# Review of the New Strategic Direction for Alcohol and Drugs – Phase 2

A report prepared for the Department of Health in Northern Ireland by the Institute of Public Health in Ireland

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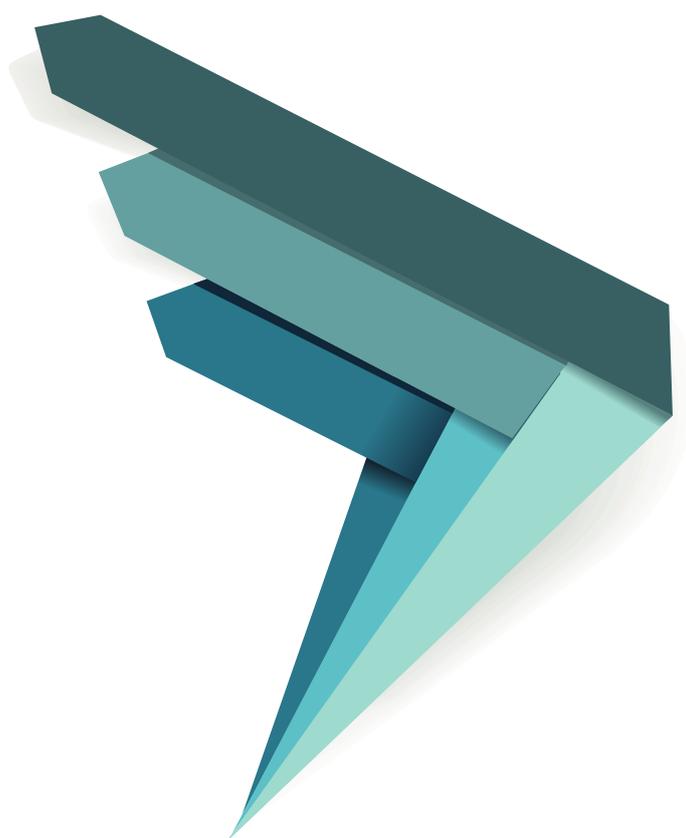
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2018

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Contents

Abbreviations

- **Drug and Alcohol Coordination Teams (DACTs):** five multi-agency partnerships comprising of all key agencies (statutory and community & voluntary) with an interest in and remit for addressing drug and alcohol-related issues and concerns in the local area.

- **Drug and Alcohol Monitoring System (DAMIS):** an 'early warning system' used by government organisations in Northern Ireland to establish information on emerging trends in drug misuse.

- **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA):** EU agency which provides the EU and its Member States with a factual overview of European drug problems and a solid evidence base to support the drugs debate.

- **New Strategic Direction for Alcohol and Drugs Phase 2 (NSD-2):** the cross-departmental strategy to reduce the harm related to substance misuse in Northern Ireland.

- **Northern Ireland Alcohol and Drugs Alliance (NIADA):** a group of voluntary and community sector organisations that provide support to those affected by alcohol and drug misuse, and their families. Members include: Addiction NI, Dunlewey, Contact NI, Start360, Ascert, Extern, Simon Community, De Paul Ireland, First Housing, Northlands and Carlisle House.

- **Remove All Prescription and Illegal Drugs (RAPID):** a health and community safety focused initiative that promotes and facilitates the removal of all types of prescription and illegal drugs from the local community.

- **Rapid Assessment and Interface Discharge (RAID):** a specialist mental health service, based in various hospitals which follows the individual's journey through rapid assessment, interface and discharge from start to finish.

- **Regional Initial Assessment Tool (RiAT)** for Substance Misuse: for use with children and young people aged 12 and under.

Acknowledgements

Data was provided by many sources to inform this report. We wish to acknowledge the cooperation and contributions of the following groups to the content of this report:

- Department of Health, Northern Ireland
- NSD Steering Group members
- Representatives from the community and voluntary sector
- Service users representatives
- Representatives from the Public Health Agency
- Representatives from the Health and Social Care Board and Trusts
- Representatives from the law and criminal justice sector
- Representatives from academia

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Executive Summary

Context

- The Department of Health in Northern Ireland has undertaken a comprehensive review of the New Strategic Direction for Alcohol and Drugs-Phase 2 (NSD-2), the region's strategy on reducing alcohol and drug-related harm since 2011.

- Structured engagement with implementation stakeholders was one component of the review. This component of the review sought to understand the factors influencing the delivery of actions set out in NSD-2.

Research approach

- A mixed methods approach was used which focused on process evaluation. Three research tools were employed - an online questionnaire, semi-structured interviews and focus groups.

- The research tools gathered data based on six evaluation criteria. Participants also shared insights on the drug and alcohol landscape, achievements and lost opportunities, and aspirations for future strategies relating to drug and alcohol-related harm.

Figure e1: Research Process

Institute of Public Health in Ireland
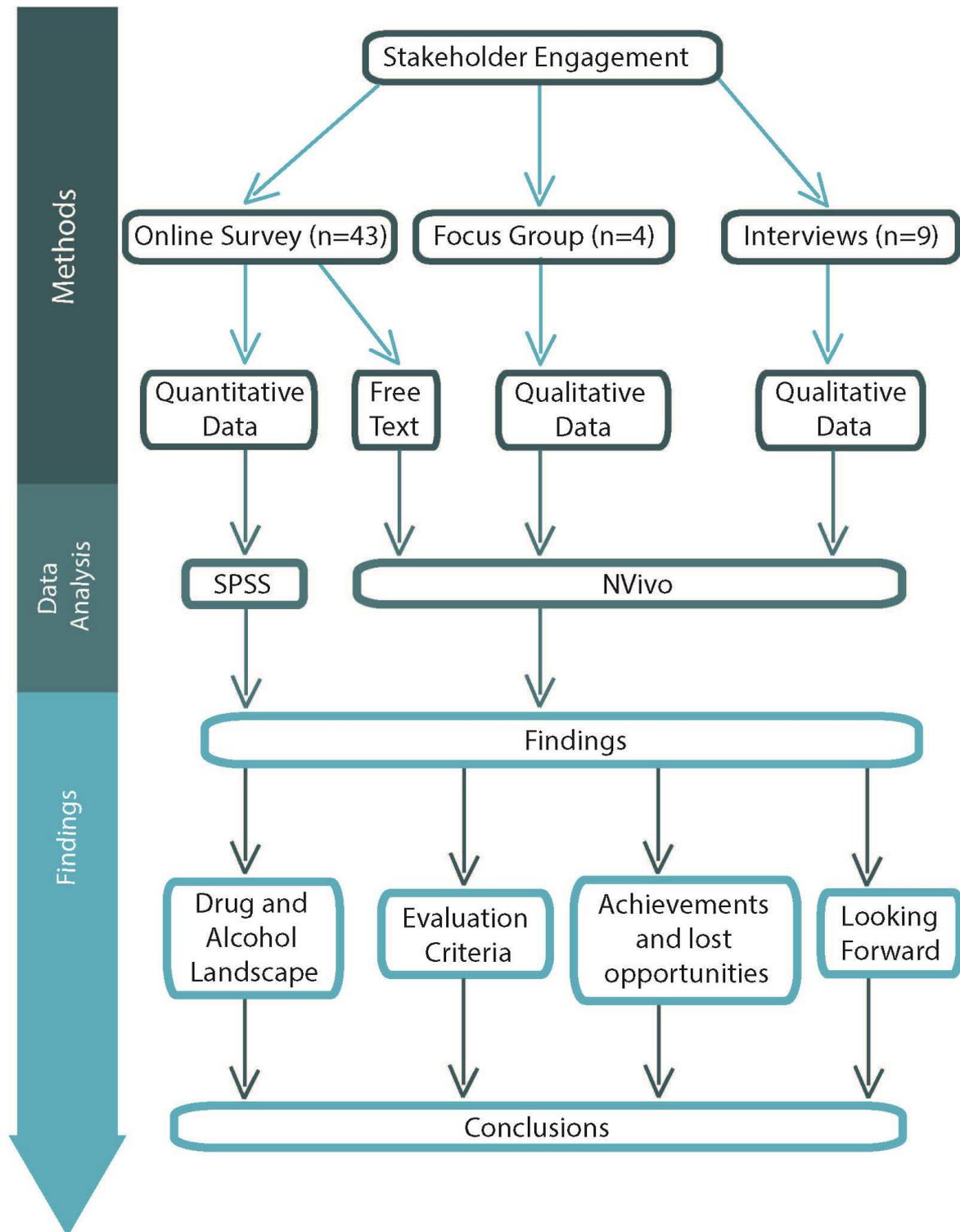
- Figure e1 presents the research process. Frequencies were generated from data collected from the online questionnaire using SPSS. Free text from the three research tools was analysed using NVivo. A deductive approach generated content according to the evaluation criteria. Thematic content analysis generated additional insights within the evaluation criteria.

- A diverse group of stakeholders with both strategic and operational roles in the delivery of NSD-2 was engaged.

- Nine interviews and four focus groups were conducted, while questionnaires were issued to 77 contacts held on the Department of Health NSD-2 stakeholder list.

- 43 valid responses to the online questionnaire were returned. 165,394 words of free text were returned across the three research tools.

Perspectives on trends in the alcohol and drug landscape

- Most participants considered that the level of alcohol and drug-related harm had escalated in Northern Ireland since 2011.

- Participants struggled to quantify the impact of NSD-2 on consumption and harms at population level. Participants considered that external factors were disruptive to reducing consumption rather than an overall failure of strategy implementation. These external factors included economic downturn, political instability, shifts in drug markets and rising polydrug use, as well as a changing pattern of alcohol-related harm.

- Participants perceived significant trends in relation to alcohol consumption, including:
  - ➢ A decline in binge drinking among younger people
  - ➢ An increase in harmful drinking patterns in the middle-aged and older population
  - ➢ An increase in the frequency and volume of home drinking and "preloading"
  - ➢ An increase in the use of high strength alcohol
  - ➢ An increase in the prevalence of polydrug use including alcohol.

- Participants perceived significant trends in relation to alcohol-related harms, including:
  - An increase in the level of alcohol-related harm in older age groups associated with both current consumption and cohort effects
  - An increase in the incidence of liver cirrhosis among both genders and in younger age groups
  - An increase in the prevalence of hidden harm, associated in part with home drinking patterns
  - An increase in the incidence of mental illness and suicidal ideation among those who are drinking excessively or alcohol dependent
  - An increase in the severity of alcohol-related violence
  - Increased complexity of service need
  - An ongoing concentration of severe and multiple alcohol-related harms among marginalised social groups.

- Participants perceived significant trends in relation to drug misuse including:
  - A sharp increase in prescription drug misuse
  - Enhanced accessibility to drugs online and the growth of online supply and social networks
  - An escalation in risk taking behaviour in relation to drug use
  - An increase in the use of new and novel psychoactive substances
  - An increase in injection drug use in Belfast in particular.

- Participants perceived significant trends in relation to drug-related harms, including:
  - Increase in the overall number of people experiencing drug-related harms
  - Increased drug-related deaths
  - Increased complexity of service need in particular with regard to mental health and to homelessness.
  - Some mitigation of the rising rate of drug-related deaths associated with early adoption of harm-reduction initiatives in particular enhanced Naloxone accessibility.

- Interpretation of data on increased service use varied. Some considered this mostly represented true increases in the level of need, others considered it mostly represented greater engagement with services associated with greater service accessibility.

- Table e1 presents the interpretation evaluation criteria used in the research.

Table e1: Evaluation Criteria

Evaluation Criteria	Definition
Relevance	The extent to which a policy's objectives are pertinent to the needs, problems and issues to be addressed
Fidelity	The extent to which the policy was implemented as planned
Effectiveness	The factors that supported or hindered desired results being achieved
Efficiency	The extent to which the desired effects are achieved at a reasonable cost
Sustainability	The continuation of benefits from a policy after major development assistance has been completed; the probability of continued long-term benefits.
Equity	The extent to which different effects (both positive and negative) are distributed fairly between different groups and/or geographical areas

Relevance

- In terms of the overall design of NSD-2, most participants considered that:

  ➢ the structure of the five pillars reflected real priorities and that the overall strategy design was logical, easy to understand and helped maintain focus in the implementation phase

  ➢ there was high level cross-departmental and cross-sectoral engagement in place to support implementation

  ➢ the strategic approach combining drugs and alcohol was beneficial, particularly in responding to an evolving picture of polydrug use

  ➢ the inclusion of a hidden harm pillar was very appropriate in the context of changing patterns of drug and alcohol consumption

  ➢ Recovery could now be prioritised as a distinct 'pillar' in addition to the focus on treatment.

- Some participants considered that implementation had, at times, struggled to be responsive and flexible to changes in drug use and the needs profile of service users. The main areas requiring better responsiveness in NSD-2 were perceived as:

  ➢ the scale of growth of alcohol and drug misuse
  ➢ the psychoactive substances market ('legal highs')
  ➢ prescription drug misuse
  ➢ dealing for profit operations
  ➢ the rise of injectors
  ➢ substitute prescribing waiting lists.

- Developments in regional commissioning were positively viewed by most, but not all, participants. Some tensions were evident in relation to how local and regional needs were assessed and how services were configured.

- Perceptions of the purpose of the research and evaluation pillar differed. Many participants considered that the monitoring and evaluation component was too high-level, focussed principally on incidence/ prevalence trends across Northern Ireland. Participants proposed a greater focus on monitoring

and evaluation of specific services and local area responses as well as sharing of tacit knowledge and experiences of implementation.

- Many participants perceived a mismatch between high implementation ambition and limited available resources.

Fidelity

- Participants considered that the implementation of NSD-2 adhered well to the values and principles set out in the 2011 strategy. Participants recognised that implementation had actioned the values and principles relating to equity, inclusion and person-centred approaches and to partnership working. Addressing local need and maintaining a long-term focus were identified as principles with lower fidelity.

- There were mixed views on adherence to the principle of value for money and save to invest with many participants unable to provide an opinion. Addressing community issues was also an area where participants perceived lower fidelity.

- Targeting those at risk and/or vulnerable was identified as a strategic priority with higher fidelity in implementation, mirroring the findings on high fidelity to equity-related values and principles.

- Introduction of the Regional Commissioning Framework was considered by many as the most significant implementation achievement of NSD-2.

- Most participants considered that the prevention agenda was under-progressed in NSD-2 due to both external factors (e.g. lack of political leadership, progress with legislation) and internal factors (e.g. diversion of energy and funding to address rising service needs).

- Consistent and committed membership of the NSD-2 Steering Group was identified as a contributor to higher fidelity in implementation.

- Participants could not easily comment on whether actions to reduce drug supply occurred as intended.

- Tables e2 and e3 summarise participant views on elements of fidelity within NSD-2.

Table e2: Aspects of NSD-2 viewed as high fidelity, low fidelity and those for which there were mixed views

Generally viewed as higher fidelity items	Generally viewed as lower fidelity items	Mixed views on fidelity
Regional Commissioning Framework	Governance structures	Accountability
Regional and local linkages	Addressing local need	Hidden harm
DACTs and Connections Service	Long-term focus	Responsiveness
Step Referral Pathway		Achievement of priorities

Table e3: Factors which were considered to have supported or hindered the fidelity of NSD-2

Generally viewed as supporting fidelity	Generally viewed hindering fidelity
Collaboration and partnership working	Reorganisation within health and social care structures
Contribution from community and voluntary sector	Competitive nature of tendering process
Workforce development	Political instability and lack of leadership
Communication and information sharing	Lack of clarity surrounding the role of commissioning within Health and Social Care Board and Trusts

Effectiveness

- There were mixed views about the effectiveness of governance structures at the strategic, operational and local levels. Some aspects of governance and accountability were working well, but that there were suggestions of a rising disconnect between strategic and operational levels.

- Tables e4, e5 and e6 summarise participant views on effectiveness.

Table e4: Aspects of NSD-2 which were viewed as effective, less effective and aspects for which there were mixed views

Generally perceived as more effective aspects of NSD-2	Generally perceived as less effective aspects of NSD-2	Aspects with mixed views on the effectiveness
Governance structures at local level	Governance structures at operational level	Governance structures at strategic level
DACTs	Advisory groups	
Joined up working, collaboration and partnership working	Funding	
Workforce development	Research and evaluation	
Regional Commissioning Framework	Prevention	
Service user involvement		

Table e5: Factors that supported effectiveness

Factors that supported effectiveness	Perceived result
Regional Commissioning Framework	Greater consistency in level and diversity of service offer
Well established partnerships and collaborative working at all levels	Co-ordinated approaches, effective working relationships, supporting efficiencies
Consistency and commitment of NSD-2 steering committee membership	Continuity of work, opportunity to challenge, meaningful representation, cross-sectoral collaborative approach
Service user involvement	Programmes and services better designed to fit client needs, greater linkage from strategic decision making to lived experience, de-stigmatisation, rapid communication of evolving elements of the drug use landscape

Table e6: Factors that hindered effectiveness

Factors that hindered effectiveness	Perceived result
'Ever rising tide' of drug and alcohol-related harm	Services becoming overwhelmed, diversion of resources away from prevention at strategic and operational levels
Rising complexity of service need	Existing linear models of care become quickly obsolete, increasingly focussed on crisis care and quantity of service rather than quality of care and recovery model
Lack of political structure	Failure to progress with key legislation, constraining of policy options – particularly in relation to the prevention agenda
Transformation in the health and social care service	Some system-level disruption in roles between the former Health and Social Care Boards, Health and Social Care Trust and the Public Health Agency
Diminished role of advisory committees	Reduced opportunity to inform strategic direction and prioritise existing and emerging issues
Some mismatch between policy and resourcing decisions	Under-resourcing of some service options, lack of faith and confidence in return on investment
Non- statutory function of DACTs	Stifling of local level innovation, limited capacity for implementation at local level
Some issues with transition within the Step model of care	Gap between Step 2 and 3 services

Efficiency

- Most participants struggled to make conclusions on efficiency domains, particularly on the value for money component.

- Table e7 summarises participant views on higher and lower efficiency within NSD-2:

Table e7: Aspects of NSD-2 which were viewed as efficient, less efficient and aspects which there were mixed views

Perceived higher return on investment	Perceived lower return on investment	Mixed views on return on investment
Regional Commissioning Framework	Multiplicity of initiatives	Hidden Harm
Contribution from community and voluntary sector organisations	Small individualised services	Connections Service
Workforce development and increased staff capacity	Public information/ awareness campaigns	Step 2 services
Harm reduction approaches		
Drug and Alcohol Coordination Teams		
Drug and Alcohol Monitoring and Information System		

Sustainability

- Most participants considered that the implementation of NSD-2 had generated changes in practice that will last into the future. Seven core activities/areas of implementation were perceived as driving sustainable positive change. These were:

  - Collaboration and partnership working
  - Regional consistency in service provision
  - DACTs local co-ordination and collaborative activities
  - Integration of drug and alcohol together at both strategic and service level
  - Service user involvement and engagement
  - Adoption of harm reduction approaches
  - Enhanced communication through information tools, networks and workshops

- In terms of examples of innovation, participants referred to a wide variety of initiatives. Examples of innovation were largely related to cross-over and collaborative initiatives in areas such as homeless, policing, community safety, child protection and youth justice. The Drug and Alcohol Monitoring

Information System (DAMIS) was perceived as a flagship innovation within NSD-2 implementation.

- Some participants considered that a focus on regional approaches and a lack of authority and resources at local level made local innovation difficult.

Equity

- The perceptions of participants were explored in terms of how equity issues were understood, approached and resourced in the implementation of NSD-2.

- Geographic inequalities were commonly perceived as a critical dimension of equity to a greater extent than socially defined communities. Rural/urban inequities in treatment services was a priority concern as were 'bottle-necks' in service provision in urban areas.

- Participants identified NSD-2 as a key player within the government approach to address health inequalities at population level. They identified that the wider economic context was driving social and health inequalities, irrespective of NSD-2, in terms of income inequality and housing.

- Some participants perceived that public awareness /health education type initiatives on alcohol may have widened inequalities by being more effective in driving behaviour change among the higher educated.

- The areas of work under NSD-2 most commonly identified as effective in the health inequalities dimension were

  ➢ Local engagements and outreach operated through DACTs
  ➢ Partnership working in the criminal justice system
  ➢ Harm reduction approaches for injecting drug users
  ➢ Engagement of families and carers especially within Step 2 services

- Cross-government and cross-sectoral cooperation at both strategic and operational levels was seen as central to addressing health inequalities. The lack of a functioning Assembly was seen as harmful to the health inequalities agenda.

- Participants raised particular concerns about the current and future response for certain vulnerable subgroups including older people, people with mental

health issues, those in addiction recovery, women and children in the child protection system.

Main achievements of NSD-2

- Figure e2 summarises the main perceived achievements of NSD-2.

Figure e2: Achievements of NSD-2

- Participants recognised that NSD-2 drove increasingly effective collaboration and partnership working at both strategic and operational level and successfully raised the profile of alcohol and drug-related harm in Northern Ireland.

- Service improvements in the domains of better availability, accessibility, equity, co-ordination and consistency were highlighted, which were largely attributed to the Regional Commissioning Framework.

- Investments in workforce development were also highlighted. The consistency, diversity of representation and commitment of the NSD steering committee was also recognised.

- The progress made on embedding transition to an evidence-informed harm reduction approach was also highlighted.

Main lost opportunities of NSD-2

- Figure e3 summarises the main perceived lost opportunities of NSD-2.

Figure e3: Lost opportunities of NSD-2

- Participants perceived that greater benefits would have accrued from:

  - ➢ Greater alignment between strategic and operational elements of NSD-2 and greater integration across government department strategic agendas

  - ➢ More structured opportunity to engage in evidence-informed future planning rather than focus on acute service provision issues

  - ➢ A swifter response to some unintended outcomes and change management issues within the implementation of the Regional Commissioning Framework.

  - ➢ More data sharing and critical evaluation on existing programmes and services

  - ➢ Protected opportunities to focus on prevention approaches at strategic and operational level and beyond the early intervention domain

  - ➢ Political stability and leadership to allow for legislative changes

  - ➢ Adoption of a person-centred comprehensive recovery model.

Looking Forward

- Respondents were invited to give their views on a future alcohol and drugs strategy. Suggestions were made in relation to the most important features / future priorities for a new alcohol and drugs strategy. Respondents were also asked to comment on any aspects of NSD-2 which should be maintained and those which should be stopped.

- Figure e4 presents a summary of the main areas for development in any future strategy:

Table e8: Features which participants highlighted should be incorporated into any future strategy

Features which participants highlighted should be incorporated into any future strategy	
Strategic and operational alignment	• Greater alignment between policy, planning and implementation • Better needs assessment • Protected focus on prevention
Governance	• Greater responsiveness • Actions linked to short, medium and long term outcomes using an Outcomes Based Accountability approach • Better linkage between the steps within the existing model of care
Long-term thinking	• A longer-term strategy supported by shorter-term action plans • A longer-term approach based on evidence and modelling of projected scale and severity of alcohol and drug-related issues • Commitment to long-term phased service development and expansion
Regional Commissioning Framework	• Joint commissioning and integration of budgets to maximise outcomes • Enhanced understanding of local evidence based practice • Commissioning, with realistic outputs and outcomes, that is reflective of the needs at community level and the requirement for specialised services

Resources	• Additional investment in tackling alcohol and drug-related harm • Longer-term funding based on population projections of need. • A regular review of the allocation of resources and consideration of further resource-sharing across health, social or community budgets.
Service provision	• Better integration of services across sectors and within the step model of care. • Joined up working around the social determinants of health. • Advanced workforce planning and development for the expansion of services with a particular focus on recovery. • Greater investment and more coordinated efforts for early intervention
Societal groups	• Involvement of service users at all levels • Greater development of services for children and families affected by addiction • More joined up approaches to addressing mental health problems, homelessness and substance misuse
Legislation	• Progression of legislation on minimum unit pricing of alcohol and the sale and supply of alcohol • Progression of legislation on drug consumption rooms.
Research and Evaluation	• Improvement, evaluation and implementation science to be placed within the monitoring and evaluation component • Implementation and sharing of the outcomes of a standardised assessment tool such as the Regional Initial Assessment Tool (RiAT) • Better understanding of the drivers of prescription drug misuse.

