



Isle of Man
Government

Reiltys Ellan Vannin

Updated Drug and Alcohol Strategy Isle of Man

2005 onwards

*Skeim S'Noa-emshiree Ellan Vannin
mysh Druggaghyn as Liggar Meshtallagh
- veih 2005 magh.*

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Foreword – Chief Minister, The Hon Donald Gelling CBE CP MLC

It is my responsibility to present the Island's first joint drug and alcohol strategy. The activities and accomplishments over the past five years have been outlined in annual reports – now the challenges and the way forward for the next few years are set out in this strategy. Widespread consultation has taken place and will continue to do so as we set about working on the recommendations contained within. We are determined to address with resolution the challenges that misuse of drugs and alcohol present to our community.

The consequences of drug and alcohol misuse cannot be underestimated - the devastating consequences which impact not just on the individual or family members but also, on the community as a whole. In the Island we recognised this five years ago when we introduced separate drug and alcohol strategies to outline plans to reduce the harm to the community. Since then significant progress has been made under the education, prevention, treatment and support and criminal justice pillars. However, as we all know no solution has been found anywhere in the world.

My committee agreed that we produce a joint drug and alcohol strategy instead of individual documents. This updated strategy focuses on specific recommendations with areas of responsibility clearly outlined for each agency and government department. We are fully committed to working in partnership throughout the community and accept that although we shall never be totally free of the problem, our efforts will focus on reducing the harm arising from the consequences of misuse. The people of the Isle of Man have an important role to play. We must all be aware and informed of the effects, risks and consequences of drugs and alcohol misuse. As parents we have responsibilities to our children and as members of this Island nation we can contribute to a positive community spirit Island-wide to ensure a better quality of life for all of us.

This updated strategy provides the opportunity to build on what we have learnt to date. We need to improve our support to parents and families at local level. Our young people are a high priority too - with the launch of our children and young people's strategy we intend to focus our efforts on the needs of these critically important members of our society.

Provision of treatment and support is vital for those with drug and alcohol problems. We are determined that this will continue to improve both within the community and the criminal justice system.

The strategy continues to focus on measures to reduce demand and supply of illicit drugs and reduce alcohol-related harm.

The review to arrive at this strategy has involved considerable input from all sections of the community. I am very grateful for all the hard work, commitment and cooperation shown by so many over the past five years. Together, as a community I am confident we will achieve success.

Hon DJ Gelling - Chief Minister

A vision for the 21st century

'To maintain and improve the quality of life for the Island, by ensuring a high level of health protection, social well-being and community safety for its citizens, by reducing the harms caused by drugs and alcohol'

Building on the previous five-year drug and alcohol strategies, this joint updated strategy is aimed at reducing the harm caused by drugs and alcohol by adopting the following principles:

- Inter-agency and cross-departmental cooperation. In the past few years we have worked to achieve this and will continue to focus our efforts on maintaining and developing this approach
- A holistic, integrated and multi-disciplinary approach. The problems associated with drugs and alcohol misuse will require the adoption of a broad-based strategy to achieve any sustainable positive results
- Based on research, knowledge, monitoring and evaluation. The focus on this important principle will be applied to all measures and initiatives in support of the strategy
- Based on measurable results. The expected outcomes are outlined in each section of the strategy and those responsible will be publicly accountable in each action plan
- Continue to cooperate with other jurisdictions. Countries world-wide are working to devise solutions to drug and alcohol problems. The Island will continue to keep abreast of global developments and contribute to and learn from other countries at relevant meetings, seminars and conferences
- Involvement of all members of the community. Drug and alcohol issues are the responsibility of everyone. This strategy must promote the involvement and active participation of the entire Isle of Man community

A vision for the 21st century - Aims

I. Lifestyle

This supports the government aims of social well-being, quality environment and good government.

Strategy AIMS

1. to reduce drug use and new recruitment to use, particularly among young people
2. to reduce harmful patterns of drinking and promote sensible drinking
3. to promote behavioural and cultural changes in patterns of drinking

II. Treatment and Support

This supports the government aims of social well-being, quality environment, sound infrastructure and good government.

Strategy AIMS

4. to increase the number of successfully treated drug users
5. to increase the number of successfully treated alcohol-dependent individuals
6. to reduce drug-related deaths
7. to reduce alcohol-related deaths

III. Community Safety

This supports the government aims of social well-being, quality environment and good government.

Strategy AIMS

8. to reduce drug-related crime
9. to reduce alcohol-related crime

IV. Coordination, Evaluation and Information

This supports the government aims of good government, positive national identity, economic progress, quality environment and social well-being.

Strategy AIMS

10. to measure the impact of the strategy
11. to ensure both the prevention of harm and its consequences are addressed by coordinated and effective measures

Introduction

The Chief Minister launched the Island's first drug strategy in 1999 followed by an alcohol strategy in 2000. Both strategies adopted a harm minimisation approach, i.e. reducing the risks of drug and alcohol-related harm. Within this approach the strategies set out aims, objectives and tasks under the headings of young people; education and prevention; treatment and support; community safety, and reducing the availability of illegal drugs. The principles behind both strategies focused on a multi-agency approach, making use of available evidence and providing the Island with consistent, accurate information. Much progress has been made over the past five years, as outlined in the annual reports issued by the Chief Minister's drug and alcohol strategy committee through the drug and alcohol coordinator's office. The international drug and alcohol strategy conference and the Island's participation in the British/Irish Council sector on drugs have all contributed to the robustness of the strategies in consulting, exchanging information and cooperating in areas of mutual concern.

In March 2003 the external validation report on the strategies was completed. The overall objective of the review was to identify any gaps or deficiencies in the existing strategies and, where necessary, take appropriate action. The outcome of this review concluded that the strategies had provided an appropriate and considered response to tackling issues of misuse and should be revised at the end of the five-year period. The review also stated there would be little benefit in fundamentally altering the current arrangements for implementing the drug and alcohol strategies. The Chief Minister's committee adopted the recommendations and elected to proceed with an updated joint drug and alcohol strategy instead of two separate documents as before.

The last five years have involved much effort in creating the necessary infrastructure for the future development and expansion of services. These structures and systems are now in place. The next stage in the development of the strategies is building on those areas proven to be effective and addressing the gaps identified during the consultation process. All elements of the policy have been brought together into a joint strategic framework with responsibility clearly assigned.

The strategy provides a comprehensive integrated approach to the harmful use of alcohol, illicit drugs and other substances.

The aim is to achieve a balance between harm reduction, demand reduction and supply reduction measures to reduce the harmful effects of drugs in the Isle of Man community. The strategy promotes partnerships between health, law enforcement and education agencies, drug users, people affected by drug-related harm, community-based organisations and industry to reduce drug-related harm in the Island. The emphasis in this joint strategy is based as before on harm minimisation with an holistic approach. It recommends the provision of more and better quality information; clear expected measured outcomes; continuation of and more creative and targeted education and prevention measures; greater emphasis on diversionary activities such as sport, together with renewed focus on

housing, training and employment. The approach remain will continue to major on cross-departmental and inter-agency cooperation in the Island, as well as on cross-jurisdictional cooperation.

The Chief Minister's strategy committee, renamed strategic group, will continue to oversee the strategies but revised membership will include the chief executives of the leading government departments responsible for their delivery, as part of a restructuring of Council of Ministers sub-committees. The drug and alcohol coordinator will continue to coordinate activities on behalf of the strategy committee. However, given the post's wider remit for 2005 and beyond, it will be incumbent on the newly structured strategic coordination group (See Appendix 1) to ensure implementation of all of this updated strategy's recommendations.

The joint updated strategy for 2005 and beyond

The source of information used for the formulation of the following aims is based on database and survey work carried out in the Isle of Man since 2001.

I. LIFESTYLE

AIM 1 to reduce drug use and new recruitment to use, particularly among young people

Cannabis and volatile substance abuse (VSA) are documented since 2001 as the most frequently used substances of experimentation among teenagers in the Isle of Man (12 to 16 years); experimentation starts as young as 10; at young adult level use continues, but the levels have yet to be assessed; evidence from UK (Thomson et al, 2004, on British holiday makers outside Britain and Rogstad KE, 2004) suggests high levels of experimentation and use in age group 18- 30 years, sometimes as polydrug use (drugs and alcohol).

Strategic objectives

1. To reduce the proportion of cannabis users
2. To reduce the proportion of VSA users
3. To discourage new recruitment to experimentation with any illicit drug
4. To delay experimentation with any illicit drug

AIM 2 to reduce harmful patterns of drinking and promote sensible drinking

Alcohol forms a part of teenage drug experimentation; by the age of 16 almost all young people have drunk alcohol; binge drinking is prevalent and documented since 2003; there is no gender gap; adult population drinking habits have not yet been documented but anecdotal evidence indicates that heavy drinking is a cultural factor and plays an important role in Isle of Man lifestyle.

Strategic objective

5. To reduce the proportion of those who misuse alcohol on a regular basis

AIM 3 to promote behavioural and cultural changes in patterns of drinking

Alcohol is part of lifestyle and if misused is harmful: harm is done to self, family and society as a whole; significant perceived cultural changes take many years (across generations); any positive change in behaviour and attitudes could lead to beneficial cultural changes.

Strategic objectives

6. To facilitate the development of new drug and alcohol partnerships between agencies who take responsibility of the strategy to be carried forward with long-term beneficial health, social and societal consequences
7. To update, implement and monitor drug and alcohol policies in the workplace

II. TREATMENT AND SUPPORT

AIM 4 to increase the number of successfully treated drug users

The number of individuals coming forward to treatment has increased over the last two years (core database). This number is likely to increase over the next five to 10 years, as indicated by local evidence-based information, and will prompt further development and expansion of services.

Strategic objectives

8. To reduce drug-related harm by preventing occurrence of blood borne diseases (HIV, Hepatitis B, Hepatitis C etc.) in injecting drug users (IDU)
9. To facilitate access to drug services
10. To achieve abstinence among drug users

AIM 5 to increase the number of successfully treated alcohol-dependent individuals

The greatest majority of those referred or self-referred to treatment agencies consists of individuals with alcohol problems; there are two categories: either young adults, male dominant (20 to 34 years) or beyond middle-age adults of mixed gender (45+ years). Two types of need are identified: the younger age group is more prone to acute effects of alcohol (e.g. accidents, arrests, societal effects), therefore in need of acute services; the older age category (for which there is highly underestimated data at present) is more prone to the chronic effects of alcohol, such as liver cirrhosis and mental health problems.

Strategic objectives

11. To assess the needs for evidence-based alcohol-related interventions
12. To facilitate access to alcohol services
13. To achieve abstinence among alcohol-dependent individuals

AIM 6 to reduce drug-related deaths

Misuse of drugs cannot only damage health, it can also prove fatal when drugs are taken accidentally or deliberately in excessive dosage; vulnerable individuals - young people, young people in care, those with mental health problems - are most at risk.

Strategic objectives:

14. To reduce and monitor the number of DRDs (Drug Related Deaths)
15. To prevent DRDs from happening in the first instance

AIM 7 to reduce alcohol-related deaths

The main cause of alcohol-related harm is intoxication, the acute form in many instances, the link between intoxication and adverse consequences is clear and strong, the patterns of drinking playing a distinct role in alcohol-related diseases, e.g. cancer, dependence syndrome, cirrhosis or heart disease. In combination with other risk taking behaviour, such as driving under the influence of alcohol or mixing alcohol with other drugs, the risk of death is heightened.

Strategic objectives

16. To reduce and monitor the number of alcohol-related deaths
17. To prevent alcohol-related deaths from happening in the first instance

III. COMMUNITY SAFETY

AIM 8 to reduce drug-related crime

Reduction of availability can be achieved by enhanced vigilance/interception based on intelligence. Higher market prices on the Island in comparison to the United Kingdom will, however, increase attractiveness to the criminal element. Volume of seizures should be indicative over time of an improved level of supply reduction.

Strategic objectives

18. To reduce availability, and achieve more disruption of local supply markets
19. To provide appropriate and timely treatment
20. To maintain an active international role, including the seizures of assets both on and off-Island.

AIM 9 to reduce alcohol-related crime

Alcohol accounts for many negative social consequences, and statistically impacts significantly on all aspects of Island life.

