Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Making Life Better –

Preventing Harm & Empowering Recovery:

A Strategic Framework to

Tackle the Harm from Substance Use

A CONSULTATION DOCUMENT

Foreword from Robin Swann MLA

Minister of Health

I am all too aware of the impact that alcohol and drug use has on individuals, our health service, our society, our communities and our families. We all know people whose lives have been scarred and altered forever through the harm caused by alcohol and drugs. It is up to all of us to play our part in tackling this issue and to effectively reduce the harm caused by substance use.

This is a consultation on a potential new strategy to replace the previous substance misuse strategy "New Strategy Direction for Alcohol on Drugs, Phase 2" (NSD Phase 2) which has been in place since 2012. We published a full review of NSD Phase 2 and launched a pre-consultation for this new strategy in 2019. Following this, stakeholders from the Voluntary and Community sector, Academia, health professionals and Government colleagues, along with service users, joined with us to help in the co-production of this new consultation document.

The review and pre-consultation highlighted many issues. They showed that while much progress had been made under the previous strategy, and there were positive signs around the level of substance use particularly among our young people, new challenges have emerged. Polydrug use is increasing the potential for serious harm and putting people at risk of tragic outcomes, the misuse of prescription medicines remains a key issue, and alcohol continues to be our society's drug of choice – causing more harm to individuals and families than any other substance. We also need to ensure that legislation, such as alcohol pricing or the classifications of drugs, and the justice system works to support our overall vision – that people in Northern Ireland are supported in the prevention and reduction of harm related to the use and misuse of alcohol and other drugs, and will be empowered to maintain recovery.

Our engagement so far has pointed to many things we can do better, including the need to better join up services for those suffering multiple needs, such as mental health and substance use. Another issue that came across strongly in the co-production process was the need for a

more holistic treatment system, providing patient centred care around the needs of the service users. The need to ensure we invest in treatment and harm reduction also featured highly, along with the need to ensure that we get better at preventing harm developing in the first place, and making sure that support is in place for individuals throughout their recovery journey.

We must choose the most effective tools to tackle this threat, which may require some changes in how we think about this problem. It has been shown that the stigma felt by those suffering harm leads to a fear of coming forward for treatment and support. This we must urgently address.

There is evidence that many people have been experiencing increased stress and isolation this year as a result of COVID-19, and some have increased their alcohol and drug use in response. This past few months has been an extremely difficult period for the Health and Social Care sector and this has put a strain on existing services, which we are working hard to address. Many services had to switch to being provided online and to quickly find new ways to operate. I want to pay tribute to the hard work and dedication of staff and volunteers working right across the sector at this very challenging time. It is now important that we learn from this experience and fine tune innovative ways of working.

I wish to thank all those who took part in the review, those who responded to the pre-consultation and especially those who helped in the co-production of this document. I hope they can see their contribution reflected in this consultation, as I believe they have all made it stronger and better, and I am extremely grateful for their efforts, especially at this most trying of times.

However, we do not wish to be complacent – we want to hear a wide range of views and ideas to make our new strategy even better. Please send us your thoughts and comments, or please take part in one of the consultation events we will be organising. Help us to make the final strategy as good as it can be, so that we can more effectively reduce the harm caused by substance use across Northern Ireland.

CONTENTS

1. THIS CONSULTATION & HOW TO RESPOND

Topic of this consultation:

1.1 **This consultation seeks views on the development of a new strategy to reduce the harm related to substance use in Northern Ireland.**

Scope of this consultation:

1.2 We are keen to hear the views of all those with an interest in addressing the harm related to substance use including:

- members of the public;
- community and voluntary sector organisations;
- service users and those who use alcohol and/or drugs;
- health bodies;
- health professionals;
- justice agencies;
- local councils;
- business and industry bodies;
- academics; and
- other Government Departments and agencies.

Geographical Scope:

1.3 The strategy falls within the scope of the devolved administration. However as some of the powers are not devolved to the Northern Ireland Assembly, we will continue to work closely with UK Government, the other devolved administrations, and the Government in the Republic of Ireland on these proposals.

Body/Bodies Responsible for the Consultation:

1.4 This consultation is being undertaken by the Health Development Policy Branch in the Department of Health.

Duration:

1.5 Since the consultation period will cover the Christmas holidays, the consultation period has been extended by 2 weeks and so will be open for 14 weeks from **Friday 30 October 2020 to Friday 05 February 2021**.

Enquiries:

1.6 For any enquiries about the consultation, please email the Department at: HDPB@health-ni.gov.uk or write to:

Making Life Better – Preventing Harm Empowering Recovery: A Consultation
Health Development Policy Branch
Department of Health
Room C4.22, Castle Buildings
BELFAST BT4 3SQ
Tel: (028) 9052 0540

How to Respond:

1.7 Online: You can respond online by accessing the consultation documents on the 'Citizen Space' web service and completing the online survey there. The online version can be accessed at the following link:

https://www.health-ni.gov.uk/SUS-consultation

1.8 Alternatively you can respond via the email or office address above, however we would much prefer responses by Citizen Space.

1.9 When you reply, it would be very useful if you could confirm whether you are replying as an individual or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:

- your name;
- your position (if applicable);
- the name of your organisation;
- an address (including postcode); and
- an e-mail address.

Consultation Response:

1.10 We will consider the responses received and publish an outcome report on the Department's website.

Accessibility:

1.11 Alternative formats of this consultation document and the questionnaire (such as other languages, large type, Braille, easy read and audio cassette) may be made available on request. Please contact the Department to discuss your requirements.

Consultation Principles:

1.12 This consultation is being conducted in line with the Fresh Start Agreement – (Appendix F6 – Eight Steps to Good Practice in Public Consultation-Engagement).[1] These eight steps give clear guidance to Northern Ireland departments on conducting consultations.

Feedback on the Consultation Process:

1.13 We value your feedback on how well we consult. If you have any comments about the consultation process (as opposed to comments about the issues which are the subject of the consultation), including if you feel that the consultation does not adhere to the values expressed in the Eight Steps to Good Practice in Public Consultation Engagement or that the process could be improved, please address them to:

Health Development Policy Branch
Department of Health
Room C4.22, Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
E-mail: HDPB@health-ni.gov.uk

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/479116/A_Fresh_Start_-_The_Stormont_Agreement_and_Implementation_Plan_-_Final_Version_20_Nov_2015_for_PDF.pdf

Equality and Rural Screening:

1.14 As per the Department of Health's Equality Scheme[2] and in order to comply with the Rural Needs Act (Northern Ireland) 2016[3], this policy has been screened for both Equality/Good Relations[4] and Rural Needs[5] impacts. These screening documents are both available at: https://www.health-ni.gov.uk/SUS-consultation.

1.15 These screenings have indicated that there is no significant negative impact from this strategy in terms of Equality of Opportunity, Good Relations or Rural Needs and thus no need for further Equality or Rural Impact Assessments. As part of this consultation, we welcome comments on these screening documents or inputs on areas where those responding may feel we should take further information into consideration in any future screening.

Consultation Question 1 – Have you any comments on either the Equality/Good Relations or Rural screening documents? Have you anything you believe we should be considering in future Equality/Good Relations or Rural screenings?

Privacy, Confidentiality and Access to Consultation Responses:

1.16 For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity may be published. When doing so, we will remove email addresses and telephone numbers from these responses; but apart from this, we may publish them in full. For more information about what we do with personal data please see the link to our consultation privacy notice at paragraph 1.17.

1.17 Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all

[2] https://www.health-ni.gov.uk/doh-equality#toc-0
[3] https://www.legislation.gov.uk/nia/2016/19/contents
[4] https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-sus-esa.pdf
[5] https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-sus-rias.pdf

disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679.

1.18 If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

1.19 DoH is the data controller in respect of any personal data that you provide, and DoH's Privacy Notice, which gives details of your rights in respect of the handling of your personal data, can be found at: https://www.health-ni.gov.uk/articles/health-development-policy-branch-and-health-improvement-policy-branch-steering-groups-privacy-notice.

2. BACKGROUND

Introduction

2.1 **This chapter outlines the history of approaches to address the harm related to substance use in Northern Ireland, as well as summarising the review of the previous strategy and the process to develop this consultation document.**

Context

2.2 While the financial cost can never bring home the full impact that substance use related harm has on individuals, families and communities across Northern Ireland, the harms related to the use of alcohol and other drugs costs Northern Ireland hundreds of millions of pounds every year. The cost of alcohol misuse alone was estimated at up to £900 million in 2008/09[6], and if we were to add in the costs of the harm related to other drugs this would almost certainly take this figure to over £1 billion[7].

2.3 Most worrying has been the increase in alcohol and drug related deaths and the legacy these leave for families and communities.

2.4 Each and every one of these deaths is potentially preventable and therefore addressing this issue must be a key priority for the Department of Health and the Executive, but also for wider civic society and for the general public.

2.5 Addressing the harm related to alcohol and other drugs is therefore a key public health priority, and must continue to be so over the coming years.

History

2.6 Since 1986, there have been a number of Government initiatives to develop and implement a strategic response to alcohol and drug use. Initially there were separate strategies for Drug (1999) and Alcohol (2000) use, however in 2001 the Model for the Joint Implementation of the Drug and Alcohol Strategies (JIM) was launched.

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[6] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf

[7] The overall cost of drug misuse was estimated at £15.4bn in England in 2014, Northern Ireland proportion of this would be £0.426 bn. https://researchbriefings.files.parliament.uk/documents/CDP-2017-0230/CDP-2017-0230.pdf

2.7 In 2004 following a review of the two strategies and of the JIM, there was agreement that a *New Strategic Direction for Alcohol and Drugs*[8] (NSD) needed to be developed to tackle the harm related to these issues in Northern Ireland. Its implementation began in October 2006.

2.8 In 2011, following a review of the initial NSD, it was agreed that it would be updated, revised, and extended. This process also allowed the NSD Phase 2[9] to reflect new trends and re-direct effort to where it was most needed or to where new issues/concerns were emerging. The strategy's implementation was subsequently extended to allow alignment with the Regional Commissioning Framework for Alcohol and Drug Services.

Review of NSD Phase 2

2.9 During 2018, the Department of Health undertook a full review[10] of NSD Phase 2. The review evaluated the impact of NSD Phase 2 on its aims of preventing and addressing harm related to substance use in Northern Ireland. The review considered three specific aspects of the implementation of the NSD Phase 2 strategy:

a) ***Outputs*** – i.e. the actions taken by Government Departments and their agencies, through the NSD structures, and the progress made;

b) ***Outcomes*** – i.e. the impact that NSD Phase 2 had on the range of indicators and outcomes it set out to achieve and the differences made for the public, service users and carers; and

c) ***Stakeholder views and structures*** – i.e. a review of the views of key stakeholders on the delivery of the NSD and the associated structures, in the context of recent and emerging Government policy.

2.10 The final review was published in January 2019[11]. In summary, the review reported some encouraging signs in relation to reductions in substance use at the population level – for example, there had been significant reductions in the levels of binge drinking and the percentage of young people who drink and get

[8] https://www.health-ni.gov.uk/articles/alcohol-and-drugs-misuse#toc-0
[9] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-new-strategic-direction-phase-2-2011-16.pdf
[10] Terms of Reference at Annex I
[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/NSD%20PHASE%202%20Final%20Review%20-%20October%202018_0.pdf

drunk. Among adults, prevalence of illegal drug use had largely plateaued and significant numbers of individuals and families continue to access treatment and support services for alcohol and drug use. In addition, drug use among young people had fallen significantly.

2.11 However, this was offset by increases in a range of indicators related to harm. For example, hospital admissions and deaths as a direct result of harm related to substance use, are high and rising, and there are ongoing concerns about polydrug use, the misuse of prescription drugs and Novel Psychoactive Substances. There appears to be a significant cohort of people engaging in increasingly risky behaviours, causing an acute increase in related harms. This has also impacted justice related issues, including organised crime, exploitation, trafficking, etc.

2.12 In terms of progress against the outputs within the NSD Phase 2, 24 (17%) of the outcomes within the strategy had been completed, 98 (70%) of the actions were classed as being on track for achievement as they were long term or ongoing in nature, and in 17 (12%) of the actions progress was being made but with some delay. 2 (1%) of the actions were not on target for achievement, mostly as other areas had been prioritised instead.

2.13 Stakeholders felt that NSD Phase 2 acted as a driver for increasingly effective collaboration and partnership working at both strategic and operational level, and successfully raised the profile of alcohol and drug-related harm in Northern Ireland. In particular, the consistency, diversity of representation and commitment of the NSD Steering Group was recognised. The Regional Commissioning Framework for Alcohol & Drugs was credited with bringing about service improvements in terms of better availability, accessibility, equity, co-ordination and consistency. Investment in workforce development was also highlighted, as was the progress made on embedding transition to an evidence-informed harm reduction approach.

2.14 However, stakeholders also felt there should have been greater alignment between strategic and operational elements of NSD Phase 2, along with better/more effective integration across the strategic agendas of other Government Departments. Also by placing focus on issues related to acute

service provision, more structured opportunities may have been missed for evidence-informed future planning. Stakeholders also felt there could have been a better response to unintended outcomes and change management issues caused by the implementation of the Regional Commissioning Framework, and benefits could also have accrued from more data sharing and critical evaluation on existing programmes and services.

Pre-Consultation Process

2.15 Following the publication of the final review, the Department took forward a pre-consultation exercise as the first step of potentially developing a new substance use strategy for Northern Ireland. A small task and finish group was set up to take forward this process[12]. The aim of the pre-consultation exercise was to seek collective agreement on the need for a new strategy, and on the outcomes, indicators and priority areas it should target, in order to agree a collective vision before moving on to develop the more detailed actions and priorities contained in this document.

2.16 The pre-consultation exercise, which closed in September 2019, involved the following 3 elements:

- an online survey using Citizen Space;
- a series of engagement events / focus groups / workshops; and
- bi-lateral meetings.

2.17 57 responses were received in total – both through the online survey and via other written submissions. A number of engagement events and meetings were also held, to capture feedback from attendees. A summary of responses[13] was considered by the Pre-Consultation Task & Finish Group, and subsequently by the NSD Steering Group, and this has informed the development of this consultation document.

[12] TOR for this group is available at Annex II
[13] Attached at Annex III

NI Audit Office (NIAO) Report on Addiction Services in NI

2.18 The NIAO published a 'value for money' review of *Addiction Services in Northern Ireland*[14] on 30 June 2020, which contained 10 recommendations and focused on 3 main messages:

- the level of harm and complexities associated with alcohol and drug use is rising;
- there are inconsistencies in the referral pathways for, and provision of, Tier 4 rehabilitation beds across the five Trusts; and
- data collection should focus more on outcomes.

2.19 Overall, the NIAO report broadly reflected the issues raised in the review of the NSD Phase 2 and mirrored many of the views from the Pre-Consultation Exercise on the development of this new strategy. The findings and recommendations from the report are incorporated throughout this strategy.

Writing Group

2.20 Finally, a task and finish group[15] was established to support the development of this consultation document through a co-production approach. The Department would like to thank the members of this group who gave freely of their time and experience to help us make this consultation better, more informative and more inclusive.

[14] https://www.niauditoffice.gov.uk/publications/addiction-services-northern-ireland

[15] Terms of Reference for this Substance Use Strategy Writing Group are set out at Annex IV.

3. KEY STATISTICS

Introduction

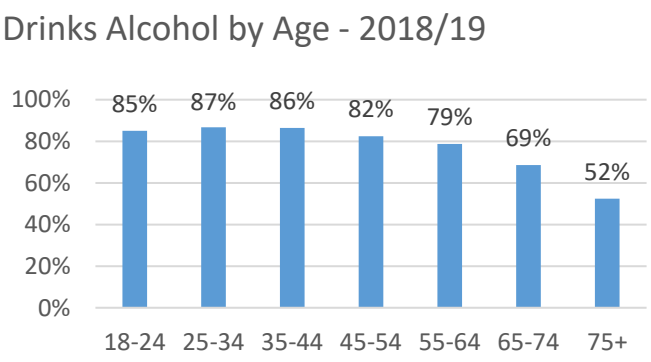
3.1 **This chapter will set out current trends in a range of key statistics in relation to alcohol and other drugs.**

Statistics

3.2 Alcohol and drug use, and the related harms, are ongoing challenges in Northern Ireland. The position is not static, the nature of substance use changes over time, and while there have been positive moves in some key indicators over the last number of years, others are moving in the opposite direction.

Alcohol Prevalence

3.3 The use of alcohol is common in Northern Ireland. The most recent survey findings indicate that 79% of respondents drink alcohol; this proportion has remained relatively consistent since 2010/11[16].



The proportion of adults who drink alcohol **declines in older age**

In 2018/19, around **four-fifths** of those aged **64 & under** drank alcohol compared with **two-thirds** (69%) of those aged **65-74** and around **half** (52%) of those aged **75 & over**

3.4 In 2017/18, a fifth (20%) of respondents reported drinking above recommended weekly limits[17], with males (31%) around three times more likely to do so than females (9%).

[16] A breakdown of survey responses is given at Annex VIII.

[17] The Chief Medical Officers' guideline for both men and women is that to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs_report.pdf

In 2017/18, a **fifth (20%)** of adults **drank in excess** of the **weekly limit**

(14 units for both males and females)

3.5 The proportion drinking above guidelines has fallen from 26% in 2010/11 to 20% in 2017/18. The proportion of males drinking above guidelines has fallen from 37% in 2010/11 to 31% in 2017/18 and the proportion of females has fallen from 15% to 9%.

	2010/11	2011/12	2013/14	2015/16	2017/18	Trend	Change 10/11-17/18
Drinking alcohol above weekly limits (aged 18+)	24%	22%	20%	20%	18%		
MALES Drinking alcohol above weekly limits (aged 18+)	37%	36%	32%	32%	31%		
FEMALES Drinking alcohol above weekly limits (aged 18+)	15%	13%	12%	11%	9%		

Male and female drinking patterns differ significantly

In 2018/19, over four-fifths of males (**83%**) were drinkers, with a tenth of males (**9%**) reporting that they thought they drank **quite a lot or heavily**

In 2018/19, almost a fifth of male drinkers (**16%**) drank on **3 or more** days per week

In 2017/18, around a third of males (**31%**) drank **in excess of the guidelines.**

In 2018/19, three-quarters of females (**76%**) were drinkers, with **2%** reporting that they thought they drank **quite a lot or heavily**.

In 2018/19, a tenth of female drinkers (**10%**) drank on **3 or more** days per week

In 2017/18, around a tenth of females (**9%**) drank **in excess of the guidelines.**

3.6 Considering deprivation, in 2017/18 there was no significant difference in the proportion who drank above the guidelines between those living in the most deprived (21%) and those living in the least deprived (22%) areas. However, those in urban areas (22%) were more likely to drink in excess of the guidelines than those in rural areas (17%).

Binge Drinking 2005-2013

3.7 Patterns of consumption are also important, with those who drink large volumes of alcohol in one sitting putting themselves at a higher risk. The most recent figures (2013) show that around 31% of adults binge drink[18] but this has fallen from 38% in 2005.

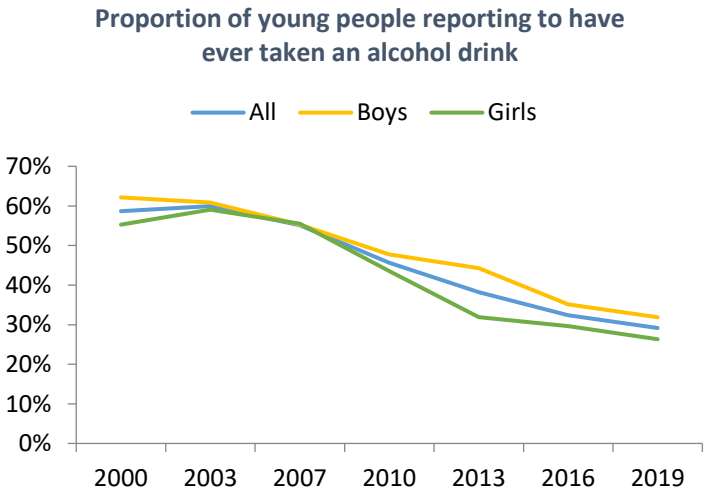
3.8 Over a third of males (35%) and more than a quarter of females (27%) had engaged in at least one binge drinking session in the week prior to the survey. Younger adults (18-29 year olds) were more likely to binge drink than older adults (60-75 year olds).