Section 1: Introduction

The New Strategic Direction for Alcohol and Drugs Phase 2 (NSD-2) is a cross-departmental strategy led by the Department of Health, which aims to reduce the level of alcohol and drug-related harm in Northern Ireland. The strategy was launched in 2011 and remains the official strategy in 2018. Five pillars form the conceptual and practical basis of NSD-2:

1. Prevention and Early Intervention
2. Treatment and Support
3. Law and Criminal Justice
4. Harm Reduction
5. Monitoring, Evaluation and Research

Within the strategy, two broad themes were identified – 'Children, young people and families' and 'Adults and the general public'. NSD-2 seeks to deliver an integrated and co-ordinated approach to tackling alcohol and drug misuse.

A number of key priorities were identified along with short and long outcomes. The Department of Health has reported annually on progress since the inception of the strategy. These reports are available on The Department of Health website. In 2016, it was agreed that a final evaluation would be undertaken. The overall aim of the review was to evaluate the impact of NSD-2 on its aims of preventing and addressing harm related to substance misuse in Northern Ireland. The review comprised three aspects of the implementation of NSD-2:

1. Outputs – the action which has been taken by Government Departments and their agencies through the NSD-2 structures, and the progress made.
2. Outcomes – the impact that NSD-2 has had on the range of indicators and outcomes it set out to achieve and the differences made for the public, service users and carers.
3. Stakeholder engagement – the views of key stakeholders on the delivery of NSD-2 and the associated structures, in the context of recent and emerging Government policy.

The Institute of Public Health in Ireland (IPH) was requested by the Department of Health (DoH) to support the stakeholder engagement element of the review. This component of the review focussed on process evaluation by exploring the views and experiences of stakeholders. Elements of process evaluation are evident in both the stakeholder engagement and outputs components of the review. Stakeholder

engagement can facilitate access to relevant data and individuals, and ensure that the approach taken is realistic, covers the most important aspects of the policy or strategy, and represents all relevant geographical areas and affected groups (EMCDDA, 2017).

1.2 Research design

1.2.1 Aim and objectives

The aim and objectives of the stakeholder engagement component were as follows:

Aim

To undertake a structured engagement with stakeholders to determine factors influencing the delivery of actions set out within the New Strategic Direction on Alcohol and Drugs Phase 2, and achievement of outcomes, with a view to informing the wider policy review and future policy for Northern Ireland.

Objectives

With reference to the policy period 2011 to 2016

1. To effectively research the most significant factors influencing the delivery of policy actions in New Strategic Direction on Alcohol and Drugs Phase 2 (NSD-2) and the achievement of outcomes, through two processes (a) a targeted review of all relevant documentation on policy implementation and (b) a structured engagement with policy and implementation stakeholders using a mixed methods approach of quantitative and qualitative analysis

2. To develop a draft report that explores and synthesises these factors and makes recommendations for future policy

3. To develop a final report that contributes to the overall review of the policy in consultation with the policy leads and relevant committees.

1.2.2 Research tools

There were two main components of the stakeholder engagement - an online questionnaire and a series of semi-structured interviews and focus groups.

The stakeholder engagement was structured around set evaluation criteria. The EMCDDA guidance to support the commissioning and managing of evaluations of drug policies was used to frame this set of evaluation criteria. The criteria applied and their definitions are set out in Figure 1:

Figure 1: Evaluation Criteria

Relevance	Fidelity	Effectiveness
The extent to which an intervention's objectives are pertinent to the needs, problems and issues to be addressed	The extent to which the policy was implemented as planned	The fact that expected effects have been obtained and that objectives have been achieved

Efficiency	Sustainability	Equity
The extent to which the desired effects are achieved at a reasonable cost	The continuation of benefits from an intervention after major development assistance has been completed; the probability of continued long-term benefits.	The extent to which different effects (both positive and negative) are distributed fairly between different groups and/or geographical areas.

The online questionnaire, interviews and focus groups gathered data across four core areas. A copy of the online questionnaire is available in the Appendix. All focus group participants and interviewees were presented with core questions relating to the implementation of the strategy. Additional targeted questions were developed according to nature of the participants' involvement in the strategy and their area of expertise.

Demographic/ background information about the stakeholders

Participants were asked about their current role, employment sector, the geographic area in which they worked and membership of NSD-2 affiliated committees. Participants were also asked to indicate if they engaged directly with service users, their involvement in NSD-2 strategic and operational activities and their role in the implementation of NSD-2. Questionnaire participants were invited to complete demographic information relating to age, gender and the number of years they had been involved with alcohol and drugs strategy in Northern Ireland.

Perspective on alcohol and drug related-harm within Northern Ireland

All participants were invited to share their views on the extent and/or changes in the levels of alcohol and drug-related harm in Northern Ireland since 2011 and whether NSD-2 had a positive or negative effect on levels of harm. Participants were invited to comment on the implementation of NSD-2 as a driver for change, any significant achievements and/or lost opportunities experienced during the lifetime of the strategy and any unforeseen factors that may have affected patterns of alcohol and drug-related harm.

Evaluation Criteria

Table 1 below gives an overview of the different aspects of the implementation of NSD-2 under each evaluation criterion.

Considerations for a future alcohol and drugs strategy

The concluding questions sought participants' views on future priorities for alcohol and drugs strategy in Northern Ireland. Participants shared views on aspects of NSD-2 which should be maintained and aspects which should not be taken forward. Participants were invited to identify any external changes in the alcohol and drug environment which needs to be considered in the development of any future strategy.

Table 1: Overview of the aspects of implementation of NSD-2 under each evaluation criterion

Evaluation Criteria	Aspects of the implementation of NSD-2
Relevance	• The appropriateness of the five pillars underpinning NSD-2 • The approach taken in deciding the content of NSD-2 • The balance achieved by NSD-2 in addressing both alcohol and drugs • Implementation of the strategic framework relevant to local and regional needs
Fidelity	• The extent to which NSD-2 kept to its values and principles • The extent to which the implementation of NSD-2 stayed on course • The extent to which the original priorities remained priorities throughout the implementation of NSD-2 • How well implementation of NSD-2 went to plan / did not go to plan
Effectiveness	• The effectiveness of the governance structures at strategic,

	operational and local level
	• Positive or negative unintended outcomes resulting from NSD-2
	• The most significant factors helping or impeding the achievement of NSD-2 outcomes
Efficiency	• The efficiency of resource allocation
	• Return on investment / 'best buys' within NSD-2
	• Elements of NSD-2 that did not represent an efficient use of resources
Sustainability	• The generation of long-term changes in practice
	• The extent to which partnership working has been enhanced
	• Examples of innovation in the implementation of NSD-2
	• Existence of any conflicts in the implementation of NSD-2 and the response
Equity	• Deployment of resources (human / financial) to target those most in need
	• The extent to which vulnerable groups have benefitted from the implementation of NSD-2
	• The extent to which NSD-2 has helped address health inequalities / how it could have been more effective in addressing health inequalities

In October 2017 the NSD-2 Steering Group agreed the Terms of Reference of the Review of NSD-2, including the stakeholder engagement. The proposed research approach and tools were presented to the NSD-2 Steering Group, with members invited to provide feedback. Changes were made to the research approach and tools based on feedback from the pilot and NSD-2 Steering Group.

1.3 Data Collection

1.3.1 Online questionnaire

The online questionnaire was issued on the 13 December 2017 with a deadline of 26 January 2018. The questionnaire link was disseminated to all relevant contacts, including NSD-2 Steering Group Members, by the Department of Health. Steering Group members were invited to circulate the questionnaire among their networks to stakeholders who had been involved in the delivery of NSD-2.

1.3.2 Semi-structured interviews and focus groups

The interviews and focus groups were organised and conducted in line with appropriate best practice guidelines. The semi-structured interviews were conducted in person or by telephone, subject to availability and practicalities. All interviews were conducted by a member of the IPH policy team. The average interview time was 69 minutes.

Focus groups took place in Belfast and were moderated by members of the IPH policy team. Each focus group lasted between 90 and 110 minutes in duration. Seating was arranged in a circular format to promote open communication, with all participants encouraged to contribute. As the discussion progressed in the focus groups and participants provided more information, probing questions were used to explore particular points in more detail and ensure the information provided was understood correctly by the facilitator(s).

All focus groups and semi-structured interviews were audio-recorded. Audio files were transcribed verbatim by an external transcription service.

1.3.3 Consent and data handling

A data handling protocol was agreed between IPH and the DoH in relation to all data collected by IPH during the engagement process in line with relevant data protection legislation in Northern Ireland. The external transcription service was required to complete a confidentially agreement, and a protocol was established for the safe transfer of material between IPH and the transcription service.

Participants signed a statement of consent prior to participation in the online questionnaire. In the interviews and focus groups this statement of consent was signed by participants. This statement of consent specified that:

- Responses would be kept anonymous and no comments ascribed to any individual
- Responses would be used only for the purpose of this report
- Any data pertaining to this consultation would be deleted on completion of this report.

Interviewees were also provided with the opportunity to review their transcripts for accuracy.

1.4.1 Quantitative Analysis

The online questionnaire contained both quantitative data, and free text responses which were suitable for qualitative analysis. Once the questionnaire had closed 71 responses were exported from Survey Monkey as Excel and SPSS files. Responses where participants had only answered question one were deleted. 16 incomplete responses which had between 18% and 76% of questions completed were retained along with 27 fully completed responses. The quantitative data were analysed to produce frequencies in relation to the evaluation criteria using SPSS (Version 24) data analysis software.

Approximately 11,913 words of free-text were returned as responses to the open-ended questions on the online questionnaire. The semi-structured interviews responses returned 90,047 words of text while the focus groups responses returned 63,434 words of text. All text responses were combined to form a dataset which was analysed qualitatively using NVivo (Version 11) qualitative data analysis software.

Qualitative analysis was carried out by members of the IPH policy team on a dual analysis approach.

1. A deductive approach using the evaluation criteria as the predetermined framework.

2. An inductive approach using thematic content analysis in order to capture significant cross-cutting themes as well as themes considered separate or additional to the specified evaluation criteria.

Once findings had been identified, the entire data set was re-read at this stage in order to ensure that findings accurately represented participants' views and experiences.

Two members of IPH policy team were involved in the analysis of the data, systematically coding and reviewing the codes to achieve a high level of inter-rater reliability. Each reviewer coded seven transcripts each. Through in depth discussions, both researchers then reviewed and agreed the final coding for each transcript in order to verify findings.

Figure 2: Research Process
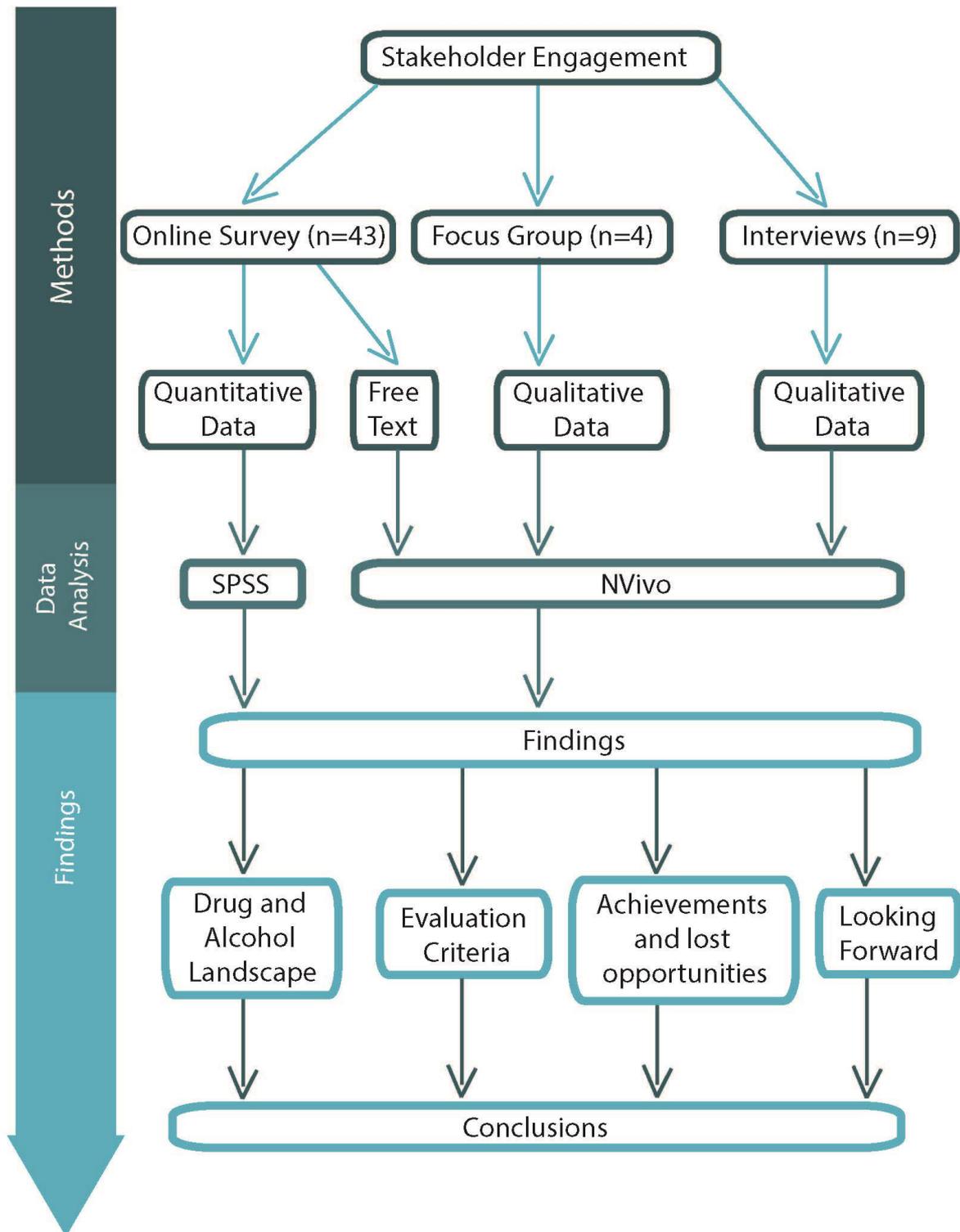
Section 2: Profile of participants

2.1.1 Online questionnaire results

There were 43 valid responses to the online consultation (27 complete and 16 incomplete questionnaires).

Participant profile

Of the 23 participants who completed the demographic information, 52% (n=12) were male and 44% (n=10) female; one respondent chose not to disclose their gender status. The majority of participants were aged 45 and over (70%; n=16) and had more than 5 years involvement with the alcohol and drugs strategy in Northern Ireland (83%; n=19). This pattern suggests that the questionnaire was successful in gaining the insights of people with substantial experience in the area of alcohol and drug policy in Northern Ireland at both the national, regional and local level.

The majority of participants (84%) worked in Northern Ireland at either a regional or local level. A small number of participants worked across the island of Ireland and the UK with one respondent working worldwide. Three local authority areas and four out of five Health and Social Care Trust (HSCT) areas were represented.

In addition to geographic location, participants were invited to identify which sector they worked in. Responses are presented in Figure 3:

Figure 3: Type of organisation in which participants worked in the context of the implementation of NSD-2
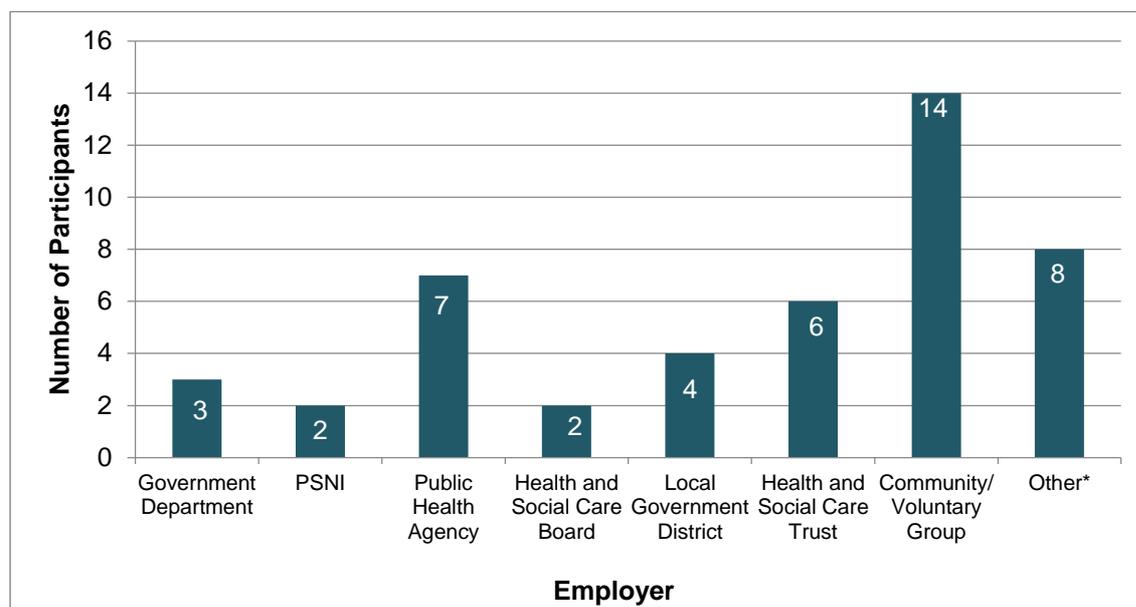
The single most frequently represented sector was the community and voluntary sector, followed by those categorised as 'Other'. This category included participants from academia, the alcohol industry, justice, education, service users and the third sector. The remaining participants were employees of statutory bodies including central and local government, health and social care and policing. Despite a small sample size, the online questionnaire appears to have captured a broad range of implementation stakeholder perspectives.

Participants were asked to indicate their membership of groups and committees affiliated with NSD-2. Responses are illustrated in Figure 4. Participants were commonly members of more than one committee or group. From the pattern observed, the questionnaire was reasonably successful in capturing the views across all the major committees linked to the implementation of NSD-2 since 2011.

Figure 4: Membership of committees affiliated with NSD-2 (n = 51; multiple responses)
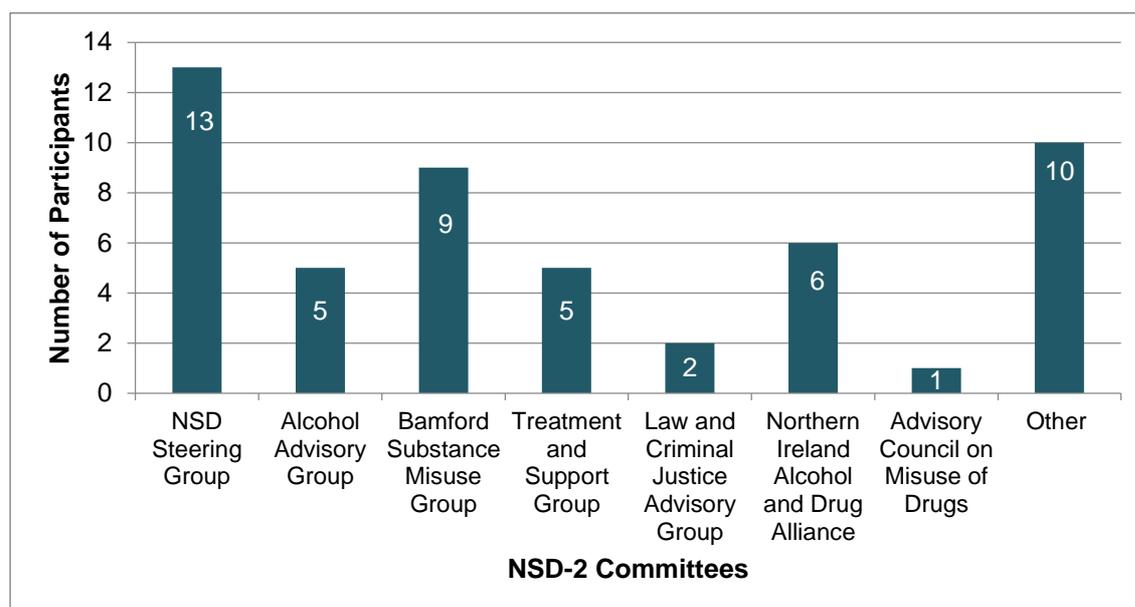
Membership of the NSD Steering Group was most common amongst participants, followed by membership of other groups such as the Drug and Alcohol Coordination Teams and the Hidden Harm Assurance Group.

Participants were asked to indicate the level of their involvement with NSD-2 in the context of strategic and operational activities. In terms of strategic activities, Figure 5 shows that participants were most likely to be involved in monitoring and evaluation and reporting on progress against NSD outcomes. Strategic activities listed on the 'other' category included the development of programmes, resources, action plans and consultation.

Figure 5: Participants' involvement in strategic activities linked to NSD-2 (n=67; multiple responses)
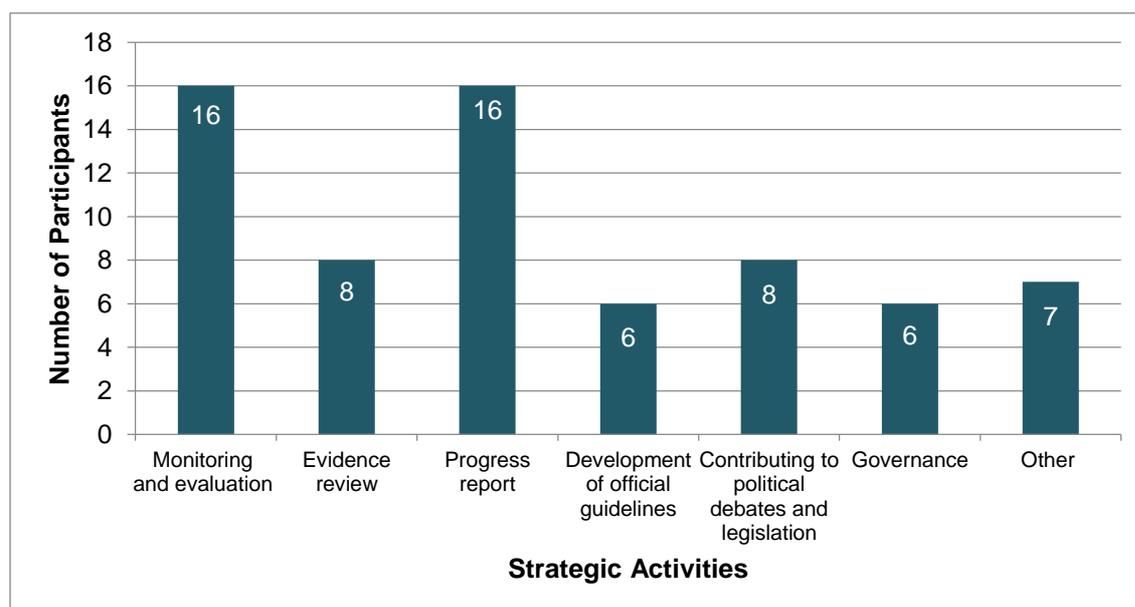
In terms of operational activities, participants were most likely to have been involved in service delivery though health and social care or other services. Participants also reported involvement in government level communication on alcohol and drug issues, as well as commissioning of services and management and allocation of resources (see Figure 6). Other operational activities included family support services, prevention and campaigning, industry communication on alcohol issues and involvement with the DACTs.

