and 2011, the most common underlying cause of death among deaths due to drug misuse was 'Poisoning by drugs, medicaments and biological substances, undetermined intent'. In 2012, the most common underlying cause due to drug misuse was joint between 'Poisoning by and exposure to narcotics and psychodysletics [hallucinogens], not classified elsewhere, undetermined intent' and 'Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent'.

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

Background

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

Alcohol-related Deaths

Definition

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

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

Table B.1 Alcohol-related deaths in Northern Ireland (2006 - 2012) according to National Statistics Definition

	2006		2007		2008		2009		2010		2011		2012 (p)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**248**	**100**	**283**	**100**	**276**	**100**	**283**	**100**	**284**	**100**	**252**	**100**	**270**	**100**
Gender														
Male	173	70	199	70	185	67	187	66	191	67	177	70	178	66
Female	75	30	84	30	91	33	96	34	93	33	75	30	92	34
Age														
Under 25	1	0	1	0	0	0	0	0	0	0	0	0	1	0
25-34	6	2	9	3	6	2	9	3	12	4	6	2	5	2
35-44	43	17	66	23	34	12	44	16	33	12	52	21	52	19
45-54	83	33	89	31	102	37	98	35	104	37	76	30	82	30
55-64	61	25	68	24	75	27	80	28	80	28	69	27	81	30
65 and over	54	22	50	18	59	21	52	19	55	19	49	19	49	18

2012 Figures are provisional. Percentages in the above table may not sum to 100 due to rounding.

Drug-related Deaths

Definition

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

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

Table B.2 Drug-related deaths in Northern Ireland (2006 - 2012) according to National Statistics Definition

	2006		2007		2008		2009		2010		2011		2012 (p)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**91**	**100**	**86**	**100**	**89**	**100**	**84**	**100**	**92**	**100**	**102**	**100**	**110**	**100**
Gender														
Male	51	56	51	59	60	67	48	57	66	72	65	64	76	69
Female	40	44	35	41	29	33	36	43	26	28	37	36	34	31
Age														
Under 25	9	10	9	10	8	9	10	12	15	16	18	18	13	12
25-34	13	14	17	20	22	25	13	15	25	27	33	32	30	27
35-44	33	36	29	34	26	29	31	37	19	21	21	21	29	26
45-54	24	26	18	21	15	17	19	23	20	22	18	18	22	20
55-64	10	11	7	8	12	13	7	8	4	4	10	10	12	11
65 and over	2	2	6	7	6	7	4	5	9	10	2	2	4	4

2012 Figures are provisional. Percentages in the above table may not sum to 100 due to rounding.

Table B.3 Deaths due to drug misuse in Northern Ireland (2006 – 2012) according to National Statistics Definition

	2006		2007		2008		2009		2010		2011		2012 (p)	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All	**49**	**100**	**48**	**100**	**53**	**100**	**46**	**100**	**63**	**100**	**58**	**100**	**75**	**100**
Gender														
Male	28	57	27	56	41	77	30	65	50	79	40	69	57	76
Female	21	43	21	44	12	23	16	35	13	21	18	31	18	24
Age														
Under 25	5	10	5	10	3	6	6	13	12	19	11	19	9	12
25-34	9	18	10	21	17	32	9	20	19	30	17	29	20	27
35-44	16	33	19	40	16	30	20	43	12	19	12	21	23	31
45-54	15	31	7	15	7	13	8	17	12	19	7	12	15	20
55-64	4	8	5	10	6	11	2	4	4	6	9	16	6	8
65 and over	0	0	2	4	4	8	1	2	4	6	2	3	2	3

2012 Figures are provisional. Percentages in the above table may not sum to 100 due to rounding.

Section 4 – Alcohol/Drug Prevalence

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

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

Background

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

The reports of the findings of the 2005, 2008 & 2011 surveys can be accessed on-line at http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm.

Summary

Consumption

- In 2011, almost three quarters of survey respondents drank alcohol (74%).
- In 2011, a higher proportion of males than females stated that they drank alcohol (78% compared with 72%).
- Younger adults (18-29 years) were more likely to drink alcohol than older adults (60-75 years) in all years (82% and 59% respectively).