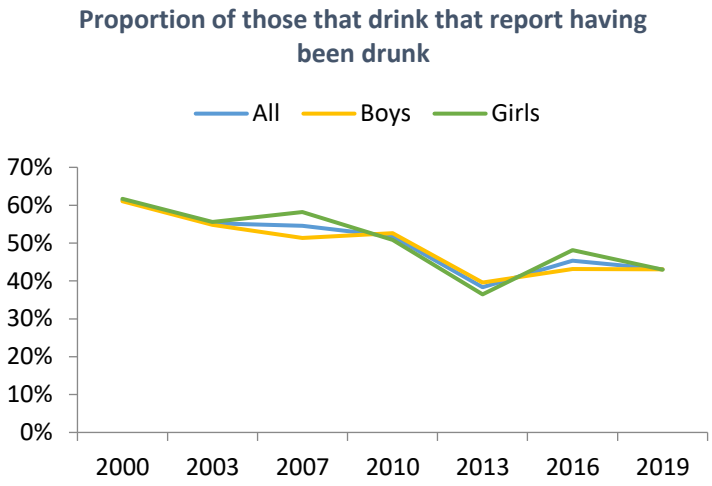
Prevalence – Children and Young People

3.9 Consumption of alcohol among our young people is also an issue of concern, with this having the potential to impact on a young person's immediate wellbeing, academic achievement, and longer term health and wellbeing as an adult.

3.10 Young Persons Behaviour and Attitudes Survey in 2019[19] shows that since 2000, there has been a decline in both the proportion of young people ever having drank alcohol and the proportion of those who drink that report having been drunk. The proportion of young people aged 11-16, reporting to have ever taken an alcoholic drink has fallen from 59% in 2000 to 29% in 2019.

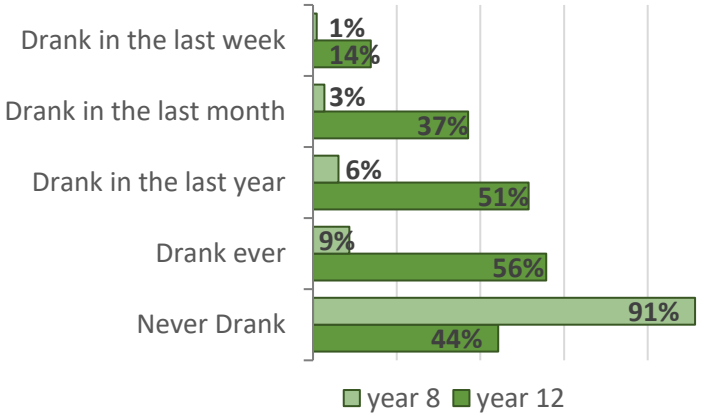
[18] https://www.health-ni.gov.uk/publications/adult-drinking-patterns-northern-ireland-survey-2013
[19] https://www.health-ni.gov.uk/articles/young-persons-behaviour-attitudes-survey

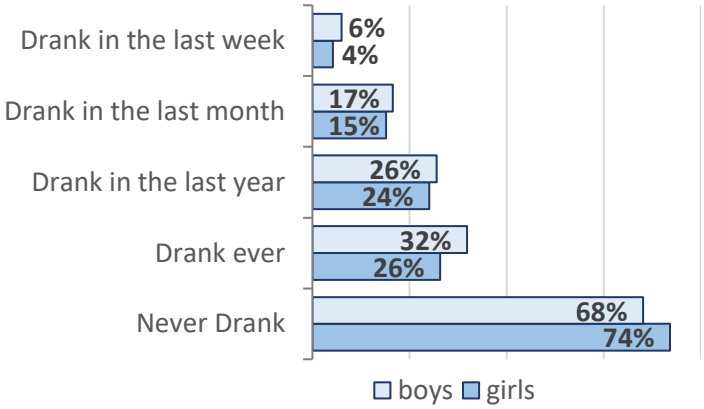




3.11 In 2019, boys (32%) were more likely to have taken a drink than girls (26%); and those in Year 12 (56%) were more likely to have done so than those in Year 8 (9%).

Have you ever taken an alcoholic drink (not just a taste or a sip)?



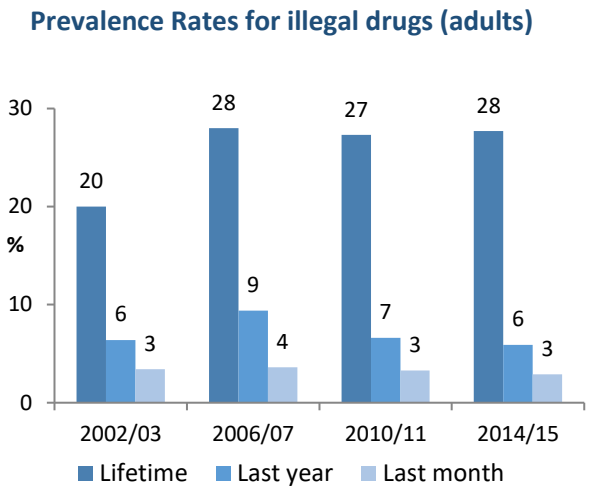


Illegal Drug Use

3.12 In terms of prevalence of other drug use among adults, the most recent Drug Prevalence Survey in 2014/15 found that more than a quarter (28%) of people surveyed reported having used an illegal drug during their lifetime, with 6% having done so during the previous year and 3% during the last month[20].

[20] https://www.health-ni.gov.uk/articles/drug-prevalence-survey

3.13 Comparing the most recent years of the survey, there has been very little change in the proportion of respondents reporting lifetime, last year or last month use of illegal drugs.



3.14 Cannabis was the most commonly reported illegal drug with a quarter of respondents (25%) reporting having ever used the drug, 5% reporting recent use in the last year and 3% reporting use in the last month. After cannabis, the most commonly reported drugs ever used were ecstasy (10%), poppers (7%) and cocaine powder (7%).

3.15 Almost a quarter of respondents (24%) reported ever taking anti-depressants, while over a fifth reported taking other opiates (22%) and sedatives or tranquillisers (21%).

3.16 In 2017/18, a pilot drugs module was included in the Health Survey Northern Ireland[21]. Whilst direct comparisons are difficult due to the different survey source and methodology, the findings from the pilot indicated similar levels of last year prevalence of illegal drugs compared with the 2014/15 Drug Prevalence Survey[22].

3.17 It should be noted that there are limitations in using a general population survey to estimate drug use. In their survey handbook, the European Monitoring Centre for Drugs and Drug Addiction[23] draw attention in particular to the fact that such surveys exclude those who are homeless and those living in institutions. Additionally, more chaotic drug users may be under-represented in household surveys. Whilst the limitations should be acknowledged, surveys do help gauge the extent of problematic drug use and are useful in capturing trend data.

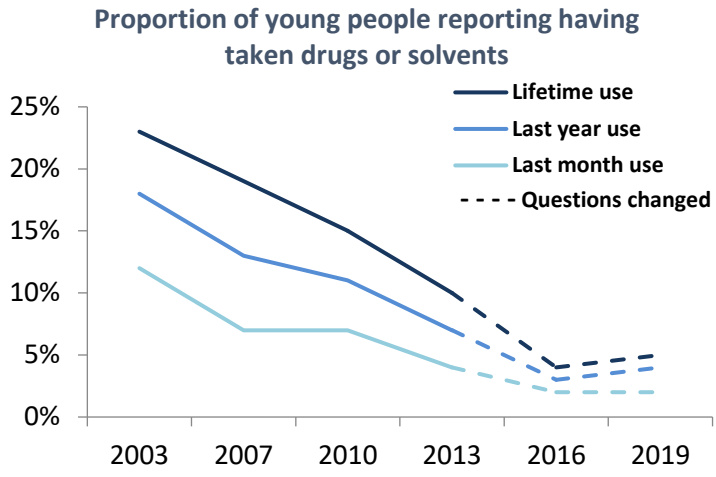
[21] https://www.health-ni.gov.uk/sites/default/files/publications/health/pilot-drugs-hsni.pdf

[22] https://www.health-ni.gov.uk/publications/all-ireland-drug-prevalence-survey-201415

[23] https://www.emcdda.europa.eu/html.cfm/index58052EN.html_en

Drug Use among Children and Young People

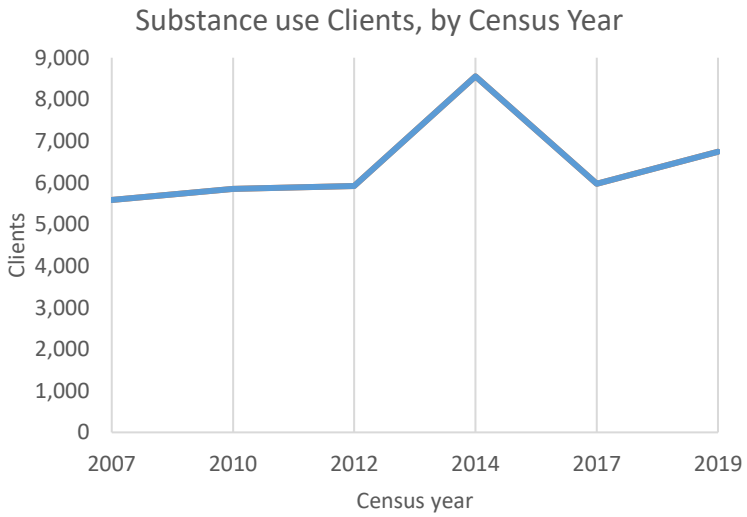
3.18 Encouragingly, among young people we have seen very significant reductions in self-reported use of other drugs and solvents.



The proportion of young people reporting ever having taken drugs has fallen from 23% in 2003 to 5% in 2019

It should be noted that the questions on young people taking drugs changed in 2016 and thus may not be directly comparable with previous years.

3.19 The most recent findings from the Young Persons Behaviour and Attitudes Survey in 2019 indicate lifetime use at 5%, last year use at 4%, and last month use at 2%.



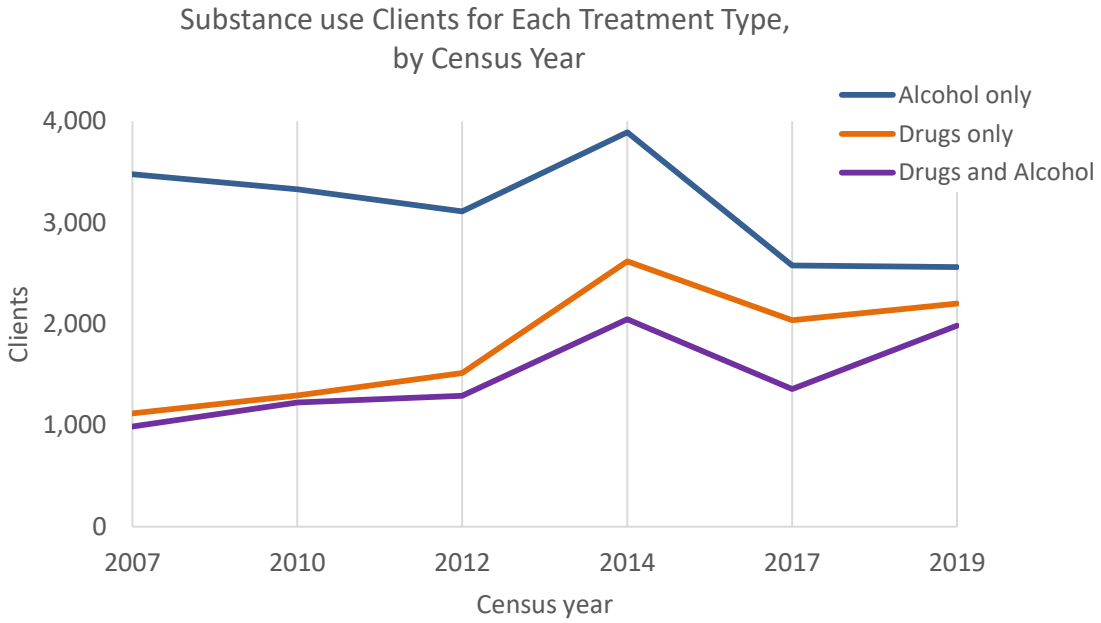
3.20 As mentioned previously, these prevalence figures are based on survey information, so there is the potential that this under-reports actual usage, but the trends should remain consistent over time.

Treatment

3.21 On 30 April 2019, a total of 6,743 persons were reported to be in treatment for use of alcohol and/or drugs[24] in Northern Ireland. The chart below shows the trend over the last 12 years. In 2019 there was an increase in the number of clients in treatment.

3.22 Previous to 2019, the number in treatment had remained relatively stable with the exception of 2014. It should be noted that additional lottery-funded alcohol projects were running during 2014 which would have contributed to the increased number of clients in that year.

3.23 Treatment types have changed over the years with increases in the proportion of clients in treatment for drugs, or drugs and alcohol, and a decrease in those for alcohol only.



In 2007, 62% of clients presented for alcohol only, by 2019 this had fallen to 38%

Clients presenting for Drugs only increased from 20% in 2007 to 33% in 2019

Drugs and alcohol increased from 18% to 29% for same period

[24] https://www.health-ni.gov.uk/sites/default/files/publications/health/drug-alcohol-census-2019.html

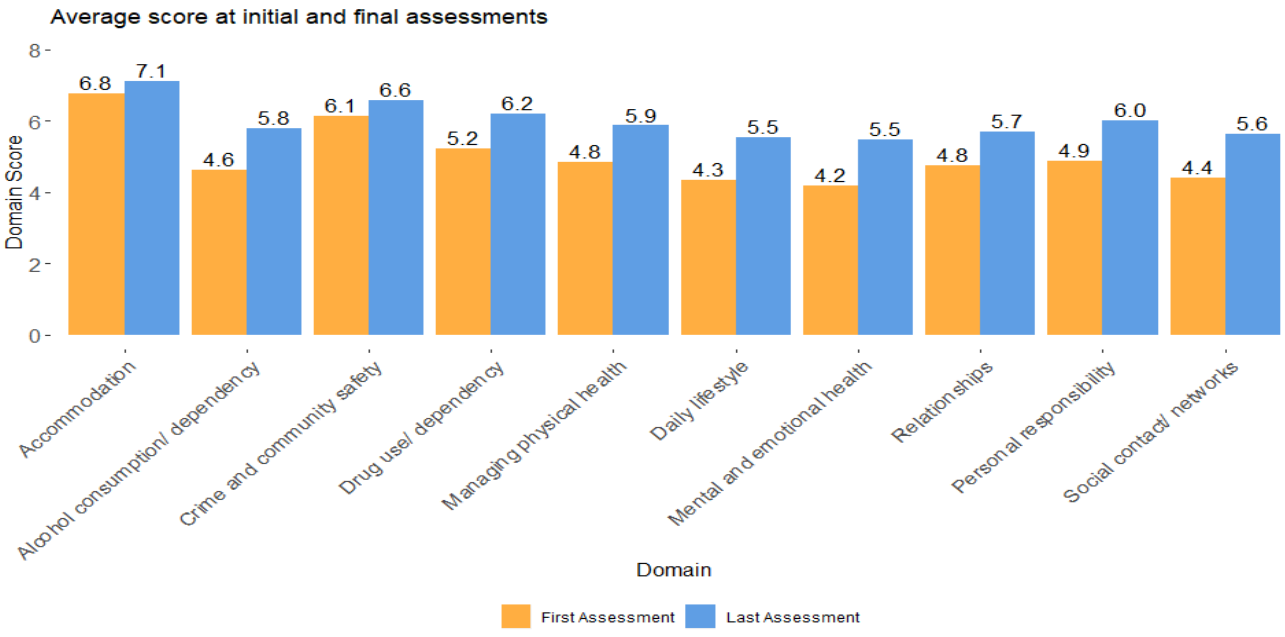
Measuring Impact

3.24 The Impact Measurement Tool (IMT) is a data collection system used to assess the effectiveness of tier one and tier two drug & alcohol services commissioned by the Public Health Agency and is split into the following typologies:

- Adult Treatment (Step 2)[25];
- Young Persons Treatment;
- Low Threshold Services;
- Parental Substance use;
- Workforce Development; and
- Targeted Prevention.

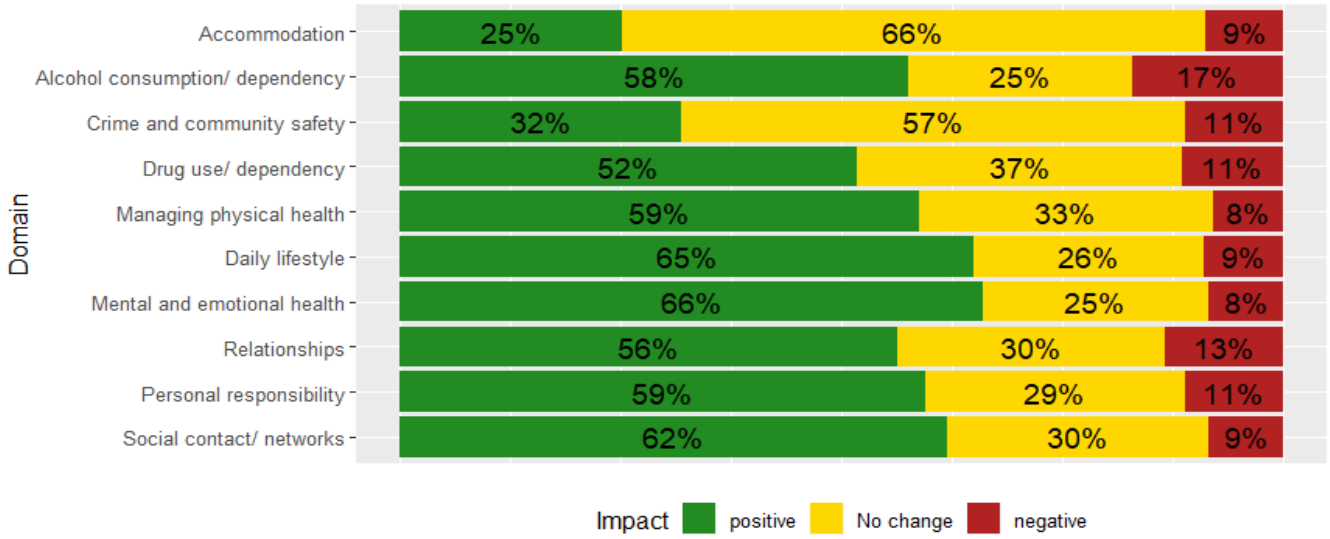
Findings relating to a number of typologies are presented below and further information is available online[26].

3.25 The **Adult Treatment** typology collects data relating to individuals aged 18 and over, who are receiving Step 2 treatment or aftercare for alcohol and / or drug use. During 2018/19 impact data was collected for 775 clients.