Figure 6: Participants' involvement in operational activities linked to NSD-2 (n=64; multiple responses)
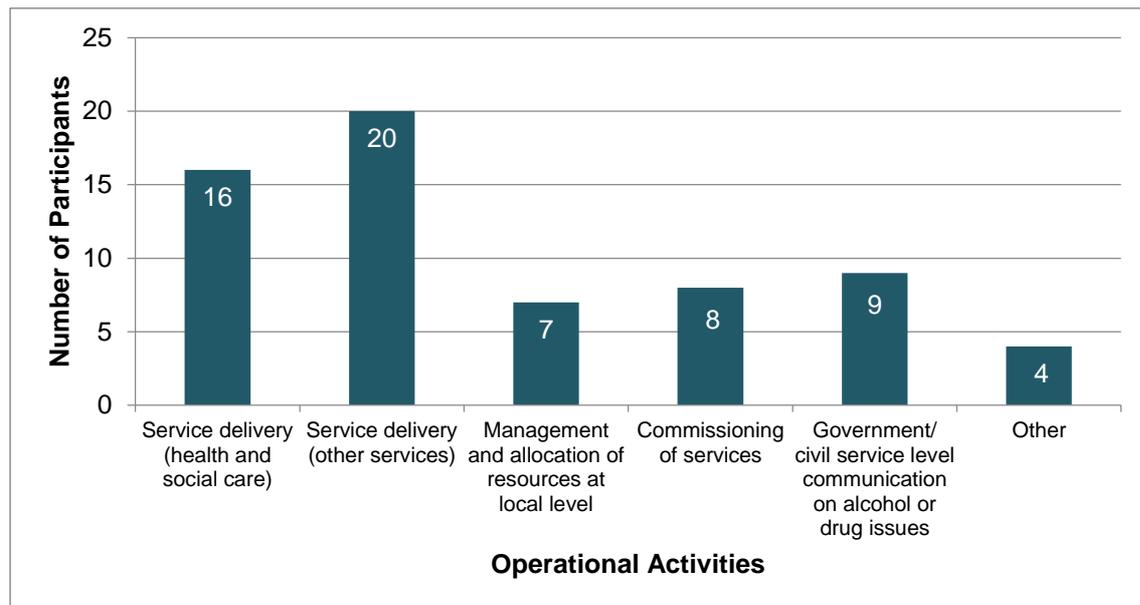
Over two thirds of participants (67.4%; n=29) regularly engaged directly with service users in the of context of the implementation of NSD-2. Engagement with service users was reported to include involvement in the commissioning, planning, delivery and review of services; service users in receipt of treatment services; support for families of service users, research, and direct consultation with service users/ through the Regional Service User Network.

2.1.2 Semi-structured interviews and focus groups

The semi-structured interviews were conducted with nine individuals, mostly representatives from the NSD-2 Steering Group. The sectors represented included academia, central government, Public Health Agency, health and social care providers and service planners and Drug and Alcohol Co-ordination Teams.

In total, 21 participants took part in the focus groups, with a reasonable gender balance achieved in respect of the interviews and focus group participants. Focus groups were conducted with service user representatives, the community and voluntary sector and representatives from law and criminal justice.

2.2 Interpretation

The findings presented are based on the views of the stakeholders who participated in this evaluation. They are not the views or opinions of the Institute of Public Health in Ireland, nor the Department of Health or any other individual or body involved in the implementation of NSD-2. The analysis refers to areas of emerging consensus, but is principally presented in such a way as to ensure all views and perspectives have been represented. There were contradictory views and experiences of implementation evident in the dataset – these are reflected without judgement as to the source or validity of that viewpoint.

In keeping with the consent and data handling protocol and in order to promote open sharing of views, all reasonable efforts were made to ensure the confidentiality of research participants. Viewpoints cannot be attributed to any individual or organisation and quotes are anonymised.

2.3 Strengths of the research

This review had a high level of engagement with views from stakeholders at all levels, from service users to top level government officials. The qualitative research adds context to the findings of the quantitative research, capturing subtle shifts in organisational culture and bringing together different perspectives and allowing for the formation of a narrative.

This component of the review adds depth to the findings reported in the progress reports on outputs and outcomes by delving into the 'black box' of implementation. Process evaluation can shine a light on the factors supporting and hindering implementation processes at many levels of implementation. The engagement process used has prompted reflective practice and open sharing of both successes and challenges in implementation among stakeholders, representing a component of action learning as well as research.

The design of the research tools was informed by international evidence including an assessment of similar reviews occurring in Ireland (Griffiths *et al* 2016), the UK (HM Government 2017) and across Europe (EMCDDA 2017). In order to bring coherence to a potentially large and diverse dataset, a defined structure was used from the outset, structured along set evaluation criteria and applied across the questionnaire, interviews and focus groups. The research tools were developed in partnership with the committee and modified in response to a pilot.

2.4 Limitations of the research

In respect of the online questionnaire results, a small number of responses were returned and this should be considered in the interpretation of the findings. Furthermore, the views of young people and children have not been captured in this review. However, in order to achieve this, a different research approach would have had to have been initiated.

Biases are likely to be evident in research of this nature. Participants can find it difficult to openly share views and experiences relating to implementation when they have an identified professional and organisational responsibility for effective delivery. It can also be difficult for participants to share views that challenge the status quo or are perceived to threaten the viability of certain programmes or services. Similarly, some stakeholders can seek to use the engagement process for a set purpose, for example to advocate for a particular investment or showcase their own contribution. In addition, this process evaluation occurs at the end rather than the beginning, and this may lead to some degree of recall bias. Due to the sector in which they worked, some stakeholders also had limited knowledge on core topics such as funding details.

Section 3: Findings

3.1 Perceptions of overall trends in drug and alcohol use

This section presents findings from the online questionnaire, semi-structured interviews and focus groups. For clarity and ease of interpretation the frequencies from the online questionnaire are presented first (the quantitative data) following by the findings from the focus groups, the interviews and the free text responses from the online questionnaire.

In the online questionnaire, participants were asked to indicate whether they thought the level of alcohol and drug-related harm declined or increased in Northern Ireland since 2011.

Figures 7 and 8 show that the majority of questionnaire participants perceived that the level of alcohol and drug-related harm in Northern Ireland had not declined over the period 2011-2016. When comparing Figure 7 and 8, slightly more participants indicated that there had been a decline in alcohol-related harm (11.4%) compared to drug-related harm (8.6%). There was significant discussion among interviewees and focus group participants and a number of themes were identified in relation to alcohol and drug consumption and related harms.

Figure 7: Participants' opinion on whether the level of alcohol-related harm declined in Northern Ireland since 2011 (n=35)
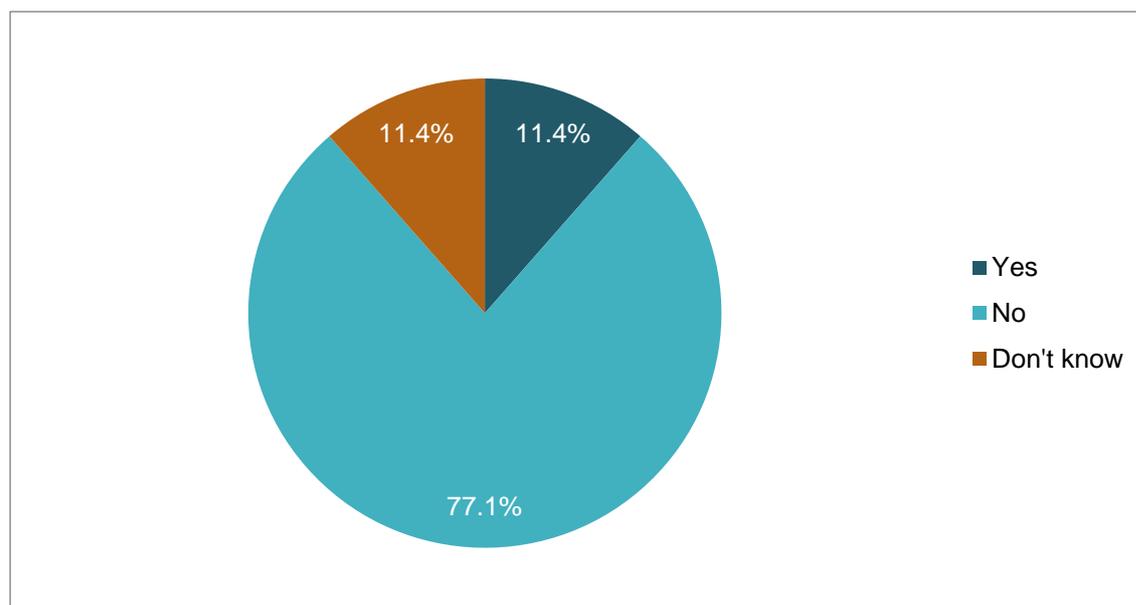
Figure 8: Participants' opinion on whether the level of drug-related harm declined in Northern Ireland since 2011 (n=35)
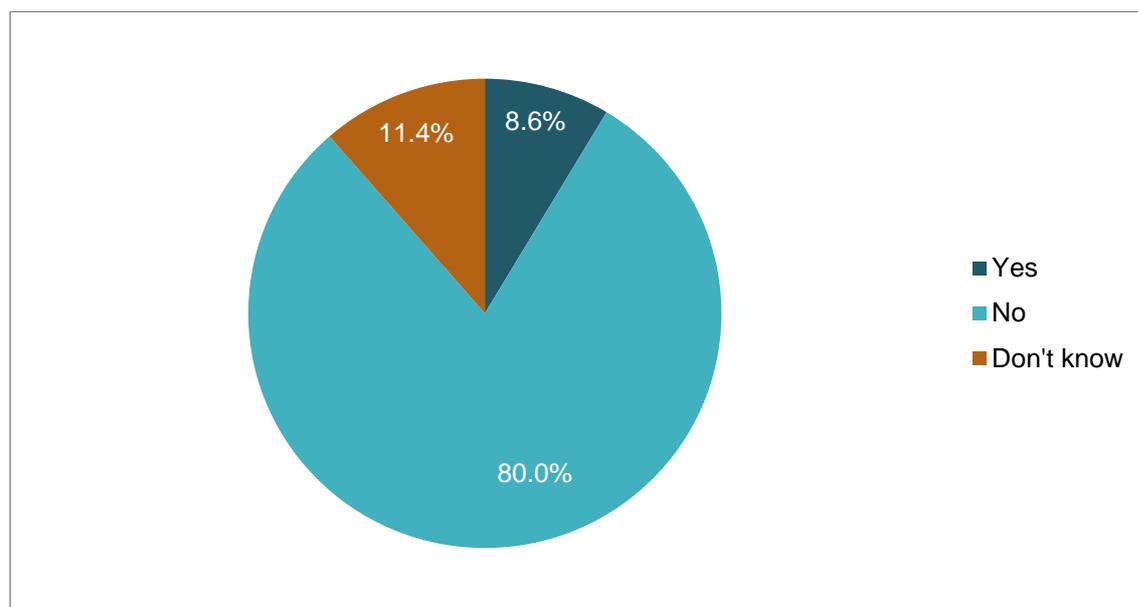
3.2 Perceptions of changes in alcohol consumption and harms

Alcohol consumption

In general, participants considered that levels of alcohol consumption in Northern Ireland remained a significant public health challenge.

"Still unacceptable levels of harmful alcohol consumption."

Participants referred to success in reducing alcohol consumption among young people, including binge drinking. Participants perceived that shifts in drinking culture had occurred only in younger age groups.

"It's still a struggle to take forward a population approach towards shifting attitudes of an entire population which will have a big impact."

Participants noted that the revised UK guidelines for alcohol consumption were likely to lead to increases in the estimation of higher risk drinking in Northern Ireland by virtue of the introduction of a lower threshold for men. Also, some participants considered that alcohol consumption among women has been escalating in recent years.

Several participants expressed concern in relation to an increase in harmful drinking patterns in the middle-aged and older population in the context of transitions to retirement and the interface between alcohol and population ageing.

"I mean my sense that it's a changing pattern rather than a simple has there been more or less."

Several participants expressed concern about the level of alcohol and drug-related problems among people interfacing with the criminal justice system. There was a concern over an ongoing intergenerational pattern of harmful drug and alcohol use alongside criminal activity. Concerns were noted regarding an increase in the level of excessive alcohol consumption in the home setting and the incidence of 'pre-loading'.

Participants expressed concerns regarding the low cost and availability of alcohol. Participants identified some changes in the higher strength alcohol retail market which were perceived to support and perpetuate heavy drinking. Participants were keen to progress the introduction of minimum unit pricing alcohol to tackle both overall consumption and 'binge' drinking.

Alcohol-related harms

Participants consistently noted that the impact of alcohol-related harm remained significantly greater than drug-related harm at population level and discussed the challenge of reorienting/ balancing combined drug and alcohol policies in this regard.

Participants commonly referred to the increasing number of alcohol-related deaths. However, some participants were cautious in interpretation as increases were perceived to reflect better coding of alcohol-related deaths in addition to an actual increase in the number of deaths.

Participants noted the dramatic increase in the incidence of liver cirrhosis for both men and women and in younger age groups.

Participants had differing views on whether increasing numbers of individuals engaging in treatment could be attributed to increasing harm or simply increased engagement with and delivery of services.

Participants recognised that the legacy effects of alcohol consumption in previous decades. It was perceived that 'cohort effects' in the current middle-aged and older people group were 'starting to hit' and expressed concerns about the upcoming health service needs.

"We still have a peak to reach in terms of alcohol-related harm – a lot of the drinking and excess drinking that went on over the last 20 years has to work its way through the system. A lot of these problems will take a while to manifest themselves".

Some participants reported that suicidal ideation and suicide is becoming increasingly apparent in the context of alcohol-related harm.

Some participants reported that the level of violence on the streets is increasing in severity, much of which is alcohol-related.

Participants considered that alcohol harm remained deeply entrenched in the most difficult to reach parts of society and disadvantaged communities and that effective engagement was still elusive.

Participants considered that service need had increased in both volume and complexity. It was noted that healthcare professionals are dealing routinely with more complex cases than they would in the past, for example more complex mental health problems for the individual and family as a consequence of alcohol.

> *"Everyone is dealing with more complexity and people coming with very immediate crisis issues that require stabilisation before treatment."*

Participants reported that overall there is an increased awareness of the harms associated with excessive alcohol consumption in the general population but noted that the perception of excessive differed between different groups.

3.3 Perceptions of changes in drug use and harms

Drug use

Participants referred to a number of changing patterns in relation to drug misuse including:

- A sharp increase in prescription drug misuse

- An increase in polydrug use (including alcohol in the mix)

- Wider availability of and ease of access to drugs online

- An escalation in risk taking behaviour in relation to drug use

- An increase in the use of new and novel psychoactive substances.

> *"Before [Community/voluntary organisation] would have been dealing 80% of the time with alcohol, we're now dealing more and more with different types of drugs and alcohol and mixing with alcohol can still be the big issues."*

Similar to those issues relating to alcohol use, participants expressed concern and some frustration regarding the extent of drug use among people interfacing with the criminal justice system.

Participants recognised that global influences were changing the supply and demand of drugs in Northern Ireland, but that these influences were poorly understood and difficult to predict.

Several participants considered that injecting drug use had increased significantly in Belfast and this trend is growing in other parts of Northern Ireland.

Some participants considered that drugs were increasingly accessible online and that there was less reliability and certainty on the composition of drugs in the context of complex supply chains.

The role of social media also featured in participant responses and discussions, with some participants perceiving that the expansion of social media has increased the efficiency of drug dealers in making drugs rapidly available and easily accessible.

<u>Drug-related harms</u>

Participants referred to a number of significant trends in drug-related harms, including:

- Increased drug-related deaths
- Increase in the number of people experiencing drug-related harms
- Increased complexity of service need relating to polydrug use
- Increased complexity of service need relating to mental health and to homelessness
- Decreases in drug-related mortality - perceived as associated with harm reduction approaches.

"I think perhaps one of the things we couldn't have expected just so much is the change in polydrug use. I mean it was already there but I think we've seen an acceleration of that. And that has a link with mental health and poor mental health."

Drug-related harm (as a result of psychoactive substances) was reported to have surpassed alcohol-related harm as the main substance misuse problem among the homeless community.

Participants expressed great concern at the significant increase in the availability and use of prescription drugs in combination with alcohol and other illicit drugs.

There were mixed views on the impact of legislation on psychoactive substances. Some considered that this had been very effective and others considered that it had contributed to the increased use of prescription drugs.

Participants viewed that availability of psychoactive substances has raised users' expectations and changed the marketplace. Some considered that people were increasingly experimenting with drugs in different combinations with less consideration of risks and interactions.

"Legal highs have introduced a much richer tapestry of drugs to the supply network."

Participants highlighted an evolving culture of risk-taking behaviour evident among a new, young cohort of drug-users which has been described as 'chaotic' and 'fatalistic'. Some participants referred to the dissolution of taboos relating to drug taking and the emergence of premeditated and planned, as well as impulsive, combination drug taking.

3.4 Perceptions of the role of NSD-2 in changing patterns of use and harm

Just under half (46%) of questionnaire participants reported that NSD-2 had a positive effect on alcohol and drug-related harm in Northern Ireland. Over a third noted that the strategy had neither a positive nor negative impact, whilst around one in seven reported that they didn't know whether the effect of NSD-2 had on alcohol and drug-related harm in Northern Ireland was positive or negative.

Figure 9: Do you think the implementation of NSD-2 has had a positive or negative effect on reducing alcohol and drug-related harm in Northern Ireland since 2011? (n=35)
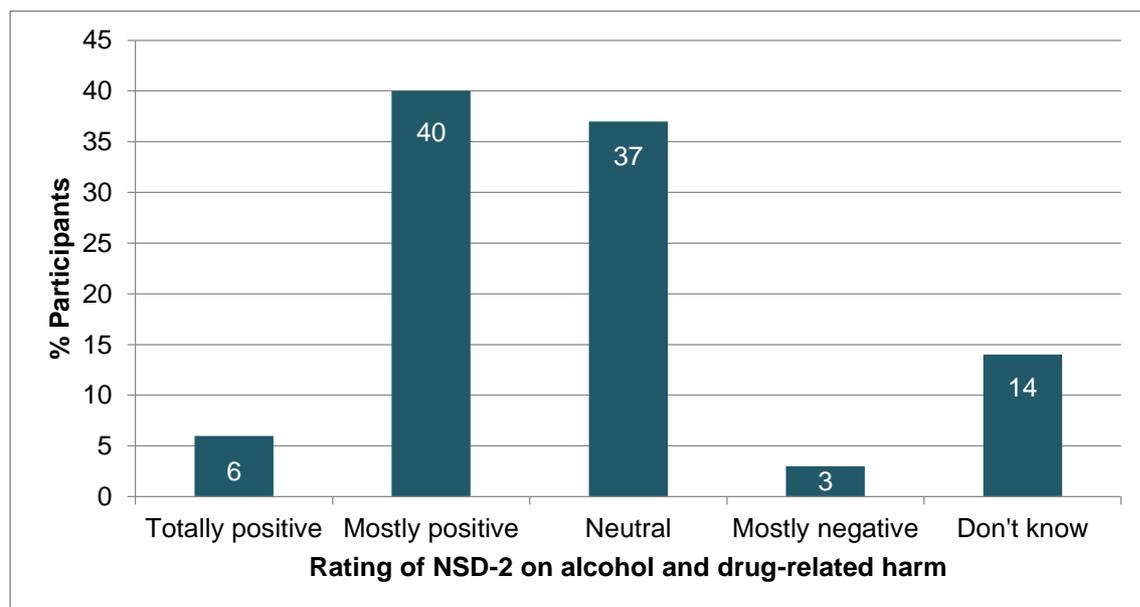
There were mixed views on the significance of the implementation of NSD-2 in driving changes in alcohol and drug-related harm. There was a consistent view that the impact was difficult, if not impossible, to capture in the context of a changing drug and alcohol landscape.

Figure 10: How significant has the implementation of NSD-2 been in driving real changes in alcohol and drug -related harm in Northern Ireland since 2011? (Alcohol n=35; Drugs n=34)
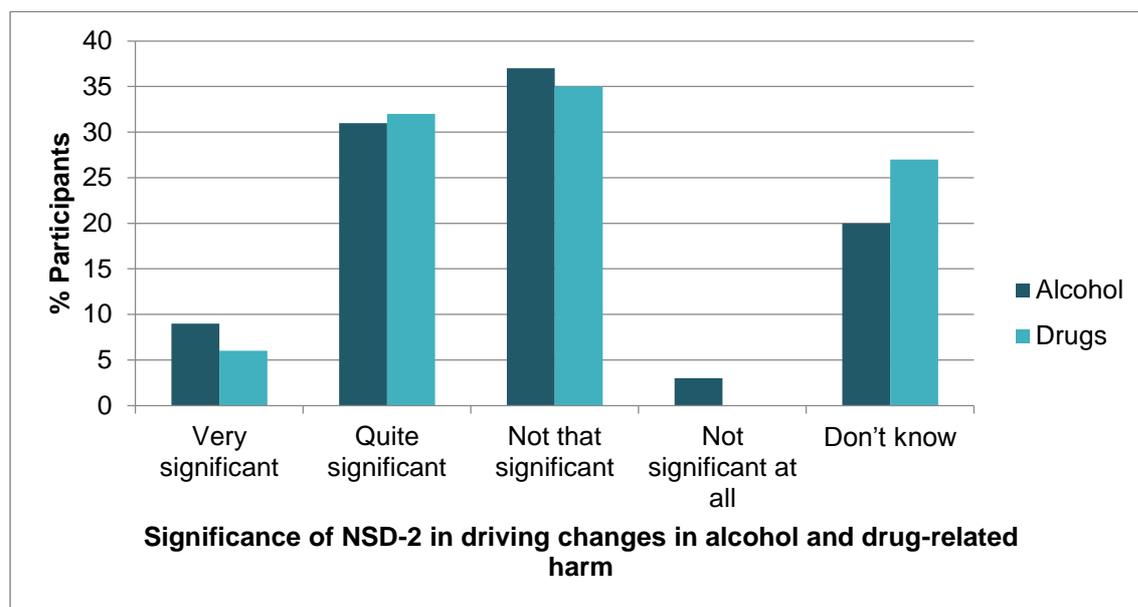
3.5 Perceptions of unforeseen factors

Three quarters of questionnaire participants could not identify any unforeseen factors, not accounted for within NSD-2, which may have helped reduce alcohol and drug-related harm. Around one in seven reported unforeseen factors which helped reduce alcohol and drug-related harm; these included the Big Lottery 'Impact of Alcohol' programme and the economic downturn (presumably in relation to reducing the affordability, and use, of drugs and alcohol).

Four in ten (41.2%) participants were able to identify unforeseen factors, not accounted for within NSD-2, which may have increased alcohol and drug-related harm. The following unforeseen factors were identified as contributors to increases in alcohol and drug-related harm:

- Polydrug use
- Prescription drug use (including impact of free prescriptions)
- Availability of new drugs and increased availability of existing drugs eg heroin
- Legal challenge from drinks industry and subsequent delay on the introduction of minimum unit pricing of alcohol
- Economic downturn resulting in more home drinking
- Absence of Northern Ireland Assembly.

3.6 Evaluation Criteria

3.6.1 Relevance

The relevance criterion examined the extent to which NSD-2 was designed in accordance with the needs, problems and issues of the alcohol and drug landscape in Northern Ireland.

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews
- Quantitative findings from the online questionnaire
- Findings from the focus groups, the interviews and the free text responses from the online questionnaire.