Recommended Daily Limits

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

- Around four fifths of respondents who had consumed alcohol in the week prior to the survey exceeded the recommended daily limit (78% in 2011).
- In 2011, approximately four fifths of both males (76%) and females (81%) exceeded the recommended daily drinking limits in the week prior to the survey.

Hazardous Drinking

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

- Of those who consumed alcohol in the week prior to the survey, just over three quarters (77%) of respondents in 2011 consumed alcohol within sensible limits. The proportion of respondents who consumed alcohol at above sensible but below dangerous weekly was 18%.
- In all years, a higher proportion of females than males stayed within their respective sensible weekly limits (80% of females compared with 74% of males in 2011).
- Younger drinkers (18-29 years) were more likely than older drinkers (60-75 years) to exceed the weekly guidelines for sensible drinking limits in 2011.

Problem Drinking

- CAGE question analysis (clinical interview questions) indicated that almost one tenth of those surveyed in 2011 (9%) had a problem with alcohol.

- Males were more likely than females to have a problem with alcohol. In 2011, this represented 11% of males and 8% of females.

4.2 Binge Drinking

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

- In 2011, 30% of respondents engaged in at least one binge drinking session during the week prior to the survey.

- A higher proportion of males (35%) than females (25%) were classified as binge drinkers in the 2011 survey.

- The proportion of respondents who had consumed alcohol in the week prior to the survey and engaged in a binge drinking session significantly decreased with age, with younger people (18-29 years) more likely than older people (60-75 years) to binge drink (50% compared with 13% in 2011).

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

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

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

Source: Young Persons' Behaviour and Attitudes Survey (2003 & 2007) Secondary Analysis, November 2005 & January 2009

Background

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

Summary

Lifetime Prevalence

- The proportion of respondents aged 11-16 who said that they had ever taken an alcoholic drink was 46% in 2010.

- Since 2003, lifetime prevalence of alcohol significantly decreased for both males (from 61% in 2003 to 48% in 2010) and females (from 59% in 2003 to 44% in 2010).

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

*Last Week Prevalence**

- In 2010, 13% of all pupils had drunk alcohol in the week prior to the survey, compared with almost one fifth (19%) in 2007.

- In 2010, 15% of males and 13% of females had drunk alcohol in the week before the survey, compared with 18% of males and 20% of females in 2007.

- In both 2007 and 2010, older pupils were more likely to have drunk alcohol during the week prior to the survey than younger pupils.

*No comparable information is available from the 2003 YPBAS

Drunkenness

- Of those who had ever drunk alcohol, over half of respondents reported to having been drunk on at least one occasion (53% in 2010).

- In 2010, males were more likely than females to have been drunk (51% of females and 53% of males).

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

4.4 Drug Prevalence among Adults (15-64 years)

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

Background

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

Summary

Lifetime Prevalence

- Lifetime use of any illegal drugs among all adults aged 15-64 years was similar in 2006/07 (28%) and 2010/11 (27%).

- Proportions were also similar for males and females during this period. This was 34% of males in 2006/07 compared with 32% of males in 2010/11. The proportions for females was identical at 22% in 2006/07 and 2010/11.

- Lifetime use of any illegal drugs among young adults aged 15-34 years decreased from 40% in 2006/07 to 37% in 2010/11.

Last Year Prevalence

- Last year use of any illegal drugs among all adults decreased from 9% in 2006/07 to 7% in 2010/11.

- Last year use of any illegal drugs among males decreased from 14% in 2006/07 to 9% in 2010/11. For females, last year use of any illegal drugs was similar at 5% in 2006/07 and 4% in 2010/11

- Last year use of any illegal drugs among young adults aged 15-34 years decreased from 17% to 12% in 2010/11. For older adults aged 35-64 years, last year use of any illegal drugs was similar at 4% in 2006/07 and 3% in 2010/11

Last Month Prevalence

- There was no significant difference in last month use of any illegal drugs among all adults aged 15-64 years between 2006/07 and 2010/11 (4% in 2006/07 and 3% in 2010/11).

