Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Preventing Harm, Empowering Recovery

A Strategic Framework to Tackle the Harm from Substance Use (2021-31)

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Foreword from Robin Swann MLA

Minister of Health

I am delighted to be able to introduce this new strategy. The fact that my Department has continued progressing this work in the middle of a global pandemic is a reflection of the priority we place on the importance of tackling the harms around substance use.

There is no doubt that COVID-19 has also had an impact on substance use across Northern Ireland. There is evidence of many changes in the patterns of drinking and drug taking and it is unclear whether these changes will remain over time. What is likely is that the need for the vital services set out in this strategy are only likely to grow over the next few years.

It is therefore vital that we maximise our resources and make our existing services even better. One of the key issues raised though our consultation was the urgent need for alignment of substance use and mental health services. Some of those who have mental health issues use alcohol and other substances to help cope with their problems, while others who use substances find that their mental health deteriorates because of the substances they take. By having these services work more efficiently together, we can make a significant improvement in the lives of service users and their families.

It is fitting therefore that this strategy is being launched in close alignment with my Department's new Mental Health Strategy. By implementing these ten-year strategies in parallel, we can strive to have closer cooperation and collaboration between these vital services.

As well as the vital work of implementing this strategy, my Department will also now begin to take forward work on Minimum Unit Pricing for Alcohol with a view to having a full public consultation to determine whether this population health measure should be introduced in Northern Ireland.

I am also delighted that this strategy has been approved by the Executive. This was a specific commitment under 'New Decade New Approach' and I am pleased that, despite the challenges we have faced in the last year, my Department can bring this action to a close. It is vital to note that many of the underlying causes of, and harms arising from, substance use are not something that can be tackled by the Department of Health alone. They are multi-faceted problems that exist across the whole of our society – poverty and deprivation; homelessness; employment and economic development; mental health and trauma; paramilitarism, community relations and justice; educational attainment; inequalities; and the legacy of the past. Tackling these societal issues will require the whole Executive to operate collectively.

It took a long time and a lot of effort to get us to the stage where we are able to publish this strategy. We had a co-production approach that encompassed a full review of the previous strategy; a pre-consultation exercise and a public consultation. I would like to thank all those who took part in this development process, as we simply could not have done as good a job without you.

I would particularly like to thank the co-production writing group who have been with this process from the start and have so generously given of their time and experience to help us make this strategy better.

Now we need to move on to the bigger and more challenging job of implementing the strategy. This has been made more challenging in the tighter budget environment left to us by the COVID-19 pandemic, but the need is evident across our communities and we must act now to stop this increasing level of harm and deliver better outcomes for the most vulnerable within our society.

Executive Summary

This strategy was produced as a specific commitment arising from the New Decade New Approach agreement and was prioritised by the Department of Health both in response to that commitment and also as a key element in our response to the Executive's overarching Programme for Government. It also has direct links with the Executive's strategic framework for public health, Making Life Better, and with the new Mental Health Strategy.

This strategy has been co-produced with the help of a wide range of stakeholders – government departments and agencies, health professionals, community and voluntary sector representatives; as well as service users and their families.

Both these stakeholders and the public consultation responses helped to flag up key areas that this strategy needed to consider:

- co-occurring mental health and substance use services;
- reducing Stigma and increasing the involvement of Service Users;
- a more holistic and flexible joined up service that supports people throughout their recovery journey;
- tackling waiting times and improving transition between services;
- focus on prevention as well as treatment;
- increasing support for young people and families – including addressing Hidden Harm;
- reinforcing workforce development, including on early identification and brief interventions; and
- not losing the focus on Alcohol which remains the most significant drug of choice for citizens across NI.

This work cannot be done in isolation and has benefited greatly for the work being done around the development of the new Mental Health Strategy and the work on suicide prevention.

As well as this, many of the actions in this strategy cut across the work of other departments and thus the strategy has been approved by the Executive and will require cross-departmental implementation. While the strategy will be Health-led, it cannot be for Health alone. There is a key role for other Government Departments which must be addressed.

This strategy sets out our proposals for tackling the harms caused by substance use over the next ten years. It sets out our vision which is that:

People in Northern Ireland are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs, have access to high quality treatment and support services, and will be empowered to maintain recovery.

The strategy also sets out the values and priorities which underpin all our efforts in this sphere. This includes setting out target groups which the strategy hopes to impact most effectively. There are a wide range of groups to be targeted and who we hope this strategy will assist. However there are three groups we believe to be most at risk of harm – those who are homeless; those who inject drugs; and those who are in contact with the justice system. This strategy will try to directly reduce the harms for those service users.

We have set out five specific outcomes that we believe will help improve services for and tackle the harms around substance use. These are:

- **Outcome A – Through Prevention and Reduced Availability of Substances, Fewer People are at Risk of Harm from the Use of Alcohol & Other Drugs across the Life Course;**
- **Outcome B – Reduction in the Harms Caused by Substance Use;**
- **Outcome C – People have Access to High Quality Treatment and Support Services;**
- **Outcome D – People Are Empowered & Supported on their Recovery Journey; and**
- **Outcome E – Effective Implementation & Governance, Workforce Development, and Evaluation & Research Supports the Reduction of Substance Use Related Harm.**

Each outcome has a number of actions listed against it as well as a range of indicators to allow for the assessment of progress. Overall, there are 57 actions to help us achieve our strategic outcomes.

Given the rapidly changing nature of substance use, while the strategy has a ten-year lifespan, a review will be conducted after 5 years, to refresh the actions and to give the opportunity for emerging evidence to be taken on board.

Specific governance groups will be established by the Department and the Public Health Agency / Health and Social Care Board to ensure the effective implementation of the strategy and monitor the impact of the actions at strategic, regional and local levels. Service users and Community and Voluntary Sector representatives will be involved at all levels in these governance bodies.

We must also ensure that we have the necessary staff to deliver on our strategy and that these staff have the skills they need to provide what is required. We should always be seeking to improve our knowledge of what works and the impact it is having. We therefore need to undertake the necessary research to provide the evidence that feeds good policy development.

Monitoring and evaluation must be an integral part of this strategy, to ensure that the most effective information is incorporated into the development and implementation of our actions and outcomes. In addition, the Department will give regular updates on the progress of the actions within the strategy.

Introduction

1. This chapter outlines the history of approaches to addressing the harms related to substance use in Northern Ireland, as well as summarising the review of the previous strategy and the process to develop this new strategic document.

Context

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[1], and if we were to add in the costs of the harms related to other drugs this would almost certainly take this figure to approximately £1.5 billion[2].

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

4. Addressing the harms related to the use of alcohol and other drugs is therefore a key public health and social care priority, and must continue to be so over the coming years.

History

5. 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. Subsequently, the New Strategic Direction for Alcohol and Drugs[3] (NSD) was developed to tackle the harms related to these issues in Northern Ireland. Its implementation began in October 2006. 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[4] to reflect new trends and re-direct effort to where it was most needed, or to where new issues/concerns were emerging.

Review of NSD Phase 2

6. In January 2019, the Department of Health published a review[5] of NSD Phase 2, which evaluated the impact of the strategy on its aims of preventing and addressing harms related to substance use in Northern Ireland.

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

8. 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, were high and rising, and there were ongoing concerns about polydrug use, the misuse of prescription only drugs and Novel

Psychoactive Substances. There appeared to be a significant cohort of people engaging in increasingly risky behaviours, causing an acute increase in related harms. This had also impacted justice-related issues, including organised crime, exploitation, trafficking, etc.

9. The review outlined that 24 (17%) of the outcomes within the strategy had been fully completed, 98 (70%) 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. The remaining two (1%) actions were not on target for achievement, as they has been stood down as other areas were prioritised instead.

10. The review also highlighted that 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 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.

11. However, stakeholders also felt there should have been greater alignment between strategic and operational elements of NSD Phase 2, along with 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 felt there could have been a better response to unintended outcomes 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

12. 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.

13. A summary of responses to this exercise was considered by the Pre-Consultation Task & Finish Group, and subsequently by the NSD Steering Group, and has informed the development of this strategy.

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

14. The NIAO published a 'value for money' review of Addiction Services in Northern Ireland[6] 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.

15. 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.

Public Consultation

16. A task and finish group was established to support the development of the strategy, beginning with the consultation document, through a co-production approach.

17. The co-produced draft strategy issued for public consultation on 30 October 2020, which ran for 14 weeks until 05 February 2021. However, this period was extended to give some respondents additional time, and all responses received were taken into account. An easy read version of the strategy was also produced and available during the consultation.

18. As part of the consultation the Department held three independently facilitated public discussions, including one with service users. In addition, the Health Development Policy Branch held 10 individual meetings with specific groups to hear their views. This meant that over 250 individuals were involved directly in the consultation process.

19. 78 formal responses were received to the consultation. In general, feedback was very positive and overall represented a significant endorsement of the overall approach and ambition of the strategy, as well as a vindication of the co-production method of production.

20. Of those who responded, 86% agreed with the screening exercises and at least 89% of respondents agreed with the vision, outcomes, values and priorities of the strategy. Over 85% agreed with the indicators and over 78% agreed that the actions would have a positive effect on both the indicators and the overall outcomes. In addition, over 80% also agreed with the timeframe and the Governance structures for implementation of the strategy.

21. The main concerns highlighted by respondents were around the implementation of the actions and the availability of the necessary resources to support delivery. Other significant concerns raised included:

    - the need to focus on prevention and ensure that it is seen as being as important as treatment;
    - the need for an increased focus on co-occurring mental health and substance use services;
    - the need for a more holistic and flexible joined-up service that supports people throughout their recovery journey;
    - increasing support for young people and families – including addressing Hidden Harm[7];
    - tackling waiting times and improving transition between services;
    - reinforcing the priority on workforce development, including on early identification and brief interventions;
    - reducing stigma and increasing the involvement of service users in the recovery process;
    - ensuring that alcohol-related harm remains a priority given that it is still the most significant drug of choice in NI; and
    - highlighting that while the strategy should be health-led, it cannot be the responsibility of Health & Social Care alone – the key roles of other Government Departments, agencies and sectors must be acknowledged and addressed.

22. There were also many detailed suggestions to help improve the actions and enhance the indicators outlined in the strategy. All of these comments were taken to the co-production writing group for their views in advance of this strategy being finalised.

Appreciation

23. So many people attended workshops and facilitation meetings or gave detailed responses and comments to the review of NSD Phase 2, the pre-consultation, and the public consultation.

24. The Department would like to thank everyone who so freely gave of their time, energy and expertise throughout the long process to get this strategy completed. It quite simply would not have been the same document without those inputs.

25. We would especially like to thank the members of the writing group for attending so many co-production meetings throughout this process and whose commitment and skills helped to make this strategy better, more informative and more inclusive.