Questions presented under the Relevance criterion

Table 2: Questions presented under Relevance criterion in online questionnaire

Questions presented under Relevance criterion in online questionnaire
1. NSD-2 followed a six-stage approach to produce a fully integrated, inclusive and coordinated strategic direction for addressing alcohol and drug misuse in Northern Ireland over the period 2011-2016. Please rate how well you feel NSD-2 was: - Based on best available data and evidence? - Informed by local needs? - Based on meaningful consultations? - Relevant to the alcohol and drug threats in Northern Ireland? - Designed to interface with local delivery structures? - Responsive to unforeseen circumstances?
2. Please share your thoughts on the approach taken to deciding the content of NSD-2.
3. Do you think that NSD-2 achieved a reasonable balance in terms of the attention paid to addressing alcohol and the attention paid to addressing other drugs? Please share your thoughts on this balance.
4. How important were each of these features in NSD-2 in supporting implementation? - A clear, vision, mission and goal - Lead institutions and partners were on board - Objectives were SMART and feasible

- Clear logic between activities and outcomes
- Lines of accountability and reporting were clear from the outset
- Resource requirements were correctly estimated and secured at the outset
- Political support was achieved and consistent

Please share your thoughts on the features of NSD-2 listed above.

5. Five pillars form the conceptual framework and practical base for NSD-2. How well did these pillars as a framework for implementation work?
    - Prevention and early intervention
    - Harm reduction
    - Treatment and support
    - Law and criminal justice
    - Monitoring, evaluation and research

Table 3: Questions presented under Relevance criterion in focus groups and interviews

Questions presented under Relevance criterion in focus groups and interviews
1. The strategic framework was based on five pillars: • Prevention and early intervention • Harm reduction • Treatment and support • Law and criminal justice • Monitoring, evaluation and research Do you think these pillars were an appropriate structure for the framework?
2. How well did the strategic framework allow for implementation relevant to particular regional/local needs?
3. How relevant do you think NSD-2 was to alcohol and drugs, do you think it was a good fit?
4. There have been a number of changes in legislation during the period of NSD-2. Can you discuss some of these changes and what they mean in terms of addressing alcohol and drug-related harm in Northern Ireland? (Law and Criminal Justice Focus Group only)
5. How has this impacted on the implementation of NSD-2 and what have been implications for individuals, families and communities? (Law and Criminal Justice Focus Group only)
6. What impact has the external environment had on the implementation of NSD-2? How have your organisations responded to the challenges which have arisen? (Law and Criminal Justice Focus Group only)

Quantitative findings from the online questionnaire

Questionnaire participants and interview/ focus group participants recognised significant strengths in the design of NSD-2. Most recognised that NSD-2 was well structured, informed by evidence as well as by consultation with stakeholders and implementation bodies. Participants considered that NSD-2 was designed in the context of the alcohol and drug threats in Northern Ireland at the time. However, in the questionnaire sample, around one in five identified that there was room for improvement in respect of use of evidence, knowledge of local needs and consultation.

The questionnaire participants identified that the responsiveness of NSD-2 to unforeseen circumstances was a key concern (Figure 11), reflecting views gathered in the interviews and focus groups. Qualitative exploration of responses on the relevance criteria returned 'reactionary responses' as a prominent theme. Overall, participants observed that the strategy had been slow to respond to the needs of the changing alcohol and drug landscape. This perceived lack of responsiveness was considered at both strategic and operational level (including allocation of resources) and amplified by a lack of political leadership and stability.

Figure 11: NSD-2 followed a six-stage approach to produce a fully integrated, inclusive and coordinated strategic direction for addressing alcohol and drug misuse in Northern Ireland. Please rate how well you feel NSD-2 followed this six stage approach.
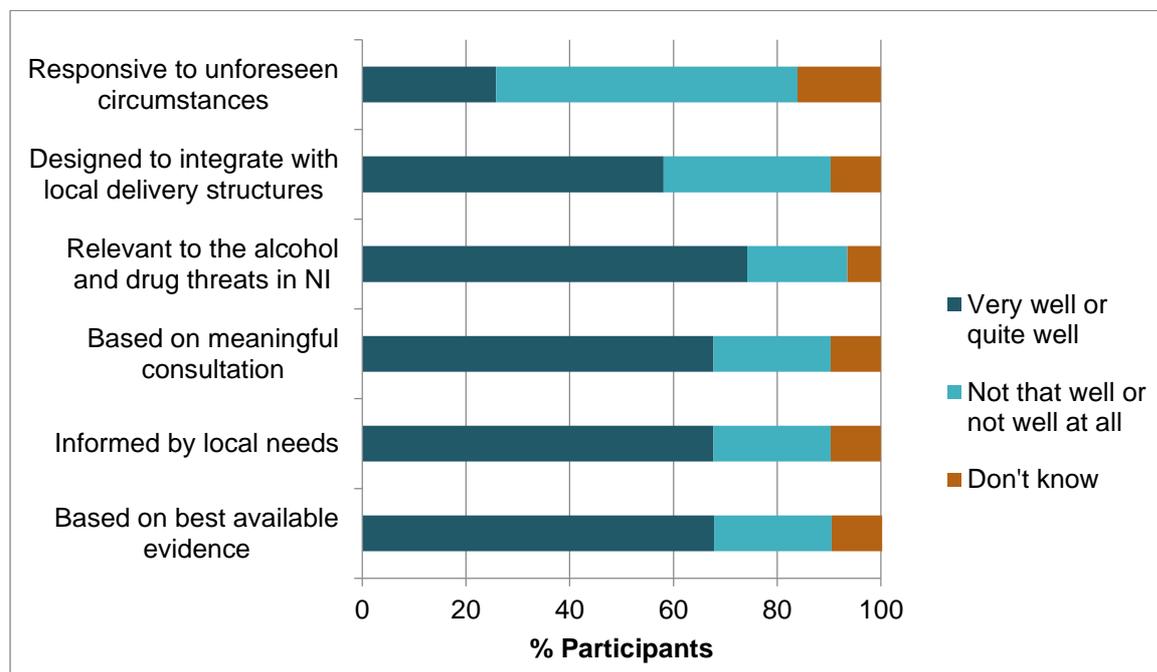
Participants reported that the strategy had not responded, in a timely and appropriate manner, to issues such as:

- the scale of growth of alcohol and drug misuse

- the psychoactive substances market ("legal highs")

- prescription drug misuse

- dealing for profit operations

- the rise of injectors

- substitute prescribing waiting lists.

It was also noted there was a rigidity which prevented resources from transferring from areas of low demand to areas of high demand as and when demand presented. A lack of live information and research on need was highlighted as contributing to the limited responsiveness of the strategy. Participants observed that the media had an influence on how NSD-2 reacted to the changing drug and alcohol environment.

Another issue emerging under the relevance criterion related to how well NSD-2 was designed to integrate with local delivery structures. Around one in four questionnaire participants considered this to be somewhat underdeveloped in the design of NSD-2.

Seven different features of NSD-2 were examined in the online questionnaire to determine how important they were in supporting implementation (Table 4). The majority of participants rated the features as either quite important or very important. In particular the online questionnaire participants reported that 'a clear vision, mission and goal' and the involvement of lead institutions and partners were amongst the most important features supporting the implementation of NSD-2.

Table 4: How important were each of these features of NSD-2 in supporting implementation?

Feature	% of online questionnaire participants rating the feature as very important and quite important	%
Lead institutions and partners were on board		90
A clear vision, mission and goal		87
Political support was achieved and consistent		83
Clear logic between activities and outcomes		83
Objectives were SMART and feasible		83

Lines of accountability and reporting were clear from the outset						70
Resource requirements were correctly estimated and secured at the outset						67
	20%	40%	60%	80%	100%	

A number of pillars formed the conceptual framework and practical base for NSD-2. 'Harm reduction' received the highest rating from participants, signalling that harm reduction was recognised as an important part of the design of the strategy. Over half of participants rated the other four pillars as working well within the conceptual framework.

Figure 12: Participants' views of how well the five pillars worked as a conceptual framework, practical base and framework for implementation of NSD-2 (n=30)
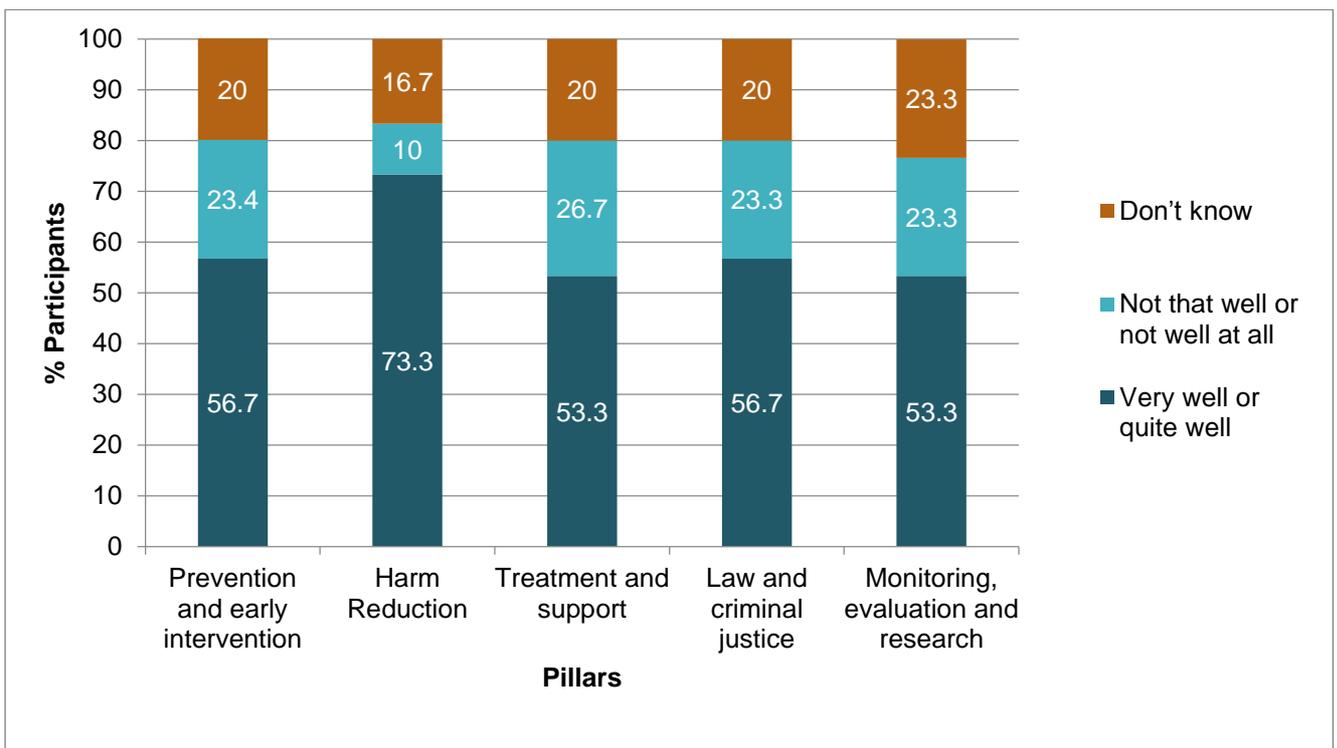
Over half of the questionnaire participants indicated that a reasonable balance of attention had been paid to drugs and alcohol within the strategy (Figure 13).

Figure 13: The extent to which participants indicated that NSD-2 achieved a reasonable balance in terms of the attention paid to addressing alcohol and drugs (n=31)
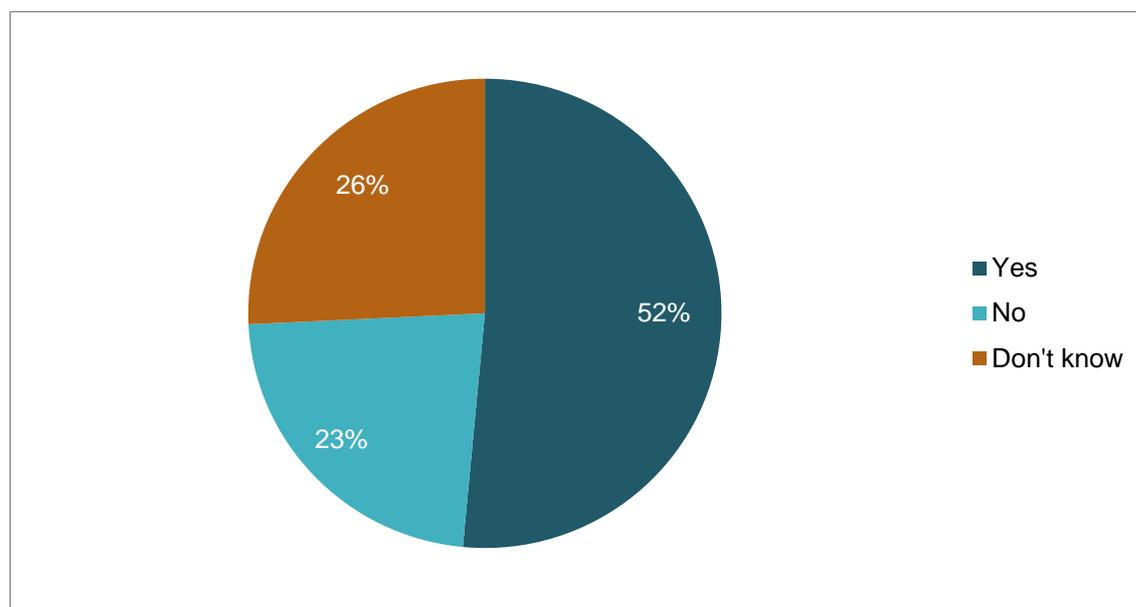
Findings from the focus groups, the interviews and free text responses from the online questionnaire

Balance of Drugs and Alcohol

The majority of participants were positive about how the strategy was integrated with both alcohol and drugs.

> *"I really do value the fact that Northern Ireland has always had an integrated alcohol and drug strategy."*

Some participants emphasised that alcohol had a greater negative impact on society; however they did not indicate that they thought alcohol should be separated from drugs in a strategy of its own.

Framework Pillars

The majority of the participants considered the pillars to be appropriate and fit for purpose to guide implementation.

> *"I think they did work very well and I think they were very appropriate for the time as well."*

The consultation process for the development of the pillars was praised for considering the views of all stakeholders. Framework pillars were thought to be relevant in reflecting the priorities at the time of development and beneficial for defining the key strands that run through the drug and alcohol landscape. However, participants did highlight how prevention was not always evident in how the strategy was delivered with some suggesting the prevention should be separate from early

intervention. Also, it was noted that while there was overlap between the pillars, at times this did not always result in movement between pillars in service provision at ground level. There were also concerns that the monitoring, evaluation and research pillar was not integrated into the strategy at the level of service commissioning and review, with some stating the services have been commissioned which are not based on analysis of actual need. Participants were also unanimous in their opinion that recovery should be included as a pillar in any future framework.

Research and Evaluation

Participants frequently stressed how research was not always linked to some of the key actions implemented as part of NSD-2. It was again emphasised that services were in place which were not based on analysis of need.

> *"One of the pillars …is about monitoring and evaluation and research. And it's been paid lip service because we have put services in place which are not based on an analysis of what the actual need is."*

It was consistently reiterated that there was a need for more monitoring and evaluation of services in order to determine which services were producing positive results. It was also noted that when some evaluation has been carried out on service impact in the past, information has not disseminated out to local initiatives.

There was a call from participants for more investment in research. It was stated that research needed to be of more recent data with information gathered from those at a local level on perceived need and patterns/trends.

Regional and Local Needs

'Regional and Local Needs' was a theme comprising mixed views in the discussion around relevance. Some participants praised NSD-2 for developing a more regionalised approach in addressing need leading to better service provision.

> *"I think actually a very strong outcome from the regionalisation has been that, you know, it has reduced the postcode lottery to a certain extent in that there are a suite of dedicated drug and alcohol commission services and those same services exist regardless of what Trust you live in."*

However, some participants stated that service provision had not been regionalised enough, due to what participants perceived as a fragmented approach in terms of the multiplicity of initiatives and structures which have been involved in delivering services.

Conversely, there was also a selection of participants who stated that the strategy became more distant from local delivery mechanisms and that the strong focus on regional consistency made it more difficult to address local need. It was also noted in this discussion that the functional role of the DACTs have become somewhat less relevant, with some DACTs finding it difficult to operate in a more regionalised environment, partly due to the fact that they are voluntary, with no statutory function.

Service Provision

A number of issues were highlighted by participants under the service provision theme. There was a perception of an evolving mismatch between the services available and the local need as driven by a rapidly changing pattern of drug and alcohol use.

Participants expressed frustration that they were unable to provide enough attention to prevention within service provision due to prioritisation of staff time and increasing demands. Participants referred to some developments in the delivery of brief intervention but emphasised that service users need more than just brief intervention in the context of prevention. It was also stated that although prevention was a pillar of NSD-2, there was a real challenge in accessing resources to deliver prevention programmes alongside service provision.

It was noted that at times care pathways could be inefficient, overly complicated, and inflexible. The move from Step 2 to Step 3 was also said to have disadvantaged service users by increasing demand on Step 3 services which were already at capacity.

Finally, there were also calls for an increase in services which support the recovery of service users.

3.6.2 Fidelity

The fidelity criterion considered the extent to which NSD-2 was implemented as intended in the strategy. This included an assessment of several dimensions of fidelity - how well NSD-2 adhered to its own values and principles and to what extent the implementation stayed on course and went according to plan.

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews
- Quantitative findings form the online questionnaire
- Findings from the focus groups, the interviews and the free text responses from the online questionnaire
- Tables summarising findings in relation to fidelity.

Questions presented under the Fidelity criterion

Table 5: Questions presented under Fidelity criterion in online questionnaire

Questions presented under Fidelity criterion in online questionnaire
1. The values and principles set out in NSD-2 are the basic tenets on which the strategy and its implementation are built. To what extent do you feel NSD-2 stuck to the principles listed below when it came to implementation? • Positive, person-centred, non-judgemental and empowering • Balanced approach • Shared responsibility • Equity and inclusion • Partnership and working together • Evaluation, evidence and good practice based • Consultation, engagement and transparency • Addressing local need • Community based • Long-term focus • Value for money and invest to save
2. NSD-2 set out seven priorities in terms of implementation. To what extent do you feel these issues remained priorities throughout the implementation of NSD-2?
3. What were the most significant areas in which the implementation went according to plan?
4. What were the most significant areas in which the implementation did not go according to plan?

Table 6: Questions presented under Fidelity criterion in focus groups and interviews

Questions presented under Fidelity criterion in focus groups and interviews
1. Do you think implementation of NSD-2 occurred as intended? For example, were there any positive or negative unintended outcomes?

Quantitative findings form the online questionnaire

NSD-2 outlined 10 principles and values upon which the strategy and its implementation were built. Questionnaire participants were invited to comment

specifically on the extent to which NSD-2 adhered to its values and principles. The findings are illustrated across Figures 14 and 15.

Fidelity to values and principles

Results from the questionnaire revealed that participants thought that NSD-2 adhered most closely to the values and principles of 'Equity and inclusion', 'Balanced approach' and 'Positive, person-centred, non-judgmental and empowering'. The two areas where questionnaire participants reported the strategy had not adhered as closely to its own values and principles were 'Addressing local need' and 'Long-term focus'. Participants perceived the attention given to addressing local need was lacking at times due to communication and resources implications. The long-term focus of the strategy appeared to be inhibited by uncertainty about funding and the need for investment beyond ten years.

Figure 14: The extent to which participants indicated that NSD-2 adhered to stated principles when it came to implementation of the strategy (n=30)
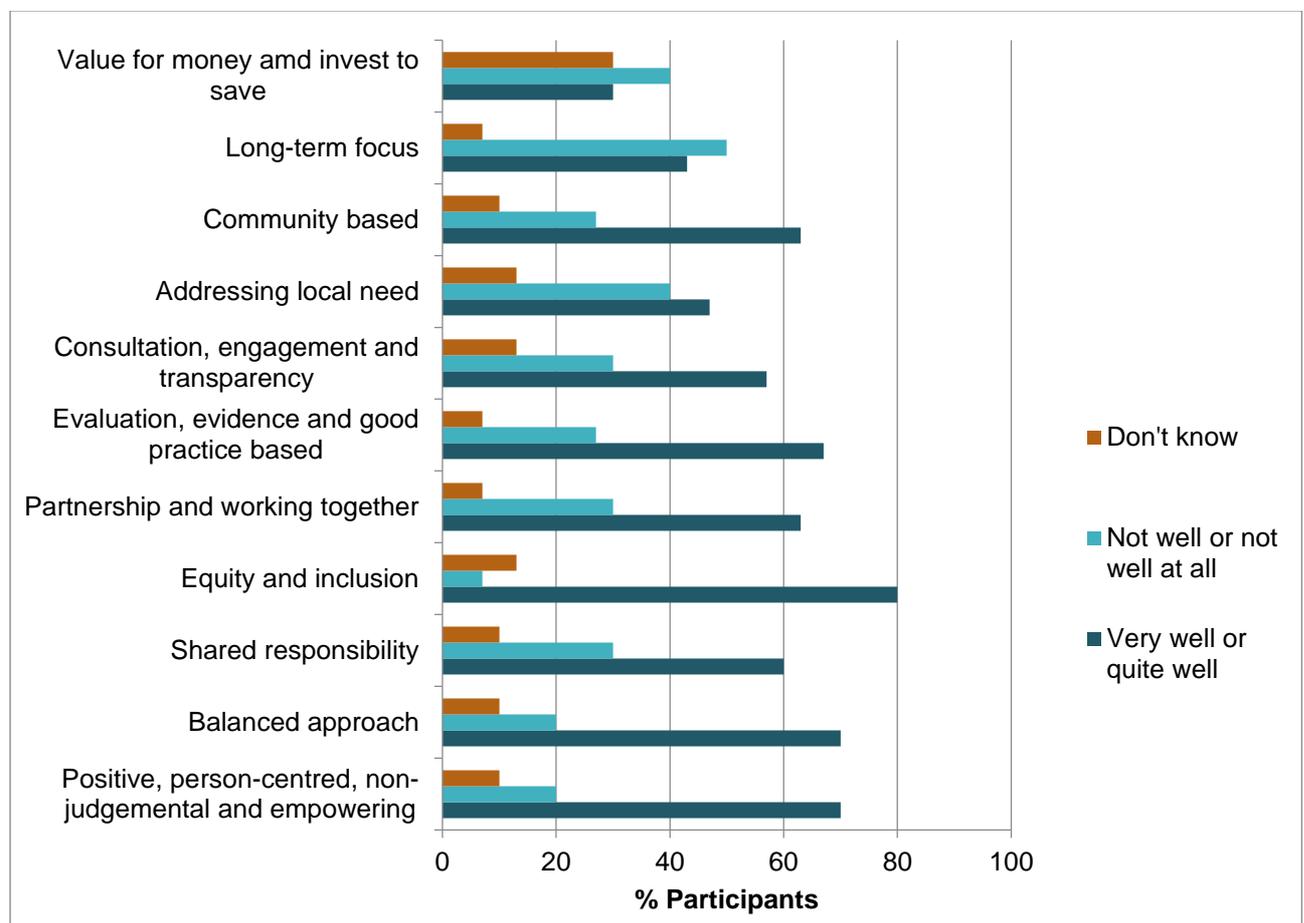
Fidelity to strategy priorities

In addition to the values and principles, NSD-2 identified priority areas for the lifetime of the strategy. Figure 15 shows the responses from the online questionnaire in terms of how well participants rated the initial priorities set out in NSD-2 remained priorities throughout the lifetime of the strategy. 'Promoting good practice in respect

of alcohol and drug-related education and prevention'; 'Targeting those at risk and/or vulnerable' and 'Workforce development' were identified as having remained priorities over the lifetime of the strategy. For participants, one issue which remained less of a priority over the duration of the strategy was 'Addressing community issues'.

