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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 first annual report of progress against the outcomes and indicators set out in that document.

The report is set out 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 contained in the document;
- **Chapter 4** shows progress on the short-term outcomes in the NSD Phase 2;
- **Chapter 5** provides a summary and concluding comments; and finally
- **Annex A** contains a more detailed update on a range of key statistics related to the strategy.

Overall, good progress has been made in the first 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 drug misuse has largely plateaued, but encouragingly 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.

In terms of progress against the short-term outcomes within the NSD Phase 2, the majority of the 74 outcomes are on track for achievement within the timescale expected. Progress against 57 (77%) of these outcomes is classified as having green status – either they have been completed or progress is being made as expected and is on track for achievement. 17 (23%) 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 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, prescription drug misuse remains a concern and we hope to be able to make further progress in this area in the near future.
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 (including children and young people), 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 very 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. It also 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.

1.7 A breakdown of the responses by sector is shown in the chart below – this does not include information on the young people involved. Overall the consultation highlighted that there was very strong support (80-100% of those who responded said they agreed with the approach taken) for the process of revising and updating the NSD and the various questions in the consultation process.

NSD Phase 2 – Final Document

1.8 Following this, the NSD Phase 2 was revised and refined to take on board the issues raised in the consultation process. 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 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:
<table>
<thead>
<tr>
<th>KEY PRIORITY</th>
<th>UPDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a Regional Commissioning Framework</td>
<td>Work has been undertaken to develop an Alcohol and Drug Services Commissioning Framework that covers all tiers of service. This was issued for consultation in March 2013.</td>
</tr>
<tr>
<td>Targeting those at risk and/or vulnerable</td>
<td>Strategy and implementation continue to target those at risk and/or vulnerable – this is on the basis of local needs assessment and prioritisation.</td>
</tr>
<tr>
<td>Alcohol and drug-related crime including anti-social behaviour and tackling underage drinking</td>
<td>Key links 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.</td>
</tr>
<tr>
<td>Reduced availability of illicit drugs</td>
<td>Key links 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.</td>
</tr>
<tr>
<td>Addressing community issues</td>
<td>DACTs and ISFs remain in place to bring forward issues from local communities, and put in place action and programmes to address these.</td>
</tr>
<tr>
<td></td>
<td>The Alcohol and Drug Services Commissioning Framework also looks at the role of Community Support Workers and how this should be structured in the future.</td>
</tr>
<tr>
<td>Promoting good practice in respect of alcohol and drug-related education and prevention</td>
<td>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.</td>
</tr>
<tr>
<td>Harm Reduction approaches</td>
<td>We are continuing to support and develop substitute prescribing, needle and syringe exchange, naloxone, and other harm reduction approaches.</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>Workforce development is a key part of the commissioning framework, and will support its roll out once finalised.</td>
</tr>
</tbody>
</table>

**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;
- Emerging Drugs of Concern / “Legal Highs”;
- Families and Hidden Harm;
- Recovery;
- Mental Health, Suicide, and Drugs and Alcohol Misuse, Sexual Violence and Abuse, and Domestic Violence;
- Alcohol;
- Local Funding; and
- 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. Progress against these indicators will be reported as the information becomes available. It should be noted that for the majority of these outcomes we would be seeking to reduce the figures. However in respect of some of the areas – particularly those presenting for treatment and possibly hospital-related admissions – 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.

3.2. The tables below set out the trends in some of the key indicators in the NSD Phase 2. In **Annex A** an update against all the key indicators since the original NSD was published in 2006 is set out.

**Prevalence**

*Alcohol*

Adults (Adult Drinking Patterns Survey)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2005</th>
<th>2008</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>73%</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td>Drinkers who exceed daily Limit</td>
<td>82%</td>
<td>81%</td>
<td>78%</td>
</tr>
<tr>
<td>Drinkers who drink above sensible levels</td>
<td>29%</td>
<td>24%</td>
<td>23%</td>
</tr>
<tr>
<td>Problem Drinking</td>
<td>10%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Drinkers who binge drink</td>
<td>38%</td>
<td>32%</td>
<td>30%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2003</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever taken an alcoholic drink</td>
<td>60%</td>
<td>55%</td>
<td>46%</td>
</tr>
<tr>
<td>Drink in the week prior</td>
<td>N/A</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>Drink and been drunk</td>
<td>34%</td>
<td>30%</td>
<td>24%</td>
</tr>
</tbody>
</table>

*Drugs*

Adults – 15-64 (Drug Prevalence Survey)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002/03</th>
<th>2006/07</th>
<th>2010/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime use of any illegal drugs</td>
<td>20%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Last year use of any illegal drugs</td>
<td>6%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Last month use of any illegal drugs</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>
### Young People – 11-16 (Young Persons Behaviour and Attitude Survey)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2003</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>lifetime use of any drugs or solvents</td>
<td>23%</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>last year use of any drugs or solvents</td>
<td>18%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>last month use of any drugs or solvents</td>
<td>12%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

### Treatment

Census of Drug and Alcohol Treatment Services in Northern Ireland

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

### Northern Ireland Drug Misuse Database

<table>
<thead>
<tr>
<th>Indicator</th>
<th>05/06</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals presented to treatment services for drug misuse</td>
<td>1,666</td>
<td>1,464</td>
<td>1,984</td>
<td>1,755</td>
<td>2,008</td>
<td>2,593</td>
<td>2,999</td>
</tr>
<tr>
<td>First Main Drug of Misuse</td>
<td>Cannabis</td>
<td>Cannabis</td>
<td>Cannabis</td>
<td>Cannabis</td>
<td>Cannabis</td>
<td>Cannabis</td>
<td>Cannabis</td>
</tr>
<tr>
<td>Second Main Drug of Misuse</td>
<td>Benzodia zepines</td>
<td>Benzodia zepines</td>
<td>Benzodia zepines</td>
<td>Benzodia zepines</td>
<td>Benzodia zepines</td>
<td>Benzodia zepines</td>
<td>Benzodia zepines</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>05/06</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol-Only Emergency Admissions</td>
<td>7,127</td>
<td>7,322</td>
<td>8,267</td>
<td>8,462</td>
<td>8,603</td>
<td>8,652</td>
<td>9,393</td>
</tr>
<tr>
<td>Drug-only related admissions</td>
<td>3,160</td>
<td>2,948</td>
<td>3,951</td>
<td>3,880</td>
<td>3,424</td>
<td>3,649</td>
<td>3,256</td>
</tr>
<tr>
<td>Alcohol and Drug related admissions</td>
<td>1,498</td>
<td>1,308</td>
<td>1,497</td>
<td>1,473</td>
<td>1,663</td>
<td>1,663</td>
<td>1,644</td>
</tr>
</tbody>
</table>

### Deaths

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011 (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol-related deaths</td>
<td>246</td>
<td>248</td>
<td>283</td>
<td>276</td>
<td>283</td>
<td>284</td>
<td>252</td>
</tr>
<tr>
<td>Drug-related deaths</td>
<td>84</td>
<td>91</td>
<td>86</td>
<td>89</td>
<td>84</td>
<td>92</td>
<td>102</td>
</tr>
<tr>
<td>Deaths due to drug misuse</td>
<td>42</td>
<td>49</td>
<td>48</td>
<td>53</td>
<td>46</td>
<td>63</td>
<td>58</td>
</tr>
</tbody>
</table>

*2011 Figures are provisional*
## Blood Borne Viruses

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>New diagnoses of Hepatitis C</td>
<td>134</td>
<td>140</td>
<td>118</td>
<td>132</td>
<td>112</td>
<td>106</td>
<td>113</td>
</tr>
<tr>
<td>Total number of reports of both acute and chronic Hepatitis B</td>
<td>72</td>
<td>76</td>
<td>104</td>
<td>101</td>
<td>89</td>
<td>101</td>
<td>123</td>
</tr>
</tbody>
</table>

## Needle Exchange

<table>
<thead>
<tr>
<th>Indicator</th>
<th>05/06</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
<th>09/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to participating pharmacies</td>
<td>8,797</td>
<td>9,997</td>
<td>8,267</td>
<td>13,389</td>
<td>15,828</td>
</tr>
</tbody>
</table>

## Crime

<table>
<thead>
<tr>
<th>Indicator</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09</th>
<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Offences</td>
<td>2,411</td>
<td>2,720</td>
<td>2,974</td>
<td>3,146</td>
<td>3,482</td>
<td>3,780</td>
</tr>
<tr>
<td>Drug seizure incidents</td>
<td>2,590</td>
<td>2,968</td>
<td>3,198</td>
<td>3,319</td>
<td>3,564</td>
<td>3,920</td>
</tr>
</tbody>
</table>

## Year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Drink-driving detections</td>
<td>4472</td>
<td>4501</td>
<td>4760</td>
<td>4514</td>
<td>4208</td>
<td>4085</td>
<td>3514</td>
<td>3451</td>
<td>3273</td>
</tr>
</tbody>
</table>
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.
### Adults and the General Public – 1 (Prevention & Early Intervention)

<table>
<thead>
<tr>
<th>Short Term Outcomes/Outputs</th>
<th>RAG Status</th>
<th>Update on Progress</th>
<th>Future Steps (if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td>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 community support service should be in place to support such a scheme. This should be consistent across all DACT areas.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local community support services reviewed and consideration given to increasing consistency across Northern Ireland.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health professionals, particularly within Primary Care and A&amp;E, trained and encouraged to undertake brief alcohol advice/intervention programmes across Northern Ireland.</td>
<td></td>
<td>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.</td>
<td>Consideration is ongoing around local schemes to support GPs to deliver brief interventions to those clients who would most benefit.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>Business case in development to enhance the number of substance misuse liaison nurses.</td>
<td></td>
</tr>
<tr>
<td>Proposals developed on how alcohol is: • priced (including consideration to minimum unit pricing); • promoted; • labelled; and • advertised.</td>
<td></td>
<td><strong>Pricing:</strong> Options have been developed for consideration by the DHSSPS and DSD Ministers in respect of the pricing of alcohol. The first key step is commissioning research to identify the impact of minimum unit pricing in Northern Ireland, which would then allow for proportionate proposals to be brought forward. This research is currently being commissioned.</td>
<td>We will continue to give consideration to taking forward action on minimum unit pricing for alcohol.</td>
</tr>
</tbody>
</table>

_Pricing:_ DSD has worked with the alcohol industry on the development of a Responsible Retailing Code of Practice -
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. Following a public consultation, 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.