Strategic objectives

21. To reduce alcohol-related disorder
22. To increase the number of individuals accessing treatment and support
23. To increase liaison and the working partnership with the licensed trade

IV COORDINATION, EVALUATION AND INFORMATION

AIM 10 to measure the impact of the strategy

The Chief Minister's strategic group is accountable for evidencing the delivery of the strategy through three types of evaluation.

Strategic objectives:

24. To ensure measurement of outputs at Working Group level (three working groups)
25. To measure the number of objectives achieved
26. To measure the success of actions taken

AIM 11 to ensure both the prevention of harm and its consequences are addressed by coordinated and effective measures

Ensuring inter-agency cooperation receives high priority is key to the strategy, in terms of delivering consistent and appropriately targeted messages linked to sustained partnership working with the media. International collaboration must remain high on the strategy's agenda to ensure the Island is represented at UK, European and global level.

Strategic objectives

27. To provide leadership and direction
28. To provide effective coordination across government departments, as well as across both statutory and non-statutory bodies
29. To identify the resources necessary to deliver the strategy

Appendices

APPENDIX 1

STRATEGY DELIVERY FRAMEWORK

The following illustrations set out the arrangements for enhancing partnerships, both strategically and operationally in support of the delivery of the strategy as part of the restructuring of Council of Ministers Committees. This aims to create greater accountability and to ensure that the monitoring and evaluation aims of the strategy are fully implemented.

Each of these groups must meet on a quarterly basis.

Figure 1 **The Chief Minister's Drug and Alcohol Strategic Group** (formerly the Chief Minister's Drug and Alcohol Strategy Committee). This group will function under the umbrella of the Council's Social Policy Sub-committee.

The aim of this strategic group is to provide strategic direction, monitor and evaluate the implementation of the strategy, set up a reporting structure and promote legislation.

The changing composition of this group includes the chief executives of the main government departments and chief officers:

Chief Minister Chairman
Minister for Department of Education
Minister for Health and Social Security
Minister for Home Affairs
Minister for Treasury
Chief Executives (Health, Education, Home Affairs)
Chief Administrative Medical Officer
Consultant Psychiatrist Drug and Alcohol Team
Director of Social Services
Collector of Customs & Excise
Chief Constable
Chief Probation Officer
Prison Governor
Drug and Alcohol Coordinator
Drug and Alcohol database manager

Where chief executives or chief officers are unable to attend deputies must attend in their absence.

When requested managers or representatives of departments and bodies may attend (by invitation only).

The responsibility for the organisation of this group lies with the drug and alcohol coordinator.

FIGURE 1 The Isle of Man Drug and Alcohol Strategic Group

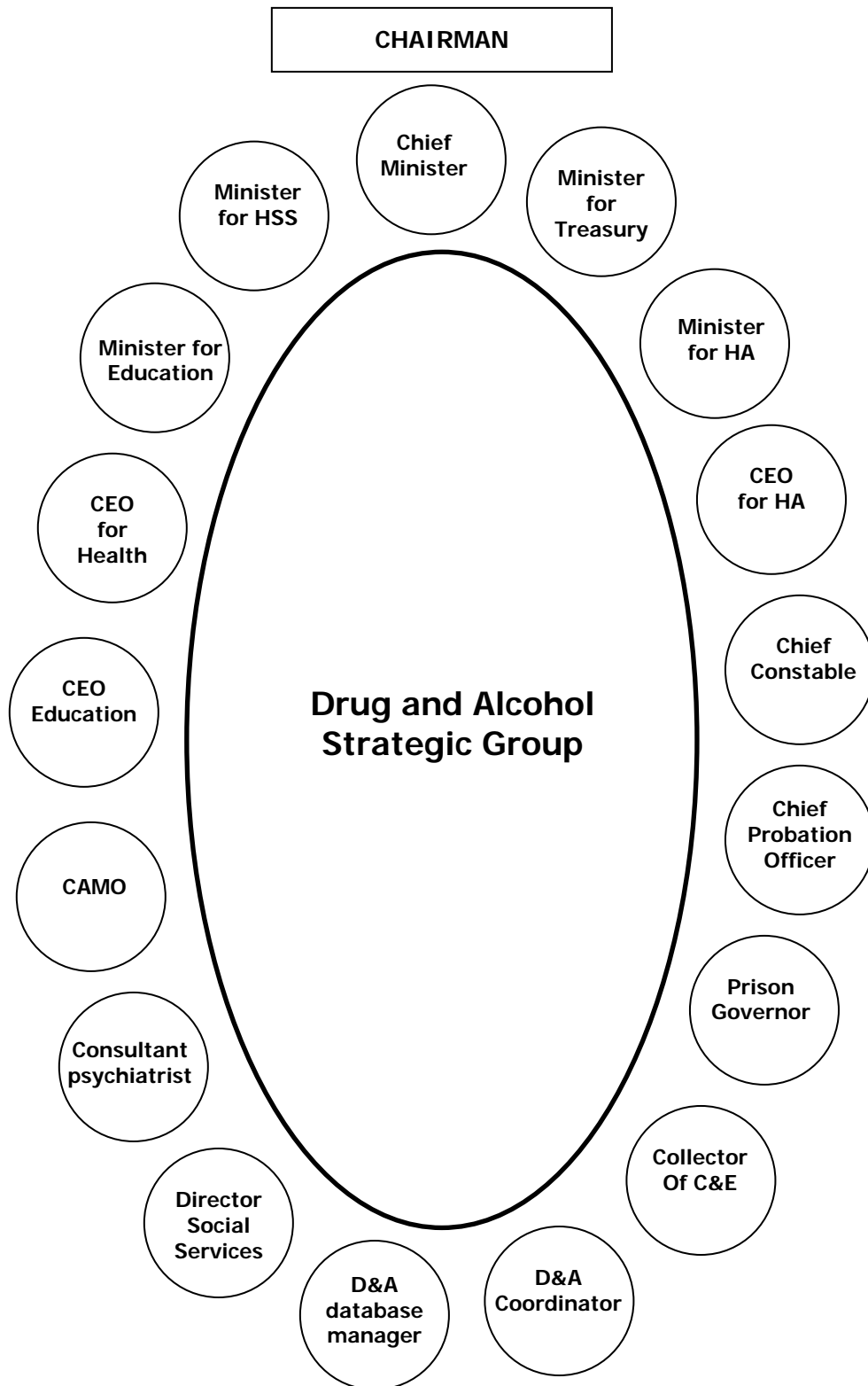


Figure 2 **The Strategy Delivery Group** – this is a new development in the delivery framework of the strategy.

The aim of this group through three cross-departmental working groups and all meeting together at least once a year, is to share information and experience, implement action plans, tackle emerging issues and provide written update reports on performance to the strategic group.

Youth and Community Adviser

Drug and Alcohol Team Manager

Prison Security Manager

Non-statutory agencies representatives

Police Drug Squad

Police Central Alcohol Unit

Probation Service Manager

Drug Education Liaison Officer

Employment Manager

Housing manager

Sport Manager

Director of Health Promotion

Assistant Director of Social Services – Children and Families

Pharmaceutical Adviser

Victim support

Customs and Excise

Residential Care Unit representative

Youth Justice Team Manager

The responsibility for the organisation of this group lies with the drug and alcohol coordinator in the short term.

The medium and long-term plan for this group is that individual departments will assume responsibility for its organisation for a specified period of time.

FIGURE 2 Drug and Alcohol Strategy Delivery Group (Three working groups)

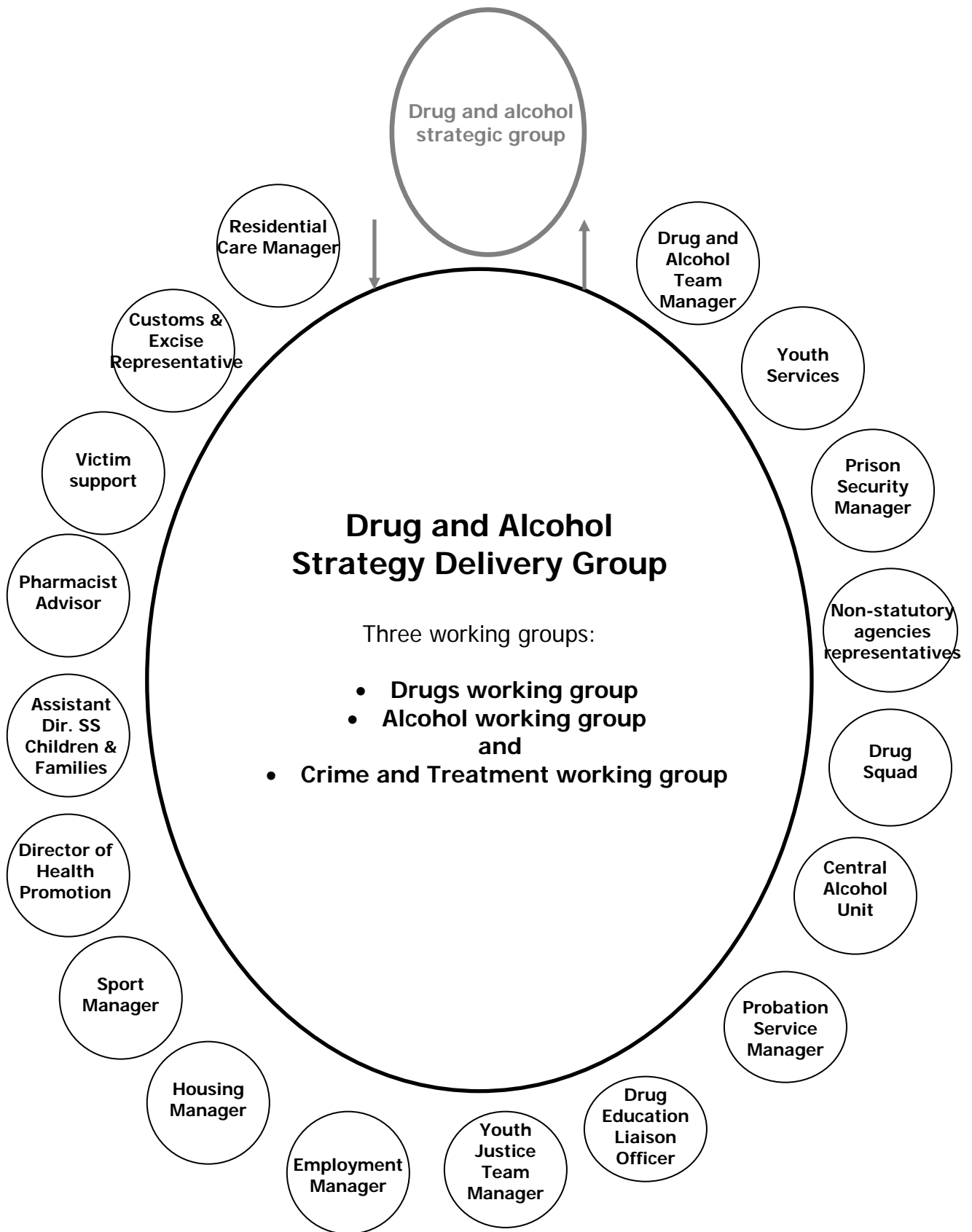
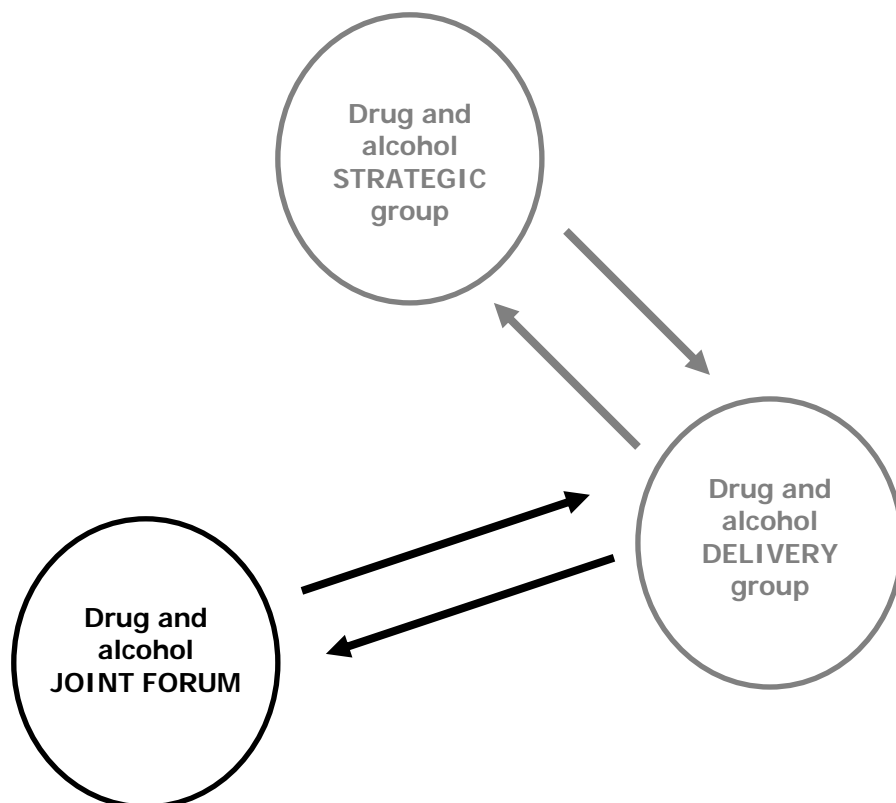


Figure 3 **Joint Forum** for all practitioners across government departments and non-statutory bodies – this group is already in operation.