- Last month use of any illegal drugs among females was similar at 1% in 2006/07 and 2% in 2010/11. This was also true for males at 6% and 5% respectively.

4.5 Problem Prevalence

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

Background

This research was commissioned by DHSSPS and used the capture-recapture method, an established method for estimating the size of covert populations. The report provides prevalence estimates for problem drug use (defined as use of opiates and/or cocaine) in Northern Ireland in 2004 and can be accessed online at the following address: http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm. At this point in time, there are no plans to repeat this research.

Summary

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

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

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

Source: Young Persons' Behaviour and Attitudes Survey (2003 & 2007 & 2010)
Secondary Analysis, November 2005 & January 2009

Prevalence rates of illegal drug use for age 11-16

	Lifetime (%)	Last year (%)	Last month (%)
Any illegal drug	15	11	7
Cannabis	7	6	3
Solvents	7	4	2
Legal highs	4	3	1
Cocaine	3	2	1
Speed	2	1	1
Ecstasy	2	2	1
Magic Mushrooms	2	1	1
Mephedrone	2	2	1
Poppers	1	1	1
Tranquillisers	1	1	1
Crack	1	1	1
LSD	1	1	0.4
Heroin	1	1	0.4
Anabolic steroids	1	1	0.4

Summary

Lifetime Prevalence

- Among all respondents, lifetime use of any drugs or solvents decreased from 19% in 2007 to 15% in 2010.
- Lifetime use of any drugs or solvents decreased among male pupils from 19% in 2007 to 17% in 2010), with lifetime prevalence among female pupils also decreasing from 19% in 2007 to 13% in 2010.
- In all years, older pupils were more likely to report ever using drugs or solvents than younger pupils.
- Lifetime use of cannabis decreased from 9% in 2007 to 7% in 2010. In relation to solvents, the proportions were similar in 2007 and 2010 at 8% and 7% respectively.
- Among males, lifetime use of cannabis was the same in 2007 and 2010 at 10%. Lifetime use of speed among males was 2% in both 2007 and 2010.
- Among females, lifetime use of cannabis decreased from 8% in 2007 to 5% in 2010, while lifetime prevalence rates increased for the following drugs: LSD (2% in both 2007 and 2010) and cocaine (3% in both 2007 and 2010).

Last Year Prevalence

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

- Last year use of any drugs or solvents was similar among male pupils at 14% in 2007 and 13% in 2010. In relation to female pupils the proportion decreased from 13% in 2007 to 9% in 2010.

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

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

- Last year use of cannabis among all pupils was similar in both 2007 and 2010 at 7% and 6% respectively.

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

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

- Last year prevalence rates for cocaine were 2% for females in both 2007 and 2010).

Last Month Prevalence

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

- Last month use of any drugs or solvents for males was also identical in 2007 and 2010 at 8% while the proportions for females was similar at 7% and 6% respectively.

- In both years older pupils were more likely to report using any drugs or solvents in the last month than younger pupils.

- Last month use of cannabis was similar in 2007 and 2010 at 4% and 3% respectively.

- The proportion of males who had used cannabis was identical 2007 and 2010 at 4%.

- Among females, last month use of cannabis was similar in 2007 and 2010 at 3% and 2% respectively.

Section 5 - Blood Borne Viruses among Injecting Drug Users

5.1 Viral Infections

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

Background

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

Summary

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

Hepatitis C

- Since the introduction of diagnostic tests in 1990, laboratories in Northern Ireland have reported a total of 1,622 diagnoses of Hepatitis C up to and including the year 2011.

- In 2011, there were 113 new diagnoses of Hepatitis C reported, compared with 134 in 2005, 140 in 2006, 118 in 2007, 132 in 2008, 112 in 2009 and 106 in 2010. In 2008 88% of new diagnoses of Hepatitis C were associated with injecting drug use.

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

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

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

Similarly in 2005/06, 9% of survey participants (25 of 292) reported not having been tested and just over one quarter (23 of 80) of IDUs infected with Hepatitis C were unaware of their infection.

Hepatitis B

- In Northern Ireland, the total number of reports of both acute and chronic Hepatitis B was 123 in 2011, 101 in 2010, 87 in 2009, 101 in 2008, 104 in 2007, 76 in 2006, and 72 in 2005. Some of these infections will have been related to injecting drug use.