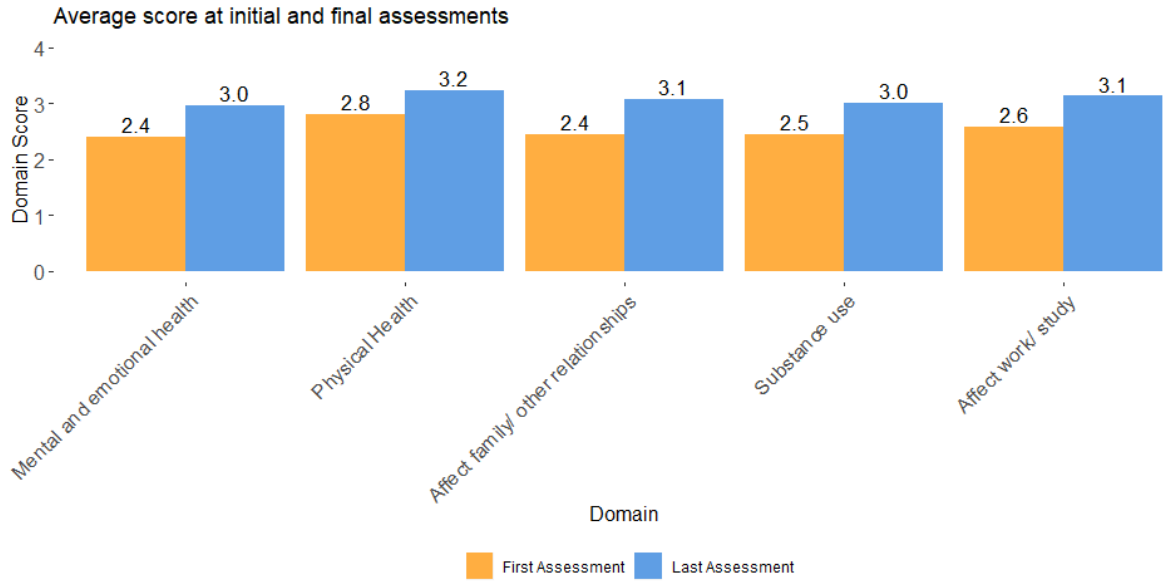


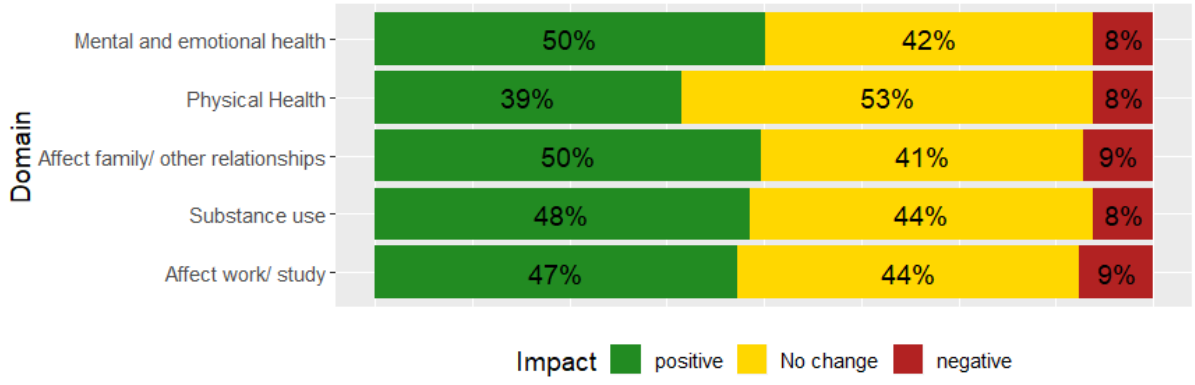
Note- The high proportion of clients seeing no change in both the Crime and Accommodation domains can be attributed in part to their first assessment being at the top of the scale (i.e. no criminal activity or satisfactory accommodation), thus no improvement could be made.

[25] https://services.drugsandalcoholni.info/node/13
[26] https://www.health-ni.gov.uk/sites/default/files/publications/health/imt-18-19.pdf



3.26 The **Youth Treatment** typology covers the provision of community based early intervention services for young people aged 11–25 who are identified as having substance use difficulties. During 2018/19, impact data was collected for 908 young people and was measured across 5 key Domains at the beginning of, during, and/or following treatment.

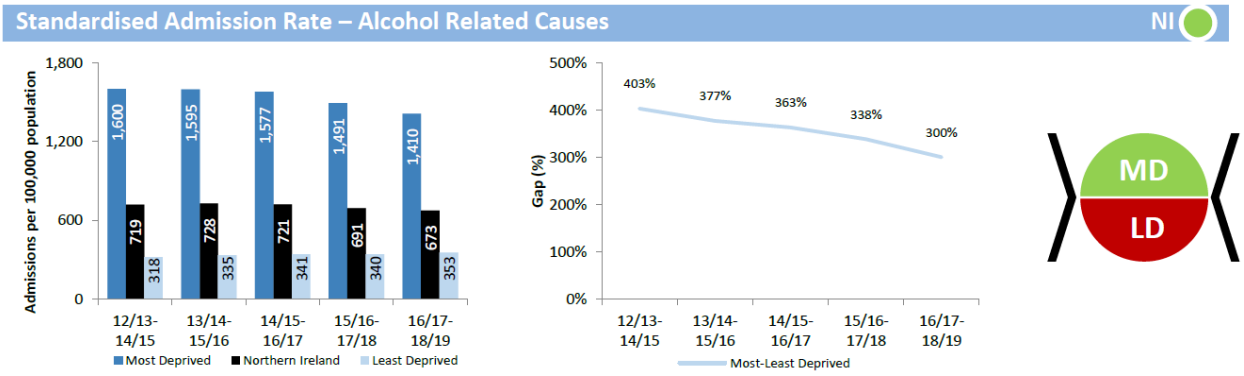




Admissions to Hospital

3.27 Admissions to hospital for alcohol (only) related diagnosis have remained at around 12,000 per year for the last 5 years, though interestingly admissions for alcohol and drug related diagnosis have fallen from 1,883 a decade ago to 1,263 in 2018/19. Admissions to hospital for drug (only) related diagnosis have also fallen from 3,346 a decade ago to 2,543 in 2018/19. However, it should be noted these figures are only for those who get admitted, not all those who attend Emergency Departments, and that both remain high.

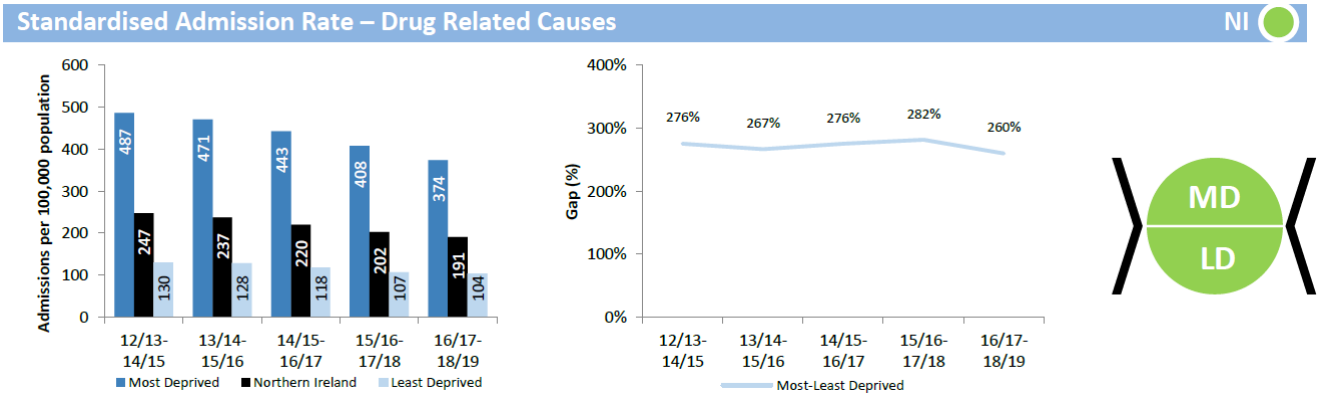
3.28 Age standardised admission rates, which allow for direct comparison over time and between different population groups, show a fall in alcohol related admissions in NI (from 719 to 673 admissions per 100,000 population) and its most deprived areas (from 1,600 to 1,410 admissions per 100,000 population) over the last five years. With a slight increase in the least deprived areas (from 318 to 353 admissions per 100,000 population), the inequality gap in admissions between the most and least deprived areas has narrowed slightly however the rate in the most deprived areas is four times the rate in the least deprived areas.



3.29 Age standardised admission rates for drug related causes also decreased over the last five years in NI (from 247 to 191 admissions per 100,000 population) and its most (from 487 to 374 admissions per 100,000 population) & least deprived (from 130 to 104 admissions per 100,000

The drug related admission rate in the most deprived areas was **more than three and a half times** the rate in the least deprived areas.

population) areas. With admissions decreasing at a greater rate in the most deprived areas than in the least deprived areas, the inequality gap narrowed slightly. The standardised drug related admission rate in the most deprived areas is more than three and a half times the rate in the least deprived areas.



Deaths

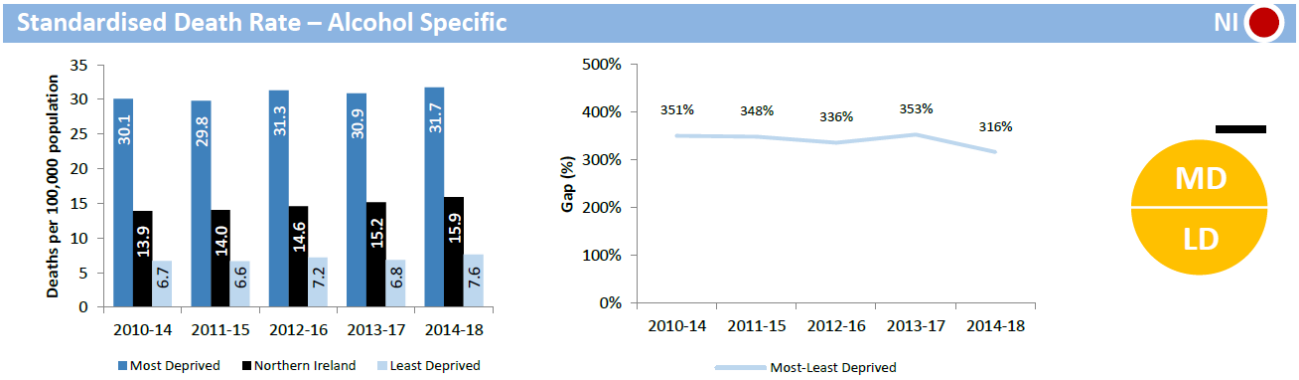
3.30 284 people[27] in Northern Ireland lost their lives related to an alcohol-specific cause and 189 from a drug-related death in 2018[28]. This is the highest number of drug-related deaths on record and, whilst not the highest number of alcohol specific deaths on record, they are approximately 17% higher than there were in 2008.

3.31 In recent years, the proportion of those who died from alcohol-specific causes aged 55-64 has increased; in 2018 this age group accounted for over a third of such deaths (36.6%), while those aged 45-54 accounted for 29.6% of the total. We therefore have to think about how alcohol impacts on people as they get older. Of the 189 drug-related deaths in 2018, 72 (38.1%) were in the 25-34 age group with a further 50 (26.5%) in the 35-44 age group – therefore we seem to have a growing cohort of young people experiencing drug related harm.

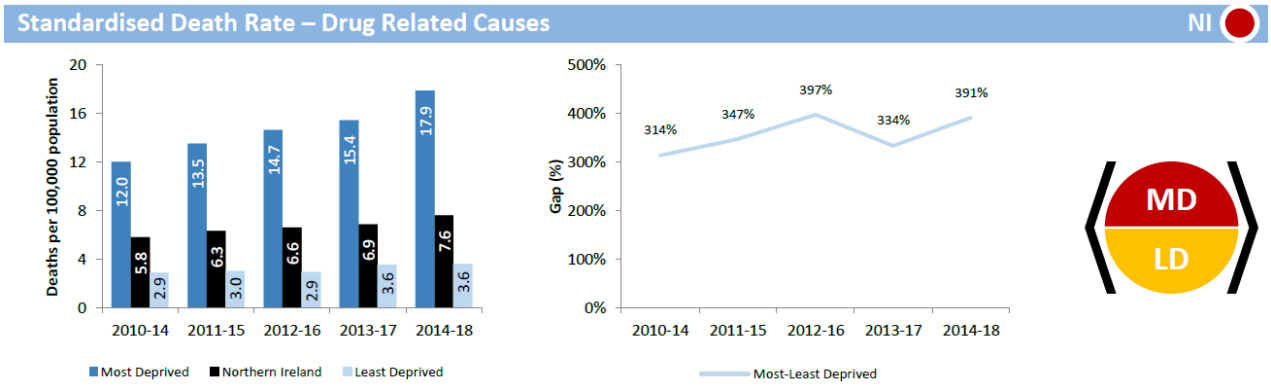
[27] https://www.nisra.gov.uk/statistics/cause-death/alcohol-deaths#toc-0
[28] https://www.nisra.gov.uk/statistics/cause-death/drug-related-deaths

3.32 The statistics (based on the period 2014 to 2018) also indicate that there are notably higher numbers of alcohol-specific deaths in areas of deprivation across Northern Ireland, with the age standardised death rate in the most deprived areas (31.7 deaths per 100,000 population) being more than four times the rate in in the least deprived areas (7.6 deaths per 100,000 population).

Alcohol specific mortality in the most deprived areas was **over four times** that in least deprived.



3.33 The statistics also indicate that there are notably higher numbers of drug-related deaths in areas of deprivation across Northern Ireland. People living in the most deprived areas are five times more likely to die from a drug-related death than those in the least deprived areas.



Costs

3.34 A report in 2008 estimated the cost of alcohol misuse alone at up to £900 million[29] made up as follows:

ANNUAL COST ESTIMATE	
Cost Element	Upper £m
Health Care	158.0
Social Work	82.0
Fire and Police	279.3
Courts and Prisons	103.6
Wider costs (including workplace)	258.2
TOTAL	**881.1**

3.35 The Dame Carol Black Review of Drugs[30] put the social cost of drug misuse in the UK at £20bn, assuming the costs to Northern Ireland match our population share then this would be around £0.6bn locally. Taking the total cost of the harm related to substance use in Northern Ireland up to £1.5bn.

3.36 However, these financial costs do not reveal the true impact that substance use related harm has on individual people, their families and on local communities across Northern Ireland.

Justice System

3.37 People with alcohol and drug issues often interact with the Justice System – for example, alcohol is a factor in 20% of all crimes, and this has been stable over time[31]. The numbers detected and convicted for drink/drug driving have fallen over the years, but there were still almost 2,000 convictions in 2017/18. Drug and alcohol driving collision figures also present a mixed picture. Overall the number of collisions of all categories involving substances are down, but the proportion of collisions that are substance use related have remained roughly static or have increased slightly. Drug seizures and drug arrests have also been increasing.

[29] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf
[30] https://www.gov.uk/government/publications/review-of-drugs-phase-one-report
[31] https://www.psni.police.uk/globalassets/inside-the-psni/our-statistics/police-recorded-crime-statistics/2019/march/crime-bulletin-mar-_19.pdf

4. WIDER CONTEXT

Introduction

4.1 **This chapter provides some of the wider context in relation to substance use. This includes other key drivers and supporting strategies, which will support addressing this key issue.**

Context and Strategic Drivers

4.2 Substance use, and the related harm, is not just an issue of personal responsibility and people's behaviours. It is very much interlinked with wider health outcomes, including health inequalities, and more widely with the economic, social and environmental circumstances in which people are born, grow, live, work and age.

4.3 We know there are overlaps and interactions between substance use and poverty/deprivation, mental health and wellbeing, community relations, community safety and justice, employment, economic development, trauma, and the impact of our past. To truly address this issue, we need to work collectively as Government and society to tackle these wider determinants.

Rights

4.4 Everything we do must be underpinned by the rights of the individual service user to be treated as a human being, with dignity and respect. Individuals have the right to access a quality service that will support them on their pathway to recovery. They should be properly consulted and involved in all aspects of their treatment.

Trauma and ACEs

4.5 Many people who come to harm from substance use have a history of trauma, as well as being particularly vulnerable to experiencing further trauma. Studies have consistently shown a high prevalence of co-occurring mental disorders in people who have problems with alcohol and drugs and clear connections with homelessness and interactions with the justice system.

4.6 Many of those who suffer most from alcohol and drug related harm have experienced domestic violence (in their family of origin and/or in intimate partner relationships) and services should be equipped to respond appropriately to this issue.

4.7 In addition, Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction, such as witnessing domestic violence or growing up with family members who have substance use disorders.

4.8 There is a need for awareness of the impact of ACES, later traumas/stressors such as domestic violence (physical, emotional, financial and sexual), sexual exploitation, bereavements, community violence, poverty etc. on people's ability to engage with services, treatment and recovery and what additional supports they may require. While research indicates women are more likely to be victims of domestic violence and sexual exploitation – men can also be victims of these traumas.

4.9 Northern Ireland is known to suffer from higher rates of trauma (and mental illness) than other parts of the UK[32], with researchers having linked to the long-term impacts of our past[33]. In addition the recently published Youth Wellbeing Survey[34], found that anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK.

4.10 All those affected need support from a wide range of services and integrated approaches are needed to address homelessness, mental health problems, unemployment and general healthcare needs.

Stigma

4.11 There is a stigma that surrounds those who experience issues with alcohol and drug use. Negative attitudes and stigma – from the public, from professionals, and from self-stigmatisation – can be a real barriers to accessing treatment and

[32] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30392-4/fulltext
[33] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf
[34] http://www.hscboard.hscni.net/our-work/social-care-and-children/youth-wellbeing-prevalence-survey-2020/

other services. We need to challenge this stigma and ensure that it is not a barrier to help-seeking behaviour.

Peer Support

4.12 There is the potential to build upon and better use the expertise and experience of peers to better support individuals throughout their recovery journey. As well as providing additional support to service users, it will give improved access to an alternate voice, so that service users are more able to feel ownership and a level of control of their recovery pathway. It can also assist those who are ready for the opportunity to support others, to gain experience, to potentially give a role or purpose, and to help their peers.

4.13 The Department will liaise with Scottish counterparts on the evaluation of their peer navigator model being run jointly between Justice and Health.

North/South and East/West

4.14 The Department of Health will continue to liaise with counterparts in Ireland through regular meetings of the North South Alcohol Policy Advisory Group (NSAPAG). This forum gives both administrations the opportunity to discuss the latest developments on alcohol related policy and legislation, and to take forward joint action where appropriate.

4.15 There is also a “Misuse of Substances” sectoral group established under the British-Irish Council (BIC). Ireland provides the administration and chairs the meetings of this sectoral group which has representation from the UK Government, Scotland, Northern Ireland, Wales, Jersey, Guernsey and the Isle of Man. This particular BIC Sectoral Group provides officials from all member jurisdictions a forum to share regular updates on alcohol and drug related policy from their respective administrations.

Impact of COVID-19

4.16 The emergence of COVID-19 has heightened the risks involved with the management of substance use services, in what is already a high-risk clinical scenario. Guidance was published aimed at helping all alcohol and drug services to address the challenges posed by the need to ensure that premises

are safe for both patients and staff in terms of social distancing measures, and that these also comply with the necessary infection control protocols[35].

4.17 The sudden challenging environment due to social distancing restrictions imposed during the COVID-19 crisis meant that measures needed to be put in place to support people with alcohol and drug issues adversely impacted by social isolation. Robust procedures ensured continuity of service provision for all service users and, although some residential services had to temporarily close, by and large, substance use services remained operational. This was achieved by using a mixture of face to face/telephone support and interventions primarily continuing on a telephone/video-link basis, and managed as appropriate within risk management, social distancing and infection control guidelines. In particular, measures were adopted to support those with more acute dependency issues, and to ensure associated services remained fully operational and accessible across all Health & Social Care Trust areas.

4.18 In response to the particular challenges posed in maintaining a viable service for this population group during this unprecedented public health situation, a COVID-19 Addictions Subgroup maintained communication flows between the Department, the HSCB, the PHA and the local Trusts. The subgroup helped to provide clarity on regional actions required in relation to the COVID-19 outbreak and how these should be applied by all addiction service providers across Northern Ireland, including addressing the broader requirements for people with dependency issues. The impact of COVID-19 on all of our treatment and support services continued to be managed within existing financial and workforce resources, and re-configured as the need arose.

4.19 At the same time, the PHA continued to highlight the health risks associated with using alcohol and drugs, with specific messaging related to the difficulties some faced during this period of social isolation, including information on where local help and support can be accessed. Further information on substance use was also developed for the general public and for people with dependency issues.

[35] https://www.health-ni.gov.uk/sites/default/files/publications/health/guidance-for-alcohol-drug-services-during-the-covid-19-pandemic-june-2020.pdf

4.20 It is vital that we use the learning from the impact of COVID-19 and the response of services to ensure we rebuild our service provision in the most effective way possible. *Mental Health Impact of the COVID-19 Pandemic in Northern Ireland – A Rapid Review*[36] outlines some evidence of the potential psychological impact of the COVID-19 outbreak among the population in NI, in terms in vulnerability to alcohol dependency and mental health problems associated with contributing social factors such as isolation, loneliness, stigma, domestic violence, economic recession, and heightened risk of unemployment. The appendix of *International Policy Guidance and Responses to COVID-19 Mental Health Recovery Rapid Review*[37] outlines risks which could be reframed as learning and what is required of services to mitigate these risks.