Figure 15: The extent to which participants indicated that the priorities set out in NSD-2 remained priorities throughout the implementation of NSD-2 (n=29-30)
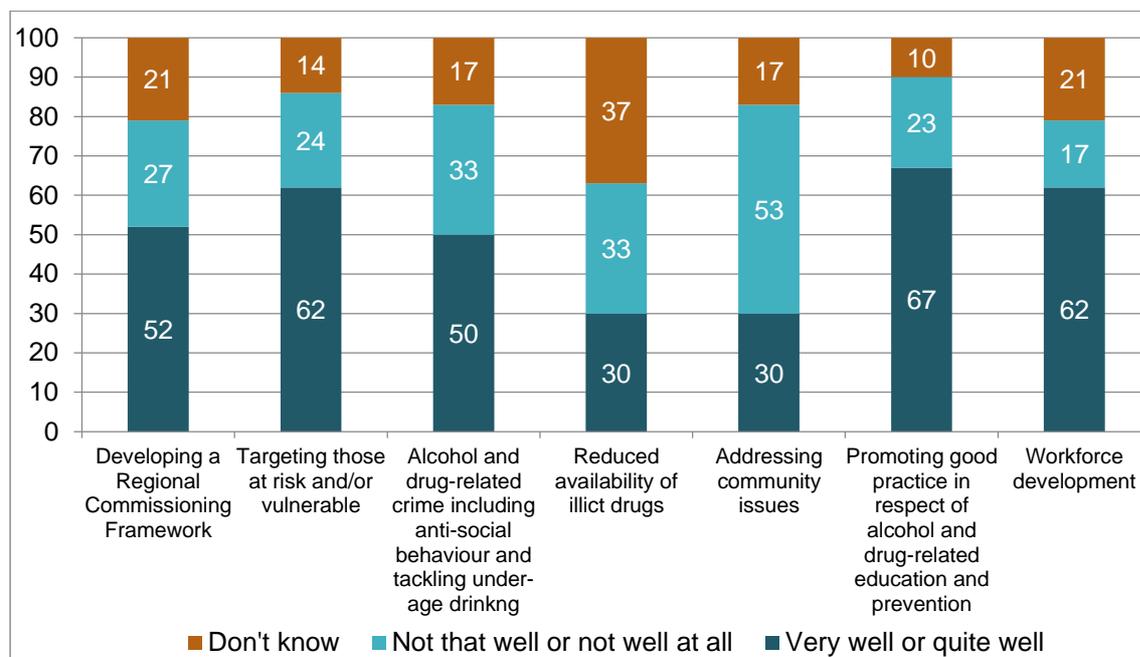
Findings from the focus groups, the interviews and free text responses from the online questionnaire

Regional Commissioning Framework

The development of the Regional Commissioning Framework featured strongly in the overall discussion about fidelity in NSD-2. The Commissioning Framework was considered a significant achievement of NSD-2 and a real strength of the strategy.

> *"The Commissioning Framework was the high point [of NSD-2]."*

The Regional Commissioning Framework was seen as something which went according to plan and delivered consistent alcohol and drug services across Northern Ireland. There was a high level of support for the Regional Commissioning Framework in that it was considered to have achieved greater consistency of service delivery across all five HSCTs. Governance, accountability and regulation of service delivery were deemed to be much stronger as a result of the Regional Commissioning Framework.

Participants welcomed the positive relationships that had been developed between community and voluntary based and statutory services as a result of the Regional Commissioning Framework. The creation of the 'Step' referral pathway was

positively received by service providers, noting that strong partnerships had been built between the different stepped services.

Workforce development was considered a strength of NSD-2 as it brought consistency in the delivery of services through the Regional Commissioning Framework. It was also noted that information sharing protocols have helped create a more seamless service for clients as they move through the referral and care pathways.

Whilst the Regional Commissioning Framework was considered to have made an important contribution to delivery of services, some participants expressed concerns. Some participants considered that the competitive nature of the tendering process was damaging to collaborative partnerships. Others considered that the tendering process led to the exclusion of smaller organisations which are less well equipped or with limited capacity to engage in the tendering process.

"It's weighted towards those organisations that have that capacity within."

"[The Regional Commissioning Framework] creates as much division as it creates equity and fairness."

There was some confusion around the commissioning process itself with participants commenting on a lack of clarity regarding the role the Health and Social Care Board and HSCTs; a lack of clarity about lobbying for services; and challenges with integration and co-ordination across departments, structures and commissioners.

The Public Health Agency (PHA) was commended on its role in commissioning and participants recognised that the work had been delivered with limited resources. Some participants indicated that there needed to be some scope within the Regional Commissioning Framework to respond to emerging and changing trends. Concerns were raised about the timeliness of renewing contracts; it was reported that renewal of contracts often happens too late, bringing with it much uncertainty about the future of the service and ultimately job security for staff. Participants highlighted the importance of addressing this issue in the context of retaining good staff in order to achieve the strategy's objectives.

Governance

Participants considered that NSD-2 had a clear vision, mission and goal from the outset, which helped shape implementation. The strategy was reported to be successful in that it identified a wide range of issues and key priorities to be addressed. NSD-2 was based on a set of values and principles which participants viewed have been adhered to varying degrees.

"Wouldn't argue about the principles but think that they have been adhered to differing degrees."

"Priorities were all achieved to some extent whether the end product meets expectations/needs is another consideration."

Participants had mixed views on the extent to which the implementation of NSD-2 was true to the original strategy. In the main, participants thought that NSD-2 stayed on course, although it was considered by some that the strategy was not fully implemented as intended. Nonetheless, it was reported that "impactful activities" resulted from the strategy in a "timely manner". Participants endorsed the need for the use of more evidence-based approaches, particularly in relation to prevention, to bring about lasting change.

Participants reported improved interagency coordination and strategic alignment; the joint approach to addressing alcohol and drugs was welcomed as was the involvement of partners at all levels. Buy-in from central and local government was acknowledged and participants welcomed the opportunities to feed into the strategy at local and regional level.

Consistent membership of the NSD-2 Steering Group was considered an achievement in that it helped retain knowledge. The contribution of new members was also valued with particular reference made to representation from the community and voluntary sector.

Whilst some participants considered NSD-2 to be logical in its approach with appropriate short and long-term outcomes, others indicated the strategy had become 'stagnant' over time and a review or 'refresh' was required earlier in its lifetime.

One of the issues highlighted in relation to NSD-2 was the challenge involved in balancing the attention given to strategic and operational issues of strategy implementation and development. Participants reported that the NSD-2 Steering Group was at times 'too operational' in its approach with differing interpretations among the group as to the purpose and Terms of Reference of the NSD-2 Steering Group. Participants perceived that the NSD-2 Steering Group was at times diverted to discussion and ownership of operational issues rather than maintaining the focus on high level strategic priorities and forward looking. Some of the factors driving this may have included the demand on service delivery and changes in the implementation and organisation of health and social care structures in Northern Ireland.

Some participants considered that the advisory committees did not deliver as intended and failed to support the overall NSD-2 Steering Group and Department leads as hoped.

Accountability

In terms of overall accountability of NSD-2, participants thought the governance structures (ie NSD Steering Group and advisory committees) didn't operate as were originally intended. Some participants were of the view that there could have been more scrutiny of the delivery of actions set out in NSD-2. Feedback mechanisms were perceived as being somewhat procedural rather than analytical, or truly refelctive.

Participants also made particular reference to the role and function of the advisory committees. Some participants considered that there were too many advisory groups

with their role and function unclear. There was a perceived lack of formal reporting mechanism for the advisory committees to the NSD-2 Steering Group. Some of these groups met infrequently and eventually ceased to meet over the lifetime of the strategy.

> *"For me where it didn't go to plan I think was the supporting structures because my understanding, and certainly at the terms of reference, those existing structures were never really implemented…..So, for me, that's the bit that went off course."*

Some participants suggested that connections between the various committees were not fully functional. Whilst not all advisory worked as well as intended, there was more positive feedback about the Bamford Substance Misuse Group.

Regional and local linkages

The establishment of the DACTs and Connection Service was generally identified as high fidelity elements of the implementation. However, participants considered that while the DACTs were established and functioned as intended in NSD-2, the effectiveness of the DACTs was somewhat under-realised. Participants considered that the DACTs could contribute more to the achievement of strategic goals with greater clarity on roles and purpose in the context of national, regional and local priorities. In addition, while individual DACTs were functioning well, the overall effectiveness was hampered by something of a disconnect between the five DACTs. The contribution of the community and voluntary sector and statutory agencies was considered key to the successful evolution of the DACTs in NSD-2.

Coherence and co-ordination between policy and regional and local level implementation featured heavily throughout the interview and focus group discussions. Participants recognised that regional commissioning was significant in this regard, with both positive and negative outcomes perceived (see previous theme).

> *"If the strategy's saying the right things then what needs to happen on the ground – there needs to be a stronger connection between policy and operations."*

Health and social care change

The health and social care system within Northern Ireland has undergone significant restructuring in recent years. This change was considered a challenge within the progress of NSD-2. Clarity in terms of lines of responsibility and accountability for delivering elements of NSD-2 was challenged by organisational change within health and social care.

> *"We've had an NSD which set out what it thought was the best approach at the time but what's actually happened is that, you know, as the authority for, the responsibility for delivering on some of those things have been hampered by organisational change within those organisations."*

Resources

Throughout the interviews and focus groups, resourcing for NSD-2 was raised consistently as a challenge when it came to implementation of the strategy. When asked about the elements of NSD-2 which did not go according to plan, participants noted that changes to available resources placed additional pressure on those tasked with implementing the strategy.

It was also reported that there are differences in the way in which HSCTs undertook actions pertaining to NSD-2 for the delivery of the mainstream treatment services. These differences were perceived to contribute to longer waiting lists for addiction services and substitute prescribing in some HSCTs.

Political stability and leadership

Participants voiced concern surrounding the absence of the Northern Ireland Assembly and the impact this was having on bringing forward legislation and implementing policy in Northern Ireland. There were concerns that the lack of political structures was hindering decision making in terms of budgeting. Participants expressed frustration about the effect of the political impasse.

"Without the ability to make decisions people are going to die from alcohol and drug-related issues."

"The inertia that exists within the broader political system, I think was an impeding factor as well."

"The most significant factor, hindering, I think, is the lack of Assembly….it's almost painful to watch the great work that the people in all the departments are trying to do to make a difference to people's lives and their hands are slightly tied by the lack of a health minister…. we need to get a government in place to allow the work to continue. To save lives, very, very simply."

There was a real sense of frustration among participants about the pace at which legislation has progressed, particularly minimum unit pricing of alcohol. Participants indicated that opportunities had been lost at the political level to drive forward the alcohol and drugs agenda.

"The changes to licensing, you know, how long did we talk about that? And you know, and minimum unit pricing as well. Glacially slow. And I found it frustrating when, you know, Scotland seemed so much more nimble on minimum unit pricing."

In respect of the Licensing and Registration of Clubs (Amendment) Bill which was brought before the Assembly in 2016, the passage of this legislation fell with the dissolution of the Northern Ireland Assembly in January 2017. Participants stressed the effort and commitment to bringing forward the legislation in terms of consultation and evidence sessions, but noted that 'politics got in the way'. Furthermore, it was also noted that this Bill has impacted on the progress towards placing the Responsible Retailing Code Northern Ireland on a statutory footing.

Participants were keen to highlight their concerns regarding the impact of the UK leaving the EU. In particular, issues relating to healthcare, policing and the drugs supply market were noted in the context of Brexit.

Hidden harm

One of the most pertinent issues highlighted under fidelity was Hidden Harm. Under the 'relevance' criterion, participants were very supportive of the inclusion of a focus on Hidden Harm within the NSD-2 policy but considered that this had become much less of a priority over time. The development of a Hidden Harm Action Plan and the establishment of a Regional Hidden Harm Implementation Forum were acknowledged as being progressive at the time, but it was repeatedly noted that Hidden harm "has fallen off the agenda". It was stated that hidden harm has received less attention within NSD-2. However, the need to address this issue with support for children and families living with substance misuse still exists. It was acknowledged, that the demise of hidden harm as a priority was unintended and didn't reflect any deliberate approach to reduce its significance as a priority issue.

> *"The whole policy weight behind supporting Hidden Harm which was a priority within the NSD doesn't even exist. There's not even an infrastructure for it. The regional group doesn't exist anymore. You know, you're trying to get things up, embed things within existing services and it's like that's all right but, you know, this isn't a priority for us."*

> *"And the hidden harm I think is one of the biggest lost opportunities because it really has lost momentum."*

Changing role and challenges for the community and voluntary sector

In terms of the implementation of NSD-2, the contribution of the community and voluntary sector was considered vital in the delivery of services. Outside of statutory and mental health services, it was reported that, community and voluntary sector organisations are delivering a considerable part of services, from prevention through to treatment services. A number of challenges were noted in relation to the delivery of services for the community and voluntary sector. These included:

- Delivery of services across a wider geographic area
- Taking responsibility for the most 'chaotic' drug users, ie those with complex and high need substances
- Existing health and social care structures and referral pathways within statutory services did not meet clients' needs.

Responsiveness

There were mixed perspectives on the level of responsiveness within NSD-2 with some reporting the strategy offered enough flexibility to adapt to changing circumstances, whilst others highlighted the need for greater flexibility.

> *"Where I think that there's difficulty with the new strategic direction, I think it is responding to things that haven't been anticipated necessarily at the start."*

> *"To me there's enough flexibility to come in and adapt."*

In relation to the Regional Commissioning Framework, participants thought it had been more difficult to respond to local issues; there was an expectation that everything will operate in the same way everywhere.

Participants acknowledged that there was some degree of responsivity within NSD-2, but there is a need for greater agility within any future strategy. There were challenges in responding to issues not anticipated at the beginning of the strategy. Participants indicated a need to respond to specific alcohol or drug-related issues or incidents more rapidly than had been the case in the past. To support this response, participants reported that research and new evidence are needed to inform the development of programmes to address polydrug use, combined mental, physical illness and substance misuse and ageing with alcohol and drug misuse issues.

> *"I think there have been some issues in addressing unexpected need. An ability to respond to these rapidly with evidence is helpful too; researchers need to play their part also."*

Many participants considered that most efforts went on 'fire-fighting' and less on prevention. Increasing service demand was perceived to upset the balance between being reactive and preventive. It was acknowledged that drug-related deaths can be a highly emotive topic. It was also reported that harm reduction services, such as take home Naloxone, and low threshold services have been effective but that the harm reduction components need to move from being simply reactionary to being sustained and strategic.

> *"Sending out harm reduction message has been positive, but need to be more proactive and not just after an incident – needs to be ongoing"*

Some participants noted that criminals are actively developing their own strategies to counteract any government approach to tackle alcohol and drug-related harm. Therefore, in this context there is a need to be able to respond rapidly to the changing external environment.

Fidelity aspects of NSD-2

Table 7: Aspects of NSD-2 viewed as high fidelity, low fidelity and those for which there were mixed views

Generally viewed as higher fidelity items	Generally viewed as lower fidelity items	Mixed views on fidelity
Regional Commissioning Framework	Governance structures	Accountability
Regional and local linkages	Addressing local need	Hidden harm
DACTs and Connections Service	Long-term focus	Responsiveness
Step Referral Pathway		Achievement of priorities

Table 8: Factors which were considered to have supported or hindered the fidelity of NSD-2

Generally viewed as supporting fidelity	Generally viewed hindering fidelity
Collaboration and partnership working	Reorganisation within health and social care structures
Contribution from community and voluntary sector	Competitive nature of tendering process
Workforce development	Political stability and leadership
Communication and information sharing	Lack of clarity surrounding the role of commissioning with Health and Social Care Board and Trusts

3.6.3 Effectiveness

The effectiveness criterion considered the extent to which NSD-2 was successful in producing desired results in relation to governance structures and outcomes.

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews
- Quantitative findings form the online questionnaire
- Findings from the focus groups, the interviews and the free text responses from the online questionnaire

- Tables summarising the findings under effectiveness.

Questions presented under the effectiveness criterion

Table 9: Questions presented under Effectiveness criterion in online questionnaire

Questions presented under Effectiveness criterion in online questionnaire
1. To what extent did the governance structures operate effectively in the implementation of NSD-2? Please share your thoughts on the effectiveness on governance structures.
2. Has the implementation of NSD-2 produced any positive unintended outcomes? If yes, what are those positive unintended outcomes? Has the implementation of NSD-2 produced any negative unintended outcomes? If yes, what are those negative unintended outcomes?
3. What were the most significant factors helping initiatives implemented as part of NSD-2 meet their objectives?
4. What were the most significant factors impeding initiatives implemented as part of NSD-2 from reaching their objectives?

Table 10: Questions presented under Effectiveness criterion in focus groups and interviews

Questions presented under Effectiveness criterion in focus groups and interviews
1. The organisations you represent have in the past or are currently delivering programmes and services as part of the implementation of NSD-2. What do you think were the most important factors which helped these programmes/services meet their objectives? What do you think were the most important factors which limited these programmes/ services in meeting their objectives?

Quantitative findings form the online questionnaire

Effectiveness of Governance Structures

Participants indicated in the questionnaire that governance structures operated most effectively at a local level. There was mixed views on the effectiveness of the governance structures at strategic and operational levels (Figure 16).

Figure 16: The extent to which participants indicated that the governance structures operated effectively in the implementation of NSD-2 (n=29)
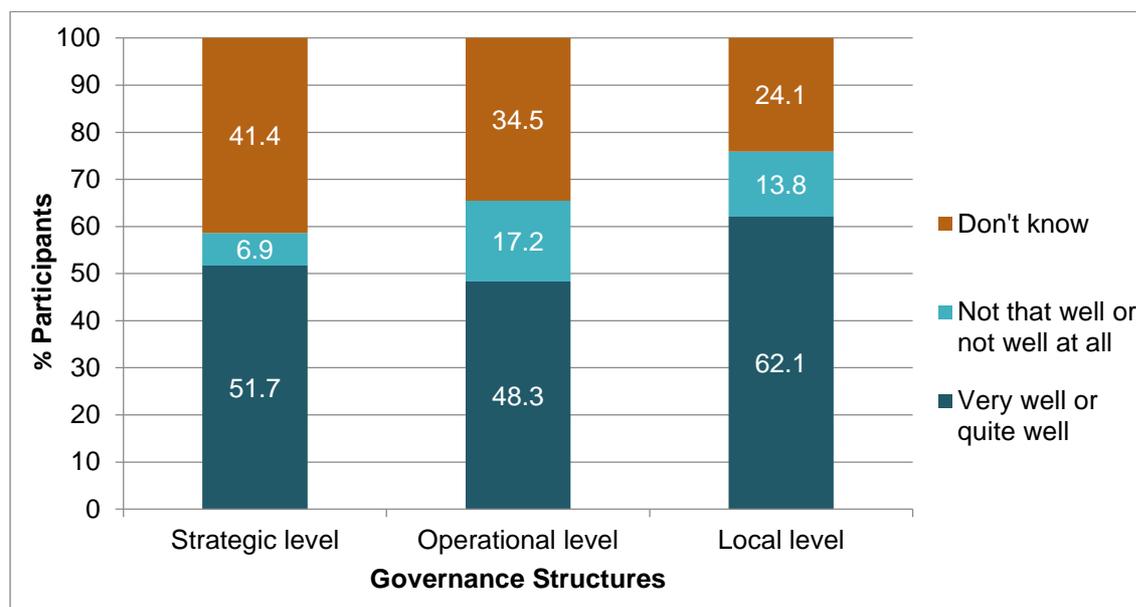
Legend:
- Don't know
- Not that well or not well at all
- Very well or quite well

Chart data:
- Strategic level: Very well or quite well 51.7, Not that well or not well at all 6.9, Don't know 41.4
- Operational level: Very well or quite well 48.3, Not that well or not well at all 17.2, Don't know 34.5
- Local level: Very well or quite well 62.1, Not that well or not well at all 13.8, Don't know 24.1

X-axis: Governance Structures
Y-axis: % Participants

Findings from the focus groups, the interviews and free text responses from the online questionnaire

Participants voiced the need for an increased strategic approach where decisions would be made around where the most demand is located. There were also concerns from participants that some initiatives are piloted with an under-developed evidence base.

> *"There's still work on focusing the work within a realistic sort of work plan and having a strong process to escalate issues or problems if progress is not being made, and being monitored for effectiveness, I think."*

It was observed by some participants that initiatives had been more focused at a local level rather than at strategic level. This was perceived by participants to be partially due to a lack of leadership. In addition, participants pointed to a separation between NSD-2 in terms of policy and implementation.

There was approval for the representations from the DACTs, the HSCTs, and the key voluntary community services on the NSD Steering Group. The DACTs were continuously referred to by participants in mostly positive tones, being seen as important to stakeholder interaction and for bringing attention to local need.

> *"DACT meetings provided good networking and achieved positives outcomes at local level."*

The connection service was also seen by participants as a contributing factor that helped services link together. Separately, participants again highlighted their dissatisfaction with the advisory groups which they perceived as not delivering results.

Unintended Outcomes

In addition, participants were asked about the unintended outcomes arising from actions taken in the implementation of NSD-2. 11% of participants stated that NSD-2 had produced positive unintended outcomes, while 81% responded "don't know" to this question. 32% of participants stated that NSD-2 had produced negative unintended outcomes, while 57% responded "don't know" to this question. The negative unintended outcomes cited included competitive tendering between organisations within the commissioning process.

Helping Factors

Helping factors which aided the progress of NSD-2 were discussed within the effectiveness criterion. The most prominent helping factor to come from this discussion centred on the dedication of those working within NSD-2.

> *"[The most important factors in supporting the NSD have been]…organisations and individuals within organisations who have been enthusiastic and keen to embrace and drive forward and take ownership of the NSD."*

Those working within NSD-2 were praised by participants for their knowledge, their enthusiasm and for taking a proactive role in tackling drug and alcohol misuse. Collaboration and partnership working were also linked to this factor, with participants mentioning the DACTs as beneficial for facilitating joined up working, information sharing and furthering opportunities for input into NSD-2.

While aspects of the Regional Commissioning Framework were seen as an impeding factor by some participants, there was positive recognition of the benefits it had brought to NSD-2. Participants acknowledged that the commissioning framework had helped establish regional consistency, as well as defining and strengthening roles and responsibilities of the different service providers at different steps.

Factors impeding

Factors impeding was a major theme within the effectiveness discussion and centred on the factors both within NSD-2 and outside of NSD-2 which participants believed had impeded progress.

The most prominent impeding factor to come from this discussion was the current political landscape in Northern Ireland. As mentioned previously, according to participants, the current political landscape was a barrier to legislative changes.

Funding also featured strongly as a factor within the discussion on effectiveness with participants emphasising how funding wasn't always available to support or continue successful initiatives. Subsequently, this was thought to restrict innovation at local level. In addition, it was seen as a disadvantage that, while previously the DACTs would have had their own resources to fund local projects, they did not have the capacity to do so now.

Participants raised the issue that the method in which funds are allocated, and in what cycles, needed to be addressed to ensure services were sufficiently prepared for their working year.

> *"For me it's just not a question of having enough money, it's about have we all sat down and thought well enough about how we spend our money."*

Participants noted that Step 3 services required additional investment and an increase in workforce capacity was deemed necessary.

The sheer scale of work involved in addressing drug and alcohol misuse was also viewed as an impeding factor by participants. It was suggested that due to the changeable nature of this issue that a broader ten year strategy with actions plans that could be refreshed every 2-3 years would be more appropriate in encouraging progress.

Finally, echoing thoughts expressed previously, it was stressed that an absence of consistency between policy and implementation was an impeding factor to progress.

Service user involvement

There was recognition of the progress that had been made in terms of service user involvement at NSD Steering Group level and across the various advisory committees. The voice of the service user was considered a real strength of NSD-2. It was noted that people who have lived experience of alcohol and drug misuse have a significant contribution to make in terms of the direction and implementation of alcohol and drugs policy in Northern Ireland. Participants expressed a need to further deepen and develop the relationship with service user representatives.