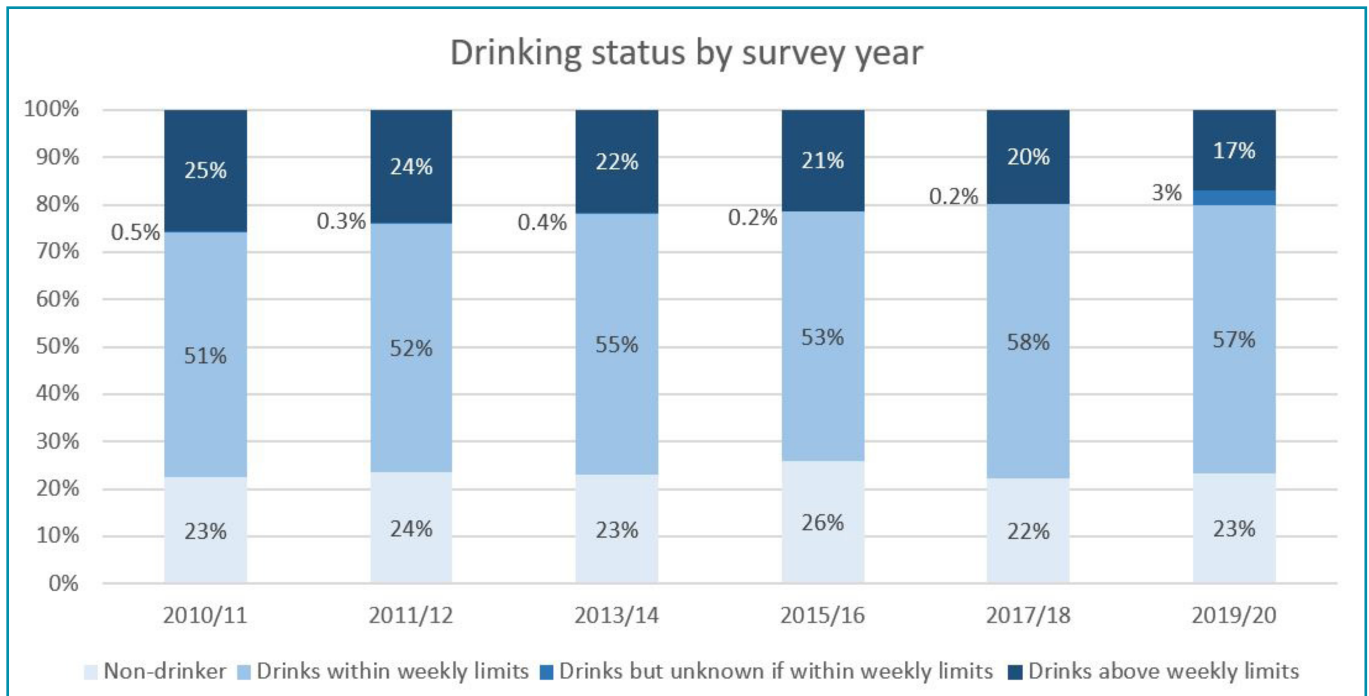
Introduction

1. 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. A range of key statistics at the time of publication of this strategy are summarised in this chapter to provide context for the outcomes that follow.

Alcohol Prevalence

2. The use of alcohol is common in Northern Ireland. The most recent survey findings indicate that 77% of respondents drink alcohol; this proportion has remained relatively consistent since 2010/11.

3. In 2019/20, under a fifth (17%) of respondents reported drinking above recommended weekly limits[8], with males (26%) around three times more likely to do so than females (9%).

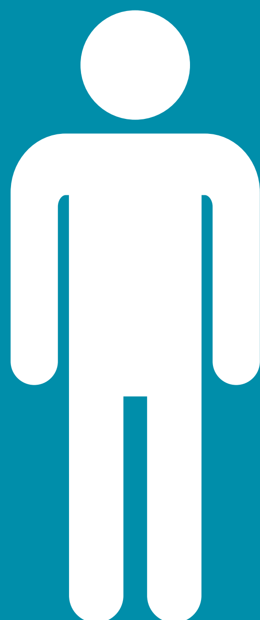


Three Quarters **(77%)** of adults aged 18 or over **drink alcohol**

- Half (50%) of all drinkers report drinking at least once a week.
- Two Thirds (62%) of drinkers had drank alcohol in the last week with 8% having drank over 14 units on the day they drank the most

Male and female drinking patterns differ significantly

Four-fifths of males **(80%)** were **drinkers**, with 26% of males reporting that they drank **above sensible weekly limits**



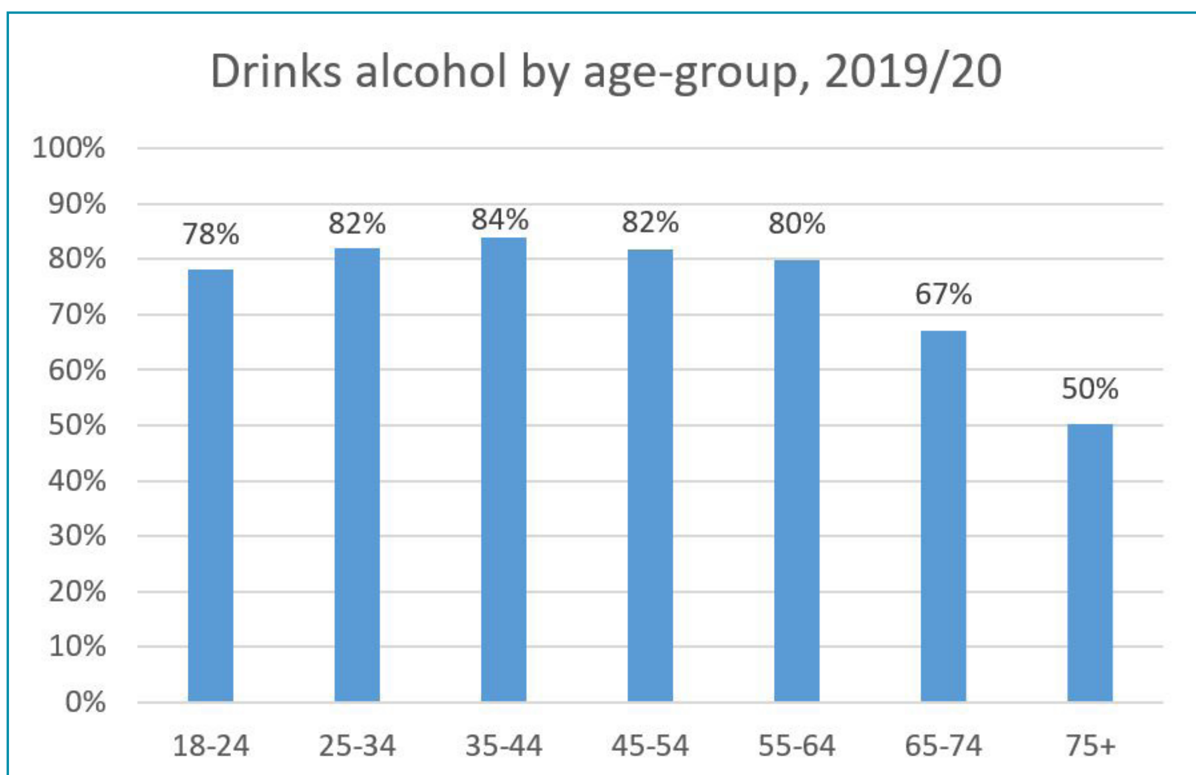
- 7% of males reported that they thought they drank **quite a lot or heavily**
- Almost a fifth of male drinkers **(19%)** drank on **3 or more** days per week
- Of those males who drank in the last week, on the **day they drank the most, 37%** had consumed **up to five units** and **20%** had consumed **over 14 units***

Three-quarters of females **(73%)** were **drinkers**, with 9% of females reporting that they drank **above sensible weekly limits**

- 3% of females reported that they thought they drank **quite a lot or heavily**
- A tenth of female drinkers **(10%)** drank on **3 or more** days per week
- Of those females who drank in the last week, on the **day they drank the most, 58%** had consumed **up to five units** and **4%** had consumed **over 14 units***

** Almost a fifth (17%) of drinkers reported they had drank more than usual in the last week – 18% of males & 17% of females*

4. The proportion of adults that drink alcohol declines in older age-groups. In 2019/20, around four-fifths of those aged 64 and under drank alcohol compared with two-thirds (67%) of those aged 65-74 and half (50%) of those aged 75 and over.
5. Respondents living in the least deprived areas were more likely to drink alcohol (82%) than those living in the most deprived areas (73%) and in 2019/20 were also more likely to indicate they drank above weekly guidelines however the trend in drinking above guidelines is unclear.
6. Considering urban and rural areas, in 2019/20 although there was no difference in the proportion of adults who drank alcohol, those in urban areas (18%) were more likely to drink in excess of the weekly drinking limit than those in rural areas (14%).



Binge Drinking

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 show that around 31% of adults binge drink[9] but this has fallen from 38% in 2005.

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).

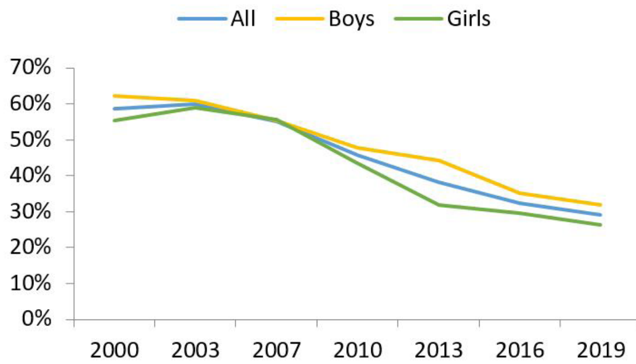
Prevalence – Children and Young People

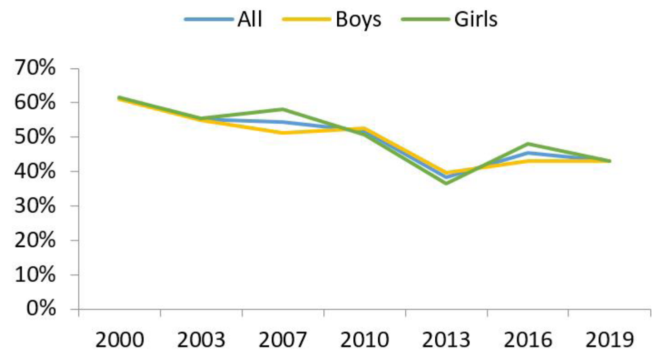
9. Consumption of alcohol among our young people is also an issue of concern, with this having the potential to impact on a young person's immediate wellbeing, academic achievement, and longer term health and wellbeing as an adult.