4.21 One of the early key learnings from the pandemic was the success for many service users of the switch to on-line/digital access to services. This resulted in a very low number of missed appointments and thus an improvement in the productivity of some services. However, while it is apparent that such a switch to digital services did suit some services users, it would not suit everyone. Face-to-face meetings will still be required for some services and for some users, and we need to ensure that we do not negatively impact on those who cannot access or have limited access to technology or on-line services. Ultimately, it is important that the services have flexibility built in so that they can be tailored to the needs of the individual service users.

Related Strategies and Policies

4.22 This strategy cannot address all the wider causes of substance use related harm and will therefore focus on where there are specific substance use related actions that can have a positive impact. However, we will work with others, and play our part in addressing these issues through the wider strategies set out below. This is not an exhaustive list but these are the main strategic drivers.

New Decade, New Approach[38] was published as part of the return of the Executive and Assembly in Northern Ireland, contains a range of commitments that will support the delivery of this strategy, in particular the commitments to:

[36] https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-impact-covid-pandemic.pdf
[37] https://www.health-ni.gov.uk/sites/default/files/publications/health/international-policy-covid19.pdf
[38] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

- publish a Mental Health Action Plan[39] and a Mental Health Strategy;
- establish an expert group to examine and propose an action plan to address links between persistent educational underachievement and socio-economic background;
- develop and implement an Anti-Poverty Strategy;
- tackle paramilitarism; and
- extend existing welfare mitigation measures beyond March 2020.

The **Draft Programme for Government's**[40] (PfG) overarching objective is "Improving wellbeing for all – by tackling disadvantage and driving economic growth". The achievement of the PfG, and in particular Outcomes: 3 (We have a more equal society); 4 (We enjoy long, healthy, active lives); 7 (We have a safe community where we respect the law and each other); 10 (We have created a place where people want to live and work, to visit and invest); and 12 (We give our children and young people the best start in life), will have a real impact on addressing substance use, and this strategy will also have a direct impact on meeting those outcomes.

Making Life Better[41] is the Northern Ireland Executive's strategic framework for public health. It is designed to provide direction for policies and actions to improve the health and wellbeing of people and to reduce health inequalities. Through *Making Life Better*, the Executive is committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

Published in 2019, the aim of the **Children and Young People's Strategy**[42] is to work together to improve the well-being of all children and young people in Northern Ireland – delivering positive long-lasting outcomes.

The Strategy has been developed in the context of the Children's Services Co-operation Act (NI) 2015, (CSCA) which places a duty on the Executive to adopt

[39] https://www.health-ni.gov.uk/publications/mental-health-action-plan
[40] https://www.northernireland.gov.uk/sites/default/files/consultations/newnigov/draft-pfg-framework-2016-21.pdf
[41] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf
[42] https://www.education-ni.gov.uk/sites/default/files/publications/education/2019-2029%20CYP%20Strategy.pdf

a strategy to improve the well-being of children and young people, and requires that for the purpose of determining children's well-being, regard is to be had to the relevant provision of the United Nations Convention on the Rights of the Child.

The **Mental Health Action Plan**[43], published by DoH on 19 May 2020, aims to initiate the reform of mental health services and provides the foundations for longer term strategic change. The Action Plan contains 38 actions designed to bring about service improvements to mental health in the short to medium term, creating a focused basis for decision making and immediate service improvements. It will link into existing strategies with the primary aim to deliver high quality services where they are needed and ensure that all people in Northern Ireland are supported in their mental health.

One of the key actions set out in the Mental Health Action Plan is to develop a new, ten-year Mental Health Strategy. This was a commitment set out in *New Decade, New Approach*, and will be the key strategic vehicle for change to mental health services over the next decade. The Strategy will be person-centred, taking a whole life approach and a whole system focus and the aim is to ensure long-term improved outcomes for people's mental health. The Strategy will be co-produced with individuals with lived experience and other stakeholders, and it is expected that a final Strategy will be published in July 2021.

Homelessness Strategy[44] **and the Interdepartmental Homelessness Action Plan**[45] the Housing Executive's homelessness strategy, Ending Homelessness Together, published in April 2017, provides strategic direction for addressing homelessness in Northern Ireland through to March 2022. The strategy recognises the important role of other agencies in providing advice, assistance and support to prevent households reaching crisis point. Partnership working is at the core of this homelessness strategy, and is reflected in its vision of 'ending homelessness together'.

[43] https://www.health-ni.gov.uk/publications/mental-health-action-plan
[44] https://www.nihe.gov.uk/Documents/Homelessness/homelessness-strategy-northern-ireland-2017-2022.aspx?ext=.
[45] https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dfc-inter-departmental-homelessness-action-plan.pdf

The Department for Communities has also led on the development of the Inter-Departmental Homelessness Action Plan to complement the Northern Ireland Housing Executive's new Homelessness Strategy. It focuses on addressing gaps in those non-accommodation services that have the most impact, or have the potential to more positively impact, on the lives and life chances of people who are homeless and those who are most at risk of homelessness.

Health and Wellbeing 2026: Delivering Together[46] sets out a ten-year approach for change in Health & Social Care, which places emphasis on health promotion, the prevention of ill-health, early intervention, and supporting independence and wellbeing. "*Delivering Together*" highlights the importance of supporting communities to create the social and environmental conditions that lead to improved health and wellbeing, and commits to supporting primary care to take a more proactive multidisciplinary approach to physical, mental and social wellbeing with a greater emphasis on prevention and early intervention.

An Emotional Health and Wellbeing Framework for Children and Young People is being jointly developed by DE, DoH and PHA. The Framework will aim to ensure that children and young people are empowered to take better care of their wellbeing and receive the right support, at the right time, according to their needs.

The Education Authority Youth Service is well positioned to provide youth specific education and support to young people on health and wellbeing, including information and support on substance use. The **Youth Service Regional Assessment of Need 2020-2023**[47] specifically mentions the impact of substance abuse amongst young people.

Protect Life 2[48] was published in September 2019. It focuses on suicide prevention as a societal issue and seeks to ensure collaborative cross-departmental engagement to address risk factors for suicide and self-harm, as well as engagement across wider society.

[46] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[47] https://www.eani.org.uk/sites/default/files/2020-02/Youth%20Service%20Regional%20Assessment%20of%20Need%202020-23.pdf
[48] https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF

The Road Safety Strategy to 2020 – The Department for Infrastructure's Road Safety Strategy includes a large number of action measures to improve road safety and to reduce deaths and serious injuries on our roads. It continues to focus on problem areas, including drink and drug driving.

Problem Solving Justice – The Justice System frequently comes into contact with people suffering from alcohol and drug related harm, often in challenging circumstances.

Problem Solving Justice is an international model being developed in Northern Ireland aimed at tackling the root causes of offending behaviour and reducing harmful behaviour within families and the community. More detail on Problem Solving Justice can be found in Chapter 7.

5. VISION, OUTCOMES, VALUES, PRIORITIES AND TARGET GROUPS

Introduction

5.1 **Based on the pre-consultation process, this chapter sets out the proposed overall vision for this new strategy, along with a number of related outcomes, and outlines a number of values that should be at the heart of developing and implementation any new strategy. A range of key priorities and target groups have also been identified.**

Vision

5.2 In support of the overall objective of the draft Programme for Government of "Improving wellbeing for all – by tackling disadvantage and driving economic growth", it is proposed that the Vision for the new substance use strategy should be:

People in Northern Ireland are supported in the prevention and reduction of harm related to the use and misuse of alcohol and other drugs, and will be empowered to maintain recovery.

Outcomes

5.3 It has been agreed that, in line with the overall approach set out in the draft Programme for Government, the new strategy would be taken forward using an Outcomes Based Accountability type approach. Rather than develop one overarching outcome, it was felt that a range of population-level outcomes would better reflect the holistic approach needed to address these multi-faceted issues. We are therefore proposing six outcomes that will help achieve the overall vision above. These are:

A. Fewer People are at Risk of Harm from the Use of Alcohol and Other Drugs.
B. Legislation and the Justice System Support Preventing and Reducing the Harm related to Substance Use.
C. Reduction in the Harm Caused by Substance Use.
D. People Access High Quality Treatment and Support Services to Reduce Harm and Support Recovery.
E. People Are Empowered and Supported on their Recovery Journey.
F. Information, Evaluation and Research Better Supports Strategy Development, Implementation and Quality Improvement.

5.4 The following chapters provide more detail on each of these outcomes along with actions to achieve them and the indicators that demonstrate progress.

Values

5.5 The development of the strategy, and its subsequent implementation, should be guided by and fully informed by the following Values:

- Person-Centred Approach: Everyone has the right to access treatment and support to help them overcome the harm caused by their substance use. Individuals and families should be at the centre of our approach to address this issue and we need to design and deliver policies and services with the support of those who use them.
- Shared Responsibility, Co-Production and Collaboration – Health-led: All partners need to be involved in addressing this issue, and while it is essential that we take a public health approach to addressing it, health alone cannot solve it. We need the support of all partners, including service users and the wider public.
- Evaluation, Evidence and Good Practice-Based: It is essential that we use high quality and up-to-date evidence to inform policy and implementation, including the use of best practice developed locally, nationally or internationally. In order to determine if this strategy and its actions are being effective, they must be subjected to appropriate evaluation and ongoing monitoring.
- Universal, but with an increased focus on those most at risk: The harm from substance use can affect people from all walks of life, age groups and backgrounds. It is therefore vital that universal services are available for all those who need them, and that prevention initiatives are widely available. However, we also know the impact of substance use is not felt equally across society, if we are to address the inequalities that exist we must get better at targeting more intensive interventions at those most at risk. Given their legal status and developmental stage, the main focus for children should be on early intervention, prevention and treatment, whilst avoiding a formal Justice response where possible. Other specific groups, such as those who suffer from homelessness, are even more effected by alcohol and drug related inequalities. We have to get much better at identifying and reaching out to those most at risk.

- Community based with local flexibility to address needs: One of the key issues that came through the review of the previous strategy was the lack of connection between the framework and what was happening at the community level. Therefore, while we will take forward regional approaches and services where possible, we should ensure that people are supported within local communities and there is an ability to deliver local solutions to local issues where needed.
- Long-term Focus: While it will be vital that we take forward short and medium term actions, and address any acute issues we are facing now, short-termism should not detract from the longer-term vision and that we focus on prevention and early intervention as much as treatment and support.

Priorities

5.6 The co-production process identified a number of priorities that must be addressed within our overall approach. These are as follows:

- Polydrug Use: One of the biggest changes that occurred over the course of the previous strategy was the increase in people using more than one substance at the same time. This includes using illegal drugs, alcohol, prescription medicines, novel psychoactive substances, counterfeit medicines, and image and performance enhancing drugs. This change has meant that providing support to individuals is increasingly complex, both in terms of treatment and harm reduction messages, and that the risk of death increases substantially. In 2018, the majority (80%) of Drug Related Deaths involved the consumption of 2 or more substances while the proportion of Drug Related Deaths with 3 or more drugs present in the body at the time of death increased from 25% in 2008 to 50% in 2016 & 2018. It is vital that we address this growing practice and ensure that we provide information and services that take account of this trend.
- Alcohol and Drug Related Deaths: The level of alcohol and drug related deaths is of increasing concern. Alcohol specific and drug related deaths are preventable and addressing this issue must be a key priority in everything we do, and will require new and innovative approaches.
- Supporting Families – including Hidden Harm: The harm caused by substance use doesn't happen in isolation and the harm is felt beyond the individual, with family members also impacted. The impact of parental or

carer substance use on their children and young people (what is often called hidden harm) is a particular concern – especially as we learn more about the impact of Adverse Childhood Experiences. We must ensure that supports are in place for family members, that family based treatment options are available were appropriate, and that we redouble our efforts to protect those children affected by Hidden Harm.

- Improving Service Access and Quality: The evidence is clear – treatment works. However, we need to ensure that there is quick access to clear service pathways and that all services are delivered in line with *Drug Misuse and Dependence: UK Guidelines on Clinical Management*[49] and the forthcoming UK Guidelines on the Treatment of Alcohol Dependence.
- Workforce Development: It is vital that we have capacity to deliver on the strategy, and that all those who work in the substance use field, and those who come into contact with people at risk, have the skills and experience to help and support people through their recovery journey.
- Supporting People throughout their Recovery Journey: Recovery is a personal journey. For some a successful outcome may be improving their quality of life and overcoming their dependence on the substance – alcohol, illegal drug, or prescription medicine – that is causing them the most harm. For others, their ultimate goal might be abstinence. The key focus for the system should be to help individuals and families to achieve their goals. Recovery can be self-led, peer-led, through mutual engagement, and can encompass all sectors. Journeys can start by simply engaging with outreach or harm reduction services, and people need to be supported to maintain recovery after treatment has ended.
- Supporting People with Co-occurring Mental Health and Substance Use: Substance use should not be a barrier to accessing services. Evidence from treatment providers suggests that presentations for substance use are becoming increasingly complex, not only with co-occurring mental health issues, but also polydrug use, homelessness, justice involvement, and other vulnerabilities and needs. Alcohol and drug use and mental health can be inter-related – mental health issues can cause people to "self-medicate" and high levels of alcohol and drug use can impact significantly on mental health. This was raised as an emerging issue in all stages of the

[49] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

process to date in the development of this consultation. We will therefore need to ensure we align our response to this issue across this strategy and the forthcoming Mental Health Strategy.

Target Groups:

5.7 During the development of this strategy, consideration was given to flagging up specific target groups who would be most affected by each of the actions being proposed to achieve the outcomes of the strategy. However, this was felt to have the potential to limit the scope of the strategy and could have led to some service users being excluded. Therefore this strategy was made universal, open to all those who use alcohol and/or drugs or are affected by the use of alcohol and/or drugs by others. No one should be excluded from accessing the services they need.

5.8 At the same time, there are some groups who are particularly at risk of being negatively impacted by the use of alcohol and/or drugs. Service providers should always keep in mind that these groups may need additional support to access existing services or even require alternative services to address their specific needs:

- children and young people, particularly looked after children;
- those transitioning from child to adult services;
- vulnerable women and individuals in the pre and post-natal period;
- those not in Education, Employment or Training (NEET);
- families / family Members impacted by others' substance use, and particularly those affected by Hidden Harm;
- people in areas of deprivation;
- those in contact with the Justice System;
- those experiencing homelessness;
- access for those in rural areas;
- those who drink at harmful levels;
- people who inject drugs;
- vulnerable members of the LGBT community;
- those experiencing significant levels of psychological trauma;
- those with mental health issues; and
- older people.

Consultation Question 2 – Do you agree with the Vision, Outcomes, Values, Priorities and Target Groups as set out in this chapter? Have you any further comments?

6. OUTCOME A – FEWER PEOPLE ARE AT RISK OF HARM FROM THE USE OF ALCOHOL AND OTHER DRUGS

Introduction

6.1 **The focus of this chapter is on preventing the harm related to the use of alcohol and other drugs, and to ensure that early interventions are in place for those most at risk.**

Indicators

General

- % of children in care, or at the edge of care, due to substance use.

Alcohol

- % of adults drinking above the UK CMO Guidelines;
- % of adults who engage in heavy episodic drinking;
- % of young people who get drunk; and
- Mean age of first drink.

Drugs

- % of adults who have used drugs in the past year/month;
- % of young people who have used drugs;
- Mean age of first drug use;
- % of young people/children partaking in polydrug use; and
- % of adults partaking in polydrug use.

Consultation Question 3 – Do you agree these indicators help to demonstrate progress against this outcome of having fewer people at risk of harm? Are you aware of any other indicators that would demonstrate such progress?

Context

6.2 The most effective way to reduce the long-term harm associated with substance use is to improve our approaches to prevention and early intervention. While risk and protective factors for alcohol and other drugs overlap, they exist in different regulatory frameworks, therefore some measures will focus specifically on alcohol and others on drugs.

6.3 In general there have been some positive trends at the population level in Northern Ireland. As set out in Chapter 4, during the course of the previous strategy, there had been some evidence of significant reductions in the levels of heavy episodic drinking ("binge drinking") and the percentage of young people who drink and get drunk.

6.4 Among adults, prevalence of illegal drug use has largely plateaued at the population level and significant numbers of individuals and families continue to access treatment and support services for alcohol and drug use. In addition, drug use among young people has fallen significantly. However, clearly we need to do more to ensure that prevalence of substance use – and its related harms – continue to fall.

6.5 It is also important to note that alcohol and drug related harm has consequences beyond the individuals themselves and beyond the health system. Preventing harm before it occurs, and intervening at an early stage for those most at risk, will have positive impacts across many sectors and on issues such as: exclusion from school, academic performance, community safety, reducing offending and reoffending, homelessness, community cohesion, emotional health and wellbeing, etc. It is therefore vital that we take a holistic and cross-sectoral/Departmental approach to prevention and early intervention, and that partners beyond health and social care play their full role.

Approach

6.6 Our approach to prevention is based on the 3 key elements of the European Monitoring Centre for Drug Dependence and Addiction (EMCDDA) definition:

- Universal Prevention (i.e. improving education and awareness in the general public);
- Targeted Prevention (i.e. interventions with individuals, groups, families or communities who are at most risk); and
- Environmental Prevention (i.e. addressing the wider cultural, social, and economic environments that influence substance use).

6.7 There have been a number of recent reviews across the UK and Ireland that have set out evidence in relation to prevention and early intervention:

- In 2015, Public Health England published "The international evidence on the prevention of drug and alcohol use"[50];
- In 2016, the Scottish Government published "What Works in Drug Education and Prevention?"[51];
- In 2017, the Health Research Board in Ireland published "The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A review of reviews"[52]; and
- In addition, there are a number of related National Institute of Clinical Excellence (NICE) guidelines[53].

6.8 In general, the evidence shows that consistent and co-ordinated prevention activities delivered through a range of programmes and in a variety of settings (e.g., at home; in school; among peers; in the workplace; throughout the local community; and in the media) are most likely to lead to positive outcomes. Evidence also suggests that modifying the environment where risky behaviour takes place can reduce harmful outcomes. It is likely that accurate and consistent information about the health and social impacts of alcohol and drug use is only effective when delivered alongside interventions that develop the skills and personal resources people need to avoid early initiation.

6.9 We must also be aware of the potential gateway to substance use provided by substances such as alcohol, tobacco and nitrous oxide, etc.

6.10 It is also important to note that there is clear evidence on prevention and early intervention approaches that are ***not*** likely to work, or can in fact have negative consequences. These include:

- standalone school-based or other prevention programmes designed only to increase knowledge about drugs;
- having ex-users deliver testimonials or using police officers to deliver standalone programmes;

[50] https://www.gov.uk/government/publications/preventing-drug-and-alcohol-misuse-effective-interventions
[51] https://www.gov.scot/publications/works-drug-education-prevention/
[52] https://www.drugsandalcohol.ie/27253/1/fHB2656_Review%20of%20reviews_web.pdf
[53] https://www.nice.org.uk/guidance/ng135; https://www.nice.org.uk/guidance/ph24; and https://www.nice.org.uk/guidance/ng64

- theatre/drama based education/awareness raising to prevent illegal drug use;
- befriending/buddying-type mentoring programmes that have no short- or long-term preventative effects on illegal drug use; and
- universal public information media programmes targeting drug use.

Alcohol Units

6.11 Analysis of the knowledge of the recommended drinking limits indicates that these are poorly known among both men and women, so steps need to be taken to raise awareness of the current *UK CMOs' Low Risk Drinking Guidelines*[54] *and* better communicate this vital information to the public in a clear manner.

Actions

6.12 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of prevention and early intervention.

General	
A1	The Department of Health will work with the Department of Education to ensure that Substance Use and Hidden Harm are included as appropriate in the work emerging from the Emotional Health & Wellbeing Framework for Children and Young People being led by the Department of Education.
A2	A Northern Ireland Prevention Approach, based on up-to-date evidence and an analysis of the risk and protective factors impacting our young people, will be developed by the PHA and delivered in Northern Ireland and reviewed after 5 years – while this will be a universal programme, it should also be targeted at those at most risk and those in disadvantaged communities.
A3	The PHA will update the drugandalcoholni.info website with up-to-date information in terms of substance use, support materials and the services available in Northern Ireland.