Research and Evaluation

Research and Evaluation featured as a theme within the discussion around effectiveness. DAMIS was considered a positive development for research and evaluation within NSD-2. It was also noted that integration with information systems across the UK will be important, particularly in the context of monitoring the impact of Brexit. Participants expressed a desire for research and evaluation to underpin all the work of the NSD Steering Group, particularly in relation to service provision.

> *"We need to be maximising resources and we need to be actually testing the things work."*

It was the view of participants that while decisions needed to be based on research and learning from outside Northern Ireland, equally it was important that Northern Ireland produced its own research to support future work. The latter was seen as being essential in anticipation of the impact of Brexit.

Conversations that occurred at NSD-2 Steering Group meetings were viewed as beneficial in encouraging dialogue around ongoing research that could influence the future direction of NSD-2. The importance of engaging with academics was also

stated as vital in terms of producing robust evaluations of ongoing services in Northern Ireland, to ensure commissioned services give value for money.

Lastly, it was observed by participants that while some evaluation of need and current services had taken place, the findings of these evaluations needed to be disseminated more effectively and used to inform decisions consistently when services were being commissioned.

Table 11: Aspects of NSD-2 which were viewed as effective, less effective and aspects which there were mixed views

Generally perceived as most effective aspects of NSD-2	Generally perceived as less effective aspects of NSD-2	Aspects with mixed views on the effectiveness
Governance structures at local level	Governance structures at operational level	Governance structures at strategic level
DACTs	Advisory groups	
Joined up working, collaboration and partnership working	Funding	
Workforce development	Research and evaluation	
Regional Commissioning Framework	Prevention	
Service user involvement		

Table 12: Factors that supported effectiveness

Factors that supported effectiveness	Perceived result
Regional Commissioning Framework	Greater consistency in level and diversity of service offer
Well established partnerships and collaborative working at all levels	Co-ordinated approaches, effective working relationships, supporting efficiencies
Consistency and commitment of NSD-2 steering committee membership	Continuity of work, opportunity to challenge, meaningful representation, cross-sectoral collaborative approach
Service user involvement	Programmes and services better designed to fit client needs, greater linkage from strategic decision making to lived experience, de-stigmatisation, rapid communication of evolving elements of the drug use landscape

Table 13: Factors that hindered effectiveness

Factors that hindered effectiveness	Perceived result
'Ever rising tide' of drug and alcohol-related harm with rising complexity of service need	Services becoming overwhelmed, diversion of resources away from prevention at strategic and operational levels
Rising complexity of service need	Existing linear models of care become quickly obsolete, increasingly focussed on crisis care and quantity of service rather than quality of care and recovery model
Lack of political structure	Failure to progress with key legislation, constraining of policy options – particularly in relation to the prevention agenda
Transformation in the health and social care service	Some system-level disruption in roles between the former Health and Social Care Boards, Health and Social Care Trusts and Public Health Agency
Diminished role of advisory committees	Reduced opportunity to inform strategic direction and prioritise existing and emerging issues
Some mismatch between policy and resourcing decisions	Under-resourcing of some service options, lack of faith and confidence in return on investment
Non- statutory function of DACTs	Stifling of local level innovation, limited capacity for implementation at local level
Some issues with transition within the Step model of care	Gap between Step 2 and 3 services

3.6.4 Efficiency

The evaluation explored participants' views on the efficiency of NSD-2. For the purposes of this evaluation efficiency has been defined as the extent to which the desired effects are achieved at reasonable cost.

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews
- Quantitative findings form the online questionnaire

- Findings from the focus groups, the interviews and the free text responses from the online questionnaire
- Table summarising findings on efficiency.

Questions presented under the Efficiency criterion

Table 14: Questions presented under Efficiency criterion in online questionnaire

Questions presented under Efficiency criterion in online questionnaire
1. How efficient was the allocation of resources in the implementation of NSD-2?
2. In terms of return on investment, what were the three 'best buys' within NSD-2? Please share your thoughts on return on investments in NSD-2.
3. Were there elements of NSD-2 that you think may not represent an efficient use of resources? If yes, what were these?

Table 15: Questions presented under Efficiency criterion in online questionnaire

Questions presented under Efficiency criterion in focus groups and interviews
1. In terms of return on investment, what do you think were the best buys within the NSD-2? / What do you think was the best value for money within NSD-2?
2. Were there elements of the NSD-2 that you feel did not represent an efficient use of resources?

Quantitative findings from the online questionnaire

Questionnaire participants rated the efficiency of resource allocation in the implementation of NSD-2. A notable proportion of participants (43%) indicated that they were not in a position to comment on the allocation of resources. Just over one third of participants reported that the allocation of resources in the implementation of NSD-2 had been 'quite efficient'.

Figure 17: Participants' view of the allocation of resources in the implementation of NSD-2 (n=28)
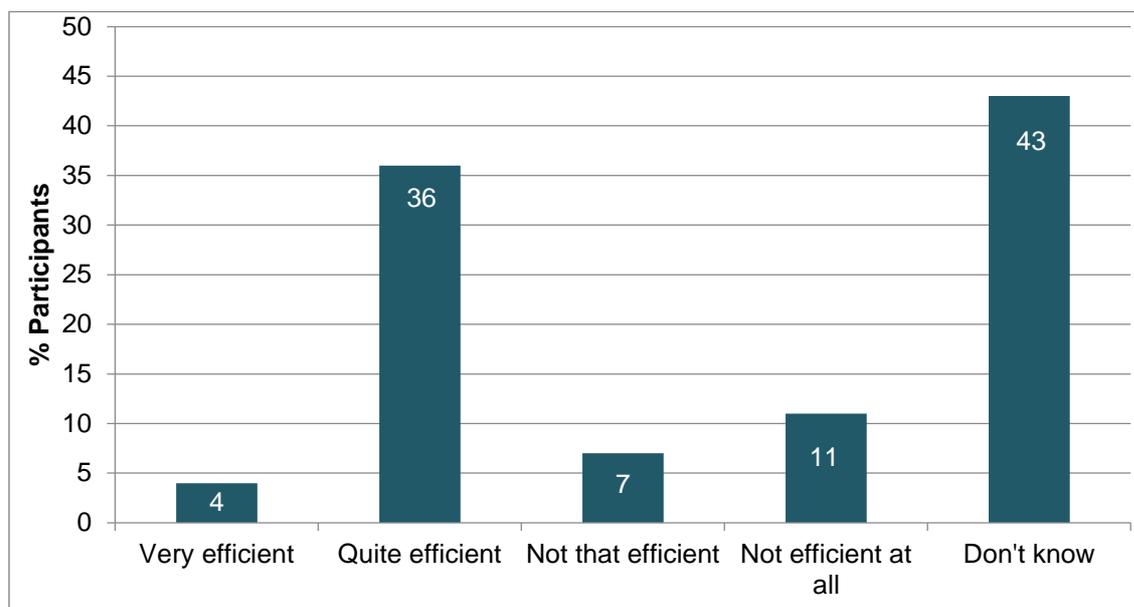
Best Buys

A number of different elements of NSD-2 were highlighted in terms of what represented good value for money. Questionnaire participants were invited to identify what they considered to be the three 'best buys' within NSD-2. Twenty-seven responses were returned; responses were not ranked in order of importance. Free text responses have been grouped along with responses from interviewees and focus group participant under the following sub-headings:

Service provision

A number of items broadly relating to service provision were considered to represent good value for money; these included the Regional Commissioning Framework and partnership delivery of service responses with the community and voluntary services. In particular, participants mentioned treatment services for young people, Step 2 services (including family support, prevention and early intervention), dual diagnosis and substance misuse liaison service as being amongst the 'best buys' resulting from NSD-2. The work around hidden harm was considered good value for money but others reported that the focus on this work has diminished over time. Brief references were made to education and prevention as representing good value for money.

A regional model has been developed for Step 4 services; this was considered to be significant piece of work, representing good value for money. Access to Step 4 services has been a major achievement in that it's a planned and coordinated part of a patient's care and they are supported through a whole care pathway.

Harm reduction approaches such as Naloxone have been considered life-saving. Whilst Naloxone was reported to be a modest programme in terms of investment, it has positively impacted very vulnerable young people.

> *"I think the expansion of the Naloxone. Simply because of the lives saved. It's a very modest programme, really is. And it has saved… and it's not just the lives, it's those really vulnerable beautiful young people that have got into something and it's a very difficult way out. And immediate help like that is very important. So it's definitely one of the best buys in my own mind."*

There was some concern that the efficiency of services is difficult to capture as there is a multiplicity of interventions implemented under the auspices of NSD-2. Nonetheless, it was noted that the cumulative impact of the different interventions appears to be having an impact. These included, brief interventions, a policing and justice based early intervention drug and alcohol referral scheme, as well as Step 2 intervention.

> *"I think we've got pretty good value for our money in terms of what we've got and what is going to the services. I suppose I'm trying to think of this in a wider sense and maybe just not about money because it's not always about money. I think I'd still come back to that perhaps some of the best buys for me might actually be the level of collaboration and partnership and social relationships, would, you know, not be about money."*

Workforce development

Numerous references were made to workforce development and increased staffing capacity as representing good value for money. Workforce development was considered a strength of the strategy in that it ensured consistency within the Regional Commissioning Framework. Some participants noted that the partnership working achieved through the DACTs was an efficient way of working at no additional cost.

Information sharing

Connections Service was highly commended and considered to have worked well given its modest investment. DAMIS was considered to be a low-cost, but highly effective service in sharing information in a timely manner as an early warning system. The system was reported to be very helpful and its impact felt across the different services and sectors.

Value for money concerns

Questionnaire participants were also asked to identify aspects of NSD-2 which did not represent an efficient use of resources. The majority (n=18; 78%) of participants said they didn't know. A small number of participants (n=2; 9%) indicated that there were elements of NSD-2 which did not represent an efficient use of resources.

These included 'Connections Service' 'Step 1 services' and the 'Advisory Groups in their current format'.

Participants presented a varied and individualised list of things they considered to be either good or poor value for money. Many of the responses were single responses and therefore should be interpreted with caution. Findings within this section reflect the collective responses from the free text questions within the online questionnaire, interviews and focus groups.

There were some negative perceptions of various public information/ awareness campaigns. For example, it was reported that the 'Dry January' initiative has relevance for the general population, but concerns were raised about the appropriateness of this initiative for people with substance misuse issues. Some participants were also critical about policing campaigns targeting drug dealing, reporting that they did not represent good value for money. Participants were also critical of small, individualised services that did not represent good value for money and detracted from the collaborative working which had been established over a number of years.

Particular reference was made to an alcohol screening programme rolled out by GPs. The approach taken was commended, but it would appear that the screening programme was less effective at the referral stage in that GPs continued to refer patients to addiction services rather than utilising Step 2 services. This subsequently led to addiction services continuing to be inundated with referrals. It was suggested that the reason this initiative was not as successful as it could have been was because it was delivered in isolation. There were calls to improve the connection between GPs and Step 2 interventions which are less resource intensive.

"You've an example of initiatives not operating within… a strategic and planned approach in order to solve the problem"

It was suggested that there is some lack of alignment between the Public Health Agency and HSCTs in terms of allocation of funding for services. It was reported that there had been a reduction in public health funding for alcohol and drug services, as a result of the Belfast HSCT investing in the community and voluntary sector for alcohol and drug services. However, a significant proportion of that funding had been allocated to an organisation which subsequently closed and the funding was re-allocated to mental health services. This was perceived to result in significant loss of funding with the community and voluntary sector and has led to lengthy waiting lists across all services.

There were concerns about the use of monies within Step 2 services not being used for the right purpose. It was reported that significant time has been lost, but efforts to rectify the situation are in place, but this scenario has not represented the best use of money.

Resource allocation

The increasing scale and complexity of the alcohol and drug-related harm featured heavily in the participants' comments. In this context, it was report that funding has

not increased to match the scale of the problem. For example, £1m was allocated to substitute prescribing 10 years ago; yet the same funding allocation still applies despite the fact the problem has grown five-fold and is continuing to increase.

There was recognition that, despite the ongoing need for funding and increased funding, it's not always about the level of funding, but how it's managed as part of the wider re-structuring of health and social care services within Northern Ireland. For example, the re-allocation of staff from alcohol and drugs to other areas of healthcare was reported to have been counter-productive. Furthermore, it was noted that a Regional Substitute Prescribing Group previously existed but no longer meets; it was noted that if this group had continued to function, it may have been in a position to foresee the increasing demand on services and advise/ respond accordingly. It was suggested that the inadequate funding allocation in terms of harm reduction and substitute prescribing has had a major impact of NSD-2.

"[There is a] need to be able to draw on funding to respond to emerging need and be able to adjust services and contracts to respond to need."

Commissioning and delivery of services

Concerns were expressed regarding the allocation of resources in terms of services and where they were delivered. There was strong sense of the immediacy in terms of service delivery. Some participants were keen to point out how success should be measured. In their view, success was keeping someone alive for another 24 hours or avoiding another death rather than measuring success by cost cutting.

It was the view of some participants that decisions to fund certain projects are made in haste and not necessarily linked to the wider drug and alcohol structures. Participants were critical of short-term programmes (three to six months) and highlighted the need for programmes lasting at least two years to determine their impact and performance.

From a contrasting perspective, it was reported that the Regional Commissioning Framework helped focus on what services should be procured and how they would be monitored. Challenges have existed in terms of the inequity legacy resulting from the Health and Social Care Boards and establishing the extent of need versus demand for services, coupled with the challenge of investing in the future through prevention.

"[The Regional Commissioning Framework] has focused on what are the key elements of service that for this amount of resource we need to commission and procure with focused minds."

Regional and local funding

There were contrasting views about the allocation of funding and provision of service across Northern Ireland. There appeared to be a lack of clarity about the level of funding across HSCTs; it was unclear whether this was as a result of different allocations or different use of resources.

One of the most notable outcomes of the regionalisation linked to the Regional Commissioning Framework has been reduced postcode lottery effect in that a suite of dedicated alcohol and drug commissioned services exist regardless of what HSCT area the service user lives in. It was acknowledged that whilst services might be delivered in a slightly different way, a more coherent set of services is available for those who need them. Some participants indicated the demand for and provision of services was very different across HSCTs in Northern Ireland.

Resources

Participants were quite critical of resource allocation for NSD-2, in that it was considered inadequate in meeting the existing and growing demand for services. There were reports of key funding streams having been cut; initiatives limited by short term project funding; resources not appropriately allocated or clients' needs met within tenders; and difficulty for services to have long term focus when they are unsure about the future of funding. In particular, it was observed that some key providers of educational programmes for young people had lost funding from major funders and therefore a coordinated source of funding is needed for programmes to be sustainable. Participants noted that there had been more streamlining of services, but this hasn't necessarily resulted in all needs being met. In addition, there had been challenges in developing services, scaling up service delivery and evaluation.

> *"I think that it's not so much that the resources aren't big, not substantially big but I think that something that wasn't realised in terms of the potential was it's a kind of the Step before the Step 2. It's early intervention and brief intervention."*

In long-term thinking, it was reported that the strategy did not have the impact on prevention anticipated; therefore costs in terms of impact in individuals, families and communities and cost to criminal justice system and health and social care have increased and are increasing.

Participants discussed the 'invest to save' model and its potential merits. A strong economic case was presented for investment in addiction services, especially in terms of criminal justice. Participants reported that:

> *"The 'invest to save' model is widely accepted but rarely implemented".*

One example given was the Rapid Assessment and Interface Discharge (RAID) model which has been piloted over the last two to three years. This model incorporates issues relating to mental health illness, ageing, self-harm and alcohol and drug misuse and facilitates earlier discharge from hospital with support in the community. It was reported that the infrastructure is in place to support the 'invest to save' model and this approach would reduce the number of admissions to acute hospitals.

There was also some discussion about the resource allocation between the Public Health Agency and Health and Social Care Board. On reflection, it was noted that funding may have been better distributed between the PHA and HSCB rather than

being solely to PHA. With all the funding given to PHA, there was a sense that the PHA then had to take responsibility for everything.

Table 16: Aspects of NSD-2 with a higher return on investment, lower return on investment and aspects which there were mixed views

Perceived higher return on investment	Perceived lower return on investment	Mixed views on return on investment
Regional Commissioning Framework	Multiplicity of initiatives	Hidden Harm
Contribution from community and voluntary sector organisations	Small individualised services	Connections Service
Workforce development and increased staff capacity	Public information/ awareness campaigns	Step 2 services
Harm reduction approaches		
Drug and Alcohol Coordination Teams		
Drug and Alcohol Monitoring and Information System		

3.6.5 Sustainability

The sustainability criterion explored the continuation of benefits from NSD-2, focusing on practice and collaboration and partnership working.

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews
- Quantitative findings form the online questionnaire
- Findings from the focus groups, the interviews and the free text responses from the online questionnaire
- Table summarising findings on sustainability.

Questions asked under the Sustainability criterion

Table 17: Questions presented under Sustainability criterion in online questionnaire

Questions presented under Sustainability criterion in online questionnaire
1. To what extent has implementation of NSD-2 generated changes in practice that will last into the future? Please share your thoughts on what changes are sustainable.
2. To what degree has the implementation of NSD-2 contributed to enhancing working relationships and partnerships? Please describe these relationships and partnerships.
3. Please share one example of innovation within the implementation of NSD-2.
4. What conflicts have been evident in implementation of NSD-2? How have these been dealt with?

Table 18: Questions presented under Sustainability criterion in focus groups and interviews

Questions presented under Sustainability criterion in focus groups and interviews
1. Partnership working has been a feature of NSD-2 with a number of collaborative programmes delivered over the period of the strategy. What benefits and challenges have there been with partnership working within your sector and with other sectors?
2. Do you think NSD-2 has changed long-term working relationships and partnerships? If so, in what way?

Quantitative findings from the online questionnaire

Figure 18 below demonstrates the views of participants on sustainable change in practice. Fifty per cent of respondents to the online questionnaire considered that the implementation of NSD-2 had generated changes in practice that will last into the future. Views were mixed on this issue with 30% of questionnaire respondents reporting that they did not feel the implementation of NSD-2 had generated such changes.

Figure 18: The extent to which participants indicated that the implementation of NSD-2 generated changes in practice that will last into the future (n=26)
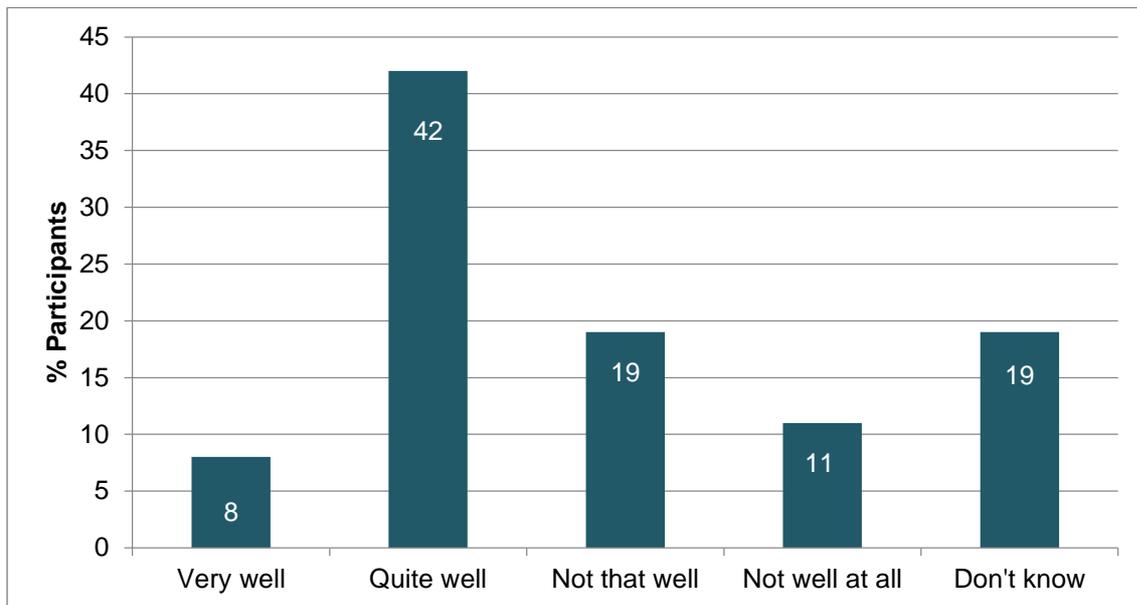
Participants responded positively about the sustainability of working relationships and partnerships as a result of NSD-2. The majority of participants were of the opinion that the implementation of NSD-2 had contributed to enhanced working relationships and partnerships.

Figure 19: The extent to which participants indicated that the implementation of NSD-2 contributed to enhanced working relationships and partnerships (n=27)
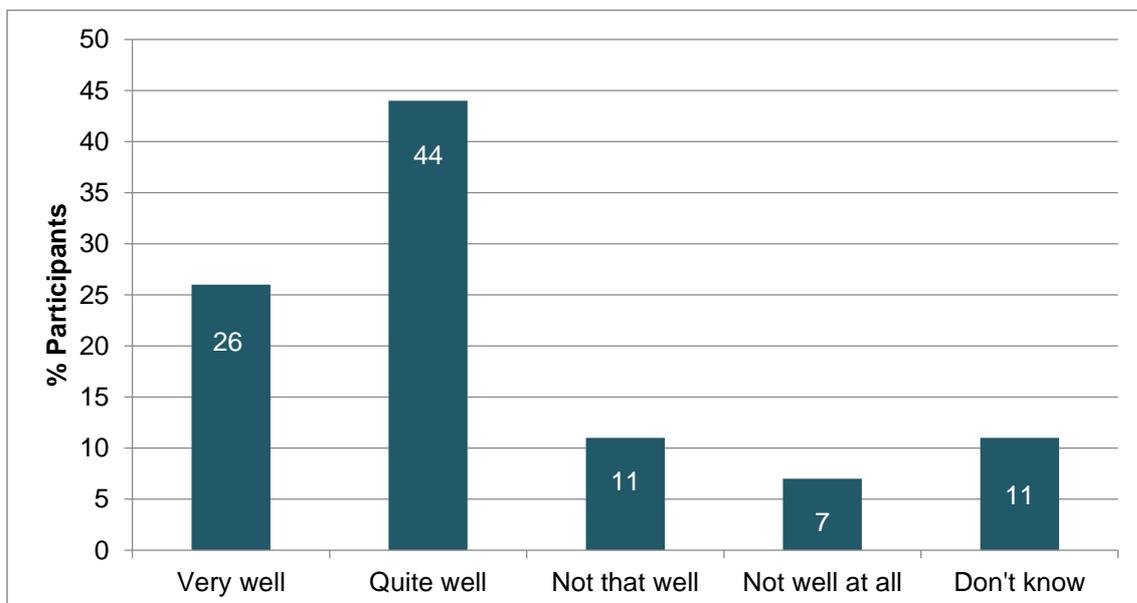
Findings from the focus groups, the interviews and free text responses from the online questionnaire

Collaboration and Partnership Working

Positivity surrounding the sustainability of working relationships and partnerships was a prominent feature of the focus groups, the interviews and the free text responses from the online questionnaire. There was a high level of support from participants for the new relationships and partnerships which had come from NSD-2, with clear evidence of the sustainability of these relationships.

> *"I observed people from different sectors making commitments to take things forward together after and between meetings and there was clear evidence that that was happening. So definitely I think there were, you know, new relationships and partnerships which I think will be sustained."*

A more joined up approach to working together between the police and community safety partnerships and the DACTs was observed by participants as a key component of sustainable models of working in the delivery of NSD-2. Collaboration between the DACTs, PHA, local authority, police and service providers around initiatives in relation to cleaning up drug paraphernalia on the streets was seen as another important example of this partnership working. Cross-sectoral working at local level with the development and growth of partnership approaches was seen as a key contribution of NSD-2 to driving sustainable change rather than direct commissioning of once-off single agency projects or services.