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

HIV

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

5.2 Viral Testing and Vaccination

Source: Statistics from the Northern Ireland Drug Misuse Database: 1 April 2005 - 31 March 2006; 1 April 2006 - 31 March 2007; 1 April 2007 - 31 March 2008; 1 April 2008 - 31 March 2009; 1 April 2009 - 31 March 2010; 1 April 2010 - 31 March 2011; 1 April 2011 - 31 March 2012; 1 April 2012 – 31 March 2013.

Background

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

Summary

- From 2005/06 to 2012/13, approximately nine-in-ten individuals who had presented to treatment services had never been tested for HIV, Hepatitis B or C.
- Over nine-in-ten individuals presenting for treatment since 2005/06 had not had any injections of the Hepatitis B vaccination course. Less than one-in-twenty had completed all 3 injections.

5.3 Needle and Syringe Exchange Scheme

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

Background

Needle and Syringe Exchange Schemes (NSES) are a service for injecting drug users (IDUs), targeted as a harm reduction measure to help limit the spread of blood borne viruses such as Hepatitis B and C and HIV. The Northern Ireland NSES began operation in pharmacies from April 2001 and publications summarising the information collected on the operation of the NSES can be accessed online at the following address:
http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm

Summary

- During 2009/10, there were 15,828 visits to participating pharmacies by users of the scheme. This is an increase of 18% (2,439 visits) on the 2008/09 figure (13,389). The corresponding number of visits for the years 2005/06, 2006/07 and 2007/08 were 8,797, 9,997 and 11,387 respectively.

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

- Over half of all visits were made by clients aged 31 and over in each of the years since 2005/06.

Section 6 – Personal Expenditure on Alcohol

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

Background

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

Summary

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

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

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

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

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

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

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

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

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

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

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

Section 7 – Alcohol / Drug-related Crime

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

Summary

The relationship between crime and the consumption of alcohol drugs is well established. The misuse of both drugs and alcohol is of increasing concern to the police and public alike.

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

Police operations have continued over recent years to focus on prevention and enforcement. Over the last year (2013/14) the newly formed PCSPs have had a specific objective to tackle alcohol related violent crime and this has led to a number of joint partnership initiatives aimed at education and prevention. One recent example was the introduction of vulnerability awareness training to Police, Door Staff and Bar Staff supported by South Belfast PCSP and Pubs of Ulster.

Other PCSPs, for example Omagh, have worked to introduce night time economy warden schemes delivering on street reassurance and help to those under the influence of alcohol.

In Belfast there have been a number of new initiatives designed to ensure compliance with licensing laws, and improvements to customer safety. These have included the introduction of a Licensed Premises Crime and Harm matrix for the City of Belfast which produces a traffic light and points system for each licensed premises in the City, which is then followed up by action planning and robust supervision of identified problem premises.

Data sharing has been introduced between the PSNI and two of Belfast's Emergency Departments to allow further examination of the extent of the alcohol /crime link.

Enforcement operations continue to be conducted as appropriate. These have included operations to ensure compliance with licensing conditions such as licencing hours and the testing of 'drink promotions' in support of the Responsible Retail Code. More specifically, in 2012 a high profile Police operation targeting illegal after hours trading took place over two months, leading to the successful prosecution of a particular problem premises and a voluntary early closing agreement between other offending premises. Initiatives around customer safety on licensed premises have also been introduced, supported and partially funded by police, including the introduction of ID Scanning devices into three Belfast City premises.

7. 1 Recorded Crime

Source: Police Service of Northern Ireland (PSNI) –Statistics Branch

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

Background

PSNI collate crime statistics for Northern Ireland in accordance with the National Crime Recording Standard. Copies of the reports produced can be accessed online at the following address:
http://www.psni.police.uk/index/updates/updates_statistics/update_crime_statistics.htm

Drug Offences

- From 2006/07 onwards, the total number of drug offences recorded year-on-year has increased (2,411 in 2006/07, 2,720 in 2007/08, 2,974 in 2008/09, 3,146 in 2009/10, 3,485 in 2010/11, 3,780 in 2011/12, 4,378 in 2012/13 and 4,732 in 2013/14).