54 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

A4	The current community support mechanisms will be reviewed by the PHA to ensure they can support the local implementation of this Strategy in the community, promote prevention, collaboration and access to services.
A5	Targeted prevention and early interventions will continue to target those young people most at risk of substance use, including looked after children, etc. Establishing effective operational relationships, including with local Youth Services, will assist in the success of this action.
A6	The *Making Every Contact Count* programme in primary care will include brief interventions and advice in respect of alcohol and drug use.
A7	The HSCB and the PHA will ensure that the Substance Use Liaison role will be included as part of the new Mental Health Service model operating across general hospitals / Emergency Departments.
A8	The Hidden Harm Action Plan will be updated by the PHA and the HSCB to ensure that supports are in place, in a stepped care approach, to mitigate the risk for those children and young people who live with substance misusing parents or carers, in particular the Joint Working Protocol on Hidden Harm will be promoted and used across all services.
Alcohol	
A9	The PHA will promote and raise awareness of the UK Chief Medical Officer low-risk drinking guidelines and understanding of alcohol units across the region.
A10	The Department for Infrastructure will seek to improve access to its Course for Drink Drive Offenders scheme – a rehabilitation scheme that aims, through education, to make drink drive offenders take more responsibility for their actions and reduce the risk of re-offending.
Other Drugs	
A11	The PHA will promote raising awareness of the harm associated with the illicit use of prescribed medicines and also the harm associated with polydrug use. This will include working with HSCB to promote awareness across primary and secondary care healthcare providers.

Consultation Question 4 – Will these actions achieve this outcome of having fewer people at risk of harm and make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

7. OUTCOME B: LEGISLATION AND THE JUSTICE SYSTEM SUPPORT PREVENTING AND REDUCING THE HARM RELATED TO SUBSTANCE USE

Introduction

7.1 **The focus of this chapter is on the wider legislative environment, how we reduce the availability of substances causing harm, and how the Justice System helps to prevent and reduce harm.**

Indicators

General

- % of people in the justice system who have substance use related issues;
- % of crimes that are alcohol and/or drug related; and
- Number of people detected for drink/drug driving offences.

Alcohol

- % of people who drink at harmful levels.

Drugs

- Number of Organised Crime Gangs disrupted;
- Number of people on Enhanced Combination Orders and/or Community Resolution Notices for substance use related offences; and
- % of population inappropriately using prescription only medications.

Consultation Question 5 – Do you agree these indicators help to demonstrate progress against this outcome of legislation and the justice system preventing and reducing harm? Are you aware of any other indicators that would demonstrate such progress?

Context

7.2 The legislative environment has an impact on the availability, accessibility, and the behavioural norms that exist in relation to the use of both alcohol and other drugs. However, it is important to note that the regulatory environment for alcohol, illegal drugs and prescription only medicines are very different.

7.3 It is also important to note that people who suffer from alcohol and drug related harm are more likely than average to come into contact with the justice system, and may have more complex issues such as higher rates of poor mental health, may have other long-term conditions, and may have a history of trauma.

Alcohol

7.4 Restrictions on the sale of alcoholic drinks in Ireland were first introduced in 1634. Further restrictions were not added for centuries until the new Northern Ireland Parliament, created in 1920, enacted the Intoxicating Liquor Act (Northern Ireland) 1923. The following decades saw many more amendments to this legislation with the current licensing laws, the Licensing (Northern Ireland) Order 1996, coming into force in February 1997.

7.5 The aim of licensing law is to try and strike a balance between the controls which are necessary for the protection of public health and the preservation of public order, the demand for individual freedom of choice and the opportunity for local businesses to continue to provide a high level of service to their customers. Following a public consultation in 2019, the Minister for Communities recently announced that a Bill will be brought forward aimed at further updating NI's liquor licensing legislation.[55]

7.6 From a public health perspective, the SAFER Initiative by the WHO[56] and Public Health England evidence review published in 2016 "*The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies*"[57] both highlight the strong evidence on policies and legislation that regulate the price and availability of alcohol, and seek to reduce drink driving, are effective in reducing alcohol-related harm.

Minimum Unit Pricing

7.7 Minimum Unit Pricing for Alcohol (MUP) is a population health measure that would set a minimum price that could be charged per unit (8 mg or 10ml) of

[55] https://www.communities-ni.gov.uk/articles/proposed-changes-liquor-licensing-laws-northern-ireland
[56] https://www.who.int/substance_abuse/safer/en/
[57] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

alcohol. Any alcoholic beverage has a set number of units; MUP therefore ensures that a drink cannot then be sold for a price lower that the number of units multiplied by the MUP.

7.8 MUP of 50p per unit of alcohol was introduced in Scotland in 2018, following years of legal appeals by the Scotch Whisky Association. A Supreme Court case was heard in late 2017, which found in favour of the Scottish Government position of introducing the measure and also found that MUP was not a breach of the EU Trade laws.

7.9 In June 2020, Public Health Scotland published a study undertaken in collaboration with the University of Glasgow which shows a decline in population alcohol consumption following the introduction of MUP. This study shows a net reduction, when compared to England & Wales, in per adult sales of alcohol from supermarkets and off-licences of between 4-5 per cent in the 12 months following the implementation of MUP. This study is very promising and indicates that Minimum Unit Pricing may be an effective measure, but it is too early to be definitive.

7.10 The National Assembly for Wales also agreed a minimum unit price of 50p per unit of alcohol and this was introduced on 02 March 2020. The Government in the Republic of Ireland has already indicated a willingness to introduce Minimum Unit Pricing and wish to liaise with Northern Ireland in order to take account of any cross-border issues regarding trade.

Alcohol Advertising

7.11 Restricting alcohol advertising is also a key element of the WHO Safer initiative to reduce alcohol consumption and related harms across the whole population. In particular, there is the potential that restrictions on alcohol marketing ensure that vulnerable groups, such as children and young people, and those recovering from alcohol dependence, are specifically protected. There is evidence to show that alcohol advertising seen by children and young people

is associated with both the initiation of drinking and with heavy drinking[58]. Powers over broadcast advertising are reserved to the UK Parliament.

Drugs

7.12 The legislative regulatory framework in relation to other drugs, including the illicit use of Prescription Medicines and New Psychoactive Substances, will also impact on the availability of these substances, and the harm they can cause, in our communities. There are links between the illicit supply of drugs and serious and organised crime, as well as impacts on communities through criminal activity, the impact of anti-social behaviour, drug-related litter, sex work, and drug-related deaths.

7.13 The legal framework relating to the misuse of drugs, including the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016, is reserved to the UK Government. The Advisory Council on the Misuse of Drugs[59] is an advisory non-departmental public body which makes recommendations to government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act and its regulations. Further detail on related legislation is available on the Department of Health's website[60].

Problem Solving Justice

7.14 The Justice System frequently comes into contact with people suffering from alcohol and drug related harm, often in challenging circumstances. These contacts therefore can provide useful opportunities to intervene early with some of the most at risk and vulnerable members of our community, support them into treatment and recovery, and help to reduce harm. This can include crisis interventions on the street, signposting to interagency support, diversion at the point of potential arrest, support within police custody, opportunities at the point of sentencing, and the delivery of healthcare in prisons.

7.15 Problem Solving Justice is an international model being developed in Northern Ireland aimed at tackling the root causes of offending behaviour and reducing

[58] Finan et al., (2020). Alcohol Marketing and Adolescent and Young Adult Alcohol Use Behaviours: A Systematic Review of Cross-Sectional Studies. https://www.jsad.com/doi/full/10.15288/jsads.2020.s19.42
[59] https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs
[60] https://www.health-ni.gov.uk/articles/misuse-drugs-legislations

harmful behaviour within families and the community. There are opportunities through this approach to consider how we manage those arrested from substance-related crimes, but also those arrested for other criminal behaviours who may have alcohol and/or drug related issues.

7.16 Problem Solving Justice is not just relevant to the Criminal Justice System but also to Civil and Family justice. A pilot of a Family Drug & Alcohol Court, designed to help families involved in care proceedings when there is parental substance use, is currently being evaluated. A Substance use Court has also been piloted. Enhanced Combination Orders allow for alternatives to a prison sentence to be considered, for sentences of 12 months or less, and this includes where an offence involves drugs.

7.17 A draft Problem Solving Justice 5-Year strategic plan is also currently being developed for wider consideration. This is based on evidence from independent evaluations of current initiatives, which includes consideration of options for the rollout of those initiatives shown to produce the right outcomes for individuals, families and communities.

Improving Health within the Justice Setting

7.18 Research tells us that many of the people in contact with the Justice System are likely to have unmet health needs, including those relating to substance use. In June 2019 the Departments of Health and Justice published the 'Improving Health within Criminal Justice' Strategy. The strategy and associated action plan, which was developed jointly between the Departments, outlines a substantial work programme to ensure that children, young people and adults in contact with the justice system have the highest attainable standard of health and well-being.

7.19 One of the action measures was to develop a Joint Health & Criminal Justice Substance Use Action Plan to further support those people in contact with the Justice System. In 2017 a Joint Strategy for the Management of Substance Use in Custody was finalised. Once the Substance Use Strategy for Northern Ireland is published, the Northern Ireland Prison Service and South Eastern Health &

Social Care Trust will take forward work to review its joint strategy, which will include a range of further actions to improve outcomes in this area.

Transition from Prison

7.20 The arrangements for service users moving from the Justice System, particularly prisons, and making the transition back into community-based services has been repeatedly identified as an area that needs attention. Providing service users with a clear pathway into support services will aid their transition and it is believed reduce the incidents of disengaging with services.

7.21 We can learn from the care after custody service established in England (RECONNECT) to see if a similar service needs to be provided that links not only Justice and Health services but also other critical services such as housing and benefits.

Actions

7.22 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of legislation, supply reduction, and how the Justice System helps to prevent and reduce harm.

General	
B1	Following evaluation of the Problem Solving Justice initiatives, further consideration will be given to their effectiveness and the need to further scale up these approaches across Northern Ireland, together with the wider roll-out of Enhanced Combination Orders/Community Resolution Notices for drug possession and drug-related offences.
B2	Appropriate services, and treatment where applicable, should be provided to those who come into contact with the justice system. As part of this, a new transition service will be developed and tested by the SEHSCT Prisons Healthcare team. This will aim to better coordinate the continuity of care for those being released from prison into the community, including connections towards ongoing appointments and treatments. Service users

	will be navigated towards the community/voluntary sector and peer support as an integral part of these arrangements.
Alcohol	
B3	Work on a new Liquor Licensing Bill being taken forward by the Department for Communities[61] provides an opportunity to strengthen alcohol licensing laws in Northern Ireland and ensure it takes account of public health issues.
B4	The Department of Health will bring forward a consultation on the introduction of Minimum Unit Pricing for Alcohol in Northern Ireland within a year.
B5	The Department of Health will work with the UK Government to tighten restrictions on the advertising of alcohol, including given consideration to the introduction of a 9pm "watershed".
B6	The Department for Infrastructure will introduce the lower drink driving limits agreed by the NI Assembly in 2016. It will continue to monitor the effects of legislation in Great Britain and Ireland that introduced certain drug driving limits, before developing proposals for any change to drug driving laws here.
Other Drugs	
B7	The NI Executive will work with the UK Government, and the Advisory Council on the Misuse of Drugs, to ensure the Misuse of Drugs Act 1971 reflects the needs of Northern Ireland and supports the delivery of the outcomes and indicators in this strategy.
B8	The PSNI and the Organised Crime Task Force will continue to co-ordinate enforcement activity and ensure that those involved in the illicit supply and distribution of drugs are targeted appropriately.

Consultation Question 6 – Will these actions achieve this outcome of legislation and the justice system preventing and reducing harm? Will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

[61] https://www.communities-ni.gov.uk/articles/proposed-changes-liquor-licensing-laws-northern-ireland

8. OUTCOME C – REDUCTION IN THE HARM CAUSED BY SUBSTANCE USE

Introduction

8.1 **The focus of this chapter is on harm reduction and support for those at the start of their recovery journey and into the treatment system as required.**

Indicators

General

- Rate of alcohol and/or drug related deaths;
- The inequality gap in the rate of alcohol and/or drug related deaths;
- Rate of alcohol and/or drug related hospital admissions; and
- The inequality gap in the rate of alcohol and/or drug related hospital admissions.

Alcohol

- % of adults drinking above the UK CMO Guidelines.

Drugs

- Prevalence of blood borne viruses among those who use drugs;
- Number of needle and syringe exchanges;
- Number of naloxone kits distributed; and
- Rate/number of naloxone kits reported to have been used.

Consultation Question 7 – Do you agree these indicators help to demonstrate progress against this outcome of reducing harm? Are you aware of any other indicators that would demonstrate such progress?

Context

8.2 Not every person who comes to harm because of their substance use is able, or willing, to stop. For those individuals, it is vital that a range of accessible non-judgemental services are in place to provide them with support and to help them take measures that reduce the harm they may suffer.

8.3 284 people in Northern Ireland lost their lives related to an alcohol-specific cause. In 2018, 196 (69.0%) alcohol-specific deaths were males and 88 (31.0%) were females[62]. It is important to note that these are only alcohol-specific deaths – alcohol is also a contributory factor in many other deaths, with links to several forms of cancer. Alcohol remains by volume the most harmful of all the substances in use across Northern Ireland.

8.4 One of the long-term harms that can be caused by excessive drinking is Alcohol-Related Brain Damage (ARBD). This is a brain disorder caused by drinking too much alcohol on a regular basis over a long period of time. It is possible to reverse many of the effects of this disorder if the symptoms (which can resemble dementia) are caught early enough.

8.5 In respect of the 189 drug-related deaths:

- Opioids were the most common group of substances reported in drug-related deaths (115), with heroin/Morphine being mentioned on 40 death certificates – a significant increase from 24 in 2017, tramadol on 27, and fentanyl on 10;
- Benzodiazepines (prescription medicines that can also be used illicitly) were the second most reported group of substances (97);
- Pregabalin (another prescription medicine) also increased significantly and was reported on 54 death certificates; and
- Alcohol was also mentioned in 23% of all drug-related deaths[63].

8.6 The greatest increases in drug-related deaths over the past ten years have been seen in men, aged 25-44. The other key trend is increasing polydrug use – including the misuse of prescription medicines and alcohol – in our most recent figures over 70% of our drug related deaths involved two or more substances.

[62] https://www.nisra.gov.uk/publications/alcohol-specific-deaths-2008-2018
[63] https://www.nisra.gov.uk/statistics/cause-death/drug-related-deaths

8.7 Recent research[64] has also shown that in Northern Ireland the most at-risk groups for drug-related deaths are younger age groups, males, those living on their own, those with low educational attainment, and there is a strong link between drug use and mental health issues and long-term illnesses.

8.8 There is also a real health inequality in both alcohol and drug related deaths. While substance use is observed across all socio-economic groups, the harm is mostly felt by those in our most deprived communities – with the most-to-least deprived gap in alcohol-specific deaths being 353%, 334% for drug-related deaths, 338% for alcohol-related admissions to hospital, and 282% for drug-related admissions.

8.9 Blood Borne Viruses (BBVs) are viruses that some people carry in their blood and can be spread from one person to another. Those who inject themselves with drugs and share needles are more susceptible to these blood borne viruses.

8.10 The misuse of prescription medication has been shown to be associated with a wide range of substance use related harms. As well as people illicitly seeking out prescription medicines, there can also be issues with involuntary addiction to prescription medications if they are not taken or prescribed in line with guidelines, this can particularly occur in relation to sedatives/tranquilisers and opioids in relation to managing chronic pain.

8.11 In 2017, Public Health England (PHE) undertook a review[65] to identify the scale, distribution and causes of prescription drug dependence, and what might be done to address it. It showed that in the year 2017 to 2018, 1-in-4 adults in England were prescribed benzodiazepines, z-drugs, gabapentinoids, opioids for chronic non-cancer pain, or antidepressants.

8.12 There are also cases where individuals try to access medication on-line if prescriptions they feel they require are not increased or stopped too quickly.

[64] https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Drug-related%20Deaths%20in%20Northern%20Ireland%20-%20Findings.pdf
[65] https://www.gov.uk/government/publications/prescribed-medicines-review-report.

This increases their chances of getting lower quality medication and incorrect dosage quantities which can lead to an accelerated risk of harm.

Harm Reduction

8.13 Harm reduction services have been proven over time to reduce alcohol and drug related harm, to provide vital and lifesaving services for those most in need, and to support people to begin their recovery journey. They also provide an important signal to those suffering from substance use related harm that their lives are meaningful and are worth saving.

8.14 It should be acknowledged that being abstinent from alcohol is not the outcome that all people will want to achieve, and harm reduction approaches will also be taken to reduce consumption at both hazardous and harmful levels. Recent research has shown that the use of controlled drinking as a harm reduction outcome is less than clear. [66]

Evidence

8.15 The recently published Northern Ireland Audit Office[67] report on substance use services states that "There is clear evidence that harm reduction projects are a cost effective way of tackling the harms related to alcohol and drug use. The Department should ensure the further development of cost effective harm reduction initiatives as part of the new alcohol and drugs strategy".

8.16 Harm reduction services include measures to reduce the spread of blood borne viruses, reverse overdoses through the supply of naloxone, provide alternatives to stabilise lives, provide advice on safer injecting and substance use, and provide guidance on how to reduce harm, the risk of overdose and death.

8.17 Much of the evidence for the effectiveness of specific harm reduction approaches is set out in "*The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A review of*

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66 https://www.researchgate.net/publication/232068307_Controlled_drinking_harm_reduction_and_their_roles_in_the_response_to_alcohol-related_problems

67 https://www.niauditoffice.gov.uk/publications

reviews"[68] published by the Health Research Board in Ireland. In addition, there are a range of National Institute for Clinical Excellence[69] (NICE) guidelines for the delivery of specific interventions. Public Health England have also published advice responding to drug related deaths[70] and the Advisory Council on the Misuse of Drugs (ACMD) produced a report specifically on reducing opioid related deaths in 2016[71].

Actions

8.18 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of harm reduction.

General	
C1	The PHA will continue to develop and expand highly accessible Low Threshold Outreach Services to meet the growing needs of those who use alcohol and other drugs.
C2	The PHA and HSCB will lead a process to develop a joined-up and integrated intensive outreach service to specifically identify and support those most at risk of alcohol and drug related deaths. It is vital that this links with existing statutory services, community and voluntary sector services, homeless services, and suicide prevention services.
C3	Increased screening and testing for blood borne viruses for those in treatment, with support to access follow-up treatment and support, including peer-led services.
C4	Suicide prevention training will be provided to all staff working in substance use related services.
C5	The Department of Health, the Department of Justice, and the PHA will continue to grow and expand the Drug & Alcohol Monitoring & Information System to ensure that up-to-date information on current trends is available to relevant key services and those at risk.

[68] https://www.hrb.ie/fileadmin/publications_files/Review_of_reviews_draft_03_FINAL_28_June_2017.pdf
[69] https://www.nice.org.uk/guidance/ph52; https://www.nice.org.uk/guidance/ng64; and https://www.nice.org.uk/guidance/cg51
[70] https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths
[71] https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk

C6	A process of strategically reviewing alcohol and drug related deaths at a regional level will be established under the Organised Crime Task Force to share trends and inform policy and practice.
C7	The PHA and the HSCB will work with experts to develop an Overdose & Relapse Prevention Framework to target those at most risk.
Other Drugs	
C8	The PHA will continue to develop and expand the Needle and Syringe Exchange Scheme, both within community pharmacies and within the community, to ensure adequacy of exchange services. This will include establishing measurement of packs distributed per person, with the aim of ensuring that we meet the WHO target of 200-300 sterile needle and syringe sets distributed per person per year.
C9	The PHA will expand the capacity of naloxone provision to people who use drugs, their peers, family members, and those likely to come into contact with those at risk of overdose. This will include establishing the need for nasal naloxone for carers and services on the periphery of substance use (such as police officers).
C10	Building on the current processes, the HSCB will put in place additional support to monitor prescribing levels and support for prescribers to better understand who may be at risk of harm through use/misuse of prescription medicines and to support associated harm reduction measures.
C11	The HSCB will produce an updated Prescription Drug Misuse Action Plan.