10. Young Persons Behaviour and Attitudes Survey in 2019[10] 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.

1in3
respondents reported having taken an alcoholic drink

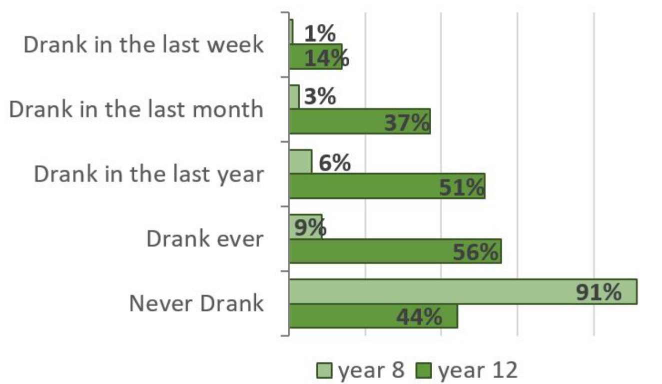
Of the respondents who had tried alcohol,
HALF
reported having their first drink aged 13 or under

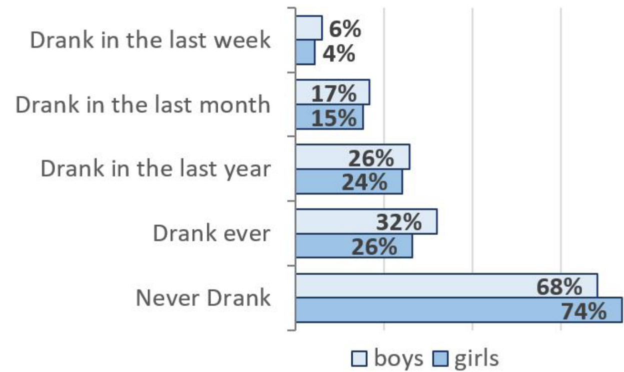




11. In 2019, boys (32%) were more likely to have taken a drink[11] than girls (26%); and those in Year 12 (56%) were more likely to have done so than those in Year 8 (9%).

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



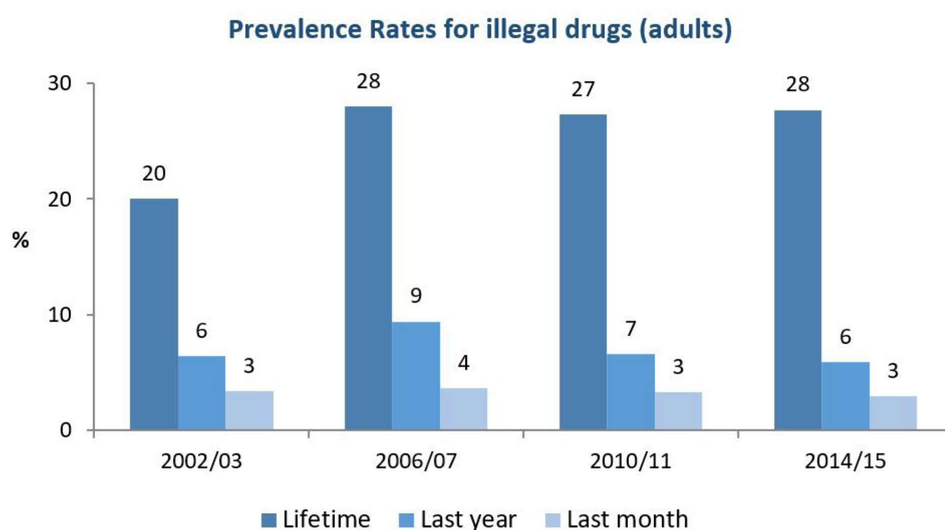


Illegal Drug Use

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[12].

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.

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%).



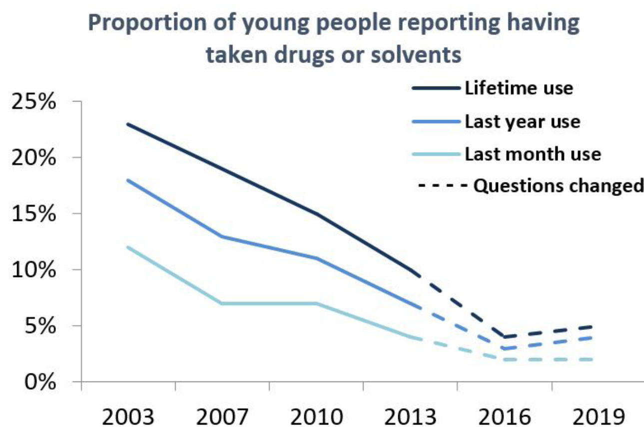
15. Almost a quarter of respondents (24%) reported ever taking anti-depressants, while over a fifth reported taking other opiates (22%) and sedatives or tranquillisers (21%).

16. In 2017/18, a pilot drugs module was included in the Health Survey Northern Ireland[13]. 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[14].

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[15] 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.

Drug Use among Children and Young People

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.

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%.

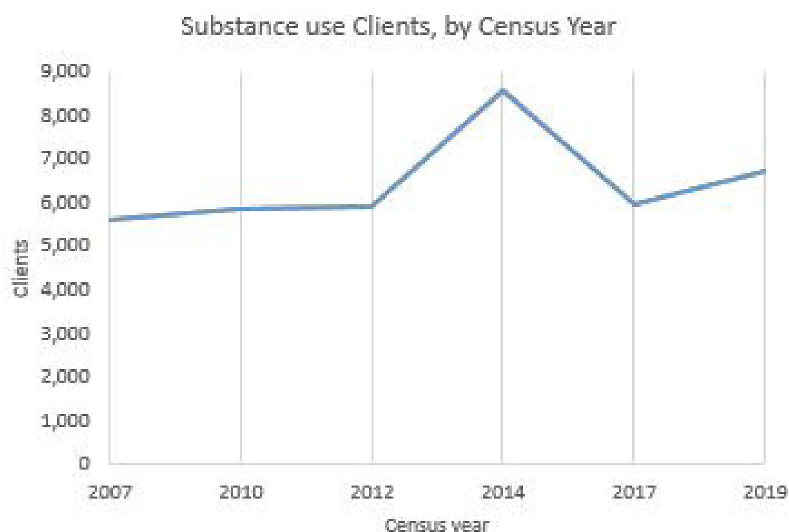
20. As mentioned previously, these prevalence figures are based on survey information, so there is the potential that this under-reports actual usage, but the trends should remain consistent over time.

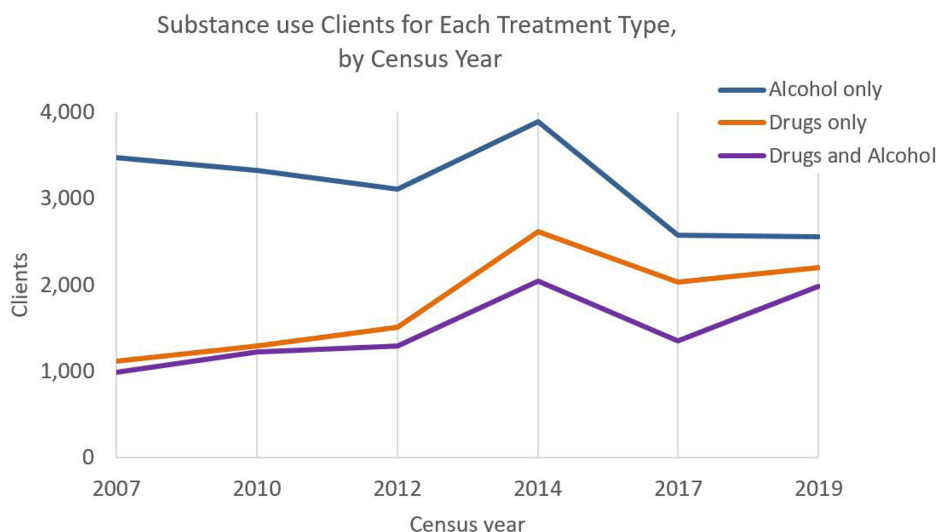
Treatment

21. On 30 April 2019, a total of 6,743 persons were reported to be in treatment for use of alcohol and/or drugs[16] 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.

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.

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

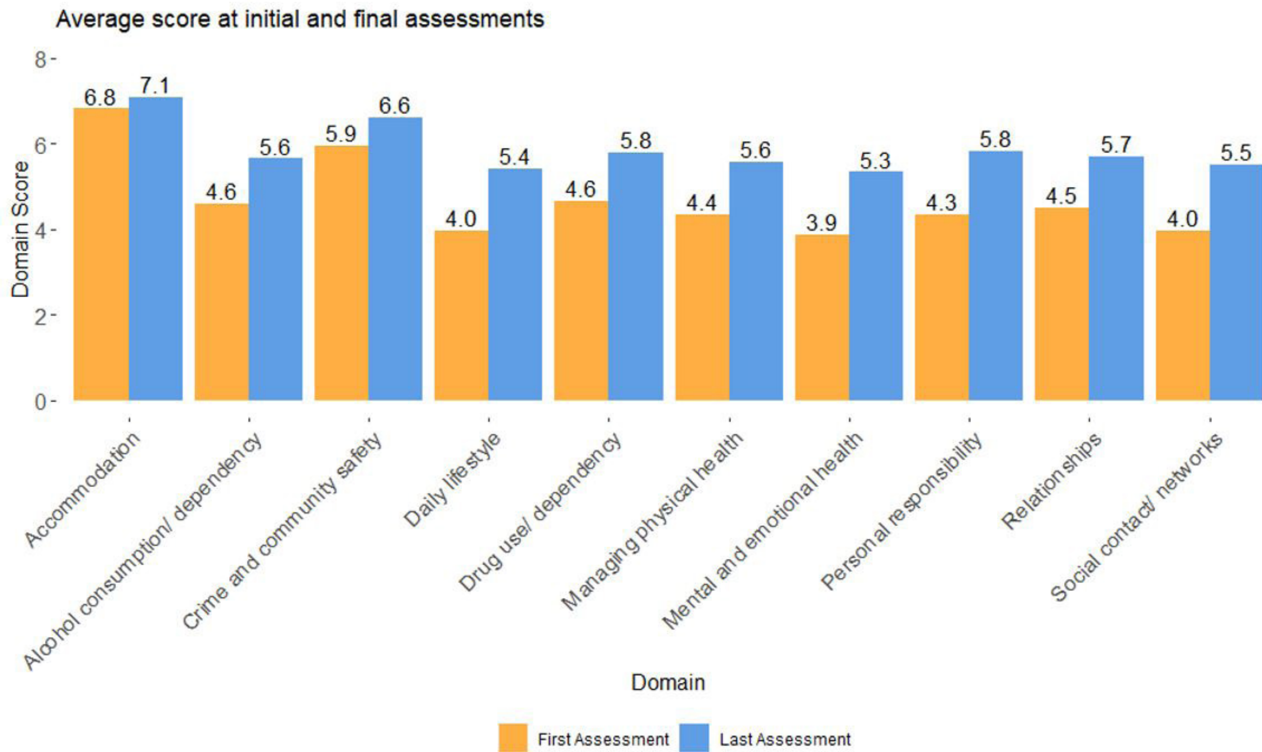
Measuring Impact

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:

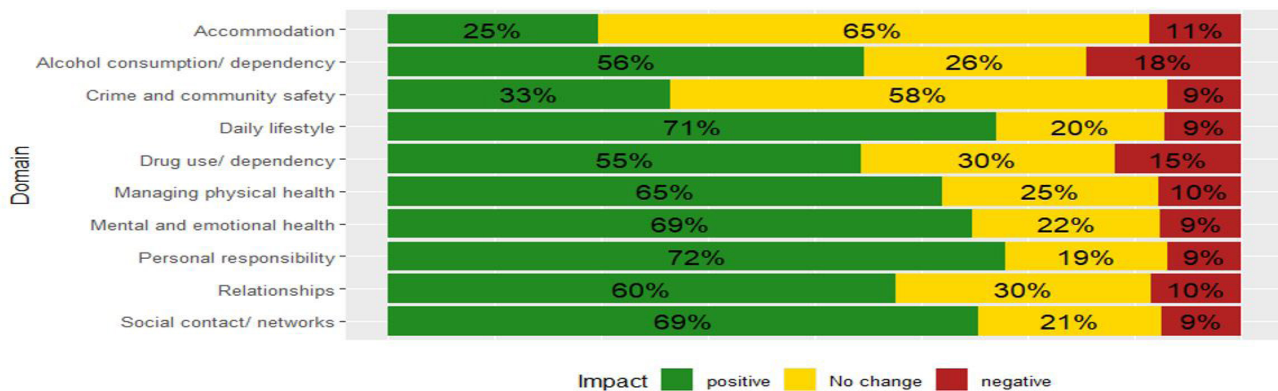
- Adult Treatment (Step 2)[17];
- Young Persons Treatment;
- Low Threshold Services;
- Parental Substance use;
- Workforce Development; and
- Targeted Prevention.