The aim of this group is to share best practice and information and report to the strategy delivery group on key issues.

FIGURE 3 **The Joint Forum**



The responsibility for the organisation of this group lies with the drug and alcohol education liaison officer, department of education in partnership with the health promotion unit, and the department of health and social security.

Other cross-departmental groups and inter-agency forums, which already exist and link in with drug and alcohol issues (e.g. home affairs drug and alcohol strategy working group; sexual health strategy group; children and young persons group) will provide updated written reports to the Chief Minister's strategic group.

Where local action teams are set up around the Island relating to other areas such as recommended in the children and young persons strategy but where drug and alcohol issues may be part of the overall problem the strategy the strategy delivery group will ensure that the relevant officers are part of these partnerships.

The Role of the Drug and Alcohol Coordinator

As the coordinator is assuming a wider remit within the Chief Secretary's Office, the responsibilities related to the drug and alcohol strategy will include:

- lead, facilitate, monitor and evaluate the implementation of all aspects of the strategy to the Chief Minister's Strategy Group
- provide advice, guidance and support throughout all levels of the strategy delivery framework
- monitor international developments
- represent the Island at the relevant overseas meetings/ seminars/ conferences

The Role of Drug and Alcohol Database Manager

As the database manager is involved in other areas of work responsibilities related to this role include:

- manage core database including outcome measurements
- manage survey work
- report on all data and information aspects of the strategy to the Chief Minister's Strategic Group and where requested to the other groups

APPENDIX 2

ACTION PLANS

DRUGS AND ALCOHOL SNAPSHOT OF UPDATED EVIDENCE

The focus of the Drug and Alcohol strategy in the Isle of Man is to reduce the harms arising from the misuse of drugs and alcohol.

In 2000 alcohol and illicit drugs ranked among the top 10 leading risk factors for the disease burden in developed countries. World Health Organisation has reported that at least 76 million persons are diagnosed with alcohol use disorders and at least 15 million with drug use disorders; the evidence also suggests that for every dollar invested in treatment: seven dollars are saved in health and social costs and; in the UK for every pound invested in treatment three pounds are saved in the criminal justice.

At European level, countries have adopted the European Monitoring Centre's for Drug and Drug Addiction key indicators for all the work involved, along with many other tools and methods. The Isle of Man has found other countries' experiences in the field valuable and has considered some of the best practice action in its updated Drug and Alcohol Strategy.

The key and core data collection will be concentrated on specific areas: lifestyle, treatment and support and crime and justice system (community safety); the sub-areas cover:

1. Drug and alcohol use in the general population, especially in the younger age groups and the vulnerable*
2. Problem drug and alcohol use (types and pattern)*
3. Drug and alcohol trends in youth
4. Drug-related infectious diseases*
5. Drug-related and alcohol-related death and mortality*
6. Demand for treatment*
7. Drug-related and alcohol-related crime
8. Drug-related social exclusion
9. Availability of illicit drugs
10. Alcohol and licensing

* denotes EMCDDA (UK, Ireland included) key indicator for drugs only; countries have adopted similar indicators for alcohol

The reason for having selected these areas and sub-areas is that they have been documented with data and information in recent years and allows for action to be initiated or continued (Action Plans of the Drug and Alcohol Strategy, Isle of Man, 2005)

CANNABIS

Cannabis is identified as the highest prevalent drug in the Isle of Man community as it is across Europe

Lifestyle: use and effects as a determinant of health

- from 2% in 10/11 year olds to 39% in 15/16 year olds with no gender differences at least once in lifetime (life time prevalence or LTP); similar figures in the British Isles, 2003); at 16 years 12% used it more than three times in the last month;
- two thirds of those who tried/ used have also smoked tobacco (14/15 year olds, HLSC 2003);
- school health education curriculum: includes cannabis;
- little known about reclassification;
- research shows if used regularly and individual predisposed to mental health problems there is an increased risk of developing psychoses
- evidence that cannabis consumption leads to use of class A drugs is controversial, and not proven

Treatment and support

- at the tip of the iceberg, currently, individuals who only use cannabis rarely present for treatment; most cases come forward for alcohol and also report cannabis use;
- limited evidence in literature about effective treatment; becoming abstinent is most effective treatment;
- cannabis oils for medical conditions like multiple sclerosis will soon be available on prescription; smoking it is strongly discouraged as potential lung harms appear to be worse than from tobacco

Community safety

- seizures: quantity varies on an annual basis and seizures solely are not an indicator of decrease or increase in use in a population;
- Drug Arrest Referral Scheme (DARS) criminal justice/ treatment interface plays important role; juvenile scheme under development;
- legislation perception: mixed: majority of 15/16 year olds (ESPAD 2003) thought that the legal status of cannabis for possession would change to 'legal' as of January 2004; same group (63%) said it would make no difference to their use; only 25% said they were more likely to use it and, that compares with figures of those who had used at least once in the last month (last month prevalence or LMP) and was 22%;
- legislation enforcement: mixed due to its recent status in reclassification.

VOLATILE SUBSTANCE ABUSE (VSA)

VSA is a highly prevalent practice in the Isle of Man community; ESPAD Report (2003) concludes: “It is striking that the high prevalence countries to a large extent are islands. It is difficult to see why this is so. A possible explanation might be that the social control in smaller societies might make it more difficult for young people to get hold of other illegal substances”.

Lifestyle: use and effects as a determinant of health

- from 2% in 10/11 year olds to 10% in 14/15 year olds and 20% in 15/16 year olds who tried at least once in lifetime (LTP);
- half or most who experimented with volatile substances did so in the last year prior to survey (11% in ESPAD cohort); Cyprus and Malta had high last month prevalence use of inhalants (ESPAD 2003);
- adult use is not documented;
- school health education curriculum: includes glues and other volatile substances; health promotion campaigns.

Treatment and support

- at the tip of the iceberg very few present for advice, treatment and support (regarded as licit substances)
- VSA is a very high risk behaviour
- abstinence is a key feature (health education); occupational health message reinforced in those occupations using volatile substances (painters, decorators); and support and treatment for the young, vulnerable and individuals exposed to volatile substances

Community safety

- DARS; juvenile scheme under development
- Office of Fair Trading liaison
- proper disposal of used volatile substance after household and building site, etc. work

ALL OTHER ILLICIT DRUGS

Are identified as low prevalent drugs in the Isle of Man community but pose **HIGH** and **SIGNIFICANT** health risk including drug related deaths (DRDs)

Lifestyle: use and as determinants of health (stimulants and depressants)

- lifetime use of other drugs: 6% for ecstasy, magic mushrooms, cocaine; 5% for amphetamines and amyl nitrites; 1-2% for crack cocaine, heroin, tranquillisers and steroids without prescription (HLSC 2003; ESPAD 2003);
- percentages are extremely small for last month use, with the exception of 1-2% for: ecstasy, cocaine and amyl nitrites (HSLC 2003, ESPAD 2003);
- major contributors in drug related deaths (DRDs) due to overdose or substantial long-term misuse (cocaine) or, due to infectious diseases, injecting drug use (IDU)

Treatment and support

- individuals who present for treatment (at the tip of the iceberg): very few in absolute numbers, but injecting behaviour is prevalent; polydrug use is a feature in these individuals, alcohol is frequently associated with the illegal polydrug use: to focus on single substance disorders is outdated;
- limited evidence in literature in terms of effective treatment with exception of methadone and related-maintenance (buprenorphine) for heroin; cocaine has no documented effective treatment; becoming abstinent is most effective treatment;
- engagement, compliance and retention of clients in drug treatment for a sufficient period of time are key indicators for harm reduction, and improved outcomes for drug misusers; enhancing outcomes of methadone maintenance with counselling and other psychosocial interventions and provision of ancillary services are essential;
- IDUs: anonymised testing for blood borne viruses (BBV) protects families and contacts; protects the wider population
- UK has documented what works through a major national drug treatment study: the National Treatment Outcome Research Study (NTORS) from which best practice is drawn; other major studies document treatment outcomes from the United States of America (quoted by NTORS)

Community safety

- seizures of any illegal drug
- DARS (criminal justice/ treatment): the crime/ treatment interface plays a key role in rapid engagement in treatment; juvenile scheme under development

ALCOHOL: BINGE DRINKING CULTURE

Excessive alcohol consumption (i.e. harmful in 14/15 and 15/16 year olds or, youth binge drinking); the phenomenon in those 18 years or older is currently not documented in the Isle of Man community, where drinking patterns may also be harmful

Lifestyle: misuse as a determinant of health

- there is evidence that a substantial number of individuals drink at “risky” or “hazardous” levels (binge drinking); 55-60% had three + binge drinking sessions in the past 30 days with no gender gap (ESPAD 2003);
- 30% of A&E admissions involved alcohol; blood alcohol concentration (BAC) as high as 240mg/100ml was documented in a young person of 14 years of age (A&E alcohol-related admissions Noble’s Hospital, 2003/2004, ongoing audit);
- approximately 1,000 individuals (16+ years) come in contact with 11 agencies; 10% were new individuals who came forward for drug and/or alcohol treatment; 68% of them are alcohol-related cases; most of them are men (over 70%) and middle aged; poly substance misuse involves alcohol and another drug, usually cannabis (2002/2003 and 2003/2004 core database annual report);

Research (UK and elsewhere):

- alcohol misuse is associated with a range of physical problems and heavy drinking is closely linked with psychiatric morbidity and other physical illness;
- 20% of general hospital beds are occupied by people with alcohol- related problems; one in seven acute hospital admissions (17%) are alcohol related (UK, 2000);
- up to 65% of all suicide attempts are linked with excessive drinking and alcohol is a major contributor to accidental death (20-30% of all accidents)
- brief interventions may reduce alcohol consumption and prevent from further dependency (reduce burden on detox); evidence controversial.