Consultation Question 8 – Will these actions achieve this outcome of reducing harm and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

9. OUTCOME D – PEOPLE ACCESS HIGH QUALITY TREATMENT AND SUPPORT SERVICES TO REDUCE HARM AND EMPOWER RECOVERY

Introduction

9.1 **The focus of this chapter is on providing accessible, high quality, substance use related treatment and support to those who need additional help. Treatment should not be seen as the end point, and support must be provided for people to continue and maintain their recovery.**

Indicators

General

- Numbers in treatment for substance use;
- Waiting times for treatment for substance use;
- Number waiting for treatment;
- Waiting time for Opioid Substitution Therapy (OST);
- Number on OST;
- Outcomes for those in treatment (Impact Measurement Tool and measures to be developed for statutory services);
- Rate of alcohol and/or drug related hospital admissions; and
- Service user feedback on treatment (to be developed).

Consultation Question 9 – Do you agree these indicators help to demonstrate progress against this outcome of accessing treatment? Are you aware of any other indicators that would demonstrate such progress?

Context

9.2 Many people who use substances may be able to reduce harm and take their recovery journey forward without specifically needing to access services. Therefore, self-care support and advice is critical to supporting people on their journey. However, some people will need further help and support on their recovery journey. Their needs are likely to differ over time, with more or less intensive services being required to meet those needs.

9.3 Treatment and support services in Northern Ireland are broadly structured in a 4-Tier model, as set out in the "Alcohol and Drug Commissioning Framework for Northern Ireland".

- Tier 1 interventions include provision of alcohol and/or drug-related information and advice, screening and referral to specialised drug treatment interventions, provided in the context of general healthcare settings, or social care, education or justice settings where the main focus is not drug treatment.
- Tier 2 interventions include provision of alcohol and/or drug-related information and advice, triage assessment, referral to structured alcohol and/or drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare. Tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions. Other typical settings to increase access are through outreach (general detached or street work, peripatetic work in generic services or domiciliary (home) visits), and in primary care settings.
- Tier 3 interventions include provision of community-based specialised alcohol and/or drug assessment and co-ordinated care planned treatment and alcohol and/or drug specialist liaison. Tier 3 interventions are normally delivered in specialised alcohol and/or drug treatment services with their own premises in the community or on hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.
- Tier 4 interventions include provision of inpatient and residential specialised drug treatment, which is care-planned and care-coordinated to ensure continuity of care and aftercare. Ideal settings to provide inpatient alcohol and/or drug detoxification and stabilisation are specialised dedicated inpatient or residential substance use units or wards.

9.4 Ensuring a clear pathway to a holistic treatment and support system and improving the quality of available treatment options is integral to achieving better outcomes. We must ensure that any silos or blockages in the system that detract from service users being able to access clear pathways to recovery are

eliminated. For example, the transition from moving from children/young person focused addiction services to adult based services has been highlighted as a challenging time for service users and one which can be fraught with difficulties due to the lack of specific connections between services.

9.5 Recent evidence, and experiences from elsewhere, provide some indication of likely future trends and the types of challenges in the years ahead. The proliferation of Novel Psychoactive Substances, misuse of prescription medicines, polydrug use, and the changing geographic and demographic profile of substance use are among the issues that will contribute to the demand for services under this strategy.

Improving Access & Removing Barriers

9.6 As outlined in the "Wider Context" section (Chapter 4), we must take into account and be fully aware of the effect that trauma and stigma have on the ability of people to access treatment and support and start themselves on the road to recovery. Individuals who have experienced significant trauma in either childhood or adulthood can develop addiction problems as a result of the psychological impact of these experiences. However stigma, either from the trauma and/or related to the addiction, can hamper any attempt at seeking support.

9.7 Women can experience barriers to engaging and sustaining involvement with treatment and rehabilitation services. Issues with childcare can also be a barrier for women attending treatment and after-care services.

9.8 We also need to consider the treatment and support services available to young people, both standalone alcohol and drug services, and the need for integrated services that respond to the complexity of young people's lives.

9.9 A recurring theme in the process to co-produce this consultation document was a concern about access to services for people who have a co-occurring mental health and substance use problem, often called "dual diagnosis". For some individuals, their alcohol and drug use and mental health is inter-related. Both general mental health difficulties and symptoms associated with psychological

trauma can lead people to "self-medicate" with alcohol and other substances to manage these aversive feelings. However, this heightened level of alcohol and drug use can, in turn, result in an exacerbation of these mental health issues. Guidelines (such as the *UK Guidelines on the Clinical Management of Drug Dependency*[72]) are clear – no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, they should work collectively together to address the issues and clients should not be referred back and forward between services unnecessarily.

9.10 However, service users often report difficulties in accessing services and unclear lines of referral. We will therefore need to address this issue both through this strategy and the forthcoming Mental Health Strategy.

9.11 Those who are homeless are also at a higher risk of harm related to substance use, with those who are rough sleepers or those using emergency accommodation particularly at risk. While substance use can lead to homelessness, homelessness can also contribute to the development of substance use problems.

Evidence

9.12 Treatment and support works. The evidence shows that investment in substance use treatment can substantially reduce the economic and social costs of substance use related harm. The *Drug Treatment Outcomes Study* (DTORS)[73] suggested that there are net benefits from treatment, with an overall benefit-cost ratio of approximately 2.5:1. This suggests that every £1 invested in treatment results in a £2.50 benefit to society. It also estimated that the cost of healthcare alone for adult substance users coming to harm but not in structured treatment was £5,380 per annum, and that healthcare costs fall by 31% when users are in treatment. There will also be additional savings to justice and other settings from ensuring the provision of accessible and quality treatment and support.

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[72] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

[73] Referenced in this Public Health England report: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf

9.13 There is a range of guidelines and evidence in respect of the effectiveness of treatment and support services. The main document is the "*UK Guidelines on the Clinical Management of Drug Dependency*"[74], page 42 of which outlines the principles for trauma informed care. A similar document is currently being produced for the treatment of alcohol dependence. In addition, in 2017, the Health Research Board in Ireland published "*The Effectiveness of Interventions related to the Use of illicit drugs: Prevention, Harm Reduction, Treatment and Recovery. A review of reviews*"[75], and there are a number of related National Institute of Clinical Excellence (NICE) guidelines[76].

Workforce Development

9.14 We must ensure that we have the capacity to deliver on this strategy. As part of this it is important to ensure that all those who work across the substance use field, and those who come into contact with people at risk, have the necessary skills and experience to help and support people through their recovery journey.

Actions

9.15 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of harm reduction.

General	
D1	The COVID-19 Addiction Services Rebuilding Plan will be implemented to ensure that substance use services are in place and that learning from how services operated during the pandemic is built into future delivery and planning for any future waves.
D2	The PHA and the HSCB will ensure that self-care advice and support is available through a range of sources, including online, via apps, etc.

[74] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf
[75] https://www.drugsandalcohol.ie/27253/1/fHB2656_Review%20of%20reviews_web.pdf
[76] https://www.nice.org.uk/guidance/ng135; https://www.nice.org.uk/guidance/ph24; and https://www.nice.org.uk/guidance/ng64;

D3	The PHA will continue to deliver a programme of workforce development in relation to substance use, in line with national standards such as DANOS[77] etc. This would include the need for a trauma-informed approach and appropriate training on stigma associated with substance use.
D4	The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines. This new plan should: • ensure that the population of NI have access to a continuum of service with clear pathways and step up/step down provision; • ensure that all services are delivered in line with the UK-wide "Drug Misuse and Dependence: Guidelines on Clinical Management"[78]; • provide support to address the wider physical, mental health, and wellbeing needs of those in treatment, including housing, education, employment, personal finance, healthcare e.g. they should be supported to stop smoking and address other physical health conditions; • recognise the importance of co-production and strengthen joint working between the community and voluntary sector, service users and peers, and the Health and Social Care Sector; and • develop a clear governance structure to provide oversight and support consistent implementation of the priorities identified within the strategy across the region.
D5	A review of Tier 3 services (to include pathways and linkages to Tier 2 services) will be completed, with the development of an implementation plan to increase access to services to those most at risk and to reduce waiting times.
D6	The PHA and the HSCB will review services available for children and young people, particularly looking at the transition of young people from children to adult services. This will include standalone services commissioned by the PHA, and the expansion of the DAMHS service within CAMHS.

[77] https://www.skillsforhealth.org.uk/resources/service-area/19-alcohol-drugs
[78] https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

D7	The HSCB will review the support provided for those with co-occurring mental health and substance use issues urgently to ensure that service are delivered in line with the relevant guidelines and ensure collaboration across all key services.
D8	Building on the ongoing project in the Western Health & Social Care Trust area to design and develop an integrated model between all Tiers of Addiction Services and the Regional Trauma Network, the proposed model will be considered and rolled out across the region.
D9	The PHA, the HSCB and the HSCTs will work to strengthen the link between maternity (including neo natal) and substance use services, and that treatment services work to reduce barriers for women and those with childcare responsibilities.
D10	Family support services will be reviewed by the PHA to ensure that evidence-based supports are available for all those who wish to avail of them, whether or not their family member is in treatment. Service models will also be updated to ensure the involvement of family members in treatment as appropriate.
Alcohol	
D11	Alcohol treatment and support services will be taken forward in line with the new UK-wide Clinical Guidelines on Alcohol, once these have been finalised.
Other Drugs	
D12	The HSCB will take forward the recommendations from the review of Opioid Substitution Therapy with a specific focus on reducing waiting times with the target that no-one waits more than 3 weeks, at most, from referral to assessment and treatment.

Consultation Question 10 – Will these actions achieve this outcome of accessing treatment and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

10. OUTCOME E – PEOPLE ARE EMPOWERED AND SUPPORTED ON THEIR RECOVERY JOURNEY

Introduction

10.1 **The focus of this chapter is on empowering recovery for those who experience harm related to their substance use. This goes beyond reducing demand to putting in place supports to help people throughout their recovery journey.**

Indicators

General

- Measure of Stigma (to be developed);
- Proportion of people in treatment who receive support to access services that promote recovery;
- Number of people involved in recovery communities or mutual aid supports; and
- Outcomes for those in recovery communities or mutual aid supports.

Consultation Question 11 – Do you agree these indicators help to demonstrate progress against this outcome of empowering people? Are you aware of any other indicators that would demonstrate such progress?

Context

10.2 People who use substances have the same right to health as anyone else, and have the same rights as non-users to access other health services – their substance use should not be a barrier to accessing wider support. For some, this will mean access to prevention and early intervention, harm reduction, treatment and support. However, some will require further help and support, not only in relation to their substance use but also the circumstance in which they are born, develop, grow, live, work and age that enable them to live longer, more active, healthier lives.

10.3 People with alcohol and drug problems are also some of the most vulnerable and excluded people within our communities and society. They can experience

stigma, and discrimination, from others in their communities, from the media and from all of society. In particular they are at risk of violence from some paramilitary and vigilante groups, which can further stigmatise them and make them less likely to come forward for treatment and support. This is unacceptable and has to change.

Recovery

10.4 Recovery is a journey – it involves people setting their own goals and aspirations, and being respected and supported to achieve this. It must also be recognised that part of the recovery journey can often involve relapse. For some people, reducing harm and stabilising their lives will be the goal, some may wish to reduce harm from and intake of their primary substance of use, and for some it might mean a move to abstinence. It is important that we value all these goals and empower people to support them. These goals may also be dynamic over time and this is why person-centred approaches are vital.

10.5 We also need to give hope to individuals and show them that their lives matter. By making recovery more visible to them, we have the opportunity to signal that individual lives matter, that positive change can be achieved and that support can be provided to people throughout their recovery journey.

10.6 Social isolation can be a real issue for those using substances and their families, including during their recovery journey. There is the potential to use recovery communities to provide safe spaces for people to connect with others on their journey and to support each other.

10.7 We also need to ensure that all our approaches, projects and services are informed by service users, their families, and other experts by experience. They have much they can add from their perspective that can improve the effectiveness and quality of our services. By listening to people who have experienced these issues, by involving them in co-designing and co-producing our services and responses, by being prepared to be challenged by their views and sharing power to make changes, we can develop new and innovative solutions to meet the challenges we are facing.

Evidence

10.8 The Health Research Board in Ireland published "*The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A review of reviews*"[79] which includes evidence in relation to recovery and re-integration that has informed this chapter. In addition, the UK Advisory Council on the Misuse of Drugs established a specialist Recovery Committee that has been providing advice and guidelines in respect of the recovery agenda[80]. There are also relevant NICE Guidelines[81].

Actions

10.9 The following actions are proposed to support progress against the outcome and indicators, based on the wider context and the evidence of what works in terms of recovery.

General	
E1	The Department of Health, the PHA and the HSCB will work with experts and key stakeholders, including those with lived experience, to address stigma as a way of reducing barriers to seeking treatment, to improve prevention and to reduce harm.
E2	We will build on the regional structure in place to support the involvement of experts by experience, service users and their families at all implementation levels of this strategy, from policy development to local service design and delivery.
E3	The PHA, the HSCB and Health & Social Care Trusts will work with service users and their families to support the development and commissioning of recovery communities, mutual aid and peer-led support including research throughout Northern Ireland.
E4	Learning from support provided in relation to deaths by suicide, the PHA will develop material and services for those bereaved by substance use. Acknowledging the complexity of these issues and the potential stigma,

[79] https://www.drugsandalcohol.ie/27253/1/fHB2656_Review%20of%20reviews_web.pdf
[80] https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs
[81] https://www.nice.org.uk/guidance/qs23/chapter/Quality-statement-7-Recovery-and-reintegration

	these should be built into existing bereavement supports and not a stand-alone service.
E5	The Department of Health will liaise with the Department for the Economy on how to ensure that there are no barriers for service users in accessing employability training and support.
E6	The Department of Health will liaise with the Northern Ireland Housing Executive and the Department for Communities on how to reduce homelessness among, and improve access to, housing for service users.

Consultation Question 12 – Will these actions achieve this outcome of empowering people and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?

11. OUTCOME F – INFORMATION, EVALUATION AND RESEARCH BETTER SUPPORTS STRATEGY DEVELOPMENT, IMPLEMENTATION AND QUALITY IMPROVEMENT

Introduction

11.1 **The focus of this chapter is on how we can improve our knowledge of what works and the impact we are having to ensure this strategy is delivering its aims and objects. It also focuses on ensuring that research and evidence feeds strategy and policy development, implementation and good practice.**

Indicators

11.2 These are enabling measures so we do not propose having specific indicators for this outcome chapter.

Monitoring

11.3 We have a range of information from surveys, hospital data, justice data, service data, etc., and it is vital that this information is collated, analysed and made available to all key stakeholders in a transparent and usable format. In addition, we need to review the monitoring information we are collecting to ensure it is fit for purpose and is required – data should not be collected unless it serves a purpose for strategic/policy development or performance management so as to focus on the information that provides the greatest insight.

11.4 We also need to ensure we take opportunities to benefit from new data sources as they come on-stream. We must also be aware of the importance of gathering the same data over a significant amount of time to ensure trends are captured and properly understood.

11.5 The sharing of information between services is a key challenge and one that we must look to address to reduce the burden on service users and to fully manage risk across all key stakeholders. All information sharing will be in line

with the requirements of the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679.

Outcomes Based Evaluation

11.6 There are a range of new actions that will be developed by partners in the delivery and implementation of this strategy. In line with the Evaluation, Evidence and Good Practice-Based value and principle for this strategy, as well as the approach taken by the Programme for Government, these should be monitored and/or evaluated on the basis of the outcomes they achieve in terms of making people's lives better and not just on process information and data. This is particularly important for new actions or innovative approaches, where the evidence may not yet point in a clear direction.

11.7 We commit that the findings from these outcome-based evaluations will be used to directly inform decision-making in both the long and short term.

11.8 As at present, no funding will be provided to projects, services or organisations which do not provide outcome or evaluation data.

Research

11.9 We also need to recognise that while we broadly know "what works", there are still many areas were evidence is lacking and outcomes are unclear. Many organisations collect and use data in various formats, so there must be a method to allow for data linkages to made, in line with GDPR requirements. In addition, substance use is dynamic so trends can change quickly and we need to ensure we have access to quickly available evidence and research that is specific to the needs of the people in Northern Ireland, as well as evidence from a national or international perspective. A planned and comprehensive research programme will therefore be essential to ensuring this strategy remains up-to-date and evidence informed as its implementation moves forward.

Actions

11.10 The following actions are proposed to achieve the outcome in relation to information, evaluation and research.

General	
F1	The Department of Health will publish regular update reports on the implementation of this strategy, outlining progress against its outcomes, indicators and actions.
F2	Consideration will be given to developing or amending current monitoring mechanisms to ensure these are robust and fit-for-purpose.
F3	The HSCB will develop an outcomes framework for all Tier 3 and Tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the PHA will continue to be required to complete the Impact Measurement Tool.
F4	A funded two-year research programme will be developed to meet the needs of the development and implementation of this strategy. A new cross-sectoral sub-group will be established to support the development and oversight of this programme. This sub-group will also consider linkages between research in this sector as well as legacy of research.

Consultation Question 13 – Will these actions achieve this outcome of better information, evaluation and research? Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?

12. MAKING IT HAPPEN – GOVERNANCE and STRUCTURES

Introduction

12.1 **It is essential that robust governance structures are put in place to ensure that the final strategy is overseen and delivered in line with the final agreed vision, and that outcomes are achieved – measured via positive progress on indicators – through the delivery of the agreed actions. This chapter will outline the proposed delivery structure for the new strategy, seeking to achieve alignment from the strategic to the local level.**

Structures

Strategic Level

12.2 As set out earlier in this document, it is vital that we see substance use within our wider approach to improving health and addressing health inequalities. It is therefore proposed that the Cross-Departmental Ministerial Committee on Public Health, which oversees the delivery of *Making Life Better* at the Executive level, provides the overall Ministerial governance for this Strategic Framework.

12.3 In order to support and advise the Ministerial Committee on Public Health, a new cross-sectoral/cross-departmental Programme Board will be established to drive forward and oversee the implementation of *Preventing Harm, Empowering Recovery*. The membership of the Programme Board will cover heath, justice, academics, community/voluntary sector, local government and vitally service users, their families, and other experts by experience. The Programme Board will establish policy advisory sub-committees on specific elements of the strategy as required.

Regional Delivery

12.4 The Public Health Agency and the Health & Social Care Board will establish a new Regional Implementation Board to oversee the delivery of the strategy within the Health & Social Care Sector, and to align with key partners in other sectors. To avoid duplication and to ensure alignment of the strategic direction across both this strategy and the forthcoming Mental Health Strategy, this

implementation board will also serve as part of the governance and delivery structures for the Mental Health Strategy.

12.5 The Organised Crime Task Force Drugs Group will continue to co-ordinate enforcement activity and intelligence sharing at the regional level. The Drug & Alcohol Monitoring & Information System (DAMIS) and Drug Deaths intelligence sharing will remain key agendas for this group. There will also be closer cooperation with relevant agencies in Ireland so that there can be early warnings of trends on a cross-border basis.

Local Delivery

12.6 *Preventing Harm, Empowering Recovery* clearly recognises that local assessment of need, and the development and delivery of services, programmes and initiatives to meet these needs, is paramount to address these issues effectively. It is therefore vital that local structures are in place that support these functions. Previously these had been delivered through the local Drug and Alcohol Co-ordination teams (DACTs), supported by the PHA and the DACTs Connections Service.

12.7 However, the local delivery landscape has changed dramatically in recent years. Policing and Community Safety Partnerships (PCSPs) are now well established and Community Planning structures at local government level also now exist. We believe there is still a need for local partnerships focused specifically on the harm related to the use of alcohol and other drugs, however, it would now be appropriate for the PHA to review the role, function and membership of Drug & Alcohol Co-ordination Teams, supported by DoH and other partners, to ensure they are effective and strategically placed to inform, support and monitor the delivery of *Preventing Harm, Empowering Recovery*. This review should include an assessment of the linkages and overlaps with other local delivery structures. DACTs will remain in place until this review is completed.

Consultation Question 14 – Do you agree with the proposal to review the role, function and membership of DACTs, and consider linkages with other local delivery structures?