Findings relating to a number of typologies are presented below and further information is available online[18].

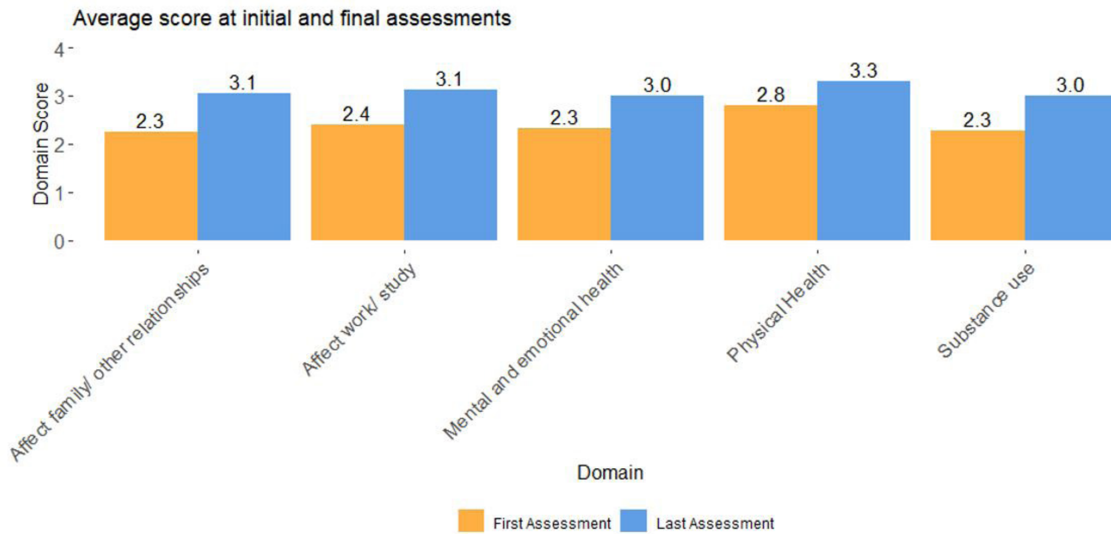
25. The Adult Treatment typology collects data relating to individuals aged 18 and over, who are receiving Step 2 treatment or aftercare for alcohol and / or drug use. During 2019/20 impact data was collected for 819 clients, of these 46% (376) had measureable outcomes.

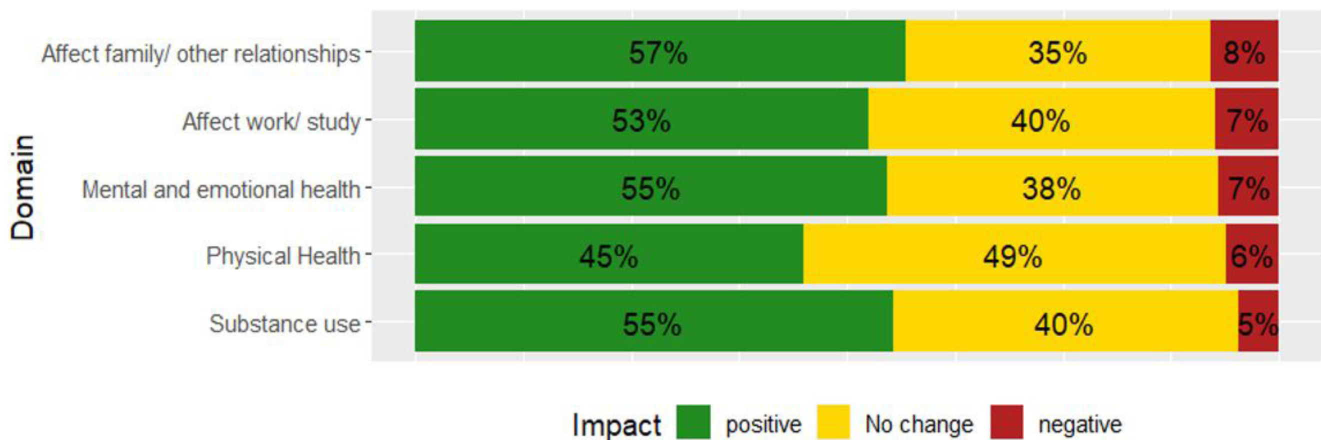


Note- The high proportion of clients seeing no change in both the Crime and Accommodation domains can be attributed in part to their first assessment being at the top of the scale (i.e. no criminal activity or satisfactory accommodation), thus no improvement could be made.



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 2019/20, impact data was collected for 771 young people and was measured across 5 key Domains at the beginning of, during, and/or following treatment, of these 79% (611) had measureable outcomes.



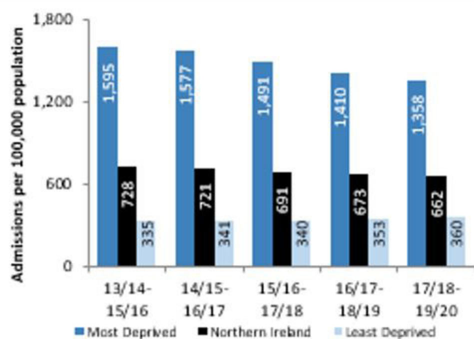


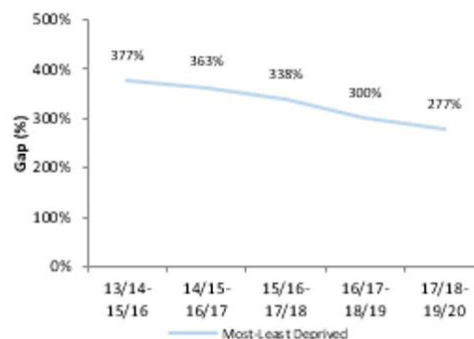
Admissions to Hospital

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 2,023 a decade ago to 1,224 in 2019/20. Admissions to hospital for drug (only) related diagnosis have also fallen from 2,894 a decade ago to 2,630 in 2019/20. 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.

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 728 to 662 admissions per 100,000 population) and its most deprived areas (from 1,595 to 1,358 admissions per 100,000 population) over the last five years. With a slight increase in the least deprived areas (from 335 to 360 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 almost four times the rate in the least deprived areas.

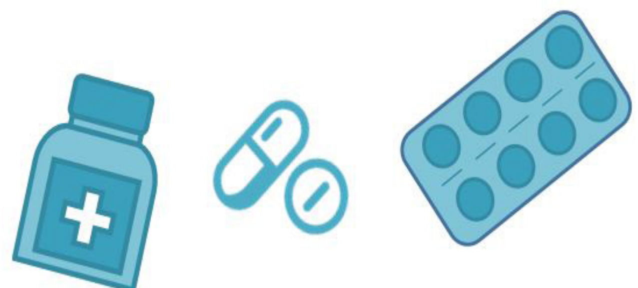
Standardised Admission Rate – Alcohol Related Causes NI



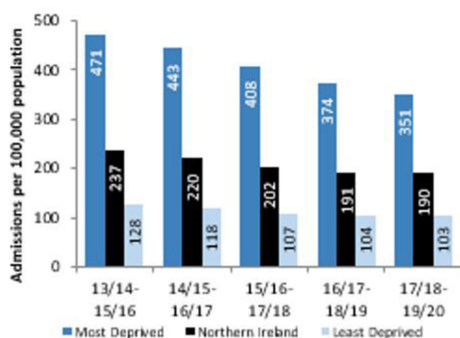


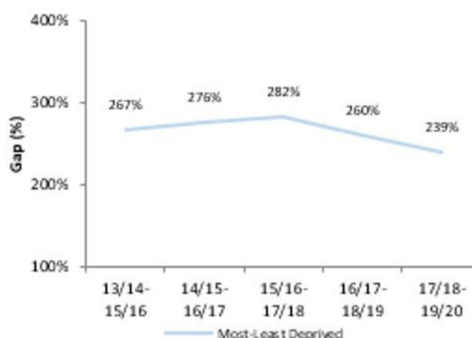
29. Age standardised admission rates for drug related causes also decreased over the last five years in NI (from 237 to 190 admissions per 100,000 population) and its most (from 471 to 351 admissions per 100,000 population) & least deprived (from 128 to 103 admissions per 100,000 population) areas. With 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 almost three and a half times the rate in the least deprived areas.

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



Standardised Admission Rate – Drug Related Causes NI





Deaths

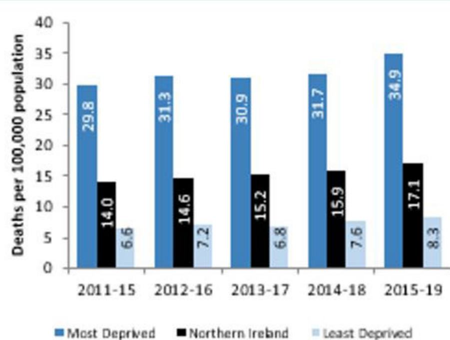
30. 336 people[19] in Northern Ireland lost their lives related to an alcohol-specific cause and 191 from a drug-related death in 2019[20]. This is the highest number of alcohol-specific deaths and drug-related deaths on record.

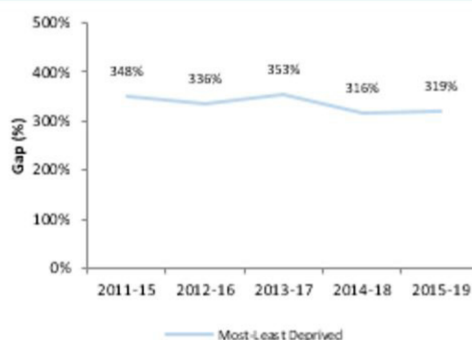
31. In recent years, the proportion of those who died from alcohol-specific causes aged 55-64 has increased; in 2019 this age group accounted for over a third of such deaths (35%), while those aged 45-54 accounted for 27% of the total. We therefore have to think about how alcohol impacts on people as they get older. Of the 191 drug-related deaths in 2019, 62 (32%) were in the 25-34 age group with a further 53 (28%) in the 35-44 age group – therefore we seem to have a growing cohort of young people experiencing drug related harm.

32. The statistics (based on the period 2015 to 2019) 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 (34.9 deaths per 100,000 population) being more than four times the rate in the least deprived areas (8.3 deaths per 100,000 population).