Treatment and support

- acute intoxication episode emergencies dealt with at A&E level; no further link for chronic treatment; however, screening with questionnaires (e.g. “CAGE”: Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers) to identify individuals at risk from heavy drinking (Ewing JA, 1984).
- one off/ occasional episodes (e.g. young people) and/or low to medium risk individuals can be dealt with by non-statutory agencies
- detox is most effective, but it requires compliance and patient will need to engage if intervention is to be successful; dependent individuals (alcohol specific morbidity) and heavy drinking and its effects on health (more than 50g pure alcohol/ day)
- services under development (Ard Aalin); effective treatments available (National Institute for Clinical Excellence, NICE)
- counselling and other complementary and alternative medicine: short- term may be effective, long-term not proven (especially for heavy drinkers)

Community safety

- drink driving law enforcement; BAC limits are under change; at present no evidence that relaxation of drinking time laws have exacerbated phenomenon ;
- criminal justice/ treatment interface: alcohol arrest referral scheme to be developed;
- legislation enforcement: licensing laws under revision; advertising

Strategic Objective 1: CANNABIS

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Drugs Working Group will take the detailed plan forward</p> <p>2. Proactive reduction of availability through market disruption, including:</p> <ul style="list-style-type: none"> - comprehensive, cohesive and non-contradictory information to individuals, families and schools; updated accredited training for staff and service workers <p>3. Law enforcement at crime/ treatment interface: DARS, drug driving</p> <p>4. Promote joint partnership initiatives e.g. with tobacco; joint departmental partnerships (e.g. Health Services and Social Services) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People) e.g. sport, training, employment and housing</p> <p>5. Health education: comprehensive revision</p> <p>7. Health promotion: target mental health and physical health</p> <p>8. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from drug misuse)</p> <p>9. Treatment and support: allow for outcome monitoring under informed consent</p> <p>10. Integrate treatment with NSF Mental Health: dual diagnosis (drug use and mental health)</p> <p>11. Cannabis user groups</p> <p>12. Evaluation to identify best practice</p>	DoE, DHA, DHSS	<p>Other government departments and non-government organisations e.g. Drug Advice Service and Helpline (DASH)</p> <p>External:</p> <p>Survey: Swedish Council on Alcohol and other Drugs (Pompidou Group of Council of Europe)</p>	<p>Lifetime prevalence (LTP)</p> <p>Last Month Prevalence (LMP)</p> <p>Access to treatment</p> <p>Abstinence at 5 years</p> <p>Other indicators in:</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle</p> <p>Reduce LTP at 16 years from 40% to under 35% by 2011</p> <p>Reduce LMP at 16 years from 12% to under 8% by 2011</p> <p>Treatment and support</p> <p>Revise polydrug treatment schemes</p> <p>Increase access for users by 25% from 2006</p> <p>Increase early access via DARS</p> <p>Increase abstinence ('never used') rate by 10% by 2010/2011; baseline: 2003</p> <p>Community safety</p> <p>Increase seizures in conjunction with increase arrests for trafficking; correlate with street price and prevalence to estimate efficiency of market disruption; increase arrest referrals to early treatment</p> <p>Increase outreach work (work in the community)</p>

Strategic Objective 2: VOLATILE SUBSTANCE ABUSE (VSA)

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Drugs Working Group will take the detailed plan forward</p> <p>2. Proactive reduction of availability, including:</p> <ul style="list-style-type: none"> - comprehensive, cohesive and non-contradictory information to individuals, families and schools; updated accredited training for staff and service workers <p>3. Law revision and Office of Fair Trading (OFT) liaison</p> <p>4. Promote joint partnership initiatives e.g. with other drug campaigns; joint departmental partnerships (e.g. Health Services and Social Services) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People) e.g. sport, training, employment and housing</p> <p>5. Health education: comprehensive revision</p> <p>6. Health promotion: target mental health and physical health</p> <p>7. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from drug misuse)</p> <p>8. Treatment and support: allow for outcome monitoring under informed consent</p> <p>9. Integrate treatment with NSF Mental Health: dual diagnosis</p> <p>10. Vulnerable, user groups</p> <p>11. Evaluation to identify best practice</p>	<p>DoE, DHA, DHSS</p> <p>OFT</p>	<p>Other government departments and non-government organisations e.g. DASH</p> <p>External:</p> <p>Swedish Council on Alcohol and other Drugs</p>	<p>LTP</p> <p>LMP</p> <p>Access to treatment</p> <p>Other indicators in:</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle</p> <p>Reduce LTP at 16 years from 20% to under 15% by 2011</p> <p>Reduce LMP at 16 years from 11 % to under 6 % by 2011</p> <p>Treatment and support</p> <p>Revise polydrug treatment schemes</p> <p>Increase access for users by 25% from 2006</p> <p>Increase abstinence rate by 10% by 2010/2011 baseline: 2003</p> <p>Community safety</p> <p>Increase in conjunction with Youth Justice Team actions</p> <p>Increase outreach work (work in the community)</p>

Strategic Objectives 3 and 4: ALL ILLICIT DRUGS

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Drugs and Crime and Treatment Working Groups will take plan forward</p> <p>2. Proactive reduction of availability through market disruption, including:</p> <ul style="list-style-type: none"> - comprehensive, cohesive and non-contradictory information to individuals, families and schools; updated accredited training for staff and service workers <p>3. Law enforcement at crime/ treatment interface e.g. DARS, drug driving; and further criminal justice intelligence development</p> <p>4. Promote joint partnership initiatives e.g. with other health policies; joint departmental partnerships (e.g. Health Services and Social Services, Health Services and Home Affairs, etc) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People) e.g. sport, training, employment and housing</p> <p>5. Health education: comprehensive revision; health promotion: target mental health and physical health</p> <p>6. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from drug misuse)</p> <p>7. Treatment and support: allow for outcome monitoring under informed consent; integrate treatment with NSF Mental Health: dual diagnosis</p> <p>8. Drug Treatment and Testing Orders (DTTOs) and other criminal justice tools (revision)</p> <p>9. User groups</p> <p>10. Evaluation to identify best practice</p>	<p>DoE, DHA, DHSS, Treasury</p>	<p>Other government departments and non-government organisations e.g. DASH</p> <p>External:</p> <p>Swedish Council on Alcohol and other Drugs</p>	<p>LTP</p> <p>LMP</p> <p>Access to treatment</p> <p>Abstinence at 5 years</p> <p>BBV prevalence</p> <p>Other indicators:</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle</p> <p>Reduce LTP at 16 years from 10 % to under 5 % by 2011</p> <p>Reduce LMP at 16 years from 5 % to under 3 % by 2011</p> <p>Treatment and support</p> <p>Revise periodically polydrug treatment schemes</p> <p>Increase access for users by 25% from 2006</p> <p>Increase abstinence (‘never used’) rate in young people by 10% by 2010/2011; baseline: 2003</p> <p>Community safety</p> <p>Increase in conjunction with DARS referrals;</p> <p>Reduce social exclusion (after prison)</p> <p>Unlinked anonymous BBV screening; HBV vaccination (offered/ completed)</p> <p>Needle exchange (improve)</p>

Strategic Objective 5: SENSIBLE DRINKING

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome and deadline
<p>1. Alcohol Working Group will take the plan forward</p> <p>2. Promote joint partnership initiatives e.g. with other health policies; joint departmental partnerships (e.g. Health Services and Social Services, Health Services and Home Affairs, Home Affairs and Department of education, etc) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People) e.g. sport, training, employment and housing</p> <p>3. Health education: comprehensive revision</p> <p>4. Health promotion: target mental health and physical health</p> <p>5. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from alcohol misuse)</p> <p>6. Treatment and support: allow for outcome monitoring under informed consent</p> <p>7. Integrate treatment with NSF Mental Health: dual diagnosis</p> <p>8. Revision of anti-social behaviour orders</p> <p>8. User groups</p> <p>9. Evaluation to identify best practice</p>	<p>DHSS, DoE, DHA</p>	<p>Other government departments and non-government organisations e.g. Alcohol Advisory Service (AAS)</p> <p>External: Swedish Council on Alcohol and other Drugs</p>	<p>[Alcohol lifetime]</p> <p>Alcohol last year</p> <p>Alcohol last month (LMP)</p> <p>Binge drinking no. sessions last month</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle Reduce LMP binge drinking at 16 years from 60% to under 40% by 2011</p> <p>Reduce 3+ LMP binge drinking at 16 years from 30% to under 20 % by 2011</p> <p>Treatment and support Revise polydrug treatment schemes and improve engagement in treatment and compliance</p> <p>Increase access for users (dependent category) from 2006</p> <p>Increase abstinence rate (decrease heavy drinking) by 10% by 2010/2011 baseline: 2003</p> <p>Community safety Increase in conjunction with alcohol arrest referrals, screening at A&E level (CAGE and brief interventions); revision of licensing</p>

Strategic Objectives 6 and 7: LIFESTYLE, ALCOHOL AND DRUGS - THE WORKPLACE

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome and deadline
<p>1. Alcohol and Drugs Working Groups will take the plan forward</p> <p>2. Promote joint partnership initiatives e.g. with other health policies; joint departmental partnerships (e.g. Health Services and Social Services, Health Services and Home Affairs, Department of Trade and Industry, Department of Transport etc) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People);</p> <p>3. Health education: comprehensive revision; Health promotion: target mental health and physical health</p> <p>4. Drink –driving and other ‘alcohol and workplace’ policies (with BAC legislation revision)</p> <p>5. User groups</p> <p>6. Treatment and support: allow for outcome monitoring under informed consent</p> <p>7. Evaluate to identify best practice</p>	<p>DHSS, DoE, DTI, DoT, DHA</p>	<p>Other government departments and non-government organisations e.g. DASH, AAS and Alcoholics Anonymous (AA)</p>	<p>Absenteeism due to binge drinking</p>	<p>To be defined by Groups Lifestyle</p> <p>Treatment and support N/a</p> <p>Immediate and ongoing</p> <p>establish new partnerships</p> <p>optimise existing ones between statutory and non-statutory organisations: by 2006</p>

Strategic Objective 8: BLOOD BORNE VIRUSES (BBV)

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Drugs Working Group will take the detailed Plan forward</p> <p>2. Promote joint partnership initiatives e.g. with other health policies; joint departmental partnerships (e.g. Health Services and Social Services, Health Services and Home Affairs, Department of Trade and Industry, Department of Transport etc) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People);</p> <p>3. Promote anonymised screening for new and existing patients in specialised treatment</p> <p>4. Health education: comprehensive revision to include Needle Exchange Scheme (NES) awareness</p> <p>5. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from drug misuse)</p> <p>6. Treatment and support: allow for outcome monitoring under informed consent</p> <p>7. Integrate treatment with NSF Mental Health: dual diagnosis</p> <p>8. User groups</p> <p>9. Evaluate to identify best practice; in line with National Institute for Clinical Excellence (NICE) and National Treatment Agency (NTA), England</p>	DHSS	<p>Other government departments and non-government organisations</p> <p>External: Health Protection Agency (HPA) England</p>	<p>Unlinked Anonymous Prevalence Monitoring Programme (UAPMP)</p> <p>Needle Exchange Scheme (NES)</p> <p>Access to treatment for BBV</p> <p>Other indicators:</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle Improve Needle Exchange Scheme (by 2006)</p> <p>Treatment and Support Decrease prevalence of indigenous BBV by 25% at three years; Baseline 2005/2006</p> <p>Revise Hepatitis C treatment options (by 2006)</p> <p>Community Safety Campaigns for use of NES</p> <p>Hepatitis B vaccination programme for targeted groups (start 2005/2006)</p>

Strategic Objectives 9 and 12: ACCESS TO SPECIALIST SERVICES DRUGS AND ALCOHOL

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Drugs and Alcohol Working Groups will take the plan forward</p> <p>2. Promote joint partnership initiatives e.g. with other health policies; joint departmental partnerships (e.g. Health Services and Social Services, Health Services and Home Affairs, etc) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People);</p> <p>3. Health education: comprehensive revision in line with treatment and support actions; priority for those in prison for drug offences</p> <p>4. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from drug and alcohol misuse)</p> <p>5. Treatment and support: allow for outcome monitoring under informed consent</p> <p>7. Integrate treatment with NSF Mental Health: dual diagnosis</p> <p>6. User groups</p> <p>7. Evaluate (by proxy: waiting times) and from indicators (new and existing patients in treatment)</p>	DHSS, DHA	<p>Other government departments and non-government organisations e.g. AAS, DASH, AA</p> <p>External: Health Protection Agency (HPA) England;</p> <p>Priory Clinic</p>	<p>New patients</p> <p>All patients</p> <p>Other indicators in: NSF Mental Health GMS Contract</p>	<p>Treatment and Support Optimise capacity building (size of DAT) by 2005/2006</p> <p>Increase number of patients coming forward (baseline 2002/2003)</p> <p>Maintain patients in treatment until desired outcome achieved:</p> <p>abstinence, near abstinence, significantly reduced use (baseline 2005/2006)</p>