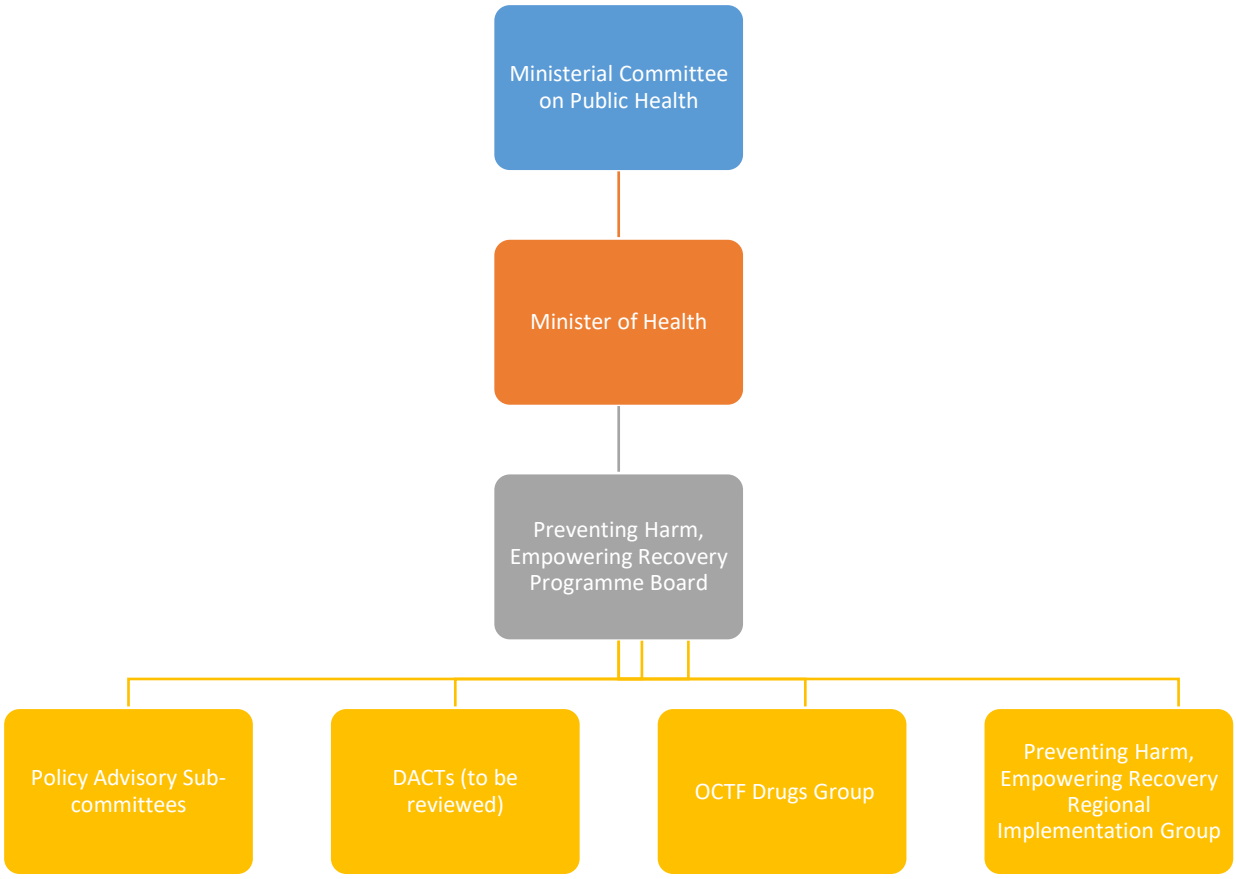
Involvement of Service Users and the Community and Voluntary Sector

12.8 Given that "Shared Responsibility, Co-Production & Collaboration" is proposed as a key value in the development and implementation of *Preventing Harm, Empowering Recovery,* service users must be represented at every level of the strategy's governance structures – from the Programme Board, to the sub-committees, to DACTs (to be reviewed), down to being involved in the design and implementation of local services. The experience and expertise of service users should be central to everything we take forward.

12.9 Similarly the community and voluntary sector play a key role in identifying issues, proposing solutions, holding the public sector to account, and advocating for their local communities and clients. It is essential that their voices are heard throughout the governance structures for *Preventing Harm, Empowering Recovery* – with membership at the programme board, the sub-committees, and DACTs (to be reviewed).

Overall Structure

12.10 We are therefore proposing the governance structure would look like the below:



Consultation Question 15 – Do you agree with the proposed governance structures? Have you any further comments?

Funding

12.11 Currently DoH invests approximately £16 million per year in delivery of the previous strategy. However, it is difficult to estimate the total funding that supported the implementation of the NSD Phase 2 as additional resources, both financial and people, were invested in its supporting actions. For example, a proportion of the Police Service of Northern Ireland budget will be spent on reducing supply, and a proportion of the Education budget will be spent on resilience and knowledge raising but it is impossible to disaggregate these out from overall budgets and universal approaches.

12.12 Following this consultation process, and the finalisation of actions, we will need to determine what funding is required to deliver on the new strategy.

Timeframe

12.13 While this is a long term strategy, it should operate initially for a five-year period before being revised and updated in light of circumstances at that time. It may be that the strategy is fully reviewed and a new one developed, or that a new action plan developed, within the overall policy framework, to be delivered in the following3 to 5 years.

Consultation Question 16 – Do you agree with the Timeframe proposed? Have you any further comments?

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ANNEX I

REVIEW OF THE NEW STRATEGIC DIRECTION FOR ALCOHOL AND DRUGS TERMS OF REFERENCE JULY 2017

INTRODUCTION

The New Strategic Direction for Alcohol and Drugs (NSD) Phase 2 is the Executive's cross-departmental strategy for preventing and addressing the harm related to substance use in Northern Ireland. It followed on from the original New Strategic Direction for Alcohol and Drugs which was reviewed and updated in 2011/12. The NSD has been a living document with additional action and priorities added during its life.

Detail

The original NSD had a five-year life span (covering the period 2006 to 2011). During 2009 and 2010, discussions were undertaken by the NSD Steering Group, the Advisory Groups, the Health and Social Care sector, and other key stakeholders on how these issues could be taken forward once the NSD ended.

It was initially agreed that an update document be developed to see how effective the NSD was in terms of delivering on its aims and objectives. This document looked particularly at the progress against the NSD's key priorities, completion of the NSD outcomes, and progress against its indicators.

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

The NSD Steering Group acknowledged that significant progress had been made, but it also recognised that the timespan for the original NSD allowed a limited amount of time for a public health strategy to be embedded and, particularly, to change culture and behaviours.

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

This process would also allow the NSD Phase 2 to reflect new trends, and re-direct effort to where it is most needed or to where new issues/concerns are emerging.

Emerging Issues

As highlighted above, since the publication of the original NSD a number of issues had emerged – and these issues now have a greater prominence in NSD Phase 2. These emerging issues were identified, noted and considered by the NSD Steering Group and the relevant Advisory Groups. This process was also informed by the Independent

Sector Forums, the Advisory Council on the Misuse of Drugs, the British-Irish Council Drug Misuse Sectoral Group, and recent research. These issues were also acknowledged in the NSD Update Report. These emerging issues include:

- Prescription or Over-The-Counter Drugs
- Emerging Drugs of Concern / "Legal Highs"
- Families and Hidden Harm
- Recovery
- Mental Health, Suicide, and Drugs and Alcohol Misuse, Sexual Violence and Abuse, and Domestic Violence
- Alcohol; and
- Local funding

Consultation

NSD Phase 2 was issued for public consultation on 04 March 2011, and the process ran until 31 May 2011. In order to aid the analysis of the responses to the consultation, the Department provided a consultation 'Response Questionnaire'. The questionnaire focused responses on the main proposals in NSD Phase 2. In addition to this, respondents were encouraged to provide any general comments.

NSD Phase 2 Extension

NSD Phase 2 was originally anticipated to be a 5-year strategy document running from 2011 to 2016. However, there was a delay in publishing and implementing the final document while awaiting Executive approval. In addition, one of the key outcomes in the Strategy was the development and implementation of a Commissioning Framework for Alcohol and Drug Services. The process to develop this framework, and to commission services within its parameters, took longer than anticipated – meaning these services only came on-stream in financial year 2015/16.

The former Minister therefore agreed to extend the implementation of NSD Phase 2 by at least a year to give the strategy its full five years of implementation, allow the newly commissioned services time to bed in and to impact on the indicators and outcomes, and allow for a better fit in with the timescale for the Commissioning Framework.

AIM OF REVIEW

The aim of this review is to evaluate the impact of NSD Phase 2 on its aims of preventing and addressing harm related to substance use in Northern Ireland. This will be a comprehensive, inter-departmental evaluation, facilitated and led by DoH, which will consider fully the outputs of the strategy, i.e. what has been done and the outcomes, what difference this has made to people's lives, etc. It will also consider the effectiveness of the current NSD structures and make recommendations on the way forward.

SCOPE OF THE REVIEW

The review will consider three specific aspects of the implementation of the NSD Phase 2 strategy:

a. ***Outputs*** – i.e. the action which has been taken by Government Departments and their agencies, through the NSD structures, and the progress made.

b. ***Outcomes*** – i.e. – the impact that NSD Phase 2 has had on the range of indicators and outcomes it set out to achieve and the differences made for the public, service users and carers.

c. ***Stakeholder views and structures*** – a review of the views of key stakeholders on the delivery of the NSD and the associated structures, in the context of recent and emerging Government policy.

It will also consider the necessary actions and structures to take forward to prevent and address substance use following the end of the current Strategy.

Given the nature of the funding, and the interconnectedness of the actions and outcomes with other government strategies and actions, it will not explicitly deal with value for money at the strategic level – but the organisations delivering on individual actions should be continuously monitoring the value for money of these at that level.

TIMING OF ASSIGNMENT

The target date for completion of the NSD Review is 31 March 2018.

NSD Phase 2 will remain extant until the review is completed and, if deemed appropriate, a new strategy is put in place.

METHODOLOGY

Each Department/Agency with responsibility for actions within NSD Phase 2 will take ownership of the evaluation of their own actions. DoH will lead on the completion of the evaluation and collate input from other Departments/Agencies.

The methodology for carrying out this evaluation is as follows:

	Action	**Detail**
1	**Evaluation of Outputs**	The evaluation of outputs can be evaluated primarily using quantitative analysis. This will involve each Department/agency with responsibility for actions in the NSD Phase 2 gathering information on what action has been taken to implement their actions. DoH gathers monitoring information on the progress of the actions on an annual basis. This will be used as a basis for evaluating the outputs, however Departments will add to this with statistical information etc. where this is available.
2	**Evaluation of Outcomes**	The evaluation of outcomes requires gathering of quantitative analysis across a range of indicators and outcomes. As part of this exercise, Departments should cross-reference any reviews or evaluations completed by their Department or by Arms Lengths Bodies, community &

		voluntary sector, highlighting any relevant information or findings therein. DoH will collate the outcome analysis.
3	**Analysis of the Effectiveness of the NSD Phase 2 and its Structures**	On behalf of DoH, the Institute of Public Health in Ireland will lead a qualitative piece of work with key stakeholders on how effective they believe the NSD strategy has been to date, what learning there has been, what could come next, and the effectiveness of the structures and learning in this area.

ROLES AND RESPONSIBILITIES

The evaluation will be led by DoH with input from the other Departments and Agencies with responsibility for actions. IPH will lead the qualitative work with stakeholders – giving a greater independence to this work.

The NSD Steering Group act as the steering group for the review. Updates on progress will be given at each meeting.

The Health Minister will agree the review and seek comments and agreement from the Executive.

OUTPUTS AND TIMETABLE

Target date for completion of the evaluation is March 2018. An indicative timetable for the various phases of the evaluation is set out below.

OUTPUT	**TARGET DATE**
1. Agree Terms of Reference	Next NSD SG Meeting
2. Evaluation of Outputs and Outcomes of NSD Phase 2 Actions	End December 2017
3. Analysis of the effectiveness of NSD Phase 2 and its Structures	End February 2018
4. Develop Options for Way Forward	March 2018
5. Finalise Report and Sign off	End March 2018

ANNEX II

PRE-CONSULTATION EXERCISE TO SEEK VIEWS ON A SUCCESSOR STRATEGY TO THE NEW STRATEGIC DIRECTION FOR ALCOHOL AND DRUGS PHASE 2
TERMS OF REFERENCE
FEBRUARY 2019

Background

The Health Development Policy Branch (HDPB) within the Department of Health (DoH) is responsible for leading and co-ordinating action on Northern Ireland's substance use strategy across government departments, the Voluntary & Community Sector and other relevant agencies on a regional and local basis. The current strategy launched in 2012 – the ***New Strategic Direction for Alcohol & Drugs Phase 2*** (NSD Phase 2) – is taken forward under the structures and mechanisms set up under NSD Phase 2 endorsed by the former NI Executive in 2012.

DoH recently reviewed and evaluated the implementation of this strategy in order to evaluate its effectiveness and is now moving forward to the next phase of the process which is to seek views on what should be included in a possible successor strategy. As part of this process, it is intended to carry out a pre-consultation exercise to help inform the development process. Separate pieces of work will look at both the evidence base and developing a successor strategy. Subject to approval, further formal public consultation would take place on any new proposed substance use strategy whenever Ministers are in place to make decisions.

The NSD Phase 2 Review Report is available online at: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports

Tasks

As part of the exercise, it will be necessary to seek out the views of a wide range of individuals, organisations, agencies, and groups. The following tasks will be carried out:

- conduct a pre-consultation exercise to help inform the development of strategic recommendations for addressing alcohol and drug-related harm in Northern Ireland to follow on from NSD Phase 2;
- collect data and evidence from the general public, interested groups, organisations involved in substance use, individual projects, healthcare professionals from the statutory, community and voluntary sector and others;
- collate said data and evidence to be set within pre-defined themes; and
- produce summary reports of data and evidence within above themes for consideration by the Advisory Group and the NSD Steering Group.

It is envisaged the data collection will primarily involve the following three elements:

- an Online Survey (using Citizen Space)
- a series of Focus Group events / workshops (aligned with the process led by the PHA and the HSCB in relation to the revision of the Regional Commissioning Framework for Alcohol and Drug Services); and
- Bi-Lateral Meetings.

It is anticipated that, as per the recommendations in the review, the pre-consultation process will be taken forward in line with an outcomes based accountability approach.

Project Requirements
In order to facilitate the development of the Pre-Consultation Exercise, a small Advisory Group will be established and tasked with looking at specific issues and developing strategic recommendations to be included in a successor strategy to NSD Phase 2. This Group will ensure adherence to the NICS document A Practical Guide to Policy Making in Northern Ireland. The group will report to the NSD Steering Group – which will retain strategic oversight of the process.

Membership will consist of officials & representatives as appropriate from: DoH, DoJ/PSNI, PHA/HSCB, the Chairs of DACTs, NIADA and RSUN/SU reps.

Roles & Responsibility

HDPB will:
- develop a framework, in consultation with the Advisory Group, for undertaking the pre-consultation process as described, including a detailed work plan which outlines proposed methodology;
- make all necessary arrangements for the focus group events i.e. venue, dates, timetables, materials and equipment. DoH will identify potential participants and provide a list of points of contact;
- provide regular progress reports to the Advisory Group;
- provide data/evidence and summary reports to the NSD Steering Group; and
- provide any additional analysis felt appropriate for the Pre-Consultation Exercise.

The Advisory Group will:
- provide expert advice and guidance;
- inform the development of the consultation framework;
- support the identification of stakeholders and engagement opportunities; and
- support the development of final report.

Timescales & Deliverables
DoH intends to commence this process during February 2019, to be undertaken in line with the Review of the Alcohol & Drugs Commissioning Framework led by the PHA. All work associated with this pre-consultation exercise should be completed by 31 December 2019.

DoH reserves the right to extend the project's timescale to enable the Pre-Consultation Exercise to be fully completed in accordance with this Terms of Reference. There should be a contingency for a further 3 months under the Project Requirements of these TOR.

OUTPUTS AND TIMETABLE
Target date for completion of the Pre-Consultation Exercise is 31 December 2019. An indicative timetable for the various phases of this exercise is set out overleaf.

OUTPUT	TARGET DATE
4. Agree Terms of Reference	08 March 2019
5. Devise Online Survey Questionnaire for Completion	19 April 2019
6. Hold Focus Groups / Pre-Consultation Events	May/June/July 2019
7. Hold a series of Bi-Lateral Discussions	May/June 2019
8. Complete Analysis of the responses for consideration by Advisory Group	30 September 2019
6. Draft Summary Report, including Options/Recommendations for Way Forward	30 September 2019
7. Present Report to NSDSG and sign off	NSD Meeting following completion of 6.

It is important to note that the outputs listed above relate solely to this pre-consultation exercise. Work will be undertaken separately by HDPB to examine the evidence base and also to begin development of a possible successor strategy for public consultation.

GDPR / Retention of Data / Intellectual Property

The General Data Protection Regulation (GDPR), which came into force on 25 May 2018, requires all of us to process personal data in accordance with the data protection principles: https://www.health-ni.gov.uk/articles/health-development-policy-branch-and-health-improvement-policy-branch-steering-groups-privacy-notice

Any data collected by HDPB shall remain the intellectual property of the Department of Health. Once commissioned, all documents/results of the study will become the property of DoH who are the accounting department for HDPB. This will include all questionnaires/survey documents used to inform the summary report.

Any online questionnaires / survey documents completed & returned to the HDPB will become the property of DoH. The results of this pre-consultation exercise will also become the property of the Department.

References

Relevant documents are available on the DoH website at:
https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports

https://www.health-ni.gov.uk/articles/alcohol-statistics

ANNEX III

PRE-CONSULTATION EXERCISE: SUMMARY of RESPONSES

NOVEMBER 2019

Background

Endorsed by the former NI Executive and launched in 2012, Northern Ireland's current cross-sectoral substance use strategy – the ***New Strategic Direction for Alcohol & Drugs Phase 2*** (NSD Phase 2) – was recently reviewed and evaluated in order to evaluate the effectiveness of its implementation. The NSD Phase 2 Review Report is available online at: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports.

In line with an Outcomes Based Accountability approach (as per the recommendations in the Final Review Report), the review process moved forward to the next phase by carrying out a pre-consultation exercise in order to seek views on what should be included in a possible successor strategy, and to help to inform the future strategy development process. The pre-consultation process is an attempt to seek collective agreement on the need for a new strategy, and on the Outcomes, Indicators and Priority Areas it should target.

The overall aim is to agree a collective vision before moving on to the more detailed action that will subsequently be taken to develop proposals for any new substance use strategy going forward. Subject to the political situation and having obtained the necessary approval to proceed, the intention is to have a further formal public consultation on these proposals in early 2020.

Pre-Consultation Exercise – Process / Approach

The Online Survey was launched on **17 May 2019** with an original closing date of 09 August 2019, which was later extended to **06 September 2019**.

Adopting a blank page approach, the pre-consultation sought the views of a wide range of individuals, organisations, agencies and groups by:

- conducting a pre-consultation exercise to help inform the development of strategic recommendations for addressing alcohol and drug-related harm in Northern Ireland to follow on from NSD Phase 2;
- collecting data and evidence from the general public, interested groups, organisations involved in substance use, individual projects, healthcare professionals from the statutory, community and voluntary sector and others;
- collating data and evidence within pre-defined themes;
- producing a summary report of data and evidence for consideration by the Pre-Consultation Advisory Group and the over-arching NSD Steering Group.

The data collection primarily involved the following 3 elements:

- an Online Survey using Citizen Space;
- a series of engagement events / Focus Groups / workshops
- Bi-Lateral Meetings.

Data Analysis

57 responses were received in total, with 15 responses received from individuals and 42 responses received from organisations. (Online Survey via Citizen Space = 30; Word / pdf versions received from organisations = 27).

The survey was mainly designed to capture views on the need for a new strategy and seek agreement on the Outcomes, Indicators and Priority Areas it should target.

Most of the survey questions contained open text fields to allow submission of views and supporting evidence. A few questions allowed a quantitative analysis in order to provide a high-level overview of what approach respondees felt should be adopted and what should be included for consideration when developing proposals for a new strategy. It should be noted however some respondents did not complete the actual survey template and merely provided submissions to the Department, meaning that all the questions were not answered and accordingly the figures below are skewed somewhat – the views represented in these submissions were captured where appropriate.