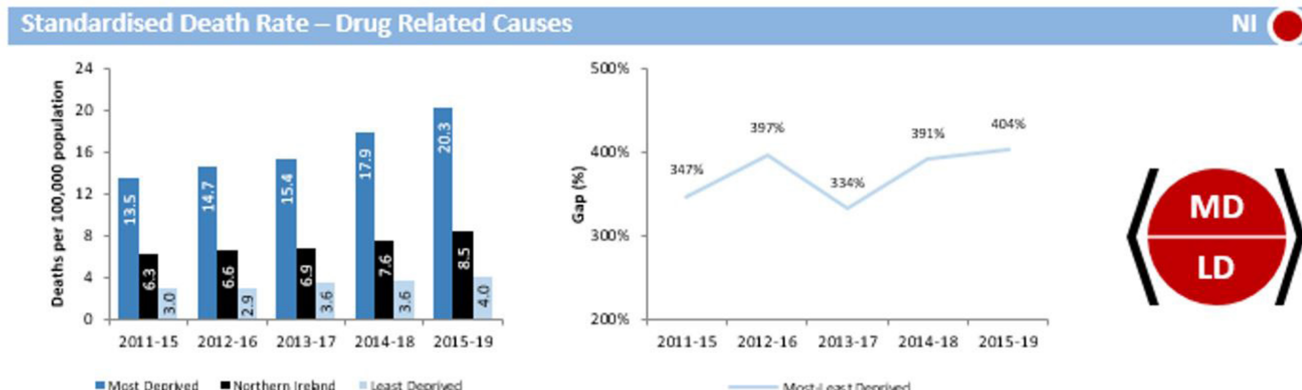
Alcohol specific mortality in the most deprived areas was **over four times** that in least deprived.

Standardised Death Rate – Alcohol Specific NI





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

34. A report in 2008 estimated the cost of alcohol misuse alone at up to £900 million[21] 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**

35. The Dame Carol Black Review of Drugs[22] 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.

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

37. People with alcohol and drug issues often interact with the Justice System – for example, since 2012/13 around one in five crimes recorded by the police have been flagged with an alcohol motivation[23]. Injury road traffic collisions attributed to alcohol or drugs also present a mixed picture. Overall the number of collisions of all categories involving substances have fallen in 2020, but the proportion of collisions that are substance use related has remained consistent over the years. The number of drug seizure incidents and drug-related arrests recorded by the police showed a mainly upwards trend between 2006/07 and 2020/21. Figures for the latest 12 months show an increase in drug seizure incidents but a fall in drug-related arrests.[24]

Introduction

1. This chapter takes a look at some of the wider context in relation to substance use, including other key drivers and supporting strategies, which must be taken into context when addressing this key issue.

Context and Strategic Drivers

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 and social care outcomes, including health inequalities, and more widely with the economic, social and environmental circumstances in which people are born, grow, live, work and age.

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. Everything we do must be underpinned by the rights of the individual service users, and their families, 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

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.

6. Many of those who suffer most from alcohol and drug related harms 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. While research indicates women are more likely to be victims of domestic violence and sexual exploitation – men can also be victims of these traumas.

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.

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 an individual's ability to engage with services, treatment and recovery and what additional supports they may require.

9. Northern Ireland is known to suffer from higher rates of trauma and mental illness than other parts of the UK[25], with researchers having linked to the long-term impacts of our past[26]. In addition the recently published Youth Wellbeing Survey[27], found that anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK.

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

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 real barriers to accessing treatment and other services. We need to challenge stigma in all its forms and ensure that it does not act as a barrier to help-seeking behaviour.

Peer Support

12. There is the potential to build upon and better use the expertise and experience of peers to improve support for 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 they have 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.

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

14. We can also learn from the experiences of our neighbouring jurisdictions. 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.

15. There is also a “Drugs and Alcohol” 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

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[28].

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.

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.

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.

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[29] outlines some evidence of the potential psychological impact of the COVID-19 outbreak among the population in NI, in terms of 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[30] outlines risks which could be reframed as learning and what is required of services to mitigate these risks.

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

22. This strategy cannot address all the wider causes of substance use related harms 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 interaction with a range of wider strategies set out at Annex II. This is not an exhaustive list but these are the main strategic drivers impacting on this strategy.

CHAPTER 4 Vision, Outcomes, Values, Priorities and Target Groups

Introduction

1. This chapter sets out the overall vision for this new strategy, along with related outcomes, and outlines a number of values that will be at the heart of implementing and delivering this strategy. A range of key priorities and target groups have also been identified.

Vision

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", the Vision for the new substance use strategy is:

People in Northern Ireland are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs, have access to high quality treatment and support services, and will be empowered to maintain recovery.

Outcomes

3. In line with the overall approach set out in the draft Programme for Government, the new strategy will be taken forward using an Outcomes Based Accountability approach. Five population-level outcomes have been developed to reflect the holistic approach needed to address these multi-faceted issues. These are:

   - **Outcome A – Through Prevention and Reduced Availability of Substances, Fewer People are at Risk of Harm from the Use of Alcohol & Other Drugs across the Life Course;**
   - **Outcome B – Reduction in the Harms Caused by Substance Use;**
   - **Outcome C – People have Access to High Quality Treatment and Support Services;**
   - **Outcome D – People Are Empowered & Supported on their Recovery Journey; and**
   - **Outcome E – Effective Implementation & Governance, Workforce Development, and Evaluation & Research Supports the Reduction of Substance Use Related Harm.**

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

Values

5. The development of the strategy, and its subsequent implementation, will 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 harms caused by their substance use. Children, individuals and families will be at the centre of our approach to address this issue and we will design and deliver policies and services with the support of those who use them and ensure they are provided with dignity and respect.
   - **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 the harms from substance use, health and social care alone cannot solve it. We need the support of all partners, including

service users and the wider public.

- **Evaluation, Evidence and Good Practice-Based:** We will 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 will be subjected to appropriate evaluation and ongoing monitoring.
- **Universal, but with an increased focus on those most at risk:** The harms 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 accessible. However, we also know the impact of substance use is not felt equally across society therefore to address the inequalities that exist, we must get better at targeting more intensive interventions and increasing accessibility for 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 will improve our ability to identify and reach 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 will ensure that people are supported within local communities and local solutions can be delivered 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, this should not detract from the longer-term vision and that we focus on prevention and early intervention as much as treatment and support.

Priorities

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

    - **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 has been raised as an emerging issue at all stages in the development process for this strategy. We will therefore need to ensure we align our response to this issue across both this strategy and the Mental Health Strategy.
    - **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.

- **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 2019, over 70% 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 56% in 2019. It is vital that we address this growing practice and ensure that we provide information and services that take account of this trend.
- **Supporting Families – including Hidden Harm:** The harms caused by substance use don't happen in isolation and the harms are felt beyond the individual, with family members particularly affected. 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 which have a significant impact on the harms related to substance use. We will ensure that supports are in place for family members (including unseen and unheard family carers), that family based treatment options are available were appropriate, and that we redouble our efforts to protect those children affected by Hidden Harm. This will be done in conjunction with the Children's Services Co Operation Act (Northern Ireland) 2015.[31]
- **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[32] the forthcoming UK Guidelines on the Treatment of Alcohol Dependence, and relevant NICE guidelines.
- **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.

Target Groups:

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 is universal, open to all those who currently or prospectively 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.

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 children and young people with lived experience of care;
   - those transitioning from child to adult services;
   - vulnerable women and individuals in the pre and post-natal period;
   - families / family Members impacted by others' substance use, and particularly those affected by Hidden Harm;
   - people in areas of deprivation;
   - access for those in rural areas;
   - those who drink at harmful levels;
   - members of minority communities including ethnic minorities and members of the LGBT+ community;
   - those experiencing significant levels of psychological trauma;
   - those with mental health issues; and
   - older people.

9. However, the evidence shows again and again that those most at risk of harm and death with regard to substance use fall into three specific groups;

   - **those experiencing homelessness;**
   - **people who inject drugs; and**
   - **those in contact with the Justice System.**

10. Service providers and those implementing the actions in this strategy must be mindful of the additional risk of harm experienced by these service users and take steps to directly alleviate that harm.

Indicators

11. Arising from the consultation and co-production meetings, a list of indicators have been developed to help evaluate progress against each of the strategic outcomes. Some of these indicators are not yet fully in place and will require further work to develop appropriate sources and datasets. Other indicators are likely to evolve over time as the structures and research set out within this strategy are implemented. In order to oversee the proper development of these indicators across the lifespan of the strategy, a new working group will be established. This group will be comprised of a number of statisticians from across relevant departments, together with policy officials, and will be responsible for overseeing the ongoing development of effective indicators for the monitoring of the strategy's outcomes.

12. In addition, one of the issues pointed out during the consultation was the need for the Department to be able to react in real time to the many changes that occur around substance use. This group will consider and develop new data sources and add new indicators as necessary, so that new changes in substance use can be monitored as they emerge and thus allow for quicker development of policy and service responses.

CHAPTER 5 - OUTCOME A

Through Prevention and Reduced Availability of Substances, Fewer People are at Risk of Harm from the Use of Alcohol & Other Drugs across the Life Course.

Introduction

1. The focus of this chapter is on: preventing the harms related to the use of alcohol and other drugs; ensuring that early interventions are in place for those most at risk; and how the wider cross-departmental legislative environment can help to reduce the availability and accessibility of substances causing harm.

Indicators

General

- **"% of children in care, or at the edge of care, where substance use is a significant factor;**
- **% of people in the justice system who have substance use related issues;**
- **% of crimes that are alcohol and/or drug related;**
- **Number of people detected for drink/ drug driving offences; and**
- **Number of people on Enhanced Combination Orders and/or Community Resolution Notices for substance use related offences.**

Alcohol

- **% of adults drinking above the UK CMO Guidelines, at increasing and higher risk;**
- **% of adults who engage in heavy episodic drinking;**
- **% of young people who get drunk;**
- **Mean age of first drink and % at age 15; and**
- **% of those drink driving who undertake offender course.**

Drugs

- **% of adults/young people who have used drugs in the past year/month;**
- **Mean age of first drug use and % at age 15;**
- **% of adults/young people partaking in polydrug use;**
- **Number of offences for trafficking of drugs recorded; and**
- **% of population inappropriately using prescription only medications.**

Context

2. The most effective way to reduce the long-term harms 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 while others will focus on other drugs.

3. This chapter highlights that the health and social care system cannot tackle these issues in isolation and therefore this strategy must by necessity be cross departmental. Other actions, such as: justice matters; licensing issues; education and youth services; and drink/drug driving; will all play a vital role. We will only be able to affect the necessary change for these most vulnerable of citizens through effective cross-departmental and cross-agency cooperation and collaboration.

4. 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.

5. 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. It is also important to note that alcohol and drug related harm has consequences beyond the individuals themselves and beyond the health and social care 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

7. 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).

8. 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"[33];
    - In 2016, the Scottish Government published "What Works in Drug Education and Prevention?"[34];
    - 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"[35]; and
    - In addition, there are a number of related National Institute of Clinical Excellence (NICE) guidelines[36].

9. 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.

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

11. 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;
- 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.

Availability and Accessibility

12. The wider 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 frameworks for alcohol, illegal drugs and prescription only medicines are very different.