Strategic Objective 10: ABSTINENCE AMONG DRUG USERS

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Drugs Working Group will take the plan forward</p> <p>2. Promote joint partnership initiatives e.g. with other health policies; joint departmental partnerships (e.g. Health Services and Social Services, Health Services and Home Affairs, Home Affairs and Department of education, etc) and links with other strategies (e.g. Strategy for Health, Sexual Health Strategy, Strategy for Children and Young People) e.g. sport, training, employment and housing</p> <p>2. Engage early and maintain in substitute treatment; promote abstinence</p> <p>3. Implement National Service Framework (NSF) Mental Health in conjunction with General Medical Services (GMS) Contract: link with specification for a directed enhanced service i.e., patients suffering from drug misuse)</p> <p>4. Informed consent specialised treatment (Drug and Alcohol Team) and allow outcome monitoring</p> <p>5. Treatment and support: allow for outcome monitoring under informed consent</p> <p>6. Integrate treatment with NSF Mental Health: dual diagnosis</p> <p>7. User groups</p> <p>8. Evaluate to identify best practice</p>	DHSS	<p>Other government departments and non-government organisations</p> <p>External: Specialist services UK</p>	<p>Abstinence rate % at 5 years</p> <p>Other indicators in: NSF Mental Health GMS Contract</p>	<p>Lifestyle Achieve abstinence even if in 2% of long-term treated clients (by 2010/11)</p> <p>Treatment and support Increase compliance with treatment;</p> <p>Increase: abstinence, near abstinence and significant reduction in use; shift from polydrug use to single use (baseline 2005/2006); measure annually</p>

Strategic Objective 13: ABSTINENCE AMONG ALCOHOL-DEPENDENT INDIVIDUALS

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Alcohol and Crime and Treatment Working Groups will take the plan forward</p> <p>All actions will be linked to strategic objectives:</p> <p>5 sensible drinking 7 alcohol and the workplace 11 evidence-based alcohol interventions 12 access to specialised services and treatment and support 16 and 17: monitoring and preventing alcohol- related deaths (especially acute intoxications; avoidable deaths) and 21, 22 and 23: the impact on alcohol related disorder</p>	DHSS	<p>Other government departments and non-government organisations e.g. AA and AAS</p> <p>External Priory Clinics and NHS Clinics UK</p>	<p>Abstinence at 5 years</p> <p>Alcohol related crime (arrests)</p> <p>Other indicators in:</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle Achieve sensible drinking in hazardous drinkers (see expected outcomes in all listed actions) (baseline: 2005)</p> <p>Treatment and support Achieve abstinence in 2% of long-term treated clients (by 2010/11)</p> <p>Community safety evidence-based reduction in alcohol-related anti-social behaviour and disorder (baseline 2002/2003)</p> <p>reduction in social exclusion; (baseline 2005/2006)</p> <p>reduction in domestic violence (baseline 2005/2006)</p>

Strategic Objectives 14 and 15: MONITOR, REDUCE AND PREVENT DRDs

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Crime and Treatment Working Group will take the plan forward:</p> <p>All actions will be linked to strategic objectives:</p> <ul style="list-style-type: none"> 1 cannabis 2 volatile substance abuse (VSA) 3 and 4: all other illegal drugs 6 drugs and the workplace 8 blood borne viruses (BBV) 9 access to specialised services and treatment and support 10 abstinence among drug users 18, 19 and 20: the alcohol related disorder impact 	<p>DHSS, DHA</p>	<p>Other government departments and non-government organisations e.g. DASH</p> <p>General Registry</p>	<p>Drug- Related Death (DRDs)s</p> <p>Prevented DRDs</p> <p>Other indicators in:</p> <p>NSF Mental Health (suicides)</p> <p>GMS Contract</p>	<p>Lifestyle Reduction in DRDs (baseline 2005/2006) (see expected outcomes in all listed actions)</p> <p><u>Proxies:</u> Reduction in overall prevalence of drug use</p> <p>Reduction in polydrug use</p> <p>Treatment and support Increase in access Increase in compliance with treatment</p> <p>Increase in uptake at all levels (GP to specialised services)</p> <p>Improve needle exchange services etc.</p> <p>Community safety Prevent overdoses: ongoing</p> <p>Decrease in drug crime disorder (both use and trafficking)</p>

Strategic Objectives 16 and 17: MONITOR, REDUCE AND PREVENT ALCOHOL-RELATED DEATHS

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Alcohol Working Group will take the plan forward</p> <p>All actions will be linked to strategic objectives:</p> <p>5 sensible drinking 7 alcohol and the workplace 11 evidence-based alcohol interventions 12 access to specialised services and treatment and support 13 abstinence among alcohol dependent individuals and heavy drinkers 21, 22 and 23: the impact on alcohol related disorder</p>	<p>DHSS, DHA</p>	<p>Other government departments and non-government organisations e.g. AA and AAS</p> <p>General Registry</p>	<p>Alcohol related deaths (ARDs)</p> <p>Prevented ARDs</p> <p>Other indicators in:</p> <p>NSF Mental Health</p> <p>GMS Contract</p>	<p>Lifestyle Reduction in ARDs (baseline 2005/2006)</p> <p><u>Proxies:</u></p> <p>Reduction in binge drinking and hazardous patterns of drinking</p> <p>Reduction in polydrug use</p> <p>Treatment and support Increase in access Increase in compliance; increase number of abstainers</p> <p>Increase in uptake at all levels (GP to specialised services)</p> <p>Increase in support for social inclusion (housing, training)</p> <p>Community safety Prevent and act upon over-drinking (WATCH schemes)</p> <p>Decrease in alcohol related crime disorder (misuse and anti-social behaviour)</p>

Strategic Objectives 18- 20: MARKET DISRUPTION, APPROPRIATE AND TIMELY TREATMENT AND INTERNATIONAL ROLE IN ASSET SEIZURE AND ANTI-MONEY LAUNDERING

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Crime and Treatment Group will take the plan forward</p> <p>All actions will be linked to strategic objectives:</p> <p>1 cannabis 2 volatile substance abuse (VSA) 3 and 4: all other illegal drugs 6 drugs and the workplace 8 blood borne viruses (BBV) 9 access to specialised services and treatment and support 10 abstinence among drug users 14 and 15: monitoring and preventing drug- related deaths (especially overdoses; avoidable deaths from blood borne viruses)</p> <p>and ultimately</p> <p>an impact on the internal and international market, money laundering, asset seizures (18-20)</p>	<p>DHA</p> <p>Treasury</p>	<p>Other government departments and non-government organisations</p> <p>External: Home Office UK</p> <p>Probation Service UK</p> <p>Other Jurisdictions</p>	<p>Seizures (purity, price)</p> <p>DARS</p> <p>Drug Related Arrests (dealing)</p> <p>Asset seizures</p> <p>Inspections</p> <p>Maritime Patrols</p> <p>International requests</p>	<p>Lifestyle Treatment and support (see expected outcomes in all listed actions)</p> <p>Community safety Development of new intelligence tactics: annual and ongoing</p> <p>Closer monitoring of street price and purity: annual</p> <p>Optimise links with DARS (Police/ Probation/DAT): annual</p> <p>Increase asset seizures: ongoing</p> <p>Revise legislation periodically (annual)</p> <p>Optimise all crime and justice links: Customs and Excise/ Police/ Probation/Prison in line with the Education and Treatment and Support partners</p> <p>Monitor serious crime: ongoing</p>

Strategic Objectives 21-23: ALCOHOL-RELATED DISORDER

Action	Lead Responsibility	Partnership with	Indicator	Expected outcome
<p>1. Alcohol Working Group will take the plan forward</p> <p>All actions will be linked to strategic objectives:</p> <p>5 sensible drinking 7 alcohol and the workplace 11 evidence-based alcohol interventions 12 access to specialised services and treatment and support 13 abstinence among alcohol dependent individuals and heavy drinkers 16 and 17: monitoring and preventing alcohol- related deaths (especially acute intoxications; avoidable deaths)</p> <p>and ultimately</p> <p>an impact on alcohol related disorder (21-23)</p>	<p>DHA</p> <p>DHSS</p>	<p>Other government departments and non-government organisation</p> <p>Licensing Bodies OFT</p> <p>External: Home Office UK</p> <p>Probation Service UK</p>	<p>Arrests</p> <p>ASBO</p> <p>Shelter</p> <p>Alcohol Arrest Referral Scheme</p> <p>Licensing and Advertising</p>	<p>Lifestyle</p> <p>Treatment and support (see expected outcomes in all listed actions)</p> <p>Community safety Licensing and advertising revised by: 2005</p> <p>Shelter: by 2006</p> <p>Alcohol arrest referral scheme: by 2006</p> <p>Reduction in alcohol-related anti-social behaviour and domestic violence (alcohol related arrests reduced by 15% by 2007; baseline 2002/2003).</p>

APPENDIX 3 Funding

At present funding and personnel resources are ring-fenced for the drug and alcohol strategy within the relevant government departments.

Whilst formal drug and alcohol programmes and initiatives are more easily costed, spending on drug and alcohol related work in other areas, such as education, enforcement and criminal justice is much more difficult to quantify as it often forms a component part of the agency's core work but cannot be identified as a single issue. To separate out what an agency actually spends on alcohol and drugs work alone has historically proved to be very difficult.

At present each department presents a business case supported by costs to the Chief Minister's drug and alcohol strategy committee. They are placed in priority order by both officers and political members and then submitted to Treasury as separate drug and alcohol strategy ring-fenced bids. If successful the amount is then placed into departmental budgets.

Whilst the ring-fenced bidding process will continue, bearing in mind that resources are scarce, joint funding between agencies and departments for particular initiatives will be encouraged.

The strategy, as two separate documents, has now been in operation for five years and the focus needs to move towards a more holistic strategy that can respond quickly to the identified local needs. The greater part of targeted resources should be spent on collaborative projects, which tackle high priority groups, e.g. drug and alcohol related offenders, polydrug users, etc. The gain in quickly addressing the needs of these groups should lead to further reduced spending at a later stage if matters are left un-addressed.

On an annual basis each department or participating agency will forward their outline business cases to the Chief Minister's strategic group. Focus should now be on shared departmental funding to support new initiatives and the prioritisation of initiatives will take this element of cooperation into account.

Additional Funds

The seized assets fund, which was established in 1994, will continue to be monitored and allocated by the assistant financial controller in Treasury. The drug and alcohol coordinator reviews these applications with the assistant financial controller. The purpose of the fund is twofold:

- To enable the proceeds of international drug cases to be applied to the specific countering of criminal activities relating to drugs in the Island; and
- To enable the proceeds of 'All Crime Seizures' to be applied to the more general initiatives against drug and alcohol misuse

The separation of these elements is because certain national courts will only agree to seized money being awarded to a particular seized assets fund provided the jurisdiction involved undertakes that the money will be specifically applied against criminal drug activities rather than the more general educational and rehabilitation initiatives to reduce the harm of drug misuse in the community.

APPENDIX 4

The consultation programme

1. Personal Interviews, Questionnaires, Use of Media and Newspapers

In order for the joint updated drugs and alcohol strategy to reflect the views of the community in the widest sense a major consultation programme prior to its drafting was undertaken by the drug and alcohol coordinator's office. The interviews were carried out over a three-month period.

Views were elicited from all sectors of the community - Tynwald members, representatives from government departments including education, health, home affairs, housing, employment, training, sport and recreation, the medical profession, care and service providers, both statutory and non-statutory agencies, service users, primary and secondary school students, Isle of Man college students, members of the public and others with particular knowledge or first hand experience of drug and alcohol issues.

The consultation programme was in two parts - a survey form distributed to over 300 individuals, supported by more than 100 personal interviews conducted by the drug and alcohol coordinator's office. Respondents' survey forms were completed anonymously, while all interviewees were assured of absolute confidentiality, in order for participants to express their views freely and openly. The summary below includes the responses as shared with the interviewers.

A public notice, requesting members of the public to respond with their views was placed in each of the Isle of Man newspapers' titles during the month of June. Four letters were received from members of the public.

In interviews with Manx Radio during the summer the drug and alcohol coordinator urged the public to submit their views.