In addition to the Online Survey, a number of engagement events and meetings were held, where attendees were encouraged to respond to the survey and where views and comments were recorded – these are broadly reflected and represented in the analysis below. In order to provide more localised flavour, each DACT also arranged events specific to their respective areas and collective responses were submitted. Similar meetings were held with service users, local community fora and DACTs/PCSPs.

Overview:

4. Does NI still need a substance use strategy?

Yes = 81%; No = <2%

5. Should any new strategy continue to cover both Alcohol & Drugs?

Yes = 81%; No = <2%

6. If still a combined strategy, should Alcohol & Drugs have equal priority?

Yes = 72%; No = 7%

8. Should a future strategy have a set of Values & Principles?

Yes = 72%; No = 0%

Outcomes & Indicators:

11. What do you believe the Key Focus of any new strategy should be?

- Early Intervention 79%
- Harm Reduction 75%
- Recovery 72%
- Treatment & Support 72%
- Prevention 72%
- Supply Reduction 44%
- Regulation, Legislation & Enforcement 40%
- Other 33%

Actions & Gaps:

17. Have you any views on where existing or additional resources should be prioritised?

- Early Intervention 68%
- Prevention 65%
- At-Risk Population Groups 58%
- Treatment & Support 58%
- Harm Reduction 53%
- Recovery 47%
- Regulation, Legislation & Enforcement 25%
- Supply Reduction 23%
- Other 12%

18. Do you believe the strategy should prioritise any of the At-Risk Population groups below?

- Young People 60%
- Homeless People 60%
- People Living in Areas of Multiple Deprivation 56%
- Pregnant Women 40%
- People Living in Rural Areas 39%
- Older People 32%
- Single Parents 28%
- Other 28%

ANNEX IV

Substance Use Strategy Writing Group
January 2020

Draft Terms of Reference

Background

The Health Development Policy Branch (HDPB) within the Department of Health (DoH) is responsible for leading and co-ordinating action on Northern Ireland's substance use strategy across government departments, the Voluntary & Community Sector and other relevant agencies on a regional and local basis. The current strategy launched in 2012 – the ***New Strategic Direction for Alcohol & Drugs Phase 2*** (NSD Phase 2) – is taken forward under the structures and mechanisms set up under NSD Phase 2 endorsed by the former NI Executive in 2012.

DoH recently reviewed and evaluated the implementation of this strategy in order to evaluate its effectiveness and is now moving forward to the next phase of the process which is to seek views on what should be included in a possible successor strategy. The NSD Phase 2 Review Report is available online at: https://www.health-ni.gov.uk/publications/alcohol-and-drug-misuse-strategy-and-reports

Subsequently the Department undertook a pre-consultation process to begin the development of the new substance use strategy. The outcomes of this process are included at Annex A.

Following a commitment within "New Decade, New Approach", the Department is now leading a co-production process to develop a new substance use Strategy.

Status

The cross-sectoral Substance Use Strategy Writing Group has been established by the Department of Health, on a task and finish basis, to co-produce a formal consultation on a new substance use strategy.

Constitution

The Writing Group shall be a Task & Finish Group set up to initially meet for a limited period (up to 6 months) to develop a draft Substance Use Strategy consultation document, with further meetings held as required to finalise the Strategy following public consultation as required. The process for the work shall be agreed at the first meeting.

Membership

Membership of the Writing Group shall comprise of representatives as detailed on the attached membership list with others being co-opted as required to provide additional expertise. Taking account of timeframe & diary availabilities etc., members should ensure deputies can attend when required to maintain consistent organisational

representation. If all members are unable to attend a particular meeting, a quorum of the Writing Group will agree actions for taking forward whenever the situation merits, with further comments invited electronically.

Objective

To provide strategic advice in respect of substance use and draft a strategy for substance use. Specific information gathering, analysis and drafting duties may be assigned to members of the Group.

Timeframe

Draft Substance Use Strategy to be published for public consultation by no later than July 2020. An interim report on progress will be available within 3 months.

The formal Public Consultation will then last for 12 weeks.

Secretariat

The group will be overseen and chaired by Health Development Policy Branch, DoH who will also provide the Secretariat.

ANNEX V

GLOSSARY OF TERMS

ACEs	Adverse Childhood Experiences
ACMD	Advisory Council on the Misuse of Drugs
ARBD	Alcohol-Related Brain Damage
BBV	Blood Borne Viruses
CAMHS	Child and Adolescent Mental Health Services
CMO	Chief Medical Officer
COVID	Coronavirus Disease
CSCA	Children's Services Co-operation Act
DACTs	Drug and Alcohol Coordination Teams
DAMHS	Drug and Alcohol Mental Health Service
DAMIS	Drug and Alcohol Monitoring and Information System
DANOS	Drug and Alcohol National Occupational Standards
DE	Department of Education
DfC	Department for Communities
DfE	Department for the Economy
DfI	Department for Infrastructure
DoH	Department of Health
DoJ	Department of Justice
DTORS	Drug Treatment Outcomes Study
EIR	Environmental Information Regulations
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FOIA	Freedom of Information Act
GDPR	General Data Protection Regulation
HDPB	Health Development Policy Branch in the Department of Health
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCTs	Health and Social Care Trusts
IMT	Impact Measurement Tool
IPH	Institute of Public Health in Ireland
JIM	Joint Implementation Model of the Drug and Alcohol Strategies
LGBT	Lesbian, Gay, Bisexual, and Transgender
MUP	Minimum Unit Pricing
NEET	Those not in Education, Employment or Training
NI	Northern Ireland
NIADA	Northern Ireland Alcohol and Drugs Alliance
NIAO	Northern Ireland Audit Office
NICE	National Institute of Clinical Excellence
NIHE	Northern Ireland Housing Executive
NSAPAG	North South Alcohol Policy Advisory Group
NSD	New Strategic Direction for Alcohol and Drugs
NSES	Needle and Syringe Exchange Scheme
OCTF	Organised Crime Task Force
OST	Opioid Substitution Therapy

PCSPs	Policing and Community Safety Partnerships
PfG	Programme for Government
PHA	Public Health Agency
PHE	Public Health England
Polydrug	The use of several, typically illegal, drugs together.
PSNI	Police Service of Northern Ireland
RSUN/SU	Regional Service User Network/Service User
SEHSCT	South Eastern Health and Social Care Trust
SG	Steering Group
Trusts	Health and Social Care Trusts
UK	United Kingdom
WHO	World Health Organisation
WHSCT	Western Health and Social Care Trust

ANNEX VI

FULL LIST OF CONSULTATION QUESTIONS

No.	Question	Page No.
1	Have you any comments on either the Equality/Good Relations or Rural screening documents? Have you anything you believe we should be considering in future Equality/Good Relations or Rural screenings?	8
2	Do you agree with the Vision, Outcomes, Values, Priorities and Target Groups as set out in this chapter? Have you any further comments?	42
3	Do you agree these indicators help to demonstrate progress against this outcome of having fewer people at risk of harm? Are you aware of any other indicators that would demonstrate such progress?	43
4	Will these actions achieve this outcome of having fewer people at risk of harm and make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	48
5	Do you agree these indicators help to demonstrate progress against this outcome of legislation and the justice system preventing and reducing harm? Are you aware of any other indicators that would demonstrate such progress?	49
6	Will these actions achieve this outcome of legislation and the justice system preventing and reducing harm? Will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	55
7	Do you agree these indicators help to demonstrate progress against this outcome of reducing harm? Are you aware of any other indicators that would demonstrate such progress?	56
8	Will these actions achieve this outcome of reducing harm and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	61
9	Do you agree these indicators help to demonstrate progress against this outcome of accessing treatment? Are you aware of any other indicators that would demonstrate such progress?	62

10	Will these actions achieve this outcome of accessing treatment and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	68
11	Do you agree these indicators help to demonstrate progress against this outcome of empowering people? Are you aware of any other indicators that would demonstrate such progress?	69
12	Will these actions achieve this outcome of empowering people and will they make positive impacts on the indicators? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	72
13	Will these actions achieve this outcome of better information, evaluation and research? Which actions would you prioritise if they cannot all be taken forward or are there other actions likely to have a bigger impact?	75
14	Do you agree with the proposal to review the role, function and membership of DACTs, and consider linkages with other local delivery structures?	77
15	Do you agree with the proposed governance structures? Have you any further comments?	79
16	Do you agree with the Timeframe proposed? Have you any further comments?	79

ANNEX VII

SUMMARY OF OUTCOMES & ASSOCIATED ACTIONS

OUTCOME A

Fewer People are at Risk of Harm from the Use of Alcohol and Other Drugs.

ACTIONS:

No.	Action	Lead(s)
A1	The Department of Health will work with the Department of Education to ensure that Substance Use and Hidden Harm are included as appropriate in the work emerging from the Emotional Health & Wellbeing Framework for Children and Young People being led by the Department of Education.	DE DOH
A2	A Northern Ireland Prevention Approach, based on up-to-date evidence and an analysis of the risk and protective factors impacting our young people, will be developed by the PHA and delivered in Northern Ireland and reviewed after 5 years – while this will be a universal programme, it should also be targeted at those at most risk and those in disadvantaged communities.	PHA DE Local Gov DoJ Other Gov Depts
A3	The PHA will update the drugandalcoholni.info website with up-to-date information in terms of substance use, support materials and the services available in Northern Ireland.	PHA
A4	The current community support mechanisms will be reviewed by the PHA to ensure they can support the local implementation of this strategy in the community, promote prevention, collaboration and access to services.	PHA
A5	Targeted prevention and early interventions will continue to target those young people most at risk of substance use, including looked after children, etc. Establishing effective operational relationships, including with local Youth Services, will assist in the success of this action.	PHA DE
A6	The Making Every Contact Count programme in primary care will include brief interventions and advice in respect of alcohol and drug use.	HSCB
A7	The HSCB and the PHA will ensure that the Substance Use Liaison role will be included as part of the new Mental Health Service model operating across general hospitals / Emergency Departments.	HSCB PHA
A8	The Hidden Harm Action Plan will be updated by the PHA and the HSCB to ensure that supports are in place, in a stepped care approach, to mitigate the risk for those children and young people who live with substance misusing parents or carers, in particular the Joint Working Protocol on Hidden Harm will be promoted and used across all services.	PHA HSCB DE
A9	The PHA will promote and raise awareness of the UK Chief Medical Officer low-risk drinking guidelines and understanding of alcohol units across the region.	PHA DOH
A10	The Department for Infrastructure will seek to improve access to its Course for Drink Drive Offenders scheme – a rehabilitation scheme that aims, through education, to make drink drive offenders take more responsibility for their actions and reduce the risk of re-offending.	DfI
A11	The PHA will promote raising awareness of the harm associated with the illicit use of prescribed medicines and also the harm associated with polydrug use. This will include working with HSCB to promote awareness across primary and secondary care healthcare providers.	PHA HSCB

OUTCOME B

Legislation and the Justice System Support Preventing and Reducing the Harm related to Substance Use.

ACTIONS

No.	Action	Lead(s)
B1	Following evaluation of the Problem Solving Justice initiatives, further consideration will be given to their effectiveness and the need to further scale up these approaches across Northern Ireland, together with the wider roll-out of Enhanced Combination Orders/Community Resolution Notices for drug possession and drug-related offences.	DoJ
B2	Appropriate services, and treatment where applicable, should be provided to those who come into contact with the justice system. As part of this, a new transition service will be developed and tested by the SEHSCT Prisons Healthcare team. This will aim to better coordinate the continuity of care for those being released from prison into the community, including connections towards ongoing appointments and treatments. Service users will be navigated towards the community/voluntary sector and peer support as an integral part of these arrangements.	SEHSCT DoJ PHA HSCB
B3	Work on a new Liquor Licensing Bill being taken forward by the Department for Communities provides an opportunity to strengthen alcohol licensing laws in Northern Ireland and ensure it takes account of public health issues.	DfC DoH
B4	The Department of Health will bring forward a consultation on the introduction of Minimum Unit Pricing for Alcohol in Northern Ireland within a year.	DoH
B5	The Department of Health will work with the UK Government to tighten restrictions on the advertising of alcohol, including given consideration to the introduction of a 9pm “watershed”.	DoH
B6	The Department for Infrastructure will introduce the lower drink driving limits agreed by the NI Assembly in 2016. It will continue to monitor the effects of legislation in Great Britain and Ireland that introduced certain drug driving limits, before developing proposals for any change to drug driving laws here.	DfI
B7	The NI Executive will work with the UK Government, and the Advisory Council on the Misuse of Drugs, to ensure the Misuse of Drugs Act 1971 reflects the needs of Northern Ireland and supports the delivery of the outcomes and indicators in this strategy.	DoH
B8	The PSNI and the Organised Crime Task Force will continue to co-ordinate enforcement activity and ensure that those involved in the illicit supply and distribution of drugs are targeted appropriately.	PSNI OCTF DoJ

OUTCOME C

Reduction in the Harm Caused by Substance Use.

ACTIONS

No.	Action	Lead(s)
C1	The PHA will continue to develop and expand highly accessible Low Threshold Services to meet the growing needs of those who use alcohol and other drugs.	PHA
C2	The PHA and HSCB will lead a process to develop a joined-up and integrated intensive outreach service to specifically identify and support those most at risk of alcohol and drug related deaths. It is vital that this links with existing statutory services, community and voluntary sector services, homeless services, and suicide prevention services.	PHA HSCB
C3	Increased screening and testing for blood borne viruses for those in treatment, with support to access follow-up treatment and support, including peer-led services.	PHA HSBC HSCTs
C4	Suicide prevention training will be provided to all staff working in substance use related services.	PHA HSCB
C5	The Department of Health, the Department of Justice and the PHA will continue to grow and expand the Drug & Alcohol Monitoring & Information System to ensure that up-to-date information on current trends is available to those at risk and shared with relevant key services.	DoH DoJ PHA
C6	A process of strategically reviewing alcohol and drug related deaths at a regional level will be established under the Organised Crime Task Force to share trends and inform policy and practice.	OCTF
C7	The PHA and the HSCB will work with experts to develop an Overdose & Relapse Prevention Framework to target those at most risk.	PHA HSCB
C8	The PHA will continue to develop and expand the Needle & Syringe Exchange Scheme, both within community pharmacies and within the community, to ensure adequacy of exchange services. This will include establishing measurement of packs distributed per person, with the aim of ensuring that we meet the WHO target of 200-300 sterile needle and syringe sets distributed per person per year.	PHA
C9	The PHA will expand the capacity of naloxone provision to people who use drugs, their peers, family members, and those likely to come into contact with those at risk of overdose. This will include establishing the need for nasal naloxone for carers and services on the periphery of substance use (such as police officers).	PHA
C10	Building on the current processes, the HSCB will put in place additional support to monitor prescribing levels and support for prescribers to better understand who may be at risk of harm through use/misuse of prescription medicines and to support associated harm reduction measures.	HSCB
C11	The HSCB will produce an updated Prescription Drug Misuse Action Plan.	HSCB

OUTCOME D

People Access High Quality Treatment and Support Services to Reduce Harm and Empower Recovery.

ACTIONS

No.	Action	Lead(s)
D1	The COVID-19 Addiction Services Rebuilding Plan will be implemented to ensure that substance use services are in place and that learning from how services operated during the pandemic is built into future delivery and planning for any future waves.	HSCB HSCTs
D2	The PHA and the HSCB will ensure that self-care advice and support is available through a range of sources, including online, via apps, etc.	PHA HSCB
D3	The PHA will continue to deliver a programme of workforce development in relation to substance use, in line with national standards such as DANOS etc. This would include the need for a trauma-informed approach and appropriate training on stigma associated with substance use.	PHA
D4	The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines. This new plan should: • ensure that the population of NI have access to a continuum of service with clear pathways and step up/step down provision; • ensure that all services are delivered in line with the UK-wide "Drug Misuse and Dependence: Guidelines on Clinical Management"; • provide support to address the wider physical, mental health, and wellbeing needs of those in treatment, including housing, education, employment, personal finance, healthcare e.g. they should be supported to stop smoking and address other physical health conditions; • recognise the importance of co-production and strengthen joint working between the community and voluntary sector, service users and peers, and the Health and Social Care Sector; and • develop a clear governance structure to provide oversight and support consistent implementation of the priorities identified within the strategy across the region.	PHA HSCB
D5	A review of Tier 3 services (to include pathways and linkages to Tier 2 services) will be completed, with the development of an implementation plan to increase access to services to those most at risk and to reduce waiting times.	HSCB HSCTs
D6	The PHA and the HSCB will review services available for children and young people, particularly looking at the transition of young people from children to adult services. This will include standalone services commissioned by the PHA, and the expansion of the DAMHS service within CAMHS.	PHA HSCB
D7	The HSCB will review the support provided for those with co-occurring mental health and substance use issues urgently to ensure that service are delivered in line with the relevant guidelines and ensure collaboration across all key services.	HSCB PHA

D8	Building on the ongoing project in the Western Health & Social Care Trust area to design and develop an integrated model between all Tiers of Addiction Services and the Regional Trauma Network, the proposed model will be considered and rolled out across the region.	HSCB HSCTs
D9	The PHA, the HSCB and the HSCTs will work to strengthen the link between maternity (including neo-natal) and substance use services, and that treatment services work to reduce barriers for women and those with childcare responsibilities.	PHA HSCB HSCTs
D10	Family support services will be reviewed by the PHA to ensure that evidence-based supports are available for all those who wish to avail of them, whether or not their family member is in treatment. Service models will also be updated to ensure the involvement of family members in treatment as appropriate.	PHA
D11	Alcohol treatment and support services will be taken forward in line with the new UK-wide Clinical Guidelines on Alcohol, once these have been finalised.	PHA HSCB
D12	The HSCB will take forward the recommendations from the review of Opioid Substitution Therapy with a specific focus on reducing waiting times with the target that no-one waits more than 3 weeks, at most, from referral to assessment and treatment.	HSCB

OUTCOME E

People Are Empowered & Supported on their Recovery Journey.

ACTIONS

No.	Action	Lead(s)
E1	The Department of Health, the PHA and the HSCB will work with experts and key stakeholders, including those with lived experience, to address stigma as a way of reducing barriers to seeking treatment, to improve prevention and to reduce harm.	DoH PHA HSCB
E2	We will build on the regional structure in place to support the involvement of experts by experience, service users and their families at all level of the implementation of this strategy, from policy development to local service design and delivery.	DoH
E3	The PHA, the HSCB and HSCTs will work with service users and their families to support the development and commissioning of recovery communities, mutual aid and peer-led support including research throughout Northern Ireland.	PHA HSCB HSCTs
E4	Learning from support provided in relation to deaths by suicide, the PHA will develop material and services for those bereaved by substance use. Acknowledging the complexity of these issues and the potential stigma, these should be built into existing bereavement supports and not a stand-alone service.	PHA
E5	The Department of Health will liaise with the Department for the Economy on how to ensure that there are no barriers for service users in accessing employability training and support.	DfE DoH
E6	The Department of Health will liaise with the Northern Ireland Housing Executive and the Department for Communities on how to reduce homelessness among, and improve access to, housing for service users.	DfC NIHE DoH

OUTCOME F

Information, Evaluation and Research Better Supports Strategy Development, Implementation and Quality Improvement.

ACTIONS

No.	Action	Lead(s)
F1	The Department of Health will publish regular update reports on the implementation of this strategy, outlining progress against its outcomes, indicators and actions.	DoH
F2	Consideration will be given to developing or amending current monitoring mechanisms to ensure these are robust and fit-for-purpose.	DoH PHA HSCB
F3	The HSCB will develop an outcomes framework for all Tier 3 and Tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the PHA will continue to be required to complete the Impact Measurement Tool.	HSCB PHA
F4	A funded two-year research programme will be developed to meet the needs of the development and implementation of this strategy. A new cross-sectoral sub-group will be established to support the development and oversight of this programme. This sub-group will also consider linkages between research in this sector as well as legacy of research.	DoH

ANNEX VIII

Alcohol Survey – Breakdown of respondents.

	Base (N)	Proportion
Overall		
All respondents	935	31%
Base (N)	935	
Gender		
Male	491	35%
Female	444	27%
Base (N)	935	
Age group		
18-29	185	50%
30-44	287	36%
45-59	276	28%
60-75	187	11%
Base (N)	935	