13. Aside from the UK Government and the Northern Ireland Health and Justice Department, other departments also have responsibility for this legislative environment, for example the Department for Communities is responsible for liquor licensing and the Department for Infrastructure for drink driving legislation.

Alcohol

14. Restrictions on the sale of alcoholic drinks in Ireland were first introduced in 1634 with further restrictions added in the 18th and 19th centuries. The new Northern Ireland Parliament, created in 1920, enacted the Intoxicating Liquor Act (Northern Ireland) 1923 which aimed to significantly reduce the number of public houses. 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.

15. 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. In October 2020, the Minister for Communities brought forward the Licensing & Registration of Clubs (Amendment) Bill to further update NI's liquor licensing legislation and help tackle the harms that alcohol can cause.[37] It is worth noting that responsibility for liquor licences are granted by courts while local councils are responsible for granting entertainment licences.

16. From a public health perspective, the SAFER Initiative by the WHO[38] 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"[39] 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 harms.

Alcohol Units

17. Analysis of the knowledge of the recommended drinking limits indicates that these are poorly known and understood among both men and women, so steps need to be taken to raise awareness of the current UK CMOs' Low Risk Drinking Guidelines[40] and better communicate this vital information to the public in a clear manner.

18. We must also ensure that that people are fully aware of the other health impacts and conditions that are affected by the use of alcohol and other drugs: including, obesity, blood-borne viruses and a range of associated cancers.

Minimum Unit Pricing

19. 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 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.

20. 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.

21. 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.

22. 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 decided that it will now progress with the introduction of Minimum Unit Pricing from January 2022.

Alcohol Advertising

23. 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[41]. Powers over broadcast advertising are reserved to the UK Government.

Drugs

24. 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.

25. 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[42] 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.[43]

Problem Solving Justice

26. People who suffer from alcohol and drug related harm are more likely to come into contact with the justice system, have more complex issues such as higher rates of poor

mental health, and may have other long-term conditions or a history of trauma.

27. Contacts with the Justice system can therefore provide real opportunities to intervene early with some of the most at risk and vulnerable members of our community, support them into treatment and recovery pathways, and help to reduce harms. 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.

28. 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. 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.

29. 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.

30. A Problem Solving Justice 5 Year Strategic Plan was developed during 2020 to enable evidence-based decisions about the future of pilot projects and to facilitate a strategic and structured roll-out.

31. Building on this work a new Adult Restorative Justice Strategy is being developed by the department of justice. The proposed strategy will provide a strategic approach to restorative practices at all stages of the criminal justice system, from early intervention in the community, formal diversion by statutory agencies, court-ordered disposals, custody and reintegration.

Youth Justice Agency

32. All children who are referred to YJA are assessed using the Youth Justice Agency Assessment (YJAA) Tool. One of the key factors of this tool explores drug and alcohol use in association with offending. There was a moderate to strong association between drug and alcohol use and offending in one third of children referred in 2020/2021. In these cases, a RIAT (Northern Ireland Regional Initial Assessment Tool for Substance Misuse) is completed. This is a Pathways assessment which helps to identify the most appropriate intervention for the child. In some cases, YJA delivers the intervention and where deemed necessary a referral on to more specialist drug and alcohol services is made.

33. As part of its commitment to earlier Stage Intervention, in particular the Community Resolution Notice Referral Scheme (CRN), YJA delivers specific educational awareness sessions with children and their parents/ carers. YJA also delivers a range of educational workshops in schools around the theme of alcohol and drug misuse, aimed at increasing awareness and reducing the risk of coming into contact with the formal justice system.

Actions

34. 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; legislation; supply reduction; and how the Justice System helps to prevent and reduce harms.

Outcome A

ACTIONS:

No.	Action	Lead(s)	Timeframe
Prevention and Early Intervention			
A1	Targeted prevention and early interventions services will target those young people most at risk of substance use, including children and young people with lived experience of care and align with and support more generic local Youth Services.	PHA DE	Ongoing
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.	PHA, DE, Local Gov, DoJ, Other Gov Depts	Ongoing
A3	The Making Contacts Count programme in primary care will include brief interventions and advice in respect of substance use.	HSCB	Ongoing
Hidden Harm			
A4	Substance Use and Hidden Harm will be addressed as appropriate in the Emotional Health & Wellbeing Framework for Children and Young People being led by DE.	DE DOH	Short
A5	The Hidden Harm Action Plan will be updated by the PHA and the HSCB to ensure there is wide awareness i.e. “Everybody’s business” and 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	Medium
Community Support			
A6	The current community support mechanisms will be reviewed by the PHA to ensure they support the local implementation of this strategy in the community, promote prevention, collaboration and access to services.	PHA	Ongoing
Availability and Accessibility			
A7	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	Short
A8	The Liquor Licensing Bill being taken forward by the Department for Communities will strengthen alcohol licensing laws in Northern Ireland and take account of public health issues.	DfC DOH	Short
A9	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	Ongoing
A10	The Department of Health will advocate to the UK Government for tighter restrictions on the advertising of alcohol, including giving consideration to the introduction of a 9pm “watershed”.	DoH	Medium

No.	Action	Lead(s)	Timeframe
Justice			
A11	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	Short
A12	The Organised Crime Task Force Drugs Sub Group will continue to co-ordinate enforcement activity and ensure that those involved in the illicit supply and distribution of drugs are targeted. This will include learning and outcomes from PSNI's Operation DEALBREAKER currently being rolled out across all the District Policing Command areas.	OCTF Drugs Sub Group, DoJ, PSNI	Ongoing
Raising Awareness			
A13	The PHA raise awareness of the harms associated with the illicit use of prescribed medicines and with polydrug use. This will include working with HSCB to promote awareness across primary and secondary care healthcare providers.	PHA HSCB	Short
A14	The PHA will update the drugsandalcoholni.info website with information on substance use, support materials and the services available in Northern Ireland and further develop engagement through social media and other channels.	PHA	Ongoing
A15	The PHA will promote and raise awareness of the UK Chief Medical Officer low-risk drinking guidelines and understanding of alcohol units.	PHA DOH	Medium
A16	Substance Use will be included as part of the new Mental Health Service model operating across general hospitals / Emergency Departments, including as part of Crisis response and services.	HSCB PHA	Medium
Drink Driving			
A17	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	Medium
A18	The Department for Infrastructure (DfI) will seek to improve access to its 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	Medium

CHAPTER 6 - OUTCOME B

Reduction in the Harms Caused by Substance Use.

Introduction

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.**
- **% of people living with ill health because of substance use.**

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.**

Context

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.

3. In 2019, 336 people died from alcohol-specific causes, 18.3% up on the 2018 figure (284), and representing the highest on record. 210 (62.5%) of these alcohol-specific deaths were males and 126 (37.5%) were females. Over the past decade, the number of alcohol-related deaths has increased by over a third (34.9%) from 249 deaths.[44] 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.

4. In respect of the 191 drug-related deaths recorded in 2019:

   - Opioids were the most common group of substances reported in drug-related deaths (128), with heroin/Morphine being mentioned on 46 death certificates – up from 24 in 2017 and 40 in 2018, tramadol on 33, and fentanyl on 9;
   - Benzodiazepines (prescription medicines that can also be used illicitly) were the second most reported group of substances (102);
   - Pregabalin (another prescription medicine) also increased significantly

and was reported on 77 death certificates (54 in 2018); and

- Alcohol was also mentioned in 16.2% of all drug-related deaths.[45]

5. 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.

6. Recent research[46] 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. A further study[47] on alcohol deaths showed that, after taking account of other factors, the most at-risk groups are those in households without access to a car, males, those living alone having been separated/ divorced or widowed, and persons aged 45-64 years. An excess risk of alcohol-related death was also associated with urban residence and with an indication of mental illness.

7. 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 harms are 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.

Blood Borne Viruses

8. 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.

Prescription Medicines

9. 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.

10. In 2017, Public Health England (PHE) undertook a review[48] 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.

11. There are also cases where individuals try to access medication online if prescriptions they feel they require are not increased or stopped too quickly. This increases their chances of getting lower quality medication and incorrect dosage quantities, which can lead to an accelerated risk of harm.

Harm Reduction

12. Harm reduction services have been proven over time to reduce alcohol and drug related harms, 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 harms that their lives are meaningful and are worth saving.

13. 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.[49]

Systematic approach to those most at risk

14. Work is ongoing in the Belfast area to develop the trialling of a whole system strategic approach to cross agency collaboration that aims to target resources and interventions at those vulnerable people most at risk – injecting drug users; homeless; and those regularly interacting with justice services. Supported by a wide range of local service providers across the housing, justice and health sectors, and based around the Doncaster model, this approach is due to be launched in autumn 2021. Evaluation of the effectiveness of this approach and learning from its implementation can be fed into the implementation of the strategy going forward.

Evidence

15. The recently published Northern Ireland Audit Office[50] 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".

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 harms, the risk of overdose and death.

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 reviews"[51] published by the Health Research Board in Ireland. In addition, there are a range of National Institute for Clinical Excellence[52] (NICE) guidelines for the delivery of specific interventions. Public Health England have also published advice responding to drug related deaths[53] and the Advisory Council on the Misuse of Drugs (ACMD) produced a report specifically on reducing opioid related deaths in 2016[54].

Actions

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.

Outcome B

ACTIONS:

No.	Action	Lead(s)	Timeframe
Drug/Alcohol Related Deaths			
B1	The PHA and HSCB will work with partners 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. The service will link with existing statutory services, community and voluntary sector services, homeless services, and suicide prevention services. This will learn from the whole system approach being trialled initially in Northern Ireland and other areas.	PHA HSCB Local Government	Medium
B2	DoH and the Organised Crime Task Force Drugs Sub Group will be key partners in work to explore the potential for a strategic review of drug related deaths at a regional level.	DoH, OCTF Drugs Sub Group	Short
B3	The PHA and the HSCB will work with experts to develop an Overdose & Relapse Prevention Framework to target those at most risk.	PHA HSCB	Medium
B4	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	Ongoing
Needle Exchange and Naloxone			
B5	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 with the aim of ensuring that we meet the WHO target of 200-300 sterile needle and syringe sets distributed per client per year.	PHA	Short
B6	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 (such as police officers). This will include providing access to nasal naloxone for carers and services on the periphery of substance use.	PHA	Short
B7	Increased screening and testing for blood borne viruses for those in treatment, with access to follow-up treatment and support, including peer-led services.	PHA HSBC HSCTs	Short
B8	The PHA will develop and implement a new harm reduction database to improve monitoring of these services.	PHA	Short

No.	Action	Lead(s)	Timeframe
Prescription Medicines			
B9	The HSCB will produce an updated Prescription Drug Misuse Action Plan which, building on the current processes, will include additional support to monitor prescribing levels and support for prescribers to better understand who may be at risk of harms.	HSCB PHA	Medium
DAMIS			
B10	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 and harm reduction support is available to those at risk and shared with relevant key services and explore expansion of the system to include a drug poisoning database based on the Welsh model to gather specific information on overdoses and drug related deaths.	DoH DoJ PHA	Short

CHAPTER 7 - OUTCOME C

People have Access to High Quality Treatment and Support Services.