The consultations proved valuable not only in providing direction for the joint updated strategy, but also served as a catalyst for forging closer links between agencies, departments and individuals engaged in drug and alcohol-related service provision and will assist in the formulation of action plans. Both the survey forms and interviews invited comments on drug and alcohol issues including:

- Education/community and young people
- Treatment and support
- Criminal justice
- Culture and lifestyle
- Delivery of the strategies

Key observations:

- The importance of continuing to deliver relevant drug and alcohol education in primary, secondary and higher education
- A greater focus on risks associated with alcohol misuse
- A recommendation for more creative, innovative education in schools delivered by specialists in the field with whom young people can identify more easily. Initiatives such as Qdos dance groups praised.
- Recommendation that education in schools prove its effectiveness
- Young people were keen to learn in greater detail about the physiological/psychological risks associated with drug and alcohol misuse and wished to be involved in the planning of education programmes
- Acknowledgement that it is crucial for all those delivering education and those in all treatment/support/criminal justice services build in monitoring, evaluation and outcomes processes for all programmes and services
- Recommendation for greater use of visual aids/interactive material
- Young people saw the value of (selected and supervised) former/current drug and alcohol misusers to address schools and young people's groups on their experiences and to raise awareness of associated risks of misuse
- Role models (sporting heroes, etc) could deliver useful anti drug/alcohol misuse messages
- Health promotion campaigns and materials to be produced in partnership with young people for greater relevancy and to be more imaginative, targeting identified groups. The Safe Nite Out campaign widely cited as an effective means of raising drug and alcohol awareness. The need to replicate these programmes in prison and hospital settings.
- The greater use of radio - in particular Energy FM - to promote awareness of drug and alcohol issues
- Education to be more holistic in its approach to drug and alcohol issues. The teaching of self esteem/self awareness/life skills to be promoted
- A call for a wider range of and access to diversionary activities, principally sport
- Inadequate accommodation and transport provision Island-wide seen as contributory factors to drug and alcohol problems
- In the main young people were concerned there was a general misconception that they were all viewed as committed drug and alcohol misusers
- The need to engage/encourage/educate parents, carers and families - with particular emphasis on young parents - to play their role in educating young people.
- To ensure provision of drug/alcohol education to vulnerable, at risk and looked after children
- The need to continue with Island wide training programmes for all those involved with drug and alcohol issues
- Recommendation for more specialist training for carers and for the production of targeted promotional materials and resources

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- Recommendation for socially excluded young people to be returned to mainstream education where possible but for teaching programmes to be appropriately targeted/adapted. Proposal that nurture groups for young people with challenging behaviour patterns be established in schools and as outreach projects across the wider community
 - While commended in principle some felt that the drug and alcohol workplace policy for the public service lacked clarity and direction in terms of warnings/dismissals protocols

While it was generally acknowledged that the drug and alcohol strategies had significantly progressed the development, scope and reach of service provision with both statutory and non-statutory agencies a number of key areas for renewed focus and emphasis emerged.

Key observations:

- Need to focus on early interventions with young people at a very early age who have exhibited mental and emotional problems to prevent later use and problems with drugs and alcohol
- Many respondents believed there was a need for agencies to raise their profile within the community to facilitate easier, more open access to the services
- Agencies to develop easy to remember 0800 type numbers displayed in more public places (e.g. bus stops)
- Agencies' development of services was restricted through constraints of funding and manpower resources
- Call for continued training for all working with drug and alcohol issues at all levels and in all settings including hospitals with concerns expressed about GPs not taking up invitations to training events
- Concerns expressed over maintaining confidentiality within a small community
- Concerns expressed about over prescribing of tranquillisers
- A call for heightened focus on alcohol issues
- A call for robust service level agreements with care provider agencies required to be more accountable
- Introduction of synergistic training programmes for care providers/agency workers and GPs, with particular emphasis on those working with looked after children
- Involve service users in consultation process over treatment and support measures
- Concern was raised over the issue of patients with mental health problems stretching resources of drug and alcohol agencies
- Call for agencies to keep abreast of the changing culture of substance misuse and develop appropriate measures
- Call for training and data requirements to be part of all service level agreements
- Widespread support of the proposed rehabilitation and detoxification unit but concern that it will be viewed as the total solution

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- Recommendation for a wet house/safe sheltered accommodation where welfare of intoxicated individuals could be managed and community's safety assured, supported by appropriate drug and alcohol misuse advice and assessment
 - Recommendation for more comprehensive after-care programmes for those discharged from treatment
 - Recommendation for strengthened contacts and working partnerships with employment and training bodies in the Island
 - Screening programme for hepatitis C and other blood-borne diseases was slow in development. Programme seen as a key proactive and preventative measure
 - Provision for children under 16 years seeking treatment and support needs greater emphasis
 - Needle exchange system seen as effective and could be extended to other outlets across the Island
 - Widespread support for interagency exchange of information and for sharing experiences/research findings with other specialists in the UK and beyond through attendance at conferences, seminars, etc to gain a global perspective
 - Data collection system proving effective but contributions not always of consistent standard for incorporation into database and need for all agencies to cooperate with core database
 - Greater emphasis on housing/accommodation provision for those with drug and alcohol problems
 - In the main the prospect of prison health care being transferred from responsibility of Department of Home Affairs to Department of Health and Social Security was viewed as a positive development
 - Need for heightened focus on treatment and support services for those in prison and after care for discharged offenders
 - Need for improved access for staff and offenders to health promotion information and agency representatives
 - Need for specialist training for prison staff on drug and alcohol issues
 - Closer working relationship with and improved access to GPs both in the community and in the prison
 - Call for a drug and alcohol worker to be based in the prison or at least to provide full time support to those in prison
 - A call for tighter auditing/tracking of all persons who enter treatment and support services and for looked after children once discharged from care agencies
 - The 9 to 5 Monday to Friday nature of agencies restricted access to treatment and support at the most critical of times
 - Pub culture/binge drinking patterns felt to be so entrenched that it will be extremely difficult to effect significant change

It was widely acknowledged that over the past five years the drug and alcohol strategies had contributed significantly to a shift in attitudes and emphasis relating to drug users moving away from punitive/custodial measures into diverting drug users into proactive treatment and support programmes. Drug dealing was now viewed separately and was still regarded as a serious offence and continued to be dealt with in a punitive manner. The Central Alcohol Unit was widely acknowledged to be a positive proactive development from the strategies particularly in working with licensees and off licenses and with other alcohol-related issues.

Key observations:

- Promote and continue to develop the arrest referral schemes for drug and alcohol users
- Need to promote the use of drug treatment and testing orders and to consider other sentencing options
- Need for continued emphasis on targeting those seeking to profit from importing/dealing in illegal substances with prime focus on Class A drugs
- Need for Proceeds of Crime Act to be implemented as soon as possible and as a matter of urgency to reflect the changing nature of criminal activities associated with illegal substance use/supply/ importation
- Perceived lack of vigilance at air and sea ports regarding importation of drugs/contraband etc
- Urgent need to review licensing legislation as soon as possible
- A number of respondents – both young and old – called for more police presence on streets at busy night time areas
- Need for continuing presence of outreach workers at particular busy night spots
- In the main, measures for safer driving, such as the lower permitted levels of the legal blood alcohol content (BAC) were supported i.e. reducing the BAC level from 80ml to 50ml

Other issues:

- Drug and alcohol strategies should be promoted widely as a real example of government's 'corporacy' approach
- Recommendation that inter agency working partnerships continue to be enhanced and progressed
- Chief executive officers should sit on Chief Minister's committee to encourage greater buy in to progress the strategies
- Marketing of strategies needs to be continued at all levels of government particularly focused at political and top government management level to ensure political and financial support and to increase widespread understanding of the serious implications for the community of increased drug and alcohol misuse
- It was widely agreed that levels of interagency and inter-departmental cooperation and sharing of information had increased significantly over the past five years

- Respondents were, in the main, supportive of internal and, more significantly, external auditing, to provide clearer direction and focus for allocation of future resources and to support effective development of the updated strategy
- There was general acknowledgement that all those working with drug and alcohol issues needed to produce valid outcome measurements and cooperate fully with the improved database system and other information requirements
- In addition to the existing coordination and delivery structure of the strategies interviewees were generally supportive of introducing an additional strategic/operational working group (quarterly meetings) spearheaded by the drug and alcohol coordinator - formed of those working in senior management positions - to facilitate the cascade and enhanced dissemination of information throughout the entire organisation
- Need for the Island to continue to be involved with and represented at relevant off Island events and to closely monitor international developments

2. Results from the Consultation Questionnaire

The questionnaire was a consultative tool administered in order to obtain information on topics and issues, which required update in the joint strategy. It was not designed for high scientific measurement of perceptions and/or priority setting, but to give an indication towards which of the three main areas addressed in the strategy need any current gaps covered.

Results

300 were distributed and 125 returned; due to poor quality of returned forms (e.g. multiple photocopies, anonymous photocopies, etc) 14 were excluded and 111 made the total number of those included for analysis, giving 36% returns. Given the purpose for which the questionnaire was distributed this is a good response, usually for such exercise the expected percentage is 30 to 40%.

The proportions in the profiles of respondents belong to the following categories:

Education, prevention and support:	12%
Treatment and support:	60%
Criminal Justice:	17%
Non-statutory agencies:	4%
Other (members of public, etc)	7%

Young people and the community

1. Is there presently sufficient emphasis on young people's education in relation to drug and alcohol issues?

% of all respondents agreeing: 32% (don't know 19%)

2. In relation to the prevention of drug misuse and alcohol misuse what is your perception of the education that young people receive in relation to associated health related problems?

% of all respondents agreeing topic needs to improve or it is needed:

transmissible (infectious) illnesses:	64%	(28% no response)
liver disease	67%	(28% no response)
pregnancy	61 %	(23% no response)
addiction	62%	(21% no response)
mental health	74%	(22% no response)
unexpected death	68%	(28% no response)

3. At present, are any of the following issues a problem (drugs and alcohol)?

% of all agreeing (% no response, difference to 100% is not agreeing)

Related crime	86%	(9%)
Public nuisance	88%	(8%)
Poor schooling	41%	(22%)
Poor performance at work	41%	(31%)
Poor career prospects	51%	(24%)
None of these	0%	
Other (please specify)	10%	

e.g: 'work absenteeism due to hangover, drink driving, sharing injecting equipment, teenage pregnancy and sexual health in general, availability, housing shortage, peer pressure and off-Island influences, poor parenting skills, family breakdown, alcohol and other health issues, poor health and family relations, nowhere for young people to go in the evenings, bullying and drug problems (and link), poor school attendance'

4. Is this issue tackled properly at present?

% of all agreeing (% no response, difference to 100% is not agreeing)

Related crime	23%	(18%)
Public nuisance	20%	(18%)
Poor schooling	28%	(35%)
Poor performance at work	17%	(45%)
Poor career prospects	13%	(39%)
None of these	0.9%	
Other (please specify)	-	

Statements- Young people and the community (% agreeing; in bracket the % no response)

One respondent said they had no opinion for any of the statements:

- the future strategy should place greater emphasis on young people and prevent them from using drugs **85% (6%)**
- the future strategy should place greater emphasis on preventing misuse of alcohol for those under 18 years old **82% (5%)**
- the future strategy should place greater emphasis on law and order and treatment and support **86% (5%)**
- young people need health education and protection, but family and social environment should play a bigger role **91% (4%)**

6. Presently there is a central role for provision of treatment and support in the strategies. Are you aware of the existence of these Island services?

% of all agreeing and (% no response)

For drug treatment **82% (4%)**

For alcohol treatment **85% (4%)**

7. In your opinion, how do you currently perceive the quality of care in relation to treatment, support and rehabilitation of individuals who attend these services?