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

Crimes where alcohol is a contributing factor

During 2012/13 PSNI established a baseline relating to those crimes where alcohol was a contributory factor. This identified that alcohol was a contributory factor in 20 per cent of all crimes recorded, while for offences of violence against the person alcohol was a contributory factor in 47 per cent of crimes of this nature. Figures for 2013/14 indicate that alcohol continues to be a contributory factor in 20 per cent of all crimes recorded, while for offences of violence against the person this has fallen to 45 per cent.

Section 8 – Drink/Drug Driving

8.1 Detections in NI

Source: Police Service of Northern Ireland (PSNI) Roads Policing Development Branch

Background

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

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

Summary

- Between 2008 to 2013, the number of drink-driving detections in Northern Ireland decreased annually from 4,700 to 3,168; a decrease of 33% over this period (Table D.1)

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

8.2 Prosecutions and Convictions in NI

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

Background

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

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

Summary

Convictions –

- The number of convictions for alcohol/drug related driving offences in Northern Ireland decreased from 3,375 in 2007 to 2,684 in 2009. (Table D.2)

- Between 84% and 87% of all convictions for alcohol/drug related driving offences were among males in each of the years from 2007 to 2009. (Table D.2)

- Between 2007 and 2009, approximately a quarter of convictions for alcohol/drug related driving offences were among those under the age of 25 years. (Table D.2)

PLEASE NOTE:

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

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

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

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

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

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

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

Source: Police Service of Northern Ireland (PSNI) – Central Statistics Branch 'PSNI Annual Statistical Report: Injury Road Traffic Collisions and Casualties'

Background

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

Summary

- Between 2004 and 2012, 5%-7% of all injury road traffic collisions (for all road users) were as a result of alcohol consumption or drug taking. (Table D.3)

- Of all fatal collisions, almost 25% in 2011 were attributed to alcohol and drugs, whereas in 2012, this had decreased to 16% (Table D.3)

- Approximately one tenth of all serious collisions were attributed to drinking alcohol or taking drugs in each of the years from 2004 to 2012. (Table D.3)

- From 2004 to 2012, approximately 5% of all slight collisions were as a result of alcohol consumption or drug taking. (Table D.3)

- In 2004 and 2005, 9% of all injury collisions attributed to alcohol/drugs were fatal collisions, compared with 2% in 2012 (Table D.4)

- In each of the years from 2004 to 2011, approximately a quarter of all injury collisions attributed to alcohol/drugs were serious collisions. This figure had reduced to 20% in 2012. (Table D.4)

Detections in NI

Table D.1 Number of Drink-driving detections in NI (2008 - 2013) – Note that previously this was Drink-Drug driving detections – PSNI only able to provide drink driving figures.

Year	2008	2009	2010	2011	2012	2013
No. Drink/Drug-driving related offence	4,700	4,645	3,994	3,889	3,590	3,168

All figures have been revised since last update.

Figures are provisional and are subject to change.

Any person who is required to submit to an evidential test is counted as a drink/drug driving detection.

Convictions in NI

Table D.2 Convictions for Alcohol/Drug related driving offences in NI (2010-2012)

	2010		2011		2012	
	n	%	n	%	n	%
All	2,459	*100*	2,345	*100*	2,209	*100*
Gender						
Male	2,028	*82*	1,944	*83*	1,781	*81*
Female	431	*18*	399	*17*	428	*19*
not specified	0	0	2	0	0	*0*
Age						
Under 18	20	*1*	14	*1*	10	*0*
18-21	255	*10*	252	*11*	216	*10*
22-24	271	*11*	225	*10*	215	*10*
25-29	372	*15*	360	*15*	328	*15*
30-34	280	*11*	291	*12*	246	*11*
35-39	276	*11*	281	*12*	234	*11*
40-44	272	*11*	236	*10*	241	*11*
45-59	581	*24*	547	*23*	553	*25*
60+	130	*5*	135	*6*	162	*7*
age not known	2	*0*	4	*0*		