**Labelling:** Labelling of alcohol products is part of the UK-wide Responsibility Deal. The industry has committed to ensuring that over 80% of products on shelves will have labels with clear unit content (by December 2013), NHS 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.

<table>
<thead>
<tr>
<th>Workplace Alcohol and Drug Policy Guidance updated, disseminated and their usage supported and encouraged.</th>
<th>A group has been established to develop updated guidelines. It has met a number of times and draft guidelines are currently being considered. Greater consideration needs to be given to how we disseminate and support the usage of the guidelines once finalised.</th>
<th>Need to engage with key stakeholders on how the guidelines are disseminated and their use supported.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information on emerging trends and drugs of misuse shared across UK and ROI Jurisdictions, particularly in relation to helping to inform the statutory role of the Advisory Council on the Misuse of Drugs (ACMD) in respect of the Misuse of Drugs Act.</td>
<td>The Department continues to feed into the ACMD and the British-Irish Council as appropriate.</td>
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<tr>
<td>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.</td>
<td>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. We supported the development of the new temporary ban legislation which is UK-wide.</td>
<td></td>
</tr>
<tr>
<td>All organisations promptly informed of changes to the drug and alcohol legislation.</td>
<td>Information is disseminated as appropriate by the Department through the PHA, the various advisory groups, the NSD Steering Group, and the DAMIS system.</td>
<td>DE continues to attend the NSD steering group and process information received through DAMIS.</td>
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<tr>
<td>Parents, communities and key professionals provided with accurate and timely information in relation to emerging drugs, including legal highs.</td>
<td>Appropriate information is placed on the <em>Talk-to-Frank</em> 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.</td>
<td>DE will pass warnings / information to ELBs / schools on request from CMO and PHA.</td>
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<tr>
<td>Group established to consider how the use of prescribed drugs can be addressed across Northern Ireland.</td>
<td>A group has been established and has met on a number of occasions. Work is continuing to finalise the outcomes of this groups discussions, and to indentify and discuss how we can take forward a small number of key actions in this area.</td>
<td>Work needs to be undertaken to finalise outcomes of this groups discussions. Consideration being given to hosting a seminar or workshop to raise awareness of this issue.</td>
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</tbody>
</table>
| 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 2012. ‘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 2012, the *Hit Home* anti drink drive message was also delivered on bus rear and bus shelter advertising as well as point-of-danger in pubs and clubs over the Christmas period.
DOE’s anti drug drive campaign entitled *Steps*, also ran on television during the summer and Christmas periods.
*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. | DOE is continuing to emphasise that driving is impaired from the very first drink. This would support the potential future lowering of the drink driving limit.
It is anticipated that similar level of anti-drink driving and anti-drug driving messages will continue to be delivered as they both remain a priority for the Department in relation to road safety. |
Roadside drug screening devices in place when available.

The DOE has been advised by the Home Office that the development of roadside drug screening devices for the purpose of testing drivers is progressing but that the first devices will not be type approved until 2014 at the earliest.

The work is dependent on decisions made following work by a scientific review panel established by DfT in 2012 to look at the drugs for which the devices would test. The exact drugs, the specified limits and the details of the driving offence will be decided following advice from the scientific review panel and subsequent public consultation. The panel’s report was published on 07 March 2013.

The Home Office has recently approved a device for the detection of cannabis only. This device will simply confirm the presence, thereby obviating the need for a doctor, but a blood/urine sample will still be required.

PSNI continues to liaise with DfT on progress with creation of drug driving offence.

Given the limitations noted, at this point PSNI has no plans to invest in the cannabis only device.

New roadside breath testing devices in place for drink drivers when available.

New Roadside Preliminary Breath testing devices with a data capture facility were procured in 2009 and these are now fully operational within PSNI.

The process to identify and obtain type approval of suitable evidential equipment that will test at the lower limits to be brought forward in the Road Traffic (Amendment) Bill will take some time. A working group, led by DOJ and including PSNI and DOE, has been established to explore the procurement of equipment required to enforce the new drink drive regime. PSNI remains committed to the purchase and use of such equipment once it becomes available.

The Home Office has recently invited providers to take part in the testing of devices to establish their suitability to enforce at lower Blood Alcohol Concentration levels in line with proposed reductions in Northern Ireland and Scotland.

PSNI continues to liaise with the Home Office on specifying new equipment and obtaining type approval and awaits the outcome of the testing period – it is hoped that there may be a list of devices published in late 2013.
<table>
<thead>
<tr>
<th>The proportion of positive preliminary breath test results reduced.</th>
<th>The PSNI launched Operation Season’s Greetings to target drink drivers throughout the Christmas and New Year period and the results should be published in early 2013. Throughout the year enforcement operations continued, including the monitoring and enforcement of the road traffic collision breathalysing policy. During Operating Season’s Greetings, the proportion of positive preliminary breath tests (PBTs) saw an increase from 6.3% in 2011/12 to 7.9% in 2012/13 despite a lower number of PBTs carried out in 2012/13.</th>
</tr>
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<tbody>
<tr>
<td>The Drink Drive (Blood Alcohol Concentration) Limit reduced.</td>
<td>Consultation on the draft Road Traffic (Drink Drive) (Amendment) Bill was issued on 10 July 2012 and closed on 05 October 2012. Synopsis of responses and the way forward approved by Minister, presented to the Environment Committee on 29 November 2012 and subsequently published. Further engagement with the Committee is ongoing and it is planned to introduce the Bill to the Assembly by April 2013.</td>
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## Adults and the General Public – 2 (Treatment & Support)

<table>
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<tr>
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<tbody>
<tr>
<td>A Regional Addiction Services Commissioning Framework developed and implemented for Northern Ireland.</td>
<td></td>
<td>Alcohol and Drug Services Commissioning Framework currently out for consultation.</td>
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<tr>
<td>The Framework should ensure that services are supported and encouraged to adopt a “recovery and reintegration” approach to treatment and support.</td>
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<tr>
<td>Local and regional Service User developments encouraged and supported.</td>
<td></td>
<td>Regional tender for a service user support service currently live. Service expected to be in place by May 2013. Work underway to ensure service user input in policy development and through the DACTs at local level.</td>
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<tr>
<td>Specific work in respect of identified vulnerable groups included in local action plans.</td>
<td></td>
<td>Local DACT action plans target vulnerable and at risk groups in light of local need. Action plans to be updated in light of the Alcohol and Drug Services Commissioning Framework.</td>
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<tr>
<td>Pilot scheme for ‘Take Home Naloxone’ to be evaluated and consideration given to its roll-out.</td>
<td></td>
<td>Naloxone currently being distributed in 3 of the 5 Health and Social care Trusts as well as Prisons.</td>
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<td>Provision of needle and syringe exchange scheme continued, and consideration given to expanding the scheme to areas with an identified need.</td>
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<td>4 additional pharmacy based sites have been identified in Dungannon, Newry, Downpatrick and Limavady. Local outreach schemes to be considered by local PHA offices.</td>
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<tr>
<td>Learning from existing schemes/initiatives, work undertaken across Northern Ireland to reduce levels of prescribing, and support people to reduce/stop taking unnecessary prescriptions.</td>
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<td>Priority area identified in Commissioning Framework.</td>
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<tr>
<td>Services in place to assist clients with a common employability barrier, (e.g. history of drug/alcohol misuse, homelessness and ex-prisoners/ex-offenders) to enter employment.</td>
<td>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. Since 5 April 2011, 298 clients with a common employability barrier have been supported by LEMIS with 67 (23%) entering employment and training.</td>
<td>DEL intends to host a ‘Drugs and Alcohol Misuse’ seminar in May /June 2013 aimed at public, community and voluntary organisations who work with clients with drug and alcohol issues. The objective is to strengthen and improve working relationships and referral mechanisms between these organisations and LEMIS providers to provide a more holistic approach to meet the needs of clients.</td>
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<tr>
<td>Education and training for professionals, carers and families in relation to substance misuse problems in older people supported.</td>
<td>PHA currently producing a resource on this issue.</td>
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<tr>
<td>Consideration given to extending arrest referral schemes to other areas across NI.</td>
<td>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.</td>
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<td>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.</td>
<td>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. Healthcare arrangements in PACE regulations have been agreed by the NI Assembly.</td>
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<tr>
<td>A continuum of treatment and support opportunities between custody and release of offenders back into the community for young and adult offenders developed – linked to the Joint Agency Offender Management Process.</td>
<td>Structures are now in place to provide appropriate continuum of treatment and support and is being rolled out for those on home leave and those returning to the community at the end of their sentence.</td>
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<tr>
<td>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.</td>
<td>A comprehensive range of psychosocial interventions are in place and work continues to develop operational delivery. Harm reduction initiatives, such as substitute prescribing, are also available as clinically determined.</td>
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<tr>
<td>Accreditation sought for the “Prisoners - Addressing Substance Related Offending” (P-ASRO) programme, or other appropriate programmes, delivered in prisons.</td>
<td>ASRO is no longer available from National Offender Management Service and alternative arrangements are currently being explored.</td>
<td>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. The SE Trust has introduced a detoxification programme and works closely with the NIPS in the management of the SPAR programme to support those at risk. The roll-out of the Take Home Naloxone Scheme in Prison settings also has a direct impact on reducing the risk of an overdose death following release from prison.</td>
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<tr>
<td>Education and information provided to parents of offenders regarding drugs and alcohol on a one to one basis and via the parent support groups.</td>
<td>Education and information to parents of young offenders is provided on a one-to-one basis and through parent support groups.</td>
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<tr>
<td>The NI Prison Service and the South Eastern HSC Trust work in partnership with Alcohol &amp; Drugs: Empowering People through Therapy (AD:EPT) to deliver psychological and educational drug and alcohol programmes for all offenders.</td>
<td>AD:EPT deliver a range of psychological and educational drug and alcohol programmes in partnership with the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.</td>
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<tr>
<td>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.</td>
<td></td>
<td>The “You, Your Child and Alcohol” was last run in Summer 2011. The campaign overall evaluated well with good awareness of the campaign and booklet, and self-reported evidence that parents were more likely to talk to their children about alcohol, and use the booklet for advice. Given the new rules in relation to Government advertising, it has been decided not to run another phase of the campaign at this stage. However, the steering group is happy to share the learning from this campaign with interested stakeholders – and to use it to inform any future work in this area.</td>
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<tr>
<td>Targeted education and awareness-raising among children, parents, and families on the risks of drug and alcohol misuse and how to prevent harm.</td>
<td></td>
<td>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 community support service should be in place to support such a scheme. This should be consistent across all DACT areas.</td>
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<tr>
<td>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.</td>
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<td>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.</td>
<td>DE is working with the Council for Curriculum, Examinations and Assessment to schedule an update of DE’s guidance on drugs and alcohol.</td>
</tr>
<tr>
<td>Young People’s Drinking Action Plan implemented.</td>
<td></td>
<td>The majority of 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.</td>
<td></td>
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<tr>
<td>Successful implementation of new liquor licensing regulations and laws.</td>
<td>A DSD public consultation seeking views on a wide range of proposed changes to the law regulating the sale and supply of alcohol in Northern Ireland was launched on 24 July 2012 and ended on 12 November 2012. The proposals consulted on represent a balanced package of reforms which aim to contribute towards a reduction in alcohol related harm and help make the licensed trade offering more sustainable and attractive to tourists. There was a high level of response to this consultation and analysis of the responses is currently ongoing.</td>
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<tr>
<td>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.</td>
<td>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. 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 and Mental Health FirstAid. This will continue to be built upon through ongoing policy development and implementation.</td>
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<tr>
<td>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.</td>
<td>Five One Stop Shop services are currently in place, operating a model informed by the evaluation of the pilot. A panel is currently in the process of awarding tenders for One Stop Shop services, results to be available shortly with contracts in place from 01 April 2013.</td>
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</table>
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 continue 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 highlight relevant information and issues relating to substance misusing offenders.