> *"I guess the fact that those partnerships are still in place across all of those sectors is the first and most important thing, with justice, with police, health and social care, community and voluntary sectors. That in itself is really critical because it is a complex issue and it does require us all working together. That's number one."*

The DACTs were considered to have been successful in linking with other sectors/ partnerships such as mental health and wellbeing and the Police and Community Safety Partnerships. There was a perception of growth in both the number and diversity of partnerships operating through DACTs in the lifetime of NSD-2. This was perceived as contributing to sustainability by creating synergies for addressing alcohol and drug issues within work led by other agencies, services and community groups.

> *"I think the maintenance of the DACTs as multi-sectoral partnerships has been and will continue to be a strength."*

Participants noted that the DACTs provided an opportunity for ownership at a local level, with some key stakeholders taking a very proactive role. Trusts were also noted by participants to be working more closely with the community and voluntary sector. Increasing cohesion between partners was recognised as a central achievement of NSD-2 that supported elements of not just sustainability, but also effectiveness and efficiency concerns.

It was the view of participants that NSD-2 has focused minds in terms of developing cross-sectoral priorities. It was noted that collaboration was effective at operational level. The Bamford Substance Misuse Group, when operating, was also cited as a good example of NSD-2 partnership and collaborative working. Participants noted greater challenges existed in achieving collaboration at strategic level, particularly from a cross-departmental perspective.

Service provision

Participants expressed strong opinions on the issue of service provision and sustainability. Overall, participants reported both increased levels of services available and more people accessing services.

The integrated nature of alcohol and drug treatment services was commended and recognised as a key element of ensuring sustainable approaches to addressing polydrug use.

Good practice was seen to be driven forward in NSD-2 through both a more competent workforce and a stepped care approach to services. Those working on the ground, finding local solutions to local problems were acknowledged for their contribution to NSD-2. However some participants did stress how the voluntary and community sector have been shouldering considerable responsibility for delivering service and required ongoing support if the model was to be sustainable.

It was reported that the consistency in service delivery resulted in service users being able to access services throughout Northern Ireland. It was the view of participants that there was increased awareness of services and support now available for substance users and their families. In particular, there was positive feedback about Step 2 community-based services which includes family support. It was noted that services were now engaging some of the most isolated clients who were previously not engaged with statutory treatment services, therefore reducing admissions to hospital. Participants emphasised that engagement of 'hard to reach' groups should be explicitly valued and resourced and seen as a core element of good practice within alcohol and drug treatment services. Reference was made to 'workshops' for substance users which have enabled some of the most vulnerable members of society to reflect on their substance misuse and has led to increased uptake of services among those who may not have considered the need for such services in the past. Engaging substance users in critical reflection and supportive group work was seen as an important to empower substance users as agents of change in their own lives, rather than being passive recipients of care services, with implications for sustainability in terms of both reduced service need and sustainable behaviour change.

Innovation

Participants noted innovative practice within service provision and collaborative working. Examples included:

- A homeless organisation working collaboratively with relevant agencies and the PSNI to tackle issues surrounding substance misuse among the homeless community

- Access to help for service users through harm reduction/ substance misuse liaison officers which made a significant difference to people who might otherwise have died

- The development of programme delivery in Looked-After Children centres

- The early stage development of a joint PSNI/ Youth Justice Agency early intervention drug and alcohol referral scheme

- The Alcohol Recovery Centre in Bradbury Health and Wellbeing Centre

- The Regional Initial Assessment Tool (RiAT)

- The availability of low threshold services in all areas

- Services to address prescription drug misuse

- The Remove All Prescription and Illegal Drugs (RAPID) drug disposal initiative project

- The drug outreach team in Belfast

Harm reduction

It was reported that the promotion of harm reduction approach is becoming slowly embedded in organisations operating closely with people using alcohol and drugs. The harm reduction model was considered to have evolved during the implementation of NSD-2. Many participants were keen to emphasise that evidence-based harm reduction programmes and supports must form a central component of any sustainable programme of supports and services.

> *"The harm reduction model adopted through NSD-2 relates not only to injecting drug use, but this pragmatic approach can be used with all substances and promotes a user led realistic means of changing behaviours."*

Concerns about the lengthy waiting lists for the substitute prescribing programme were raised at NSD Steering Group level. The success of the take home Naloxone harm reduction programme was also acknowledged and it was noted that this approach has improved over time, with more professionals more open and receptive to the concept of harm reduction approaches.

Participants recognised an increasing acceptance of harm reduction approaches. This was perceived as a 'culture change' or change in ethos across the broad range of drug and alcohol treatment service.

The development of needle and syringe exchange facilities was also highlighted as a success of NSD-2. It was reported that over 20 sites are now in place within community pharmacies, with additional sites planned for the Belfast area. Plans are in place to expand needle and syringe exchange progammes among other professionals such as those working the homeless community.

"There are a number of areas that have worked extremely well – the needle exchange for one. The Naloxone was another. Two shining examples of where we had nothing before and now we have a very effective service. And we plan to expand that."

Communication / Information sharing

Participants highlighted that communication and information sharing were core components of effective, co-ordinated, cohesive and sustainable service planning and delivery. Participants referred to developments in the context of NSD-2 in two main domains – firstly in relation to information sharing tools and systems and secondly with regard to the value of face-to-face exchange and networking.

NSD-2 was the lever for the development of the Drug and Alcohol Monitoring and Information System (DAMIS) which has been commended. It was reported that this information sharing system is working well, is very accessible for frontline staff and has improved information dissemination and early warning. DAMIS has been reported to be a very useful information sharing tool, providing timely and relevant information on local development and changes in drug trends. It is now the accepted means of disseminating information out to practitioners and has demonstrated itself to be a sustained, and sustainable, tool for rapid communication. DAMIS was considered to have universal application across all sectors. Whilst the current system is working well, there were calls for it to be extended to service users in the form a text messaging service.

DACT meetings were considered by participants as beneficial for information sharing with regards to local issues and priorities in each particular area, contributing to the adoption of sustainable approaches.

"DACTs….they do identify their own priorities and having the right, you know, a wide group of stakeholders around the table, you know, having that forum for issues to be brought forward and discussed, to be able to share information around what is going on, you know, in each of those stakeholder's worlds as it were, there's an outcome from that because we're better informed, we've a more complete picture at a local level."

However, it was noted that there was a lack of communication between the five DACTs themselves and a difficulty in sharing information between statutory and voluntary sector providers.

The Connections Service, which was developed through the DACTs, was commended in terms of networking events. Support provided through the Connections Service for the development of service directories was also highlighted as having made a significant contribution. The Connections Service was also reported to be cohesive in bringing together work on prevention and education and providing a stronger foundation and clearer vision.

Within the structures of NSD-2 the advisory committees, when operating well, provided a forum for different sectors to discuss services delivery at a regional level. However, participants did highlight that there was a lack of information sharing within NSD-2, with the flow of information from ground level to higher levels, and from higher levels to ground level seen as slow at times.

3.6.6 Equity

Within this process evaluation, equity has been defined as the extent to which different effects (both positive and negative) are distributed fairly between different groups and/or geographical areas. Participants responding on the fidelity evaluation criterion within the online questionnaire (Figure 14 in section 3. 6.2) considered that NSD-2 had adhered very well to the principle of equity when it came to implementation of the strategy. Participants perceived high fidelity to the principle 'targeting those at risk and/or vulnerable'.

In addition to the data on equity that emerged through examination of the fidelity evaluation criteria, this section presents data on equity as an evaluation criterion in its own right. This section digs a little deeper into the ways in which equity was actioned by exploring the perceptions of implementation on equity issues and how equity concerns may have influenced the allocation of resources. The inclusion of equity as an evaluation criterion for drug policy was emphasised within the EMCDDA guidelines on evaluation of drug policies. (EMCDDA 2017)

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews.

- Quantitative findings form the online questionnaire.

- Table outlining the groups which have benefitted from NSD-2

- Findings from the focus groups, the interviews and the free text responses from the online questionnaire.

Questions presented under the Equity criterion

Table 19: Questions presented under Equity criterion in online questionnaire

Questions presented under Equity criterion in online questionnaire
1. To what extent was the deployment of resources (human resources/financial) in implementing NSD-2 targeted those most in need?
2. To what extent do you think the groups listed below have benefited from the implementation of NSD-2?   • High-risk drinkers   • People with alcohol dependency   • Occasional drug users

- Chronic drug users

- People in recovery

- Homeless people

- Ethnic minorities including Travellers

- LGBT+

- Children engaged with the child protection system

- Families of people using alcohol or drugs

3. To what extent has implementation of NSD-2 contributed to addressing health inequalities?

4. In what way could the implementation of NSD-2 have been more effective in addressing health inequalities?

Table 20: Questions presented under Equity criterion in focus groups and interviews

Questions presented under Equity criterion in focus groups and interviews
1. To what extent have adults and young people, known to the criminal justice system with substance misuse issues, benefitted from NSD-2? (Law and criminal justice focus group only)
2. What other societal groups do you feel have benefitted most from the implementation of NSD-2?

- High-risk drinkers

- People with alcohol dependency

- Occasional drug users

- Chronic drug users

- People in addiction recovery

- Homeless people

- Ethnic minorities including travellers

- LGBT+

- Children engaged with child protection system

Quantitative findings from the online questionnaire

Questionnaire participants were asked to indicate the extent to which the deployment of resources (human and financial) was targeted at those most in need. Most (52%) participants didn't know if the resources had been targeted at those most in need, whilst one third of participants indicated that this had been achieved 'quite well'. This data is not very useful in capturing views and experiences of equity considerations in the resource allocation. It is evident that most participants had very limited

awareness of how equity concerns influenced resource decision making. The research question remains pertinent but a different research method and approach may be required to answer it.

The online questionnaire included a list of societal groups relevant to the equity dimensions. Participants perceived that those most immediately affected by alcohol and drugs, ie substance users were more likely to have benefited from the implementation of NSD-2. Participants were of the view that benefit had been achieved for those already engaged with state services with known harms associated with alcohol and drug use, for example chronic drug users, those who are alcohol dependent, those engaged in the child protection system or the homeless. Despite earlier concerns regarding the fidelity of implementation in relation to the hidden harm agenda, participants did perceive that families of people using alcohol and drugs had benefitted to some extent.

In contrast, occasional drug users and those in recovery were perceived as less likely to have benefitted from the strategy, alongside the Traveller community and the LGBT+ community. This may be related to lower engagement with statutory services. This may indicate issues relating to engagement with these groups. The findings could also be interpreted as showing that NSD-2 work focussed on addressing established harms rather than a wider population-based prevention early intervention agenda.

<u>Findings from the focus groups, the interviews and free text responses from the online questionnaire</u>

Geographic differences

A key learning from the analysis of the focus groups, the interviews and free text responses from the online questionnaire was that geographic differences were perceived as the most important dimension of equity rather than social groups or communities defined along other lines. Discussions relating to equity focused both on different societal groups and the equitable implementation of NSD-2 in terms of regional and local differences. There was a sense that those living in urban areas were at greater advantage in terms of access to services. This was perceived as services in rural areas being removed or rationalised as well. In addition, there was a perception that rural service users were disadvantaged by virtue of transport and travel costs for accessing services. It was also noted that the location of services in urban centres has resulted in saturation of services in these locations.

The issue of whether rural dwellers with alcohol and drug-related problems were being included in the overall statistics was also raised as a potential concern. It may therefore be valuable to consider this dimension within the monitoring and evaluation framework for any future drug and alcohol policy in Northern Ireland and within key performance indicators relating to service design and delivery.

Differences in the availability of addiction services were also reported; it was noted that due to the high demand in the Belfast area, long waiting lists exist. In contrast it was reported that in the North West region, places on the substitute prescribing

programme are available almost immediately. Forecasting and rapid identification of 'bottle-necks' in service delivery in different regions would appear to be an important issue for future service planning.

Societal groups and health inequalities

There was a high level of awareness of health inequalities within NSD-2. Participants at all levels were acutely aware of the higher risk of drug and alcohol-related harm among disadvantaged and marginalised groups as well as the effects of alcohol and drug use as drivers of material deprivation and criminality.

Overall, participants considered that NSD-2 as a whole was a strategy with the capacity to directly affect health inequalities by virtue of the known social profile of alcohol and drug-related harm. In other words, the absolute effects on health inequalities were well understood.

However, there were some concerns with regard to the effectiveness of NSD-2 in addressing relative inequalities. Some participants expressed a concern that NSD-2 was introducing some measures that would be more effective in reducing harmful use of alcohol and drugs among those who are higher educated. In addition, participants noted that wider economic circumstances in Northern Ireland were driving inequalities irrespective of NSD-2, particularly with regard to income inequality and housing issues.

> *"I think NSD is making a modest contribution to off-setting that [health inequalities], but that those inequalities continue to increase for reasons outside the control of NSD."*

Some participants considered that public awareness campaigns contributed to widening relative inequalities by driving behaviour change and help-seeking among those with higher levels of education. In contrast, the work of the DACTs was considered to be focussed on difficult to reach groups with an ethos of direct engagement with the most disadvantaged. The challenge of tackling harmful alcohol and drug use among people living in disadvantaged communities with sometimes limited opportunities in their lives was commonly discussed.

In terms of the commissioning of services, there is a specific requirement within contracts to prioritise disadvantaged or vulnerable groups (eg Travellers, LGBT). It was acknowledged that the monitoring of the impact of services on disadvantaged groups was poor; this is reportedly due to reluctance by services users to provide the necessary information. Lower uptake of services among those from disadvantaged communities was a concern.

Equity was a recognised element of commissioning of services. Requirements for access to services for vulnerable or disadvantaged groups was stipulated in the contract between the commissioning body and service delivery agency.

It was reported that substantial health inequalities still exist and that the joined up thinking that is necessary to address health inequalities can't happen without a co-

ordinated effort at government level. The absence of the Northern Ireland Assembly was considered a critical barrier here.

It was noted that:

"We're living in too modern an age for it [change] to take as long as it does."

Participants were keen to emphasise that efforts to tackle alcohol and drug-related harm by a range of organisations intervening with different users groups, impacts on wider society, supporting not just better health but lower crime and better community safety. It was considered that there was still an 'us and them' approach to alcohol and drug-related harm in some discourse and stated that there was a real need to move on from considering drugs and alcohol as only an issue for the poor and disadvantaged sectors of society.

It was noted that alcohol-related harm among lower socio-economic groups is a significant issue, but it needs to be tackled by a broader range of strategies (not just NSD-2) linking and working together. This approach is considered effective in addressing health inequalities. There were calls for greater linkage between strategies on the equity dimension, in particular with the implementation of the Children and Young People's Strategy and the Hidden Harm Action Plan.

Participants highlighted the challenge of addressing inter-generational cycles of alcohol and drug-related harm linked to engrained social and economic disadvantage within some communities. It was stated by participants that a focus on this issue within NSD-2 could have been transformational.

It was noted that infrastructure had improved in Northern Ireland in general to support ethnic minorities engaging with health and social care services including translation services. Some participants proposed that better information is needed – both in terms of different languages and sensitivity to cultural issues - in relation to help-seeking and treatment services for alcohol and drug issues among new communities in Northern Ireland.

People engaged with the criminal justice system

Participants emphasised that around three-quarter of offenders have an alcohol or drug-related problem. It was acknowledged that whilst offenders have equal rights to services, NSD-2 gave greater recognition to the needs of offenders with alcohol or drug-related problems then had previously been the case. It was the view of participants that there had been a positive shift in mind-set towards offenders and this has been demonstrated through the close working between the health, justice and forensic science sectors.

"I think probably what worked from our point of view was recognition that offenders were citizens first"

In terms of offending, it was reported that if greater emphasis is placed on addressing alcohol and drug-related problems among offenders, this is likely to have a beneficial impact on society; fewer offenders going into or returning to probation or

prison. In addition to recognising the needs of victims, participants perceived it necessary to consider the vulnerability of the perpetrator and what can be done to reduce the impact they have on society. It was noted that those working with offenders may need to consider the impact and harms caused by offenders differently.

This social group was considered to have been supported within NSD-2, but it was acknowledged that measuring impact was difficult and that further research in this area may be useful to programme development.

Some participants emphasised the value of drink and drug-driving legislation and enforcement activities with calls for greater recognition of the role that this plays in benefitting society as a whole.

Older people

Participants considered older people to be something of a 'hidden group' in terms of substance misuse. It was increasingly recognised that there was an issue of problematic drinking in the older age groups. However, participants were concerned that there was insufficient direction at both strategic and operational level in terms of how to recognise, engage and effectively respond to the interface between drug and alcohol issues and population ageing. The service response was considered underdeveloped, particularly where there are allied issues of isolation, loneliness, mental and physical ill-health and physical or sensory disability.

It was reported that the community and voluntary sector is a leader in the areas of older people's needs and with the right approach, older people will talk about their alcohol and drug consumption. Concerns were raised over reduced funding for services for older people and the challenge of accessing supports with the current social care system.

Injecting Drug-users

Participants referred to the needs of the drug-injecting population as a high vulnerability group central to equity concerns. New and more sophisticated drug networks are emerging, presenting a very real challenge in addressing drug supply networks and mechanisms. Specific reference was made to a 'dealing for profit operation' which emerged in Belfast about five years ago. Whilst the increase in injecting drug-users had been predicted, there was criticism of the service response in that users were unable to access treatment in a timely manner.

Needle exchange and other harm reduction programmes including Naloxone were seen to have pro-equity measures protecting the lives of the most vulnerable chronic drug users.

Family

'Family' was identified as a key group to consider within the equity dimension of NSD-2. Participants discussed the degree to which family members affected by drug

and alcohol-related harm were increasingly considered. This was recognised at policy level through the hidden harm work and at service level.

Participants noted that the support for family members that was incorporated into Step 2 services, encouraging families to be part of the treatment process and support the service user, was an important measure. There has been greater recognition that family members have their own needs and can be supported within existing services.

Overall, participants viewed that the work on supporting families and hidden harm was a valuable component of equity but that there needed to be more support on offer and that the support offered needed further refinement. There was a concern over the low uptake of family support/ hidden harm supports with many families not seeking help or recognising that help is available, because they remain focused on the needs of the substance user.

High risk drinkers

A number of references were made to high risk drinkers in the context of vulnerable societal groups. Participants noted a greater awareness among high risk drinkers that they were drinking at a level that was associated with considerable risk and a better understanding of the harms associated with heavy drinking.

Participants reported that there was better streamlining of services for people with alcohol dependency. Other measures such as low threshold services were considered to have been beneficial in reaching this group. Participants expressed considerable frustration at the lack of progress on minimum unit pricing of alcohol which would have directly benefitted high risk drinkers.

Homelessness

People experiencing homelessness were identified as a particularly vulnerable group. There were mixed views among participants about the level of help and support available for homeless individuals. At a strategic level, it was reported there was no representative from the homeless sector on NSD Steering Group. It was the view of participants that there was a lack of focus on homelessness within NSD-2 or at NSD Steering Group meetings. However, some attention had been given to 'street drinkers', but this was limited.

Outside of NSD-2, it was suggested that 'homelessness' is now higher on the policy agenda than it had been, with greater investment in homelessness; more outreach to homeless people; and greater engagement with the homeless community including efforts to provide treatment services.

Overall, there were mixed views on homelessness and how it has been addressed at policy and service level. Some participants suggested homelessness services were very fragmented, whilst others reported the response from services was good.

Mental health

Throughout the interviews and focus groups, the complexity of alcohol and drug-related problems and association with mental health problems were discussed. Participants identified individuals with mental health problems as a particularly vulnerable group. In this context, participants were critical of mental health services and waiting times, particularly for people in crisis. Participants recognised the level of need which exists, but thought that service providers need to explore other options in order to meet client needs.

There was criticism of the health and social care services for patients sectioned under the Mental Health Act; it was reported that patients are hospitalised for a week, discharged with medication and directed to homelessness services. This was considered an inappropriate course of action given that someone with a mental health problem is not in a positon to make decisions about housing.

A further concern in relation to mental health services was the lack of partnership working between the relevant agencies. It was reported that people with mental health problems are not always treated with respect because of their alcohol and/or drugs misuse and in fact, some agencies refuse to work with individuals because of their alcohol and/or drug misuse, amounting to a discriminatory action within service delivery.

The limited dual diagnosis service across Northern Ireland was highlighted as a concern in terms of addressing mental health and substance misuse. It was reported that the system surrounding this service does not appear to be working as effectively as it should be, with patients given an appointment card and required to return at a later time/ date. Efforts to enhance the service were commended, but overall the service was considered to be underdeveloped in most cases poorly suited to the multiple vulnerabilities of the service users.

People in addiction recovery

Recovery featured heavily in the overall discussions about NSD-2 and how recovery was a missing component of the strategy. Some considered:

"NSD wasn't a recovery based strategy."

Recovery was considered a gap in terms of service delivery. For people in addiction recovery, discharge from services was viewed as a high risk period for relapse. Participants sought greater transitional support for people discharged from formal addiction treatment services. It was suggested that specific programmes could be developed to provide help and support in the following areas:

- Financial matters
- Housing
- Cooking
- Managing a budget

- Networking/Social skills

Participants perceived that there has been significant investment in individuals in terms of treatment for alcohol and drug misuse, but little investment at the recovery stage when people need to develop coping mechanisms to avoid relapse.

Women

Women were identified as a group requiring very specific support. It was reported that women with substance misuse problems face significant difficulties in accessing help and care and a huge stigma still exists which prevents women from help-seeking with substance misuse problems. Participants considered that often the vulnerabilities experienced by women are not well enough recognised and there were calls for the development of services specifically for women.

Young people

There was a strong sense among participants that children and young people were among those who had benefited most from NSD-2. Participants were buoyant about the reductions in harmful consumption of alcohol and drugs in children and young people with the hope that this would deliver lasting change into the future. However, some participants cautioned that the extent to which this actually reflects a widening of inequality or a reduction in inequality within children and young people is unknown. It was noted that children and young people should remain a priority group within future alcohol and drugs policy, with a defined focus on children engaged with the child protection system as both victims of alcohol-related harm and high risk for harmful consumption.

Despite the progress that has been reported in reduced alcohol and drug use, young people are still considered to be one of the hardest to reach groups, particularly those excluded from services or those who refuse to engage.

Concerns were also raised about younger and less experienced drug users engaging in risky drug-taking behaviour, which some perceived to be more extreme than was previously the case.

Participants referred to the lack of respect among some young people - both for themselves and for others. The challenge of anti-social behaviour in the context of alcohol and drug misuse was perceived as mainly a problem relating to young people. It was acknowledged that further work addressing this issue may be warranted.

3.7 Achievements and Lost opportunities

In addition to discussion around the evaluation criteria, participants were questioned on the most significant achievements and lost opportunities within the implementation of NSD-2. Findings from these discussions are detailed below.

3.7.1 Achievements

Participants identified a number of areas as achievements of NSD-2.

Figure 20: Achievements of NSD-2

Collaboration and co-ordination

- Fostered increasingly effective collaboration and partnership working at both the strategic and operational levels
- Drove a more cohesive, coordinated response to tackling a wide range of drug and alcohol issues
- Improved partnership working within service delivery
- Implemented an effective new information sharing system - the Drug and Alcohol Monitoring and Information System (DAMIS).

Service development

- Increased availability of services
- Increased accessibility of services
- Created a more consistent and equitable service offer through the transfer to a Regional Commissioning Framework

- Developed the Connections Service which brought together work on alcohol and drugs prevention and education. This service provided a stronger foundation for co-ordinated local working.

Use and development of knowledge and skills

- Utilised the knowledge and experience of NSD Steering Group members
- Invested in a timely manner in workforce development linked to implementation of the Regional Commissioning Framework.