Source: Department of Justice (Data are not comparable with previous years)

Injury Road Traffic Collisions

Table D.3 Injury Road Traffic Collisions attributed to alcohol/drugs[1] as a proportion of all Injury Collisions (2004-2012)

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

[1] Based on the principal causation factor

Table D.4 Injury Road Traffic of Collisions attributed to alcohol/drugs[1] (2004 – 2012)

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

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

Source: Statistics Branch, Police Service of Northern Ireland, Lisnasharragh

Section 9 - Disruption of Drug Supply Markets

Source: Police Service of Northern Ireland (PSNI)

Summary

- Success against crime gangs continues with 27 gangs frustrated, 53 gangs disrupted and 18 gangs dismantled in 2011/12. This compares to 30 frustrated, 46 disrupted and 28 dismantled gangs in 2010/11. (Table E.1)

9.1 Drug Seizures and Arrests

Source: Police Service of Northern Ireland (PSNI) – Central Statistics Branch 'PSNI Annual Statistical Report: Drug Seizures and Arrests'

Background

PSNI reports statistics on the quantities of drugs seized and on the number of seizure incidents on a financial year basis. Copies of the reports produced can be accessed online at the following address:
http://www.psni.police.uk/index/updates/updates_statistics/updates_drug_statistics.htm

Summary

Seizures

- From 2006/07 to 2011/12, the total number of drug seizure incidents recorded year-on-year has increased (2,590 in 2006/07, 2,968 in 2007/08, 3,198 in 2008/09, 3,319 in 2009/10, 3,564 in 2010/11, 3,920 in 2011/12 and 4,474 in 2012/13).

- In each of the years since 2006/07, cannabis was the drug most commonly seized. From 2006/07 through to 2008/09, ecstasy (including the BZP derivative) and cocaine were the second and third most commonly seized illegal drugs in Northern Ireland respectively, however since 2009/10 cocaine seizures exceeded ecstasy seizures.

- In 2012/13, information was collected on benzodiazepines, of which there were 450 seizures.

Arrests

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

Table E.1 Frustrated, Disrupted and Dismantled drug gangs (2006/07 - 2011/12)

Year*	Frustrated	Disrupted	Dismantled
2006/2007	6	4	2
2007/2008	29	25	4
2008/2009	41	17	5
2010/2011	30	46	28
2011/2012	27	53	18

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

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

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

Background

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

Summary

Alcohol

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

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

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

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

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

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

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

Drugs

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

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

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

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

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

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

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

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

Section 11 – Views on Alcohol and Drug Related Issues

Source: NI Omnibus Survey – September 2012

- Almost half (46%) of respondents agreed or strongly agreed with the statement 'I am concerned about alcohol related issues in my local area'. In contrast, 38% of respondents disagreed or strongly disagreed with the statement.

- Almost two out of five respondents (38%) agreed or strongly agreed that 'I am concerned about drug related issues in my local area' compared with 41% who disagreed or strongly disagreed.

- Among those reporting concern, the most cited reason given for concern about alcohol related issues in the local area was 'underage drinking' (63%) followed by 'rowdy and drunken behaviour' (10%). As for drug related issues, over two out of five of the respondents (42%) stated 'drug use/abuse' was the primary drug related issue in the local area, followed by 'drug-dealing' (33%).

- Four out of five respondents (79%) stated that there was no change in the level of alcohol related issues in their local area in the last 12 months. A similar proportion of respondents (83%) stated there was no change in the level of drug related issues in their local area in the last 12 months.

- Respondents stated that the PSNI was the most likely organisation to be approached about an alcohol (7%) or drug (5%) related issue in their local area.

- Almost one tenth of respondents (9%) had heard of the Northern Ireland Assembly's New Strategic Direction for Alcohol and Drugs Phase 2 2011-16.

- Taking everything into account, 57% of respondents expressed some, a lot or total confidence that enough is being done to tackle alcohol and/or drug related issues in Northern Ireland.

- Respondents expressed higher levels of confidence in the PSNI's work to tackle alcohol and/or drug related issues across Northern Ireland than that of any other organisation, with 71% having either some, a lot or total confidence.