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.

Education and awareness sessions provided to young people who, though the criminal justice system, are subject to statutory supervision in the community and are assessed as Tier 1.

 Appropriately tailored education and awareness sessions are provided to young people assessed and subject to statutory supervision.
## Children, Young People and Families - 2 (Treatment & Support)

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</thead>
<tbody>
<tr>
<td>Development of a framework of Treatment and Support Services for those aged under 18.</td>
<td></td>
<td>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 which is currently out for consultation.</td>
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<tr>
<td>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.</td>
<td></td>
<td>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.</td>
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<tr>
<td>The Regional Hidden Harm Action Plan implemented.</td>
<td></td>
<td>The Regional Hidden Harm Action Plan has been reviewed and updated. Implementation of the action plan is ongoing, with some areas of work having been significantly developed in line with the emerging evidence base.</td>
<td>Implementation of the reviewed plan</td>
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<tr>
<td>The Regional Initial Assessment Tool embedded within the Youth Justice Agency, and work taken forward to roll it out to other key sectors.</td>
<td></td>
<td>RIAT is embedded within the Youth Justice Agency. A steering group is currently developing a pilot within HSCTs which will inform the updating of the RIAT tool.</td>
<td>Feedback from practitioners within the YJA and the HSCTs will inform the updating of the tool and work will then be undertaken to roll the tool out more widely.</td>
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<tr>
<td>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.</td>
<td></td>
<td>All young people admitted to Woodlands are assessed for drug and alcohol misuse to ensure that the appropriate services and monitoring is provided.</td>
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<tr>
<td>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.</td>
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<td>Work to establish appropriate protocols between the relevant organisations at times of transition continues.</td>
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## Community Safety and Anti-Social Behaviour

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<tr>
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<tbody>
<tr>
<td>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.</td>
<td></td>
<td>Key NSD outcomes were outlined to PCSP managers when they were brought together in late October. PCSP managers are aware of the need to develop these relationships in order to assist in addressing alcohol and drug related anti-social behaviour.</td>
<td>DoJ will continue to engage with PCSP managers to reinforce those key messages.</td>
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<tr>
<td>Assess the level alcohol plays in Sexual Violence and Domestic Violence; further work will flow from that assessment.</td>
<td></td>
<td>Consideration of how best to assess the level alcohol plays in Sexual Violence and Domestic Violence is ongoing.</td>
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<tr>
<td>Community Safety Strategy recognises the role of alcohol and drug misuse.</td>
<td></td>
<td>The Community Safety Strategy includes the theme of alcohol and drug misuse. A delivery plan has been created and has been accepted by the Minister for Justice and the Justice Committee.</td>
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<tr>
<td>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.</td>
<td></td>
<td>The PSNI and Belfast Health and Social Care Trust have developed a pilot 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.</td>
<td>It is anticipated that the pilot initiative will be rolled out to the other A&amp;E Departments in Belfast over the coming months.</td>
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<tr>
<td>Promotion of schemes at a local level that tackle anti-social behaviour linked to alcohol misuse (and underage drinking).</td>
<td></td>
<td>The Department, through PCSPs and other Criminal Justice organisations, continue to encourage the development of local initiatives to tackle anti-social behaviour linked to alcohol misuse. A number of applications for funding under the criminal confiscation scheme that address anti-social behaviour linked to alcohol misuse have been received and some have been awarded funding.</td>
<td>The Department will continue to engage with PCSP managers to reinforce this key message.</td>
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</table>
Cross-Government approach taken to addressing issues related to Alcohol and the Night-Time Economy Seminar.  

| Cross-Government approach taken to addressing issues related to Alcohol and the Night-Time Economy Seminar. | Information published by the Department of Justice as part of the Northern Ireland Crime Survey (NICS) shows some positive movements in respect of the Night-Time Economy (NTE) – with an increase in the proportion of respondents who felt ‘very safe’ (from 26% to 30%) and a subsequent decrease in those who felt ‘a bit unsafe’ (15% to 11%) when socialising in their town centres in the evening. Findings also show a reduction in the proportion of respondents who felt ‘a bit unsafe’ whilst waiting for public transport in the NTE, falling from 23% in 2009/10 to 19% in 2010/11. Around two-fifths of respondents considered ‘people drinking or being drunk in public’ as the single most serious problem within the night-time economy (40% in 2009/10 and 38% in 2010/11), and over two-thirds of respondents felt that alcohol-related anti-social behaviour (ASB) is a very or fairly big problem in the NTE (69% in NICS 2009/10 and 67% in NICS 2010/11). Results from both sweeps of the survey show that around a third of respondents felt alcohol-related ASB had increased during the previous 12 months (33% in NICS 2009/10 and 31% in NICS 2010/11), with less than a tenth (7% and 8% respectively) of the opinion that the problem had decreased. Further information on the survey can be found at: http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/northern-ireland-crime-survey-s-r/nics-2009-10-2010-11-night-time-economy-bulletin.pdf. | Work with the Alcohol Industry and Pubs of Ulster on rolling out the Purple Flag accreditation. | An enhanced steering group has been established to consider the rollout of Purple Flag and to elevate the profile scheme across all Government Departments. DHSSPS sits on this steering group, along with other key stakeholders and the learning from this scheme should be used to improve the night-time economy across Northern Ireland. |
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.

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.
### Supporting Outcomes – Monitoring, Evaluation and Research

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<tr>
<td>The Regional Impact Measurement Tool (IMT) continues to be completed for all initiatives funded as part of the New Strategic Direction.</td>
<td>R</td>
<td>There is ongoing development of the IMT and reports are produced as appropriate.</td>
<td>Consideration need to be given to how the IMT fits with the commissioning framework.</td>
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<tr>
<td>Consideration given to developing one overarching monitoring system including Drug Misuse Database (DMD), Substitute Prescribing and Needle Exchange; also an Alcohol Misuse Database established.</td>
<td>R</td>
<td>Discussions are ongoing but have been delayed by the need to reflect what is in the alcohol and drug services commissioning framework.</td>
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<tr>
<td>A rolling research programme developed and updated on an annual basis.</td>
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<td>Research is being undertaken on the potential impact of minimum unit pricing for alcohol.</td>
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<tr>
<td>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.</td>
<td>R</td>
<td>The DAMIS is in place and operational. We will continue to monitor its usage and the revise the scheme as required.</td>
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<tr>
<td>The NI Prison Service in partnership with the South Eastern HSC Trust will have undertaken a review of the Prison Strategy to tackle alcohol and drug issues among prisoners.</td>
<td>R</td>
<td>SEHSCT and NIPS are engaged in ongoing joint working arrangements to address issues around the abuse of prescribed medication. New procedures are in place in Magilligan and Hydebank Wood to reduce the range of tradable drugs which are delivered as in possession medication.</td>
<td>A pilot has been launched in Maghaberry to address the same issue and it is expected that a policy will be in place there in the next few months.</td>
</tr>
<tr>
<td>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.</td>
<td>In 2011, the consumption of drugs or alcohol by driver or rider accounted for 10.9% of killed or seriously injured casualties (96 people), the most common causation factor. From 01 April 2010, separate data is available on the collision causation factors ‘Impaired by alcohol’ and ‘Impaired by drugs’. It should be noted, however, that disclosure control is applied to data in line with the requirements of the Code of Practice for Official Statistics. Where this applies data are merged or suppressed in published reports in order to ensure that the identity of individuals or any private information relating to them is not revealed.</td>
<td>Work will continue to shorten existing timescales in forensic analysis to avoid undue delay.</td>
<td></td>
</tr>
<tr>
<td>Results of the Night-Time Economy module of the NI Crime Survey published.</td>
<td>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.</td>
<td>A further survey is to be undertaken and published in 2013.</td>
<td></td>
</tr>
</tbody>
</table>
### Supporting Outcomes – Workforce Development