Leadership and representation

- Raised the profile of the harm caused by alcohol and drugs
- Designed an effective strategy with a clear vision, mission and goals from the outset, which helped to shape and support implementation
- Retained a committed and consistent membership on the NSD Steering Group
- Provided greater opportunity for representation and meaningful involvement of service users and the community and voluntary sector
- Provided a framework for the development of legislation relating to responsible retailing of alcohol.

Harm reduction

- Made significant progress on embedding an evidence-informed harm reduction ethos and culture within services and decision-making
- Grew and developed an effective network of needle exchange facilities.

3.7.2 Lost opportunities

Participants identified the following areas as the most significant lost opportunities within the implementation of NSD-2.

Figure 21: Lost Opportunities of NSD-2

Strategy/ policy integration

- Limited integration of NSD-2 across government departments and within some other relevant policy agendas

- Strategy could have been more strongly linked with the commissioning process

- Insufficient emphasis on social and community development with the strategy

- Implementation of the strategy sometimes over complicated with disjointed policy

- Lack of feedback on how the strategy was being operationalised.

Forward-planning

- Limited knowledge on 'what was coming down the line' in terms of patterns of consumption and harms – a lack of data collected to inform both acute responses and long-term planning

- Limited opportunities to adequately discuss and assess future options and innovations due to diversion of efforts to responding to service demands

- Short-term commissioning cycles made it difficult to engage in long term meaningful work at service level.

Service commissioning and planning

- Inconsistency in joint planning and commissioning across some statutory and voluntary agencies

- Transition to the voluntary community services into the 'Step' model led to a gap between Step 2 and Step 3 services, with negative consequences for accessibility of services

- Some local projects were discontinued as they did not meet the exact conditions set out within the strategy.

Failure to capture learning/evaluation of programmes and services

- Limited data gathered from external projects such as the 'Impact of Alcohol' programme.

Lack of progress on prevention

- Not enough attention paid to prevention – it was perceived that this agenda was repeatedly squeezed out due to pressing issues in service delivery and that there was a sense of 'legislative and policy inertia' in moving forward associated with the status of the Northern Ireland government .

Limited progress on recovery

- Failure to embrace a comprehensive recovery model within reconfigured services.

3.8 Looking Forward

This section details the factors that participants indicated should prioritised in any future strategy in relation to alcohol and drug misuse.

Presented in this section are:

- Questions from the online questionnaire, focus groups and interviews
- Findings from the focus groups, the interviews and the free text responses from the online questionnaire.

Table 21: Questions presented under Looking Forward in the online questionnaire

Questions presented under Looking Forward in the online questionnaire
1. What do you see as the most important features of a new alcohol and drugs strategy for Northern Ireland?
2. What should be prioritised in a new strategy?
3. What should be maintained in a new strategy?
4. What should be stopped?
5. What external changes in the alcohol and drug environment need to be taken into account within any future strategy?

In the focus groups and interviews some additional bespoke questions were used to add depth to the specialist views of those participants. These questions focused on the role of the participants and the sector they represented.

Findings from the focus groups, the interviews and the free text responses from the online questionnaire

Listed below are the features which participants highlighted should be incorporated into any future strategy regarding drug and alcohol misuse

Table 22: Features which participants highlighted should be incorporated into any future strategy

Features which participants highlighted should be incorporated into any future strategy	
Strategic and operational alignment	• Greater alignment between policy, planning and implementation • Better needs assessment • Protected focus on prevention
Governance	• Greater responsiveness • Actions linked to short, medium and long term outcomes using an Outcomes Based Accountability approach • Better linkage between the steps within the existing model of care
Long-term thinking	• A longer-term strategy supported by shorter-term action plans

	• A longer-term approach based on evidence and modelling of projected scale and severity of alcohol and drug-related issues • Commitment to long-term phased service development and expansion
Regional Commissioning Framework	• Joint commissioning and integration of budgets to maximise outcomes • Enhanced understanding of local evidence based practice • Commissioning, with realistic outputs and outcomes, that is reflective of the needs at community level and the requirement for specialised services
Resources	• Additional investment in tackling alcohol and drug-related harm • Longer-term funding based on population projections of need. • A regular review of the allocation of resources and consideration of further resource-sharing across health, social or community budgets.
Service provision	• Better integration of services across sectors and within the step model of care. • Joined up working around the social determinants of health. • Advanced workforce planning and development for the expansion of services with a particular focus on recovery. • Greater investment and more coordinated efforts for early intervention
Societal groups	• Involvement of service users at all levels • Greater development of services for children and families affected by addiction • More joined up approaches to addressing mental health problems, homelessness and substance misuse

Legislation		• Progression of legislation on minimum unit pricing of alcohol and the sale and supply of alcohol • Progression of legislation on drug consumption rooms.
Research and Evaluation		• Improvement, evaluation and implementation science to be placed within the monitoring and evaluation component • Implementation and sharing of the outcomes of a standardised assessment tool such as the Regional Initial Assessment Tool (RiAT) • Better understanding of the drivers of prescription drug misuse.

Section 5: Conclusions

What did the stakeholder engagement component contribute to the review?

The findings from this stakeholder engagement are one component of a wider review of the implementation of the NSD- 2. The approach used was successful in capturing rich data on the lived experience of stakeholders working to reduce alcohol and drug-related harm in the region. The tacit knowledge shared by these stakeholders can be a useful contributor to discussions on future alcohol and drug priorities. The conclusions below contextualise findings from the stakeholder engagement with findings from the annual progress reports published by the Department of Health and the final review document produced.

Did stakeholders perceive a pattern of alcohol and drug use and harms consistent with the NSD-2 key indicators?

Stakeholders' perceptions of the evolving patterns of alcohol and drug consumption and harms were mostly in line with the data collected on key indicators. For example, stakeholders recognised the progress made in reducing alcohol consumption by children, as mirrored in survey data, and were optimistic about an ongoing shift in drinking culture in this group. However, the basket of harms in the current indicator set matched less well with the harms highlighted by the stakeholder group.

Stakeholders presented a more multidimensional interpretation of harm encompassing strongly elements of mental ill-health and hidden harms. On the other hand, stakeholders did not raise the issue of rising HIV diagnoses despite significant increases evident in the key indicators.

Stakeholders provided additional insights into shifts in alcohol and drug use and harms, and the potential drivers of those harms, beyond the raw counts presented in the key indicator set. The insights deepen understanding of facets of alcohol and drug use and harms that are not recorded or recordable through statutory information systems – information relating to activities and harms that are hidden, sometimes illegal, 'subclinical' or heavily stigmatised.

Both stakeholder perceptions and key indicators reflect that the alcohol environment in Northern Ireland is changing. Polydrug use, a pattern of rising harms and increased complexity of service need were the core changes identified. The emerging issues cited in the opening section of the NSD-2 strategy document published in 2011 are in many ways similar to the ongoing concerns raised in the stakeholder engagement. However, the volume, complexity and severity of many alcohol and drug-related harms appear to have amplified since then.

What are the potential implications of the patterns perceived by stakeholders?

Some stakeholder observations on changing patterns of consumption and harm may warrant deeper consideration. Some perceptions may not be measurable, others may be flagging up important trends not yet detected or recordable within current

monitoring systems. There are potentially important insights for configuring future strategic priorities.

Based on stakeholder perceptions of trends in use and harms, the following areas may be important to consider within any future strategy:

➢ Enhancing strategic oversight of 'supply and accessibility' indicators (eg. affordability of high strength alcohol, online drug markets)

➢ Measuring and understanding poly drug use

➢ Incorporating systems to monitor the interface between substance misuse and mental health indicators

➢ Conceptualising and recording 'service complexity' as well as volume of service use

➢ Focussing on alcohol use and harms among older people

➢ Tracking 'soft concepts' such as attitudes and cultures to drug and alcohol use

➢ Building a shared understanding of data returned through health information systems and surveys (eg coding and interpretation)

➢ Building understanding of the inter-relationship between alcohol and drug use and mental ill-health and the best intervention points

➢ Understanding the effects of changes in social determinants (in particular economic and housing issues).

What conclusions can be drawn from the assessment of evaluation criteria on the issue of strategy design?

In general, stakeholders perceived that the aspirations set out in the NSD-2 document were fit for purpose and that the overall strategy design, structure and approach was well configured.

Stakeholders prized the joint alcohol and drug approach.

Based on the views of stakeholders, the following areas may be important consider within the design phase of any future strategy:

➢ Resourcing the overall strategy in line with current and projected needs

➢ Designing a mechanism to protect resources of time, energy and money for prevention within the overall strategic approach

➢ Examining the feedback mechanism between assessment of local needs and service commissioning

➢ Making recovery a more central element of the strategic approach

➤ Revisiting the research and evaluation component of the strategy to encompass more evaluation and monitoring at regional/service level as well as reporting on high level trends in prevalence.

What conclusions can be drawn from the assessment of evaluation criteria on strategy implementation?

In general, a strong culture of cross-sectoral working was embedded within NSD-2 and highly valued. Multi-sectoral representation, knowledge sharing and co-design of policy solutions were seen as the cornerstone of effective implementation.

There was a reasonable match between stated and delivered priorities. By extension, some issues which did not feature on the priority list seemed to return lower ratings on aspects of fidelity. For example, hidden harm emerged with a 'higher relevance and lower fidelity' pattern - participants perceived that the implementation had not progressed to the intended extent. This may have been driven by the fact that hidden harm was not in fact one of the six stated priorities of NSD-2.

The Regional Commissioning Framework emerged as a key lever across many evaluation criteria contributing to aspects of fidelity, effectiveness, efficiency and equity. Overall this was perceived as a very significant achievement with multiple positive returns, but there were also a few concerns about unintended negative consequences.

The overall perception was that services had improved in terms of level of provision as well as in the domains of accessibility and consistency in the service offer in different regions. Service developments were significantly supported by timely investment in workforce development. However, participants generally considered that the positive improvements were struggling to meet the 'ever rising' tide of service demand as well as issues of increased complexity in service need.

Another area of significant achievement was harm reduction with perceived progress on both soft (changes in culture, embedding of approach) and hard outcomes (establishment of needle exchange networks and take home Naloxone).

Lack of political leadership and stable government were a common frustration at both strategic and operational levels. Participants identified a constraining effect from absent government structures. This was particularly acute in relation to the passage of legislative measures relevant to prevention as well as harm reduction.

What about equity within NSD-2?

Participants were highly engaged on the equity dimensions of NSD-2. The value placed on the strategic commitment to equity, and engagement with disadvantaged communities, was evident in data collected across a number of the evaluation criteria. Data returned on inequalities was particularly rich and diverse.

Based on the views of participants, the following areas may be important consider in the inequalities component of any future strategy:

- Raising the profile of the overall impact of NSD-2 on regional health inequalities
- Enhancing systems to monitor and respond to rural/urban and geographic inequalities in waiting lists
- Reporting on inequalities within key performance metrics
- Capturing the inequity impact of local engagement and outreach linked to DACTS
- Enhancing existing partnership working with the criminal justice system and the child protection system
- Considering a wider portfolio of policy and programme options for harm reduction in line with best evidence
- Considering how to better address alcohol and drug-related harm for older people, people with mental health issues, those in recovery and for women.

Working with a complex 'tapestry' of drug and alcohol use and harms

Overall, NSD-2 had 5 pillars, 2 themes, 13 values and principles, 8 objectives and 8 priorities. The complexity of the strategy structure made the review quite challenging but this complexity likely reflects the diversity of the issues and the need for deep cross-sectoral approaches.

Participants found it difficult to assess the overall impact of NSD-2 in the context of a volatile external operating environment. There were criticisms in terms of the ability of the strategy to adapt and respond to acute increases in service need and complexity (mainly in the drugs field) occurring on the background of stepwise increases in alcohol-related harms.

Investment in analysis to forecast future projected needs as well as fluctuations in service need may be helpful in developing strategic responses that are pro-active as well as reactive and increase 'preparedness'.

Some research questions returned a significant number of 'don't knows'. Broadly speaking, these related to high level governance issues, value for money assessments and the 'supply and availability' dimension (for example whether actions to reduce drug supply occurred as intended). This would indicate that there may be value in growing existing evidence in relation to the relative return on investment from key elements of the strategy.

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Appendix

Stakeholder Questionnaire

Section 1. Background information and consent

Section 2. Respondent information

Section 3. 'Helicopter view' - high level assessment on impact

Section 4. Future opportunities

Section 5. Overall strategy assessment by evaluation criteria

Section 6. Outcome areas

Section 1. Background information and consent

This questionnaire is being used to gather information as part of the Department of Health Northern Ireland review of the implementation of the New Strategic Direction for Alcohol and Drugs - Phase 2. This part of the review focusses on stakeholder engagement. It aims to capture the views and experiences of those directly involved in implementation of policies and programmes linked to the New Strategic Direction in the period 2011 to present. The Department of Health will use this information to inform the development of future alcohol and drug strategy in the region.

The questionnaire should take about 15-30 minutes to complete. You can answer the questions in the one sitting or over several sessions if preferred. The information collected through this questionnaire will be used solely for the purposes of the review and informing future strategy. Responses will not be attributed to or identifiable as, any individual or organisation in the final report. Data submitted by you will be handled in accordance with data protection regulations.

If you require any support with responding to this questionnaire, please contact NSDquery@publichealth.ie and your queries will be dealt with confidentially.

You do not need to answer all the questions. We are interested in your views on NSD Phase 2 in general as well as hearing about your specialist experience.

1. By completing this questionnaire, I consent to the information provided by me to be used as indicated above.	Continue		Exit questionnaire

Section 2. Respondent information	
2. What geographic area does your work relate to?	Northern Ireland as whole Ireland and Northern Ireland UK as a whole Europe Local government district/council Health and Social Care Trust Other (please specify)
3. If your work relates to a local area of Northern Ireland please identify that area.	Free text

4. Which groups have you been a member of in the implementation of NSD-2? Please tick all that apply	NSD Steering Committee	Alcohol Advisory Group
	Bamford Substance Misuse Subgroup	Treatment and Support Advisory Group
	Law and Criminal Justice Advisory Group	NI Drinks Industry Group
	Northern Ireland Alcohol and Drug and Alliance	Advisory Council on Misuse of Drugs
	Other (please name)	None

5. What type of organisations has been your main employer in the context of the implementation of NSD-2?	Government Department	
	Police Service of Northern Ireland	Public Health Agency
	Health and Social Care Board	Local government - council
	Health and Social Care Trust	Advocacy group
	Community and voluntary group	Other
	Prison Service of Northern Ireland	

6. Which branch/ division/ team within that	Free text

	organisation you have mostly worked for since 2011?		
7.	If your employed is a government department please indicate which department.	Department of Health	Department of Education
		Department of Health, Social Services and Public Safety	Department of Infrastructure
		Department for Communities	Not applicable
		Department for Social Development	Other
		Department of Justice	
8.	Have you regularly engaged directly with service users (ie those who have in the past or are currently availing of treatment and/or support services) in the context of implementation?	Yes	
		No	
9.	If yes, please describe the nature of this engagement.	Free text	
10.	In the implementation of NSD-2 which of these strategic activities were you directly involved with? Tick all that apply	Monitoring and evaluation	Evidence review
		Progress reporting	Development of official guidelines
		Contributing to political debates and legislation	Government
		Other (please specify)	None
11.	Which of these operational activities were you directly involved with? Tick all that apply	Service delivery (health and social care)	Service delivery (other services)
		Management and allocation of resources at regional or local level	Commissioning of services
		Governance/civil service level	Other (please specify)

	communication on drug and alcohol issues		
12. Please describe in your own words the main role that you have played in the context of implementation of NSD-2?	Free text		

Section 3. 'Helicopter view' - high level assessment on impact			
13. In your opinion, has the level of alcohol-related harm declined in Northern Ireland since 2011?	Yes	No	Don't know
14. What have been the main changes in the pattern of alcohol-related harm?	Free text		
15. In your opinion, has the level of drug-related harm (including prescription drugs, but excluding alcohol) declined in Northern Ireland since 2011?	Yes	No	Don't know
16. What have been the main changes in the pattern of drug-related harm?	Free text		
17. Do you think the implementation of NSD- 2 has had a positive or negative effect on alcohol and drug-related harm in Northern Ireland since 2011?	Totally positive Mostly positive Neutral Mostly negative Totally negative Don't know		
18. How significant has the implementation of NSD-2 been in bringing about changes in alcohol-related harm in Northern Ireland since 2011?	Very significant Quite significant Not that significant Not significant at all Don't know		
19. If you have any thoughts on how the implementation of NSD-2 has been a driver for change in alcohol-related harm, please comment.	Free text		
20. How significant has the implementation of NSD-2 been in bringing about changes in drug-related harm in Northern Ireland since	Very significant Quite significant Not that significant		

2011?	Not significant at all Don't know

21. If you have any thought how the implementation of NSD-2 has been a driver for change in drug-related harm, please comment.	Free text		
22. What do you see as the most significant achievement of the NSD-2?	Free text		
23. What do you see as the most significant lost opportunity of the NSD-2?	Free text		
24. Were there any unforeseen factors, not accounted for within the NSD-2 that helped reduce alcohol and drug related harm?	Yes	No	Don't know
25. If yes, please describe.	Free text		
26. Were there any unforeseen factors, not accounted for within the NSD-2 that that may have increased alcohol and drug related harm?	Yes	No	Don't know
27. If yes, please describe?	Free text		

Section 4. Overall strategy by evaluation criteria

Relevance

28. NSD-2 followed a six-stage approach to produce a fully integrated, inclusive and coordinated strategic direction for addressing alcohol and drug misuse in Northern Ireland over the period 2011-2016. How well do you feel the NSD-2 was: o Based on evidence? o Informed by local needs? o Based on meaningful consultation? o Relevant to the alcohol and drug threats in Northern Ireland? o Designed to integrate with local delivery structures? o Responsive to unforeseen circumstances?	Very well
	Quite well
	Not that well
	Not well at all
	Don't know
29. Please share your thoughts on the approach taken to deciding the content of NSD-2.	Free text

	Yes	No	Don't Know
30. Do you think that the NSD- 2 achieved a reasonable balance in terms of the strategic focus placed on alcohol and the strategic focus placed on drugs?			

31. Please share your thoughts on this balance.	Free text

32. How important were each of the features of the strategy listed below in supporting implementation? o A clear vision, mission and goal o Lead institutions and partners were on board o Objectives were SMART and feasible o Clear logic between activities and outcomes o Lines of accountability and reporting were clear from the outset o Resource requirements were correctly estimated and secured at the outset o Political support was achieved and consistent	Very important Quite important Not that important Not important at all Don't know

33. Please share your thoughts on the features listed above.	Free text

34. Five pillars form the conceptual base for NSD-2. How well did these pillars as a framework for implementation work? o Prevention and early intervention o Harm reduction o Treatment and support o Law and criminal justice o Monitoring, evaluation and research	Very well Quite well Not that well Not well at all Don't know

35. Please share your thoughts on the use of these five pillars to structure implementation.	Free text

Fidelity

36. The values and principles set out in the New Strategic Direction for Alcohol and Drugs Phase 2 are the basic tenets on which the strategy and its implementation are built. To what extent do you think NSD-2 stuck to the principals listed below when it came to implementation? o Positive, person-centred, non-judgemental and empowering o Balanced approach o Shared responsibility o Equity and inclusion o Partnership and working together	Very well Quite well Not that well Not well at all

o Evaluation, evidence and good practice based o Consultation, engagement and transparency o Addressing local need o Community based o Long-term focus o Value for money and invest to save o Built on existing work o Access to information	Don't know
37. Please share your thoughts on the principals listed above.	Free text
38. NSD Phase 2 set out seven priorities in terms of limitations. To what extent do you feel these issues remained priorities the implementation of NSD Phase 2? o Developing a Regional Commissioning Framework o Targeting those at risk and/or vulnerable o Alcohol and drug-related crime including anti-social behaviour and tackling under-age drinking o Reduced availability of illicit drugs o Addressing community issues o Promoting good practice in respect of alcohol and drug-related education and prevention o Workforce Development	Very well Quite well Not that well Not well at all Don't know
39. Please share your thoughts on these priorities.	Free text
40. What were the most significant areas in which the implementation went according to plan?	Free text
41. What were the most significant areas in which the implementation did not go according to plan?	Free text
Effectiveness	
42. To what extent did the governance structures operate effectively in the implementation of NSD- 2? o Strategic level (Steering Group and Advisory Committees) o Operation level (Bamford sub-group on alcohol and drug misuse) o Local level (DACTs and Connections Service)	Very well Quite well Not that well Not well at all

	Don't know
43. Please share your thoughts on the effectiveness of the governance structures.	Free text
44. Has NSD Phase 2 produced any positive unintended outcomes?	Yes
	No
	Don't Know
45. If yes, what are these positive unintended outcomes?	Free text
46. Has NSD Phase 2 produced any negative unintended outcomes?	Yes
	No
	Don't Know
47. If yes, what are these negative unintended outcomes?	Free text
48. What were the most significant factors helping initiatives implemented as part of NSD-2 meet their objectives?	Free text
49. What were the most significant factors impeding initiatives under NSD Phase 2 from reaching their objectives?	Free text
Efficiency	
50. How efficient was the allocation of resources in the implementation of NSD- 2?	Very efficient
	Quite efficient
	Not that efficient
	Not efficient at all
	Don't know
51. In terms of return on investment, what were the three best buys within the NSD Phase 2?	Free text
52. Please share your thoughts on return on investments in NSD-2.	Free text

53. Were there elements of the NSD- 2 that you think may not represent an efficient use of resources?	Yes	
	No	
	Don't know	
54. If yes, what were these?	Free text	
Sustainability		
55. To what extent has implementation of NSD- 2 generated changes in practice that will last into the future?	Very well	
	Quite well	
	Not that well	
	Not well at all	
	Don't know	
56. Please share your thoughts on what changes are sustainable.	Free text	
57. To what degree has the implementation of the NSD-2 contributed to enhancing working relationships and partnerships?	Very well	
	Quite well	
	Not that well	
	Not well at all	
	Don't know	
58. Please describe these relationship and partnerships.	Free text	
59. Please share one example of innovation within the implementation of NSD-2?	Free text	
60. What conflicts have been evident in implementation of NSD- 2?	Free text	
61. How have these been dealt with?	Free text	
Equity		
62. To what extent was the deployment of resources (human resources/financial) under the NSD-2 targeted at those most in need?	Very well	
	Quite well	
	Not that well	

	Not well at all
	Don't know
63. To what extent to you think the groups listed below have benefitted from the implementation of NSD- 2? o High Risk drinkers o People with alcohol dependent o Occasional drug users o Chronic drug users o People in recovery o Homeless people o Ethnic minorities including Travellers o LBGT+ o Children engaged with child protection system o Families of people using drugs	A lot
	A little
	Not that much
	Not at all
	Don't know
64. To what extent has the implementation of NSD-2 contributed to addressing health inequalities?	Free text
65. In what way could the implementation of NSD- 2 have been more effective in addressing health inequalities?	Free text
Section 5. Looking Forward	
66. What do you see as the most important features of a new alcohol and drug strategy for Northern Ireland?	Free text
67. What should be prioritised?	Free text
68. What should be maintained?	Free text
69. What should be stopped?	Free text
70. What external changes in the alcohol and drug environment in Northern Ireland need to be taken into account within a future strategy?	Free text
Section 7	
71. What is your age	<18 years
	18-24 years
	25-34 years
	35-44 years
	45-54 years
	55-64 years
	65+ years

72. What is your gender?	Male
	Female
	Transgender
	Bi-gender
	Non-gendered
	Other
	Prefer not to disclose
73. How many years have you been involved with drug and alcohol strategy in Northern Ireland?	Less than 2 years
	2-4 years
	5-10 years
	10-15 years
	More than 15 years

Thank you for completing this questionnaire.

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