Introduction

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;**
- **Service user feedback on treatment (to be developed);**
- **% of the people who overdose following release from prison; and**
- **No/% of people receiving treatment in Prisons.**

Context

2. Many people who use substances may be able to reduce harms 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.

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.

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. The transitioning arrangements for moving from the Justice System back into the local community service is also a key risk point and an area of concern.

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

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.

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.

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.

Co-ocurring Mental Health issues and Substance Use (Dual Diagnosis)

9. A recurring theme in the process to co-produce this strategy 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[55]) 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.

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. The Services must consider the patient first, and adjust the systems to fit the patient, rather than expect the patient to fit the system.

Crisis Services

11. The new Mental Health Strategy proposes moving forward with the improvement of crisis services and new delivery methods through the creation of a Regional Mental Health Crisis Service to provide help and support for persons in mental health or suicidal crisis. The plan is that the crisis service will be fully integrated in mental health services and be regional in nature. We must ensure that substance use is fully integrated with this new service.

Homelessness

12. 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.

13. As part of the British-Irish Council (BIC) Work Sector on Alcohol and Drugs, the Northern Ireland Executive is the lead on taking forward a workstream around "Considering approaches to meeting the health and social needs of people who are homeless and use drugs/alcohol". This work will be undertaken in conjunction with colleagues from the BIC Housing work sector during 2021/22.

Improving Health within the Justice Setting

14. 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.

15. 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.

Strategy for Women and Girls in contact with the Justice system

16. In the course of their engagement on the development of a justice-wide strategy to support and challenge women and girls in contact with the justice system, Justice officials noted a number of themes outlined by stakeholders and those with lived experience, with regard to substance use:

    - societal issues/contributory factors to offending, including trauma/abuse,

mental health, substance use (and their links to each other);

- the need for a cross-executive response and appropriate strategic and delivery links across the two strategies (the justice-wide women and girl's strategy and substance use strategy); and
- the need for bespoke (rehabilitative and therapeutic) services for women and girls with addiction/substance use issues.
- These will be taken into account in the implementation of both this strategy and the new Mental Health Strategy.

Transition from Prison

17. The arrangements for service users moving from the Justice System, particularly the prison community, and making the transition back into local 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.

18. 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.

Evidence

19. 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 harms. The Drug Treatment Outcomes Study (DTORS)[56] 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.

20. 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"[57], 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"[58], and there are a number of related National Institute of Clinical Excellence (NICE) guidelines[59]. All actions should be delivered within appropriate guidelines.

Actions

21. 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.

Outcome C

ACTIONS:

No.	Action	Lead(s)	Timeframe
Alcohol and Drug Services Strategic Plan			
C1	The PHA and the HSCB will produce, across all tiers of service, a new outcomes-focused strategic plan, to replace the Alcohol and Drugs Services Commissioning Framework. This new plan will: • ensure that the population of NI have access to a continuum of service with clear pathways and step up/step down provision; • ensure equal access to community detox for alcohol and other drugs across NI; • ensure that all services are delivered in line with the UK-wide "Drug Misuse and Dependence: Guidelines on Clinical Management"[60] and NICE Guidelines; • 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. should be supported to stop smoking and address other physical health conditions; and • recognise the importance of co-production and strengthen joint working between the community/voluntary sector, service users and peers, and the Health & Social Care Sector.	PHA HSCB	Short
C2	The HSCB and the PHA will review services available for children and young people, particularly looking at the transition of young people from children to adult services.	HSCB PHA	Medium
C3	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 HSCB	Ongoing
Co-occurring Mental Health and Substance Use Services			
C4	The Health service will create a managed care network, with experts in dual diagnosis supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full need of those with co-occurring issues. In addition, the HSCB will further review the support provided for those with co-occurring mental health and substance use issues.	HSCB PHA HSCTs	Medium

No.	Action	Lead(s)	Timeframe
C5	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	Medium
Justice			
C6	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.	SEHSCT, DoJ PHA HSCB	Short
Advice and Support			
C7	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. Consideration will also be given to expanding available helpline/web chat services to cover substance use.	PHA HSCB	Medium
C8	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	Medium
C9	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, and appropriate NICE guidelines.	PHA HSCB	Short
Opioid Substitution Therapy			
C10	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	Short
COVID-19			
C11	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. This will include an emphasis on initiatives to tackle the increase in substance use waiting lists that have occurred since COVID-19 emerged, to ensure these are urgently reduced to pre-COVID levels.	HSCB HSCTs	Short

CHAPTER 8 - OUTCOME D

People Are Empowered & Supported on their Recovery Journey.

Introduction

1. The focus of this chapter is on empowering recovery for those who experience harms 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.**

Context

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.

Stigma

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

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 harms and stabilising their lives will be the goal, some may wish to reduce harms 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.

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.

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.

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.

Alcohol Related Brain Injury

8. One of the long-term harms that can be caused by excessive drinking is Alcohol-Related Brain Injury (ARBI). This is a prolonged cognitive impairment due to changes in the structure and function of the brain linked to chronic, excessive alcohol consumption on a regular basis over a long period of time. The condition results from a combination of the toxic effects of alcohol on the brain, the effects of chronic dehydration, vitamin and nutritional deficiencies, head injury and disturbances to the blood supply of the brain. It refers to a wide range of specific disorders including hepatic encephalopathy, frontal lobe dysfunction, and Wernicke-Korsakoff syndrome. It is possible to reverse many of the effects of this disorder if the symptoms (which can resemble dementia) are caught early enough.

9. Some work has recently been done to bring together clinicians, policymakers and organisations working across addiction, mental health neurorehabilitation and homelessness from across the UK and Ireland in order to improve awareness and understanding of ARBI and the associated supportive approaches. It is important that we better understand the scale of this issue, in order to develop interventions and future support pathways to help people with ARBI to recover.

Evidence

10. 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”[61] 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[62]. There are also relevant NICE Guidelines[63].

Actions

11. 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.

Outcome D

ACTIONS:

No.	Action	Lead(s)	Timeframe
Stigma and recovery capital			
D1	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 harms.	DoH PHA HSCB	Short
D2	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	Medium
D3	PHA to develop appropriate information sources that focus on the reduction of stereotyping of drug users, use of inappropriate language, etc. These could then be offered to journalists, local politicians, community representatives, and other appropriate persons.	PHA	Medium
D4	Department of Health will liaise with the Department of Justice and other key stakeholders on how to reduce violence, or the threat of violence, towards drug users from some paramilitary and vigilante groups.	DoH DoJ, PHA, PSNI	Medium
Alcohol Related Brain Injury			
D5	The HSCB will review the need in relation to ARBI and will subsequently develop, as required, appropriate service models and pathways to support those impacted by ARBI to recover.	HSCB PHA	Medium
Wider Support			
D6	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, these should be built into existing bereavement supports and not a stand-alone.	PHA	Short
D7	DoH 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/or support.	DfE DoH	Medium
D8	DoH will liaise with the Northern Ireland Housing Executive and the Department for Communities through the inter-departmental homelessness plan in relation to how to reduce homelessness among, and improve access to housing for, service users.	DfC, NIHE DoH	Short

CHAPTER 9 - OUTCOME E

Effective Implementation & Governance, Workforce Development, and Evaluation & Research Supports the Reduction of Substance Use Related Harm.

Introduction

1. This chapter is focused on ensuring the successful implementation of this strategy. To accomplish this will require us to focus on several specific areas. Firstly we will outline the proposed delivery structure for the new strategy, seeking to achieve alignment from the strategic to the local level, and with the Mental Health Strategy and other key drivers. To do that, it is essential that robust governance structures are put in place to ensure that this strategy is overseen and delivered in line with the vision, and that outcomes are achieved – measured via positive progress on indicators – through the delivery of the agreed actions.

2. Next, it is essential that we ensure that staff on the ground are fully equipped with the skills they need to provide the right assistance across an ever widening landscape.

3. We also need to improve our knowledge of what works and the impact we are having to ensure this strategy is delivering its aims and objects. Therefore we need to ensure that research and evidence feeds strategy and policy development, implementation and good practice.

Indicators

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

Workforce Development

5. 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.

Structures

Strategic Level

6. 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.

7. 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. It will also link, as appropriate, to the governance structures for the new Mental Health Strategy and the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention.

Regional Delivery

8. 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 link closely with the governance and delivery structures for the Mental Health Strategy.

9. The Organised Crime Task Force Drugs Sub Group will continue to co-ordinate enforcement activity and information sharing at the regional level. The Drug & Alcohol Monitoring & Information System (DAMIS) and Drug Deaths information 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

10. 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.

11. 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.

12. This review will include an assessment of the linkages and overlaps with other local delivery structures. DACTs will remain in place until this review is completed. As part of this review consideration should be given to an Annual meeting being held between all DACTs (or other bodies following the review) to allow for improved communication and the sharing of best practice across the region.

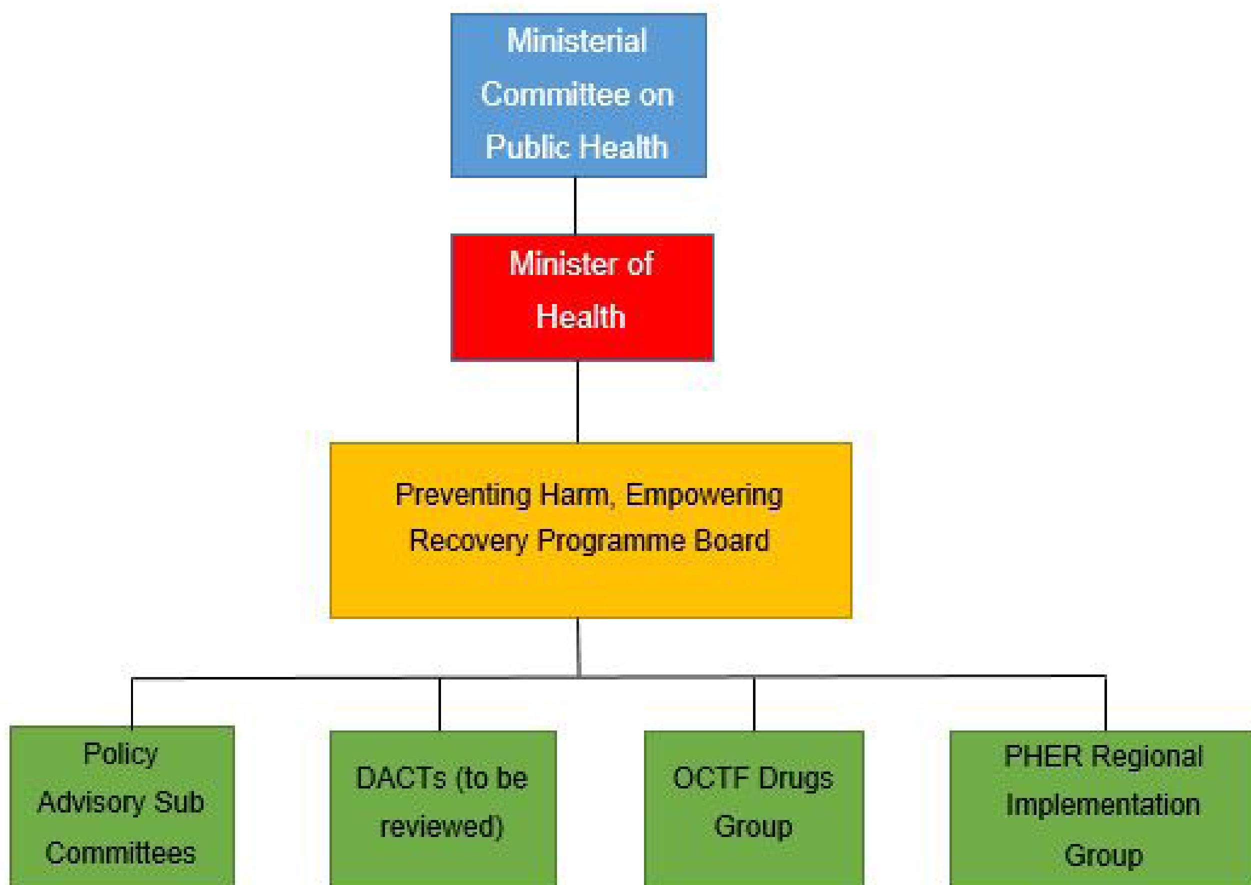
Involvement of Service Users and the Community and Voluntary Sector

13. 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.