<table>
<thead>
<tr>
<th>Short Term Outcomes/Outputs</th>
<th>RAG Status</th>
<th>Update on Progress</th>
<th>Future Steps (if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of workforce development initiatives reviewed.</td>
<td></td>
<td>Workforce development services funded by the PHA are monitored on a quarterly basis to ensure courses are meeting identified needs.</td>
<td></td>
</tr>
<tr>
<td>Informed by this review, workforce development initiatives are better co-ordinated, and front-facing workforce better equipped to provide early effective intervention.</td>
<td></td>
<td>Commissioning framework has prioritised the development of a range of courses.</td>
<td></td>
</tr>
<tr>
<td>Improved awareness and opportunities for Criminal Justice Organisations to avail of training programmes.</td>
<td></td>
<td>All training courses are open to criminal justice organisations. The awareness of and opportunities for appropriate staff training programmes continues to be improved.</td>
<td></td>
</tr>
<tr>
<td>Organisations work together to share information and secure a greater understanding on the composition and impacts of legal highs (or any other new drug).</td>
<td></td>
<td>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. The Department of Justice is a key contributor to the newly established DAMIS that ensures greater awareness of new psychoactive substances amongst key Criminal Justice staff.</td>
<td></td>
</tr>
<tr>
<td>Dissemination of the Drugs and Alcohol National Occupational Standards (DANOS) for all sectors in Northern Ireland.</td>
<td></td>
<td>DANOS information is available to all services.</td>
<td></td>
</tr>
<tr>
<td>Training in respect of Hepatitis C and other blood borne viruses for those working with Injecting Drug Users continues to be delivered.</td>
<td></td>
<td>Training is available in these areas.</td>
<td></td>
</tr>
<tr>
<td>YJA ensures that service delivery staff have the skills and knowledge to deliver alcohol and drugs interventions at Tier 2.</td>
<td></td>
<td>Practitioners are appropriately trained to deliver alcohol and drug interventions / programmes.</td>
<td></td>
</tr>
</tbody>
</table>
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. |  |
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 and Annex A), 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 74 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 first year, good progress has been made on a number of these outcomes. Progress against 57 (77%) of these outcomes is classified having green status – either they have been completed or progress is being made as expected and is on track for achievement. 17 (23%) 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.
Section 1 - Numbers presenting to treatment


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 online at http://www.dhsspsni.gov.uk/stats&research/pubs.asp

Summary
Alcohol-only Misuse
- On 1 March 2012, 3,111 individuals were in treatment for alcohol-only misuse compared to 3,328 individuals on 1 March 2010, 3,476 individuals on 1 March 2007 and 3,074 individuals on 1 March 2005. Although there was a 13% increase in the number of individuals in treatment between 2005 and 2007, the number of individuals in treatment for alcohol-only misuse as of 1 March 2012 fell back to 1% higher than the 2005 level.

- On 1 March 2012, 66% of those in treatment for alcohol-only misuse were male and 34% were female. The corresponding figure for 1 March 2010 was 69% male and 31% female, for 1 March 2007 65% male and 35% female, and for 1 March 2005 62% male and 38% female.

- On 1 March 2012, the vast majority (97%) of individuals in treatment for alcohol-only misuse were aged 18 years and over, while 3% were under 18 years of age (representing 91 individuals). This was similar to 1 March 2005 when almost all (98%) of the individuals in treatment were 18 years and over and 2% were under 18 years of age. However the two Censuses carried out at 1 March 2007 and 1 March 2010 found that the proportion of individuals who were under 18 years of age was higher (11% in 2007 representing 377 individuals and 10% in 2010 representing 319 individuals).

Drug-only Misuse
- On 1 March 2012, 1,514 individuals were in treatment for drug-only misuse compared to 1,294 individuals on 1 March 2010, 1,118 individuals on 1 March 2007 and 1,030 individuals on 1 March 2005. This represents a 47% increase in the number of individuals in treatment between 1 March 2005 and 2012.

- On 1 March 2012, 69% of those in treatment for drug-only misuse were male and 31% were female, compared to 76% male and 24% female on 1 March 2010, and 68% male and 32% female on both 1 March 2007 and 1 March 2005.

- On 1 March 2012, 94% of individuals in treatment for drug-only misuse were aged 18 years and over, while just 6% (representing 97 individuals) were under 18 years of age. This represented the lowest number of under-18s in all four years. On 1 March 2010, 87% were aged over 18 and 13% were aged under 18. On 1 March 2007, 84% were aged over 18 and 16% were aged under 18 (representing 176 individuals). On 1 March 2005, 90% were aged over 18 and 10% were aged under 18.
**Alcohol and Drug Misuse**

- On 1 March 2012, 1,291 individuals were in treatment for both alcohol and drug misuse, compared to 1,224 individuals on 1 March 2010, 989 individuals on 1 March 2007 and 960 individuals on 1 March 2005. This represents a 34% increase in the number of individuals in treatment between 1 March 2005 and 2012.

- On 1 March 2012, 75% of those in treatment for both alcohol and drug misuse were male and 25% were female, compared to 79% male and 21% female on 1 March 2010, 69% male and 31% female on 1 March 2007 and 73% male and 27% female 1 March 2005.

- On 1 March 2012, 84% of individuals in treatment for both alcohol and drug misuse were aged 18 years and over while 16% were under-18s (representing 210 individuals). On 1 March 2010, 87% were aged over 18 and 13% were aged under 18. On 1 March 2007, 70% were aged over 18 and 30% were aged under 18 (representing 294 individuals). On 1 March 2005, 90% were aged over 18 and 10% were aged under 18. The number of those in treatment under 18 years of age at 1 March 2012 was more than double the number of those in 2005.

**Alcohol and/or Drug Misuse**

- On 1 March 2012, 5,916 individuals were in treatment for alcohol and/or drug misuse compared to 5,846 individuals on 1 March 2010, 5,583 individuals on 1 March 2007 and 5,064 individuals on 1 March 2005. This represents a 17% increase in the number of individuals in treatment between 1 March 2005 and 2012.

- On 1 March 2012, 69% of those in treatment for alcohol and/or drug misuse were male and 31% were female, compared to 73% male and 27% female on 1 March 2010, 66% male and 34% female on 1 March 2007 and 65% male and 35% female 1 March 2005.

- On 1 March 2012, 93% of individuals in treatment for alcohol and/or drug misuse were aged 18 years and over while 7% were under-18s (representing 398 individuals). On 1 March 2010, 89% were aged over 18 and 11% were aged under 18. On 1 March 2007, 85% were aged over 18 and 15% were aged under 18 (representing 847 individuals). On 1 March 2005, 95% were aged over 18 and 5% were aged under 18. The number of those aged under 18 in treatment at March 2012 was 47% more than at March 2005.

Other source: Statistics from the Northern Ireland Drug Misuse Database: 2005/06 – 2011/12

**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/stats&research/pubs.asp](http://www.dhsspsni.gov.uk/stats&research/pubs.asp)

**Summary**

**Drug Misuse**

- In 2011/12, 2,999 individuals presented to treatment services for drug misuse compared to 2,593 individuals in 2010/11, 2,008 individuals in 2009/10, 1,755 individuals in 2008/09, 1,984 individuals in 2007/08, 1,464 individuals in 2006/07 and 1,666 individuals
in 2005/06. It should be noted that 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.

- Since 2005/06, the majority of those presenting to treatment services for drug misuse were male (72% in 2005/06, 77% in 2006/07, 69% in 2007/08, 72% in 2008/09, 72% in 2008/09, 72% in 2008/09 and 75% in 2011/12).

- In 2005/06, just over half (51%) of individuals presenting to treatment services for drug misuse were aged 25 years and under; this proportion fell to 42% in 2006/07 and then to 36% in 2007/08, and then rose to 37% in 2008/09, 40% in 2009/10 and 41% in 2010/11, before falling to 39% in 2011/12. The next most common age groups presenting for treatment in both 2005/06 and 2006/07 were 30-39 year olds (21% and 26% respectively), however since then it has been those aged 40 years and over (29% in 2007/08, down to 26% in 2011/12).

**Main Drug of Misuse**

- Since 2005/06, the main drug of misuse for individuals presenting to treatment services for drug misuse was cannabis (Main drug for 49% of individuals in 2005/06 and 41% of individuals in 2011/12).