Drugs (% of all agreeing and in bracket % of no response)

- Enough facilities 11% (26%)
- Clear referral pathways 38% (29%)
- Good access 31% (33%)
- Very well equipped facilities 14% (41%)
- Waiting time: short waiting time 23% (51%)
- Enough staff 19% 44%)
- Appropriately qualified staff 33% (47%)
- Patients are satisfied with service as a whole 15% (52%)
- Social support (e.g. housing) 7% (44%)
- Social security (e.g. family welfare) 17% (52%)
- Employment (e.g. training courses) 9% (56%)

Alcohol (% of all agreeing and in bracket % of no response)

- Enough facilities 10% (31%)
- Clear referral pathways 36% (31%)
- Good access 28% (36%)
- Very well equipped facilities 12% (42%)

- Waiting time: short waiting time 20% (51%)
- Enough staff 15% (47%)
- Appropriately qualified staff 32% (48%)
- Patients are satisfied with service as a whole 17% (59%)
- Social support (e.g. housing) 6% (47%)
- Social security (e.g. family welfare) 16% (54%)
- Employment (e.g. training courses) 6% (58%)

Health, treatment and support statements (% agreeing; in bracket the % no response)

2% had no opinion on any statement:

- Treatment and support should remain central because problems with drugs and alcohol will never go away **83% (6%)**
- Treatment and support should play a secondary role after law and order and education **28% (5%)**
- Individuals who use/misuse drugs or alcohol should be encouraged to come forward for treatment at any stage in order to facilitate rehabilitation and after- care services **93% (4%)**
- Individuals who misuse drugs or alcohol should be encouraged to come forward for treatment at any stage in order to protect their health and others' health **94% (4%)**
- Individuals who misuse drugs by injecting may need anonymous testing for transmissible diseases (e.g. hepatitis B, hepatitis C, HIV, etc.) **82% (8%)**
- Treatment and support are secondary to imprisonment **21% (6%)**
- Social support and social welfare need emphasis **90% (6%)**
- Multi- agency collaboration plays a key role **92% (4%)**
- Greater empowerment of non statutory agencies in supportive roles **78% (12%)**

9. Are you aware of the existing Island services/ agencies who deal with drug and alcohol related crime?

% of all agreeing and (% no response)

- For drug related crime **69% (7%)**
- For alcohol related crime **66% (8%)**
- For schemes alternative to prison **55% (7%)**

10. In your opinion have these services proved effective in providing a safe community?

10% left this answer blank

This type of crime has **remained stable** in the past five years **13%**

This type of crime has decreased in the past five years	0.9%
This type of crime has increased in the past five years	41%
Don't know	35%

Community safety/ criminal justice statements (% agreeing; in bracket the % no response)

5% had no opinion on any of the statements:

- Criminal justice agencies are succeeding in reducing drug and alcohol related crime **11% (19%)**
- The judicial system is fair **33% (19%)**
- Criminal justice needs further improvement in order to deliver a more effective service, i.e. good outcomes (e.g. structures such as equipment, facilities; process-appropriately trained staff, etc.) **79% (16%)**
- Island's legislation is appropriate to community safety **39% (27%)**
- Island's legislation has kept pace with UK and international legislation **34% (25%)**
- A balance exists between criminal justice, treatment and support and education **30% (23%)**
- Imprisonment should be directed towards drug dealing **75% (16%)**
- Imprisonment for drug users should be backed up with treatment and support while in custody and continued on release **88% (11%)**

These results are informative, but far from being conclusive and priorities need to be checked further.

3. Strategy Review Day – October 2003

In October 2003 the drug and alcohol coordinator, on behalf of the Chief Minister's drug and alcohol strategy committee organised a review day for practitioners. One of the aims of the day was to discuss future challenges facing those working with drug and alcohol issues in different areas and how to address these challenges in the future. Below is a summary of feedback from different groups.

44 workers, principally practitioners representing 24 different agencies from education and prevention, treatment and support and criminal justice attended – in itself a clear demonstration of the strategies' overriding commitment to multi-agency and cross-departmental collaboration.

The feedback from this part of the day's programme included:

Education and Prevention

Challenges faced:

- Presenting facts in an accessible and relevant way
- Dealing with cultural and peer pressure issues
- Re-shaping public perception of young people

How to address this:

- Reinforce education in schools and in informal educational environments
- Provide further education for parents and greater community involvement
- Look at ways of imbuing young people with a heightened sense of excitement and self-confidence and offer a positive alternative to drug/alcohol experimentation
- Conduct survey in collaboration with young people – look at how to make it pertinent to them
- Ensure teaching staff in school and colleges 'buy into' the project and work closely with researchers
- Peer education

Challenges within the schools system:

- Ensure sufficient time allocated for delivering drug and alcohol education in the curriculum
- Difficulties in delivering a cross-curricular approach embracing parents, families and community

Challenges:

- Place less emphasis on examinations
- Raise profile of drug/alcohol and PSHE education – suggest further multi-agency educational training

Treatment and Support

Challenges:

- KPIs and statistics – how these are gathered and published
- Detox
- Inequality in accessing services
- Dispelling stereotypical preconceptions
- Confidentiality queries – monitoring
- Measuring detox – gaining resources, local detox facility, stigma of psychiatric 'label'

-
- Community and public healthcare education – importance of treatment
 - Inability to treat for blood-borne diseases – what's the point of screening?
 - Housing – provision of appropriate accommodation for those continuing to misuse substances.
 - Provision of anonymous services
 - Political expediency
 - Inappropriate information handling systems
 - Duplication of information handling systems
 - Strategic conflict
 - Diverse presentation of need
 - Hazards of over-specialisation and reducing skill base
 - Geographical constraints
 - Proximity and problems of confidentiality
 - Poor access to services
 - Fluctuating needs, changing time scales
 - Conflict in philosophy of different agencies
 - Lack of understanding and sharing pathways
 - Potential imbalance of professional interests

How to overcome these challenges?

- Cross-professional training
- What's available and who provides what?
- Island-wide housing policy – evidence to be produced for this?
- Bringing agencies together
- Advocacy role for service users
- Education and marketing advocate for practitioners – training
- Appropriate information technology
- Diverse service provision
- Shared care
- Robust data handling systems
- Ongoing research
- Peripatetic outreach – clinical mobility
- Agencies with in-built audit mechanisms

Criminal Justice

Challenges:

- Island culture
- Policing insufficient
- Parental guidance education
- Legislation/judiciary – reclassification of cannabis and other Class C drugs in relation to Proceeds of Crime Act
- Alcohol-related health problems
- Data collection and analysis
- Lack of public transport, especially out of hours
- Licensed establishments and their responsibilities

How to meet these challenges?

- More collation of information and better understanding of data
- Media campaigns for culture change
- More information on effects/associated effects of risk
- Breath-testing equipment
- Real and effective consultation on the ground
- Resourcing schemes
- Better information and research
- Sentencing reviews
- Promoting safer communities
- Need to look at Proceeds of Crime Act

APPENDIX 5

GLOSSARY

Abstinence

Refraining from drug and/ or alcohol use.

Addict

An addict is a person who has an addiction, which means they cannot take their mind off a certain craving, and this usually refers to tobacco (e.g. nicotine addiction), alcohol or another drug. Substance misuse is addictive by nature if continued after experimentation addiction also defined as uncontrollable craving for a drug or a pleasurable activity.

Age of initiation

The age of first use of a drug or substance.

Aim

An aim describes the overall result that the intervention is intended to achieve. An evaluation will assess whether the stated aims have been achieved.

AIDS (Acquired immunodeficiency syndrome)

A syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immuno –suppression.

Alcohol dependent (sometimes known as: chronic drinker)

No exact definition is given, but individuals usually drink a high number of units per day and per week, sometimes having an alcoholic drink first thing in the morning; if the individual stops drinking, usually advised to do so and, if it is not done under medical supervision, they can develop withdrawal symptoms and could also die; the dependency syndrome (alcohol) is a serious condition and is always cared for through appropriate treatment bodies. An alcohol dependent individual is usually binge drinking on a daily basis, at levels of more than 50g pure alcohol/ day.

Alcohol unit

A unit of alcohol is 10ml of pure alcohol. Counting units of alcohol can help us to keep track of the amount we're drinking. The list below shows the number of units of alcohol in common drinks:

- A pint of ordinary strength lager (Carling Black Label, Fosters) - 2 units
- A pint of strong lager (Stella Artois, Kronenbourg 1664) - 3 units
- A pint of bitter (John Smith's, Boddingtons) - 2 units
- A pint of ordinary strength cider (Dry Blackthorn, Strongbow) - 2 units
- A 175ml glass of red or white wine - around 2 units
- A pub measure of spirits - 1 unit
- An alcopop (eg Smirnoff Ice, Bacardi Breezer, WKD, Reef) - around 1.8 units

Lagers and ciders sold in bottles are usually stronger than those sold on draught. The labels of some bottled drinks will tell you how many units of alcohol are in the bottle.

ASB, ASBO

Anti-Social Behaviour; Anti-Social Behaviour Order.

ASRO

Addressing Substance Related Offending.

Audit

Audit is a quality assurance process that checks actions and procedures against established guidelines and standards.

Baseline

The baseline aims to establish the status of a target area or group before an intervention starts. It usually sets out a replicable range of measures on various characteristics of the area or group that the intervention hopes to change. Without baseline measures it is virtually impossible to establish whether any change has occurred.

Best practice

On the evidence available, the best intervention to produce improved outcomes for an identified issue.

Binge drinking

Five or more standard pub drinks in a row in a single session (session in this case is less than 2-3 hours and age is less than 18 years); also, 14 or more units for women and 21 or more units for men in a week: either in one-two binge sessions or spread during the week; usually, if spread during week these are more than 21 units for women and more than 28 units for men; 14-21 units for women per week and 21-28 units for men/ week: pattern defined as at risk drinking; above 21 units for women and 28 units for men is harmful drinking.

Blood-borne virus

A virus that can be transmitted from an infected person to another person by blood-to-blood contact, including through the sharing of injecting equipment, sexual contact and/or other internal body fluids (blood, serum, plasma); infectivity depends on type of organism and on receptivity of host (recipient) and their immunity status; currently most of these organisms do not give immunity, but the evolution is towards chronic diseases, cancer or opportunistic infections which inevitably leads to death.

CAGE questionnaire

Four clinical interview questions, the CAGE questions, have proved useful in helping to make a diagnosis of alcoholism (chronic harmful drinking). The questions focus on **C**utting down, **A**nnoyance by criticism, **G**uilty feeling, and **E**ye-openers. The acronym CAGE helps the physician to recall the questions (Ewing JA, 1984).

Caldicott Guardian

A senior health or social care professional with responsibility for promoting information governance within the organisation.

CARATS

Counselling Assessment Referral Advice and Throughcare Service (England).

CJA

Criminal Justice Act (England).

CDRP

Crime & Disorder Reduction Partnership (local partnerships involving the police, local authority and health services).

Chronic drinker

(see alcohol dependent).

CJIT

Criminal Justice Information Technology.

CJS

Criminal Justice System (the Home Office/ Home Affairs, Department of Constitutional Affairs and Crown Prosecution Service along with agencies such as the police, courts, correctional services).

Core Database

A central database which collects a minimum dataset based on a standard template/ format of collection of data in order to produce anonymised information for planning (of services) purpose. The alcohol and other drugs core database collects data and produces information only on these two lifestyle factors, for the purpose of drug and alcohol service planning.

CPS

Crown Prosecution Service.

CRB

Criminal Record Bureau.

CSAP

Correctional Services Accreditation Panel.

Constraints

Constraints refer to barriers, priority setting issues, shortage of resources, etc. and create delays in projects or interventions delivery.

Current use

Individuals who usually use at present or have used substances minimum a month prior to a survey; the measure of current use is expressed through the indicator last month prevalence (LMP).

Decriminalisation

Removal of a behaviour or activity from the scope of the criminal justice system; it concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other measures, like administrative sanctions, may be used in an effort to regulate the behaviour or activity that has been decriminalised.

Demand-reduction strategies

Demand-reduction strategies seek to reduce the desire for and preparedness to obtain and use drugs. These strategies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug-related harm.

Detoxification

The means by which a drug-dependent person may withdraw from the drug's effects; most desirable outcome in the drug and alcohol services.

DfES; DoE

Department for Education and Skills (England); Department of Education.

DH; DHSS

Department of Health (England); Department of Health and Social Security.

DAT

Drug Action Team (England); Drug and Alcohol Team (Isle of Man).

DIP (former CJIP)

Drug Intervention Programme (Criminal Justice Interventions Programme).