- After cannabis, since 2005/06 the next main drug of misuse of individuals presenting to treatment services was benzodiazepines (Next main drug for 14% of individuals in 2005/06 rising to 24% of individuals in 2011/12).
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 7,127 in 2005/06 to 9,393 in 2011/12. This represents a 32% increase in the number of admissions in six years. (Table A.1)
- In 2011/12, just under three quarters (73%) of those admitted in an emergency were male and 23% were female. A similar gender split was observed over the previous three years. (Table A.1)
- For all years since 2005/06, approximately half of those admitted to hospital in an emergency were aged 45-64 years. For all years, next came those aged 35-44; however the percentage of these overall has fallen from 25% in 2005/06 to 18% in 2011/12. For all years, next came those aged 65+, however the percentage of these overall has risen from 14% in 2005/06 to 18% in 2011/12. Generally speaking, the age profile of those admitted for alcohol only related conditions has remained fairly constant across all years. (Table A.1)

Drug-Only Emergency Admissions
- In 2011/12 there were 3,256 emergency admissions to hospital for drug-only related conditions compared to 3,649 in 2010/11, 3,424 in 2009/10, 3,880 in 2008/09, 3,951 in 2007/08, 2,948 in 2006/07 and 3,160 in 2005/06. This represents a 3% increase in the number of admissions from 2005/06 to 2006/07, a 34% increase from 2006/07 to 2007/08 and a 2% decrease from 2007/08 to 2011/12. (Table A.2)
- In 2011/12, 52% of those admitted in an emergency were female and 48% were male. The percentage of those admitted in an emergency that were female has generally decreased year-on-year from 60% in 2005/06. (Table A.2)
- Between 2005/06 and 2011/12, just over four-fifths of all those admitted to hospital in an emergency for drug-only related conditions were aged between 18 and 64. There was little difference between the 18-24, 25-34, 35-44 and 45-64 age groups with approximately one fifth of all admissions relating to each age group every year. In general, the age profile of those admitted in an emergency for drug only related conditions has remained fairly constant across all years. (Table A.2)

Alcohol and Drug Emergency Admissions
- Between 2005/06 and 2009/10 the number of emergency admissions to hospitals for alcohol and drug related conditions were fairly constant (1,498 in 2005/06; 1,308 in 2006/07; 1,497 in 2007/08; 1,473 in 2008/09 and 1,478 in 2009/10). In 2010/11 the
number of emergency admissions to hospitals for alcohol and drug related conditions rose by 13% to 1,663. In 2011/12, this fell slightly to 1,644. (Table A.3)

- In 2011/12, 56% of those admitted were male and 44% were female. A similar gender split (55-57% male and 43-45% female each year) was observed over the all the years since 2005/06, with the exception of 2010/11 when the split was 59% male and 41% female. (Table A.3)

- 29% of those admitted in 2011/12 were aged 45-64 years, while 24% were aged 35-44 years, 23% were aged 25-34 years and 19% were 18-24 years old. The 45-64 year age group was the most commonly admitted group in 201/12, 2010/11 and 2008/09, while the 35-44 year age group was most commonly admitted group in 2009/10, 2007/08, 2006/07 and 2005/06. (Table A.3)

Table A.1 Alcohol-only related admissions* to hospital (2005/06 – 2011/12)

<table>
<thead>
<tr>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7,127</td>
<td>100</td>
<td>7,322</td>
<td>100</td>
<td>8,267</td>
<td>100</td>
<td>8,462</td>
<td>100</td>
<td>8,603</td>
<td>100</td>
<td>8,652</td>
<td>100</td>
<td>9,393</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5,253</td>
<td>74</td>
<td>5,371</td>
<td>73</td>
<td>6,214</td>
<td>75</td>
<td>6,359</td>
<td>75</td>
<td>6,360</td>
<td>74</td>
<td>6,284</td>
<td>73</td>
<td>6,835</td>
</tr>
<tr>
<td>Female</td>
<td>1,874</td>
<td>26</td>
<td>1,951</td>
<td>27</td>
<td>2,053</td>
<td>25</td>
<td>2,103</td>
<td>25</td>
<td>2,243</td>
<td>26</td>
<td>2,369</td>
<td>27</td>
<td>2,559</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>147</td>
<td>2</td>
<td>155</td>
<td>2</td>
<td>167</td>
<td>2</td>
<td>183</td>
<td>2</td>
<td>181</td>
<td>2</td>
<td>136</td>
<td>2</td>
<td>127</td>
</tr>
<tr>
<td>18-24</td>
<td>295</td>
<td>4</td>
<td>289</td>
<td>4</td>
<td>342</td>
<td>4</td>
<td>358</td>
<td>4</td>
<td>326</td>
<td>4</td>
<td>354</td>
<td>4</td>
<td>399</td>
</tr>
<tr>
<td>25-34</td>
<td>637</td>
<td>9</td>
<td>620</td>
<td>8</td>
<td>758</td>
<td>9</td>
<td>723</td>
<td>8</td>
<td>709</td>
<td>8</td>
<td>738</td>
<td>9</td>
<td>789</td>
</tr>
<tr>
<td>35-44</td>
<td>1,786</td>
<td>25</td>
<td>1,778</td>
<td>24</td>
<td>1,910</td>
<td>23</td>
<td>1,911</td>
<td>23</td>
<td>1,842</td>
<td>21</td>
<td>1,605</td>
<td>19</td>
<td>1,693</td>
</tr>
<tr>
<td>45-64</td>
<td>3,281</td>
<td>46</td>
<td>3,509</td>
<td>48</td>
<td>3,955</td>
<td>48</td>
<td>4,106</td>
<td>49</td>
<td>4,274</td>
<td>50</td>
<td>4,438</td>
<td>51</td>
<td>4,728</td>
</tr>
<tr>
<td>65+</td>
<td>981</td>
<td>14</td>
<td>971</td>
<td>13</td>
<td>1,135</td>
<td>14</td>
<td>1,181</td>
<td>14</td>
<td>1,271</td>
<td>15</td>
<td>1,381</td>
<td>16</td>
<td>1,657</td>
</tr>
</tbody>
</table>

* 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 2005/06 – 2008/09**:

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

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

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Description</th>
<th>ICD-10 code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F100</td>
<td>Acute intoxication</td>
<td>K703</td>
<td>Alcoholic cirrhosis of liver</td>
</tr>
<tr>
<td>F101</td>
<td>Harmful use</td>
<td>K704</td>
<td>Alcoholic hepatic failure</td>
</tr>
<tr>
<td>F102</td>
<td>Dependence syndrome</td>
<td>K709</td>
<td>Alcoholic liver disease, unspecified</td>
</tr>
<tr>
<td>F103</td>
<td>Withdrawal state</td>
<td>K730</td>
<td>Chronic persistent hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>F104</td>
<td>Withdrawal state with delirium</td>
<td>K731</td>
<td>Chronic lobular hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>F105</td>
<td>Psychotic disorder</td>
<td>K732</td>
<td>Chronic active hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>F106</td>
<td>Amnesic syndrome</td>
<td>K738</td>
<td>Other chronic hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>F107</td>
<td>Residual and late-onset psychotic disorder</td>
<td>K739</td>
<td>Chronic hepatitis, unspecified</td>
</tr>
<tr>
<td>F108</td>
<td>Other mental and behavioural disorders</td>
<td>K740</td>
<td>Hepatic fibrosis</td>
</tr>
<tr>
<td>F109</td>
<td>Unspecified mental and behavioural disorder</td>
<td>K741</td>
<td>Hepatic sclerosis</td>
</tr>
<tr>
<td>G312</td>
<td>Degeneration of nervous system due to alcohol</td>
<td>K742</td>
<td>Hepatic fibrosis and hepatic sclerosis</td>
</tr>
<tr>
<td>G621</td>
<td>Alcoholic polyneuropathy</td>
<td>K746</td>
<td>Other and unspecified cirrhosis of liver</td>
</tr>
<tr>
<td>I426</td>
<td>Alcohol cardiomyopathy</td>
<td>K860</td>
<td>Other diseases of pancreas</td>
</tr>
<tr>
<td>K29.2</td>
<td>Alcohol gastritis</td>
<td>X45</td>
<td>Accidental poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>K700</td>
<td>Alcoholic fatty liver</td>
<td>X65</td>
<td>Intentional self-poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>K701</td>
<td>Alcoholic hepatitis</td>
<td>Y15</td>
<td>Poisoning by and exposure to alcohol, undetermined intent</td>
</tr>
</tbody>
</table>

Table A.1 Alcohol-only related admissions* to hospital (2005/06 – 2011/12)
** 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 (2005/06 – 2011/12)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>All</td>
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<td>100</td>
<td>2,948</td>
<td>100</td>
<td>3,951</td>
<td>100</td>
<td>3,880</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,273</td>
<td>40</td>
<td>1,290</td>
<td>44</td>
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<td>18-24</td>
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<td>35-44</td>
<td>709</td>
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<td>658</td>
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<td>129</td>
<td>4</td>
<td>148</td>
<td>4</td>
<td>164</td>
</tr>
</tbody>
</table>

* 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 2005/06 – 2011/12**:

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T11-F16, F19</td>
<td>Mental and behavioural disorders due to drug use (excluding tobacco and volatile solvents)</td>
</tr>
<tr>
<td>X40-X44</td>
<td>Accidental poisoning by drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>X60-X64</td>
<td>Intentional self-poisoning by drugs, medicaments, and biological substances</td>
</tr>
<tr>
<td>X85</td>
<td>Assault by drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>Y10-Y14</td>
<td>Poisoning by drugs, medicaments and biological substances, undetermined intent</td>
</tr>
</tbody>
</table>

** 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 (2005/06 – 2011/12)

<table>
<thead>
<tr>
<th></th>
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</thead>
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<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
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<td>1,497</td>
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<td>852</td>
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<td>823</td>
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<td>Age</td>
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<td>23</td>
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</tbody>
</table>

* 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 2005/06 – 2008/09**:

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<th>ICD-10 code</th>
<th>Description</th>
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</thead>
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<td>Mental and behavioural disorders due to use of alcohol</td>
</tr>
<tr>
<td>F11-F16, F19</td>
<td>Mental and behavioural disorders due to drug use (excluding tobacco and volatile solvents)</td>
</tr>
<tr>
<td>G31.2</td>
<td>Degeneration of the nervous system due to alcohol</td>
</tr>
<tr>
<td>G62.1</td>
<td>Alcoholic polyneuropathy</td>
</tr>
<tr>
<td>I42.6</td>
<td>Alcoholic cardiomyopathy</td>
</tr>
<tr>
<td>K29.2</td>
<td>Alcoholic gastritis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X86.0</td>
<td>Alcohol induced chronic pancreatitis</td>
</tr>
<tr>
<td>X40-X44</td>
<td>Accidental poisoning by drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>X45</td>
<td>Accidental poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>X60-X64</td>
<td>Intentional self-poisoning by drugs, medicaments, and biological substances</td>
</tr>
<tr>
<td>X85</td>
<td>Assault by drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>ICD-10 code</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>F11</td>
<td>Mental and behavioural disorders due to use of opioids</td>
</tr>
<tr>
<td>F13</td>
<td>Mental and behavioural disorders due to use of sedatives or hypnotics</td>
</tr>
<tr>
<td>F14</td>
<td>Mental and behavioural disorders due to use of cocaine</td>
</tr>
<tr>
<td>F16</td>
<td>Mental and behavioural disorders due to use of hallucinogens</td>
</tr>
<tr>
<td>F100</td>
<td>Acute intoxication</td>
</tr>
<tr>
<td>F102</td>
<td>Dependence syndrome</td>
</tr>
<tr>
<td>F104</td>
<td>Withdrawal state with delirium</td>
</tr>
<tr>
<td>F106</td>
<td>Amnesic syndrome</td>
</tr>
<tr>
<td>F108</td>
<td>Other mental and behavioural disorders</td>
</tr>
<tr>
<td>G312</td>
<td>Degeneration of nervous system due to alcohol</td>
</tr>
<tr>
<td>H26</td>
<td>Alcohol cardiomyopathy</td>
</tr>
<tr>
<td>K700</td>
<td>Alcoholic fatty liver</td>
</tr>
<tr>
<td>K702</td>
<td>Alcoholic fibrosis and sclerosis of liver</td>
</tr>
<tr>
<td>K704</td>
<td>Alcoholic hepatic failure</td>
</tr>
<tr>
<td>K73</td>
<td>Chronic hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>K74</td>
<td>Fibrosis and cirrhosis of liver</td>
</tr>
<tr>
<td>K731</td>
<td>Chronic lobular hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>K732</td>
<td>Chronic active hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>K738</td>
<td>Other chronic hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>K746</td>
<td>Other and unspecified cirrhosis of liver</td>
</tr>
<tr>
<td>X40</td>
<td>Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics</td>
</tr>
<tr>
<td>X42</td>
<td>Accidental poisoning by and exposure to narcotics and psychostimulants [hallucinogens], not elsewhere classified</td>
</tr>
<tr>
<td>X44</td>
<td>Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>X46</td>
<td>Other mental and behavioural disorders</td>
</tr>
<tr>
<td>X61</td>
<td>Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified</td>
</tr>
<tr>
<td>X62</td>
<td>Intentional self-poisoning by and exposure to narcotics and psychostimulants [hallucinogens], not elsewhere classified</td>
</tr>
<tr>
<td>X63</td>
<td>Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system</td>
</tr>
<tr>
<td>X64</td>
<td>Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>X65</td>
<td>Intentional self-poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>X85</td>
<td>Assault by drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>Y10</td>
<td>Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent</td>
</tr>
<tr>
<td>Y11</td>
<td>Poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-Parkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent</td>
</tr>
<tr>
<td>Y12</td>
<td>Poisoning by and exposure to narcotics and psychostimulants [hallucinogens], not elsewhere classified, undetermined intent</td>
</tr>
<tr>
<td>Y13</td>
<td>Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent</td>
</tr>
<tr>
<td>Y14</td>
<td>Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent</td>
</tr>
<tr>
<td>Y15</td>
<td>Poisoning by and exposure to alcohol, undetermined intent</td>
</tr>
</tbody>
</table>

** 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
- The number of alcohol-related deaths in Northern Ireland increased from 246 in 2005 to 283 in 2007, before falling to 276 in 2008, then rising to 284 in 2010 and then falling back to 252 in 2011. (Table B.1)
- In each of the years from 2005 to 2007, 70% of alcohol-related deaths related to males. This fell to a low of 66% in 2009, before rising back to 70% in 2011. (Table B.1)
- Since 2005, there have been 1,872 alcohol-related deaths recorded. One fifth (20%) of alcohol-related deaths have been among those aged under 45, with approximately one third (34%) among 45-54 year olds and just under a half (46%) among those aged 55 and over. (Table B.1)
- In each of the years from 2005 to 2011, the most common underlying cause of death among all alcohol-related deaths was ‘Alcoholic liver disease’.

Drug-related Deaths
- The number of drug-related deaths in Northern Ireland according to the National Statistics definition was fairly constant between 2005 and 2009 (84, 91, 86, 89 and 84, in 2005, 2006, 2007, 2008 and 2009 respectively), however the number of drug-related deaths has risen over the last two years (92 in 2010 and 102 in 2011). This represents a 21% increase between 2005 and 2011. (Table B.2)
- Between 2005 and 2007, almost three fifths of drug-related deaths were among males and approximately two fifths among females. However in 2008, approximately two thirds (67%) of drug-related deaths were among males and approximately one third (33%) among females. In 2009, 57% of deaths were among males, with 72% of deaths among males in 2010 and 64% of deaths among males in 2011. (Table B.2)
- The highest proportion of drug-related deaths in 2005 was among the 45-54 age group (24%), while in 2006, 2007, 2008 and 2009 it was among those aged 35-44 years (36%, 34%, 29% and 37% of deaths respectively), and in 2010 and 2011 the highest proportion of drug-related deaths was among the 25-34 age group (27% and 32% of deaths respectively). In 2005, 18% of drug-related deaths were among those aged under 25 years, compared to approximately one in ten in 2006 (10%), 2007 (10%), 2008 (9%) and 2009 (12%), then in 2010, the proportion rose to 16%, before returning to 18% in 2011. For those aged 45 and over, the proportion of drug-related deaths decreased from 45% in 2005 to 40% in 2006, and remained around 36% from 2007 to 2010, before falling to 29% in 2011. (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’.

**Deaths due to Drug Misuse**

- In 2005, 50% of drug-related deaths were due to drug misuse. This gradually rose to 60% in 2008, and then fell back to 55% in 2009, before rising again to a high of 68% in 2010. It then fell to 57% in 2011. *(Table B.3)*

- The majority of deaths due to drug misuse were among males for all years between 2005 and 2011 (69% in 2005, 57% in 2006, 56% in 2007, 77% in 2008, 65% in 2009, 79% in 2010 and 69% in 2011). *(Table B.3)*

- For all years between 2005 and 2011, the largest proportion of deaths due to drug misuse was among either those aged 25-34 years (29% in 2005, 32% in 2008, 30% in 2010 and 29% in 2011) or aged 35-44 years (33% in 2006, 40% in 2007 and 43% in 2009). *(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’.

**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.

<table>
<thead>
<tr>
<th>ICD-10 code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10</td>
<td>Mental and behavioural disorders due to use of alcohol</td>
</tr>
<tr>
<td>G31.2</td>
<td>Degeneration of the nervous system due to alcohol</td>
</tr>
<tr>
<td>G62.1</td>
<td>Alcoholic polyneuropathy</td>
</tr>
<tr>
<td>I42.6</td>
<td>Alcoholic cardiomyopathy</td>
</tr>
<tr>
<td>K29.2</td>
<td>Alcoholic gastritis</td>
</tr>
<tr>
<td>K70</td>
<td>Alcoholic liver disease</td>
</tr>
<tr>
<td>K73</td>
<td>Chronic hepatitis, not elsewhere classified</td>
</tr>
<tr>
<td>K74</td>
<td>Fibrosis and cirrhosis of liver (Excluding K74.3-K74.5 – Biliary cirrhosis)</td>
</tr>
<tr>
<td>K86.0</td>
<td>Alcohol induced chronic pancreatitis</td>
</tr>
<tr>
<td>X45</td>
<td>Accidental poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>X65</td>
<td>Intentional self-poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>Y15</td>
<td>Poisoning by and exposure to alcohol, undetermined intent</td>
</tr>
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</table>
Table B.1  Alcohol-related deaths in Northern Ireland (2005 - 2008) according to National Statistics Definition

<table>
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<th>Year</th>
<th>All</th>
<th>Gender</th>
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</thead>
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<tr>
<td>2011</td>
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<td>100</td>
<td>177</td>
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</tbody>
</table>

2011 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.

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

Table B.2  Drug-related deaths in Northern Ireland (2005 - 2008) according to National Statistics Definition

<table>
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<th>Age</th>
</tr>
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<td>2008</td>
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<tr>
<td>2009</td>
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<tr>
<td>2011</td>
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<td>65</td>
</tr>
</tbody>
</table>

2011 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 (2005 – 2007*) according to National Statistics Definition

<table>
<thead>
<tr>
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<th>2005</th>
<th>2006</th>
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<th>2008</th>
<th>2009</th>
<th>2010</th>
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<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
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<td>100</td>
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<td>100</td>
<td>53</td>
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<td><strong>Gender</strong></td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Male</td>
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<td>69</td>
<td>28</td>
<td>57</td>
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<tr>
<td><strong>Age</strong></td>
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<td>25-34</td>
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<td>10</td>
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<td>33</td>
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<td>0</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

2011 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.


Summary

Consumption
- Almost three quarters of survey respondents drank alcohol (73% in 2005, 72% in 2008 and 74% in 2011).
- A higher proportion of males than females stated that they drank alcohol in all years of the survey (77% compared to 70% in 2005, 74% compared to 70% in 2008 and 78% compared to 72% in 2011).
- Younger adults (18-29 years) were more likely to drink alcohol than older adults (60-75 years) in all years (in 2005, 86% and 55% respectively; in 2008, 83% and 54% respectively; and in 2011, 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 limits in all years (82% in 2005, 81% in 2008 and 78% in 2011).
- In all years of the survey, approximately four fifths of both males (81% in 2005, 79% in 2008 and 76% in 2011) and females (83% in 2005, 83% in 2008 and 81% in 2011) 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 compared to 76% in 2008 and 71% in 2005. This is a statistically significant increase since 2005. The proportion of respondents who consumed alcohol at above sensible but below dangerous weekly limits decreased from 23% in 2005 to 19% in 2008 and 18% in 2011.
- In all years, a higher proportion of females than males stayed within their respective sensible weekly limits (74% of females compared with 67% of males in 2005; 78% of
females compared with 74% of males in 2008 and 80% of females compared with 74% of males in 2011). The proportion of males staying within their respective sensible weekly limits has increased significantly since 2005.

• Younger drinkers (18-29 years) were more likely than older drinkers (60-75 years) to exceed the weekly guidelines for sensible drinking limits in all years.

**Problem Drinking**
- CAGE question analysis (clinical interview questions) indicated that in both 2005 and 2008, one tenth (10%) of those who drank in the week prior to the survey were highly likely to have a problem with alcohol. This fell to 9% in 2011.

- Males were more likely than females to have a problem with alcohol in all years, however the likelihood for males having a problem decreased over the three years of the survey, while for females it increased (in 2005, 13% of males and 7% of females; in 2008, 11% of males and 10% of females; and in 2011, 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. This was a further decrease from 2008, when almost one third (32%) of respondents engaged in at least one binge drinking session during the week prior to the survey. This was a significant decrease since 2005 in the proportion of adults who binge drink.

• A higher proportion of males (35%) than females (25%) were classified as binge drinkers in the 2011 survey. This compares with 35% of males and 29% of females in 2008 and 43% of males and 33% of females in 2005. The percentage of male binge drinkers decreased between 2005 and 2008, however there was no further decrease between 2008 and 2011. There was a steady decrease in the percentage of female binge drinkers between the three survey years.

• 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 in all years of the survey (54% compared to 16% in 2005; and 56% compared to 12% in 2008; and 50% compared to 13% in 2011).

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](http://www.csu.nisra.gov.uk)

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

**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/stats&research/pubs.asp

**Summary**

**Lifetime Prevalence**

- The proportion of respondents aged 11-16 who said that they had ever taken an alcoholic drink (not just a taste or a sip) decreased from 60% in 2003, to 55% in 2007 and then to 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 in all years of the survey.

**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 in all years (56% in 2003, 55% in 2007 and 53% in 2010).

- In 2003 and 2007, females were more likely than males to have been drunk (56% of females and 55% of males in 2003; and 58% of females and 51% of males in 2007), whereas in 2010, males were more likely than females to have been drunk 51% of females and 53% of males in 2010).

- 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/stats&research/pubs.asp.

**Summary**

**Lifetime Prevalence**

- Lifetime use of any illegal drugs among all adults aged 15-64 years increased from 20% in 2002/03 to 28% in 2006/07, before decreasing to 27% in 2010/11.
• Lifetime use of any illegal drugs among males increased from 27% in 2002/03 to 34% in 2006/07, before decreasing to 32% in 2010/11. For females, lifetime use of any illegal drugs increased from 13% in 2002/03 to 22% in both 2006/07 and 2010/11.

• Lifetime use of any illegal drugs among young adults aged 15-34 years increased from 31% in 2002/03 to 40% in 2006/07, before decreasing to 37% in 2010/11. Among older adults aged 35-64 years lifetime use of any illegal drugs increased from 11% in 2002/03 to 19% in 2006/07 and 20% in 2010/11.

• Since 2002/03, lifetime use of the following drugs increased among all adults aged 15-64 years: cannabis (from 17% to 24%); cocaine (from 2% to 7%); magic mushrooms (from 4% to 6%); poppers (from 6% to 9%); ecstasy (from 6% to 9%); and amphetamines (from 4% to 6%).

• There were increases since 2002/03 in lifetime use of cocaine among both males and females, and among both young adults and older adults.

Last Year Prevalence

• Last year use of any illegal drugs among all adults aged 15-64 years increased from 6% in 2002/03 to 9% in 2006/07, before decreasing to 7% in 2010/11.

• Last year use of any illegal drugs among males increased from 10% in 2002/03 to 14% in 2006/07, before decreasing to 9% in 2010/11. For females, last year use of any illegal drugs increased from 3% in 2002/03 to 5% in 2006/07, before decreasing to 4% in 2010/11.

• Last year use of any illegal drugs among young adults aged 15-34 years increased from 12% in 2002/03 to 17% in 2006/07, before decreasing to 9% in 2010/11. For older adults aged 35-64 years, last year use of any illegal drugs increased from 2% in 2002/03 to 4% in 2006/07, before decreasing to 3% in 2010/11.

• Last year use of the following drugs among adults aged 15-64 years increased from 2002/03 to 2006/07 before decreasing in 2010/11: cannabis (from 5% to 7% to 5%); cocaine (from 0.5% to 2% to 1.5%); and poppers (from 0.5% to 1.3% to 0.8%).

Last Month Prevalence

• There was no significant difference in last month use of any illegal drugs among all adults aged 15-64 years between previous surveys (3% in 2002/03, 4% in 2006/07 and 3% in 2010/11).

• Last month use of any illegal drugs among females increased (from 1% to 2%), while last month use of any illegal drugs among males decreased (from 6% to 5%).

4.5 Problem Prevalence


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:
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)

Secondary Analysis, November 2005 & January 2009

Summary

Lifetime Prevalence

- Among all respondents, lifetime use of any drugs or solvents decreased from 23% in 2003 to 19% in 2007 and further to 15% in 2010.

- Since 2003, lifetime use of any drugs or solvents decreased among male pupils (from 26% in 2003 to 19% in 2007 and then to 17% in 2010), with lifetime prevalence among female pupils also decreasing (from 20% in 2003 to 19% in 2007 and 13% in 2010).

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

- Lifetime use of cannabis and solvents decreased from 2003 to 2010 among all pupils: cannabis (from 16% in 2003 to 9% in 2007 and 7% in 2010) and solvents (from 10% in 2003 to 8% in 2007 and 7% in 2010).

- Among males, there were decreases since the 2003 survey in the lifetime use of cannabis (from 19% in 2003 to 10% in both 2007 and 2010), speed (from 3% in 2003 to 2% in both 2007 and 2010), and solvents (from 10% in 2003 to 8% in 2007 and 7% in 2010).

- Among females, lifetime use of cannabis decreased from 14% in 2003 to 8% in 2007 and 5% in 2010, while lifetime prevalence rates increased for the following drugs: LSD (from 1% in 2003 to 2% in both 2007 and 2010) and cocaine (from 2% in 2003 to 3% in both 2007 and 2010).

- Lifetime use of cannabis decreased across all age groups from 2003 to 2007. However, although it decreased further for 12 to 15 year olds up to 2010, lifetime use of cannabis increased slightly for 16 year olds.

Last Year Prevalence

- Among all respondents, last year use of any drugs or solvents decreased from 18% in 2003 to 13% in 2007 and 11% in 2010.

- Since 2003, last year use of any drugs or solvents decreased among male pupils (from 20% in 2003 to 14% in 2007 and 13% in 2010) and among female pupils (from 16% in 2003 to 13% in 2007 and 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.
• Last year use of the following drugs decreased from 2003 to 2010 among all pupils: cannabis (from 13% in 2003 to 7% in 2007 and 6% in 2010), and solvents (from 6% in 2003 to 4% in both 2007 and 2010).

• Among males, there were decreases since the 2003 survey in the last year use of cannabis (from 15% in 2003 to 7% in both 2007 and 2010).

• Among females, last year use of cannabis decreased from 11% in 2003 to 6% in 2007 and 4% in 2010, while last year prevalence rates increased for cocaine (from 1% in 2003 to 2% in both 2007 and 2010).

• Last year use of cannabis decreased across all age groups from 2003 to 2007. However, although it decreased further for 12 to 15 year old up to 2010, last year use of cannabis increased slightly for 16 year olds.

**Last Month Prevalence**

• Among all respondents, last month use of any drugs or solvents decreased from 12% in 2003 to 7% in both 2007 and 2010.

• Since 2003, last month use of any drugs or solvents decreased among male pupils (from 13% in 2003 to 8% in both 2007 and 2010) and among female pupils (from 10% in 2003 to 7% in 2007 and 6% in 2010).

• In all 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 decreased from 2003 to 2010 among all pupils from 8% in 2003 to 4% in both 2007 and 2010.

• Among males, there was a decrease since the 2003 survey in the last month use of cannabis (from 10% in 2003 to 4% in both 2007 and 2010).

• Among females, last month use of cannabis decreased from 7% in 2003 to 3% in 2007 and 2% in 2010.

• Last month use of cannabis decreased across all age groups from 2003 to 2007. However, although it decreased further for 12 to 15 year olds up to 2010, last month use of cannabis increased slightly for 16 year olds.
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 to 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

**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 2011/12, 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](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 to £11.80) and 2007 (£18.00 compared to £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)

<table>
<thead>
<tr>
<th>All persons aged 18 years and over</th>
<th>Base = 100%</th>
<th>Year 2006</th>
<th>Year 2007</th>
</tr>
</thead>
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<td>£40.01 - £50.00</td>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>£50.01 and over</td>
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<td></td>
</tr>
<tr>
<td>n =</td>
<td>1126</td>
<td>1125</td>
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</table>
Table C.2  Weekly expenditure on alcohol by all persons under 18 years of age (2006 and 2007)

<table>
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<tr>
<th>Base = 100%</th>
<th>Year</th>
<th>2006</th>
<th>2007</th>
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</tr>
<tr>
<td>n =</td>
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<td>409</td>
<td>439</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Total</td>
<td>£18.20</td>
<td>£11.80</td>
</tr>
</tbody>
</table>
Section 7 – Alcohol / Drug-related Crime
Source: Northern Ireland Policing Board (NIPB) and the Police Service of Northern Ireland (PSNI)

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

A 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.