Drug

A substance that produces a psycho-active effect or alters mental processes, such as thinking or emotions. The term psycho-active substance is more neutral than the term "drug" because it does not refer to the legal status of the substance. Within the context of this strategy it is used to include alcohol, pharmaceutical drugs and illegal drugs. It also takes account of performance- and image-enhancing drugs and substances such as inhalants (see).

Drug dependence

Drug dependence is characterised by a strong desire to take a drug. Among the indicators of dependence are impaired control over drug use, a higher priority given to drug use than to other activities and obligations, increased tolerance, physical withdrawal symptoms and repeated drug use to suppress withdrawal.

Drug –related harm

Any adverse social, psychological, legal or other consequence of drug use that is experienced by a person using drugs or by people living with or otherwise affected by the actions of a person using drugs.

DTTO

Drug Treatment and Testing Order.

EMCDDA

European Monitoring Centre for Drugs and Drug Addiction (a European Union body specialised in international work on various aspects of illegal drugs: research, legislation, etc.).

ESPAD

The European School Survey Project for Alcohol and other Drugs: European-wide study of 15/16 year olds' lifestyle based around the measurements of use of alcohol, drugs, tobacco, gambling, etc.

ETE

Employment Training Education.

Evaluation

An evaluation is a systematic assessment of whether the stated aims and objectives of an intervention have been met. Evaluations allow questions about the effectiveness, efficiency and acceptability (to clients and to the community) of projects and programmes to be answered.

Evaluation can consider the context and process of implementation as well as the outcomes achieved. Evaluation involves the collection and analysis of reliable, relevant and valid data. Evaluation should allow better and more informed decisions to be made about the future of an intervention. The systematic assessment can be stepped: level of achievement, extent of level achieved (efficiency) and effectiveness (impact assessment). If costs are also measured for various interventions along with their effectiveness, then this evaluation is known as cost- effectiveness and results give the 'value for money' for a particular intervention (i.e. most effective for the least spend).

Evidence-informed practice

Evidence-informed practice involves integrating the best available evidence with professional expertise to make decisions.

FTE; WTE

Full-time equivalent; whole-time equivalent

Harm-reduction strategies

Harm-reduction strategies are designed to reduce the impacts of drug and alcohol-related harm on individuals and communities. The government does not condone illegal risk behaviours such as injecting drug use: it acknowledges that these behaviours occur and that it has a responsibility to develop and implement education, public health and law enforcement measures designed to reduce the harm that such behaviours can cause.

Harm minimisation

Harm minimisation is the primary principle underpinning the drug and alcohol strategy and refers to policies and programmes aimed at reducing drug and alcohol-related harm. It aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including abstinence-oriented strategies. Harm minimisation includes preventing anticipated harm and reducing actual harm. Harm minimisation is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction.

Harmful drug use

A pattern of drug use that has adverse social, physical, psychological, legal or other consequences for a person using drugs or people living with or otherwise affected by the actions of a person using drugs. It applies to illicit drug use when a prescribed drug is used in inappropriate doses.

Hepatitis B (see blood borne viruses); chronic liver damage is the outcome in high proportion of those infected; vaccination exists.

Hepatitis C (see blood borne viruses)

Chronic liver damage is high in those affected (85%); currently no vaccine.

HIV (see blood borne viruses)

A human retrovirus that leads to AIDS (see AIDS).

Impact assessment

(see Evaluation).

Illegal drug

A drug whose production, sale or possession is prohibited by law.

Illicit drug

A drug which can be lawfully bought (prescription), but which can be misused.

Indicator (sometimes Key Performance or Key Threshold Indicator)

A measurement tool allowing services to record their performance in various areas; a baseline recording can become the benchmark for future recordings of the same indicator (e.g. drug-related deaths indicator); when using more than one indicator to allow for a more complex and comprehensive measurement tool, the result is an index (e.g. The Scottish Index of Multiple Deprivation (SIMD) 2004: identifies the most deprived areas across Scotland. It is based on 31 indicators in the six individual domains of Current Income, Employment, Housing, Health, Education, Skills and Training and Geographic Access to Services and Telecommunications).

Inhalants

Illicit substances inhaled for psycho-active effects – for example, glues, aerosol sprays, paints, industrial solvents, thinners, petrol and cleaning fluids (see drug).

IDU

Injecting Drug User is a person who misuses drugs by injecting it intravenously.

Intervention

An intervention is a policy, programme, service or project designed to bring about specified change to target areas or groups. For example, a drug education programme, a drug treatment service for young people or a peer education project. Interventions are often planned and implemented by several agencies working together.

IT

Information Technology.

Legal drug

A drug whose production, sale or possession is not prohibited.

Lifestyle

One of the four determinants for health, along with environment, biology (genetics) and health services; in the case of drugs and alcohol the lifestyle (behaviour) affects health and also quality of life (health) and maybe how long a person lives; drugs have a more direct impact on health with most users having only experimented a few times and moving away from them due to: illegality and possible career interference; alcohol has a different status and is misused differently; drinking patterns and behaviour affect different people in different ways. Lifestyle is the most complex

health determinant and constitutes an important one in most diseases and disabilities. The previous drug and alcohol strategies referred to education and prevention as an Aim. This has now been expanded to lifestyle as the term encompasses a more holistic approach.

Last month prevalence

(see current use).

LCJB

Local Criminal Justice Board.

Lifetime prevalence

Having experimented with a substance at least once in life. Expressed as indicator, per 100 individuals asked in a survey (have you **ever** used...).

Lifetime use

(See lifetime prevalence).

MAPPA

Multi-Agency Public Protection Arrangements.

Money laundering

Money laundering is the process by which criminals attempt to conceal the origin of the proceeds of their illegal activities. If successful, laundering allows them to maintain control over these proceeds and provides a legitimate cover for their source of income.

Monitoring

Monitoring is linked to, but not the same as, evaluation. Monitoring is an ongoing process involving the continuous or regular collection of key information about an intervention's inputs, outputs and outcomes eg routine collection of information about number of clients accessing a service. The main aim of monitoring is to assess whether an intervention is going as planned, and whether any change in focus and/or activity is necessary. Having a comprehensive monitoring system in place helps to ensure that evaluations are robust and cost effective. Monitoring data often provides at least some data towards evaluation. It measures the 'expected' (see also "Surveillance").

Narcotic drugs

Substance that can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs declared illicit.

NDS-PMF

National Drug Strategy- Performance Management Framework (England).

NOMS

National Offender Management Service.

NPD; NPS

National Probation Directorate; National Probation Service.

NPSISS

National Probation Service Information Systems Strategy.

NTA

National Treatment Agency (England).

Needle and syringe exchange programme or scheme (NES)

Authorised programme for distributing and disposing of needles and syringes; sometimes known as Needle Syringe Programs (NSP).

Needs Assessment

This is a type of evaluation the aim of which is to work out the current and future level of drug misuse in specific populations (eg geographical areas, age categories, employment categories). A needs assessment could be done to establish the nature and extent of drug use in an area and to assess whether the currently available services address that need. This information helps to plan and implement services. In some cases, this information may be available from existing information sources. Ideally, needs assessment should be a continuous and flexible process.

New recruitment

Commencement of drug use.

NICE

National Institute for Clinical Excellence was set up as a Special Health Authority for England and Wales on 1 April 1999. It is part of the NHS and its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current 'best practice'. The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques and procedures) and the clinical management of specific conditions. NICE offers the NHS and its patients a new service, which it is intended, shall earn and retain, the confidence and the respect of the community as a whole. The equivalent body in Scotland is SIGN.

NTORS

National Treatment Outcome Research Study.

Non-medical use of drugs

The use of pharmaceutical drugs either alone or with other drugs in order to induce or enhance a drug (psycho-active) experience.

OASys

Offender Assessment System.

O-DEAT

OASys Data Evaluation and Analysis Team.

Objective

Objectives are tightly linked to the aims and refer to the specific results of the intervention. The objectives should ideally be specific, measurable, achievable, realistic and have an indication of the timescale. An evaluation will assess whether the objectives have been achieved. If objectives are measurable and have a date attached then it should be possible to express them as targets.

Opportunities

Facilitation of best practice (see NICE) in line with resource availability.

OSAPP

Offender Substance Abuse Prevention Programme.

Outcome (Target)

The results of the intervention. Outcomes can be understood as a 'hierarchy' that includes immediate impacts, intermediate outcomes and long term goals. For example, the outcomes of harm reduction services may range from decreasing the amount of needle sharing amongst their client group to increasing the numbers of clients who have become drug free. Outcomes can be 'soft' (eg improvements in self-esteem and family relationships) as well as 'hard' (getting into employment). There may be a difference between the intended outcome, as set out in the project objectives, and the actual outcome, established through a process of evaluation and monitoring.

Output

A result of a process which has had an input, defined by resources: material, financial, human, time. It differs from outcome.

Overdose

The use of a drug in an amount that causes acute adverse physical or mental effects. Overdose may produce transient or lasting effects and can sometimes be fatal.

Partnership Approach

In the context of this strategy a partnership is defined as a close working relationship between the government departments, local government, statutory and non-statutory agencies, communities (including drug users and those affected by drug-related harm), business and industry, community-based organisations, professional workers and research agencies.

Performance- and image-enhancing drugs

A range of drugs used to improve physical or mental capacity or to influence body shape (e.g. steroids).

Pharmaceutical drugs

Drugs available through a pharmacy: over-the-counter and prescription medicines.

Polydrug use

The use of more than one psychoactive drug, simultaneously or at different times. The term 'polydrug' user is often used to distinguish a person with a varied pattern of drug use from someone who uses one kind of drug exclusively.

Prevalence

A measure of a phenomenon, e.g. use of a substance, a chronic disease, which once appeared in a population adds to the characteristics of that population; (see lifetime use, hepatitis B when it affects the liver).

Prevention

Within the context of the strategy, prevention refers to preventing harmful drug use and preventing drug-related harm. Prevention includes preventing the uptake of illegal drugs.

Process Evaluation

The aim of this type of evaluation is to find out exactly how an intervention works. Key issues for a process evaluation may include the nature and characteristics of

clients, case management procedures, discharge, aftercare and referral, accessibility of the service, client retention, intra-agency coordination and an analysis of the underlying rationale and logic of the project. This type of evaluation can be useful if an intervention is to be repeated somewhere else because it helps to identify why something worked. Case studies, descriptive designs and client satisfaction surveys are often used in process evaluation.

Prohibition

Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

PSA

Public Service Agreement (Home Office England key targets).

PSO

Probation Service Officer.

PSR

Pre Sentence Report.

Psychoactive effects

Effects that alter mental processes – mood, cognition, thinking or behaviour.

RDS; R&D

Research Development and Statistics (HO); Research and Development (NHS).

Risk perception of use

What society perceives that the availability and use of a substance is.

Sensible Drinking (see Binge Drinking)

One-two units a day for women and two-three units per day for men (up to no more than 21 units for women and 28 units for men in a week).

SDA

Service Delivery Agreement.

SOCA

Serious Organised Crime Agency (England: to be established when legislation passed).

SOTP

Sex Offender Treatment Programme.

SSR

Specific Sentence Report.

STEPS

Standard Technical Environment for Probation Service.

Supply-reduction strategies

Supply-reduction strategies are designed to disrupt the production and supply of illegal drugs. They may also be used to impose limits on access to and the availability of legal drugs – an example is legislation regulating the sale of alcohol to people under the age of 18 years.

Surveillance

Mechanisms in place which measure the 'unexpected'. (See also 'Monitoring'). Although apparent the same these are two different processes: any service can be monitored; when a case of a disease or a similar phenomenon appears in a population, it is a result (finding) of surveillance.

TPO

Trainee Probation Officer

UNDCP

United Nations Drug Control Programme: the United Nations Office on Drugs and Crime (UNODC) is a global leader in the fight against illicit drugs and international crime. The Drug Programme was established in 1991 and the Crime Programme in 1997.

Uptake

The commencement of drug use.

User groups

Group/organisation representing the interests of drug users.

Volatile Substance Abuse

Abuse of solvents, thinners, petrol, etc (see also inhalants).

Vigilance

Updated and well-informed professionals maintain a level of alertness, which is especially important when dealing with illegal drugs.

YOT; YJT

Youth Offending Team (local partnerships bringing together bodies such as the police, probation and local authority services); Young Justice Team

APPENDIX 6

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