In July 2008 the PSNI launched Operation SNAPPER (Supporting No Alcohol In Public through Partnership Enforcement and Regulation). This initiative focused on underage drinking, on street drinking and drinking at other events. Between 1 July 2008 and 31 March 2009, over 20,000 items of alcohol were seized, 654 persons reported to PSNI Youth Diversion Officers, 291 persons reported to local councils for prosecution, 33 persons reported to public prosecution service.

7.1 Recorded Crime
Source: Police Service of Northern Ireland (PSNI) – Central Statistics Branch
‘PSNI Annual Statistical Report: Recorded Crime and Clearances’

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:

Drug Offences
• From 2006/07 to 2010/11, 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 and 3,780 in 2011/12).

• 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 and 78% in both 2010/11 and 2011/12).
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
- From 2004 to 2006, the number of drink-driving detections in Northern Ireland rose from 4,472 to a high of 4,760, before gradually decreasing to a low of 3,273 in 2012 (a decrease of 31% between 2006 and 2012). (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: Northern Ireland Office (NIO) Statistics and Research Branch

Background
The figures that the NIO use in relation to court prosecutions and convictions are based on extracts from the PSNI operational database (Integrated Crime Information System) and refer to those defendants against whom criminal proceedings were completed in each of the listed years. While care is taken in collating the data, they are subject to the inaccuracies inherent in any large-scale operational system and to variation in recording practice over time. The statistical coverage is restricted to those criminal prosecutions in which the PSNI is involved, excluding prosecutions brought by certain government departments, public bodies and private individuals.

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. Where there has not been a finding of guilt (e.g. on acquittal or committal for trial on all charges) it is usually that for which the greatest penalty could have been imposed.

**Summary**

**Prosecutions** - Figures for Prosecutions in 2007 and 2008 are not available. 2009 figures have yet to be published.

- The number of prosecutions for alcohol/drug related driving offences in Northern Ireland has increased by 6%, from 2,767 in 2004 to 2,946 in 2006. *(Table D.2)*

- Almost nine-in-ten prosecutions for alcohol/drug related driving offences were among males in each of the years from 2004 to 2006. *(Table D.2)*

- In each of the three years from 2004 to 2006, approximately four fifths of alcohol/drug related driving offences were among those over the age of 25 years. *(Table D.2)*

**Convictions** – *(Updated figures for Convictions to be provided for 2007/8 by DOJ – Not as yet received)*

- The number of convictions for alcohol/drug related driving offences in Northern Ireland increased from 2,679 in 2004 to a high of 3,377 in 2007, before decreasing to 2,775 in 2008. *(Table D.3)*

- Between 86% and 88% of all convictions for alcohol/drug related driving offences were among males in each of the years from 2004 to 2008. *(Table D.3)*

- Between 2004 and 2006, approximately 21% of convictions for alcohol/drug related driving offences were among those under the age of 25 years. This rose to 23% in 2007 and 24% in 2008. *(Table D.3)*

- The vast majority of prosecutions for alcohol/drug related driving offences between 2004 and 2006 resulted in a conviction irrespective of gender or age (figures for prosecutions are not available after 2006). *(Table D.4)*

**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)**
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 2008, 6%-7% of all injury road traffic collisions (for all road users) were as a result of alcohol consumption or drug taking. Since 2009, this has fallen to 5%. (Table D.5)

• Of all fatal collisions, almost a quarter in both 2004 and 2005 (24% in both years) were attributed to alcohol or drugs. This fell to 16% in 2006, then rose to 18% in 2007 and 20% in 2008, before falling to 17% in 2009, then rising to 20% in 2010 and falling to 16% in 2011. (Table D.5)

• Approximately one tenth of all serious collisions were attributed to drinking alcohol or taking drugs in each of the years from 2004 to 2011. (Table D.5)

• From 2004 to 2008, approximately 5% of all slight collisions were as a result of alcohol consumption or drug taking. Since 2009, this has fallen to 4%. (Table D.5)

• In 2004 and 2005, 9% of all injury collisions attributed to alcohol/drugs were fatal collisions, compared to 5% from 2006 to 2008, 6% in 2009, 4% in 2010 and just 3% in 2011. (Table D.6)

• In each of the years from 2004 to 2011, approximately a quarter of all injury collisions attributed to alcohol/drugs were serious collisions and over two thirds were slight collisions. (Table D.6)

Detectsions in NI
Table D.1 Number of Drink-driving detections in NI (2004 - 2012) – Note that previously this was Drink-Drug driving detections – PSNI only able to provide drink driving figures.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Drink/Drug-driving detections</td>
<td>4472</td>
<td>4501</td>
<td>4760</td>
<td>4514</td>
<td>4208</td>
<td>4085</td>
<td>3514</td>
<td>3451</td>
<td>3273</td>
</tr>
</tbody>
</table>

(Note that figures for 2004-2008 have been revised since last update)
**Prosecutions and Convictions in NI**

Table D.2  Prosecutions for Alcohol/Drug related driving offences in NI (2004 - 2006)
Figures for Prosecutions in 2007 and 2008 are not available and 2009 are not available.

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>All</td>
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<td>100</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>88</td>
<td>2509</td>
</tr>
<tr>
<td>Female</td>
<td>339</td>
<td>12</td>
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<td></td>
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<tr>
<td>Under 18</td>
<td>22</td>
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<td>31</td>
</tr>
<tr>
<td>18-21</td>
<td>274</td>
<td>10</td>
<td>261</td>
</tr>
<tr>
<td>22-24</td>
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<td>10</td>
<td>310</td>
</tr>
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<td>25-29</td>
<td>357</td>
<td>13</td>
<td>418</td>
</tr>
<tr>
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<td>384</td>
<td>14</td>
<td>403</td>
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<td>35-39</td>
<td>374</td>
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Table D.3  Convictions for Alcohol/Drug related driving offences in NI (2004 -2006)

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
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<th>2007</th>
<th>2008</th>
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<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
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<td>2679</td>
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<td>2809</td>
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<td></td>
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<td>2346</td>
<td>88</td>
<td>2418</td>
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<td>2447</td>
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<tr>
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<td>12</td>
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<td>14</td>
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<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>29</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>18-21</td>
<td>268</td>
<td>10</td>
<td>253</td>
<td>9</td>
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<td>10</td>
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<tr>
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<td>341</td>
<td>13</td>
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<td>14</td>
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<tr>
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Table D.4  Convictions as a proportion of Prosecutions for Alcohol/Drug related driving offences in NI (2004 - 2006) Figures for Prosecutions in 2007, 2008 and 2009 are not available.

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<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
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<td>97</td>
<td>97</td>
<td>95</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
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<td>96</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>95</td>
<td>94</td>
<td>81</td>
</tr>
<tr>
<td>18-21</td>
<td>98</td>
<td>97</td>
<td>95</td>
</tr>
<tr>
<td>22-24</td>
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<td>98</td>
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</table>

Injury Road Traffic Collisions

Table D.5  Injury Road Traffic Collisions attributed to alcohol/drugs as a proportion of all Injury Collisions (2004-2011)

<table>
<thead>
<tr>
<th>Year</th>
<th>Fatal collision</th>
<th>Serious collision</th>
<th>Slight collision</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>No. attributed to alcohol or drugs</td>
<td>% attributed to alcohol or drugs</td>
<td>All</td>
</tr>
<tr>
<td>2004</td>
<td>128</td>
<td>31</td>
<td>24</td>
<td>895</td>
</tr>
<tr>
<td>2005</td>
<td>127</td>
<td>30</td>
<td>24</td>
<td>835</td>
</tr>
<tr>
<td>2006</td>
<td>110</td>
<td>18</td>
<td>16</td>
<td>904</td>
</tr>
<tr>
<td>2007</td>
<td>105</td>
<td>19</td>
<td>18</td>
<td>838</td>
</tr>
<tr>
<td>2008</td>
<td>98</td>
<td>20</td>
<td>20</td>
<td>814</td>
</tr>
<tr>
<td>2009</td>
<td>104</td>
<td>18</td>
<td>17</td>
<td>826</td>
</tr>
<tr>
<td>2010</td>
<td>51</td>
<td>10</td>
<td>20</td>
<td>726</td>
</tr>
<tr>
<td>2011</td>
<td>57</td>
<td>9</td>
<td>16</td>
<td>706</td>
</tr>
<tr>
<td>Year</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>---</td>
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<td>2009</td>
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<td>2010</td>
<td>10</td>
<td>4</td>
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</tr>
<tr>
<td>2011</td>
<td>9</td>
<td>3</td>
<td>68</td>
<td>25</td>
</tr>
</tbody>
</table>
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 and 3,920 in 2011/12).

- 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 drugs in Northern Ireland respectively, however between 2009/10 and 2011/12 cocaine seizures exceeded ecstasy 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 and 2,543 in 2011/12).

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

<table>
<thead>
<tr>
<th>Year*</th>
<th>Frustrated</th>
<th>Disrupted</th>
<th>Dismantled</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/2007</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>2007/2008</td>
<td>29</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>2008/2009</td>
<td>41</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>2010/2011</td>
<td>30</td>
<td>46</td>
<td>28</td>
</tr>
<tr>
<td>2011/2012</td>
<td>27</td>
<td>53</td>
<td>18</td>
</tr>
</tbody>
</table>

* 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%) 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 2007 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 approximately a third said it was not a problem at all (33% in 2007 and 26% 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%)

- 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 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).