14. 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

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



Monitoring

16. 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.

17. We 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.

18. 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 (UK GDPR).

Outcomes Based Evaluation

19. 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.

20. 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.

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

Research

22. 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 be 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.

23. 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. This should take into account the learning to be derived from work on previous repositories on alcohol/drug research.

24. We should also take into account existing quality research and surveys such as the Young Persons Behaviour and Attitudes Survey. In addition we should be mindful of work coming out of the UK/Ireland Alcohol Research Network (ACORN), the North South Alcohol Policy Advisory Group (NSAPAG) and the British-Irish Council (BIC) Alcohol and Drugs Work Sector.

25. The Organised Crime Task Force Drugs Sub Group will continue to co-ordinate enforcement activity and sharing at the regional level.

Actions

26. The following actions are proposed to achieve the outcome in relation to workforce development, implementation and governance as well as information, evaluation and research.

Outcome E

ACTIONS:

No.	Action	Lead(s)	Timeframe
Implementation and Governance			
E1	DoH will establish a new cross-sectoral/cross-departmental Programme Board to drive forward and oversee the implementation of Preventing Harm, Empowering Recovery.	DoH	Short
E2	The PHA and the HSCB 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.	PHA HSCB	Short
E3	PHA will 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.	PHA DoH	Medium
E4	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, PHA HSCB HSCTs	Ongoing
Workforce Development			
E5	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 HSCB	Ongoing
E6	Suicide prevention training will be provided to all staff working in substance use related services.	PHA, HSCB	Short

No.	Action	Lead(s)	Timeframe
Evaluation and Research			
E7	DoH will publish regular update reports on the implementation of this strategy, evaluating progress against its outcomes, indicators and actions.	DoH	Ongoing
E8	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 with a view to aligning to one outcome framework across all services in the longer term.	HSCB PHA	Medium
E9	A funded two-year rolling 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, as well as advise all stakeholders in relation to best practice, what works, and outcome monitoring/evaluation.	DoH	Short
E10	Consideration will be given to developing or amending current monitoring mechanisms (such as the health survey, the substance misuse database, Young people's behaviour and attitude survey, etc.) to ensure these are robust and fit-for-purpose.	DoH PHA HSCB	Short

1. This strategy has been approved by the Minister for Health and by the NI Executive as a whole and will form the basis of policy in this area going forward.

Timeframe and Review

2. This strategy has been designed to cover a ten-year period until 2031. However, since substance use is a rapidly developing sector, a review and update will be conducted after a five-year period so that cognisance can be taken of the latest developments in this policy area. A review at this stage will also allow for an opportunity to refresh the strategy actions and update to reflect the picture at that time.

Funding

3. DoH invested approximately £16 million per year in the delivery of the previous strategy. However, it is difficult to estimate the total funding that supported the implementation of that strategy 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.

4. Further details on the additional budget we believe will be required to fully implement this strategy will become apparent as information is clarified and finalised. However, our initial projections are that we will need in excess of £6m per annum of additional expenditure in order to progress all of the actions and thus achieve our outcomes.

5. It should be noted that not all new actions within the strategy require funding, and we are also looking at re-prioritising funding and re-configuring existing services where possible. However, other proposed actions will require additional funding. The Department of Health will be bidding for these additional resources as a matter of priority, but we must acknowledge the difficult financial situation which exists at the time of this strategy's publication. It is not possible to fund implementation from within the Department's existing resources and delivery of the full strategy is therefore dependent on the provision of additional funding for the Department.

Equality and Rural Screening

6. As per the Department of Health's Equality Scheme[64] and in order to comply with the Rural Needs Act (Northern Ireland) 2016[65], this policy has been screened for both Equality/Good Relations and Rural Needs impacts. The Equality screening will be published in the 'Policies screened and EQIAs' section on the DoH website at: https://www.health-ni.gov.uk/doh-equality.

7. 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. However Equality Impact Assessments will be conducted on individual services as they are implemented whenever necessary.

Accessibility:

8. Alternative formats of this strategy (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 or if you have specific queries relating to this strategy.

Please e-mail: hdpb@health-ni.gov.uk

ANNEX 1 Glossary

ACEs	Adverse Childhood Experiences
ACMD	Advisory Council on the Misuse of Drugs
ARBI	Alcohol-Related Brain Injury
BBV	Blood Borne Viruses
CAMHS	Child and Adolescent Mental Health Services
CMO	Chief Medical Officer
COVID	Coronavirus Infectious Disease
CRN	Community Resolution Notice
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
RIAT	Regional Initial Assessment Tool for Substance Misuse
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
YJA	Youth Justice Agency
YJAA	Youth Justice Agency Assessment

ANNEX 2

Related Strategies & Policies

Programme for Government

The Programme for Government (PfG) is the over-arching framework and work programme under which NI Executive policies operate. The NI Executive is committed to an ambitious and comprehensive programme of work that will harness the full power of joined-up action across Departments. It is committed to making sure that this is a Programme for Government that fully reflects and responds to the needs of our society and protects the environment in which we live and work.

A proposed strategic framework of Outcomes presents a picture of the kind of society we want to see. An inclusive society in which people of all ages and backgrounds are respected and supported. A society which has no barriers to people living prosperous and fulfilling lives.

The Outcomes and supporting Key Priority Areas were subject to public consultation[66] and an Equality Impact Assessment in the early part of 2021. Consultation closed on 30 April, and officials are currently preparing an analysis of responses received, before presenting findings and options to Ministers.

New Decade, New Approach[67]

This 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:

- publish a Mental Health Action Plan[68] 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.

Making Life Better[69]

This 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.

Mental Health Action Plan

The Mental Health Action Plan[70], 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.

Mental Health Strategy

The publication of a new 10-year Mental Health Strategy was identified as an immediate priority for the Northern Ireland Executive in New Decade, New Approach (NDNA) and was one of the key actions set out in the Mental Health Action Plan. The Department of Health committed to taking this work forward as a key priority, and a draft Mental Health Strategy 2021-2031 was published for public consultation in December 2020 following an intensive period of co-production. The consultation ran until March 2021, during which time 428 responses were received from broad range of organisations and individuals.

The **Mental Health Strategy 2021-2031** was published on 29 June 2021, alongside a funding plan for mental health which sets out the resources required for implementation. The Strategy is person-centred, takes a whole life approach and a whole system focus and the key aim is to ensure long-term improved outcomes for people's mental health. It focuses on the promotion of wellbeing across the lifespan, an emphasis on recovery and the reduction of stigma, and seeks to ensure consistency, equity of access, and choice for those accessing services and support. The central tenet of the Strategy and its vision is the focus on putting the individual and their needs at the centre, respecting diversity, equality and human rights. It also sets out clearly that meaningful and effective co-production and co-design should happen at every stage.[71]

Community Relations

The Executive Office also coordinates on a range of strategies aimed at improving community relations and tackling paramilitarism. These include the 'Together: Building a United Community' (T:BUC) Strategy[72], published on 23 May 2013, reflects the Executive's commitment to improving community relations and continuing the journey towards a more united and shared society. There are seven headline actions within the strategy:

- Removal of Interfaces by 2023;
- Establish 10 shared housing neighbourhoods
- Establish 10 shared education campuses
- Develop 4 urban village schemes
- Develop significant body of cross-community sporting events
- Pilot 100 shared summer schools by 2015

- Get 10,000 young people not in education, employment or training on the United Youth strategy.

Significant progress has been made to date, with a number of the headline action exceeding the targets set in the Strategy. The Executive remains committed to the delivery of the headline actions and wider good relations funding programmes to fully realise the overarching aim of building a truly united and shared society.

Children and Young People's Strategy

Published in 2019, the aim of the Children and Young People's Strategy[73] 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 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.

Homelessness Strategy[74] and the Interdepartmental Homelessness Action Plan[75]

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'.

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

Health and Wellbeing 2026: Delivering Together[76] 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.

Northern Ireland Hepatitis C Elimination Plan Phase 1, 2021-2025[77]

The World Health Organisation (WHO) has set out a commitment to eliminate hepatitis B and hepatitis C as major public health threats by 2030. The United Kingdom has signed up to achieve this goal, and England and Scotland have set earlier elimination dates of 2025 and 2024 respectively. This action plan focuses on hepatitis C elimination in Northern Ireland over the next 4 year period, from 2021 to 2025. A further plan will follow to cover 2025 to 2030. Hepatitis C infection remains disproportionately prevalent in several marginalised groups. Making Life Better, the strategic framework for public health in Northern Ireland, sets out the overriding approach of a need for greater intensity of action for those with greater disadvantage. Our elimination efforts must therefore ensure that response is proportionate to need, with a particular focus on engaging with marginalised groups to raise awareness that this is a curable condition, encouraging people to get tested, and helping more people to access treatment.

An Emotional Health and Wellbeing Framework for Children and Young People

This 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.

Youth Service Regional Assessment of Need 2020-2023

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[78] specifically mentions the impact of substance abuse amongst young people.

The ‘A Life Deserved: “Caring” for Children and Young People in Northern Ireland’ strategy[79]

This Strategy and the associated implementation plan aim to support actions which impact positively on the lives and outcomes of the children and young people. To improve their outcomes and help them achieve their full potential in line with their peers, this Strategy describes the pledge to support children and young people in care, i.e. those in foster care, residential care, supported accommodation, supported lodgings and placed with parents. It applies to those who are on the ‘edge’ of care, that is:

- Living in families with intense needs and requiring intensive supports [on the edge of coming into care];
- Returning home from a period in care [on the edge of a (short) period in care]; or
- Leaving care to make the journey into adult life [on the edge of ageing out of care].

Also to those leaving care, that is young people who have left care and are still in need of some support, including those who have been adopted; those who are living in a family under a Private Law Order and those who are supported in independent living in early adulthood. For the purposes of this Strategy, these children and young people are all referred to as care-experienced.

'STILL WAITING' A Rights Based Review of Mental Health Services and Support for Children and Young People in Northern Ireland[80]

This Report is the culmination of a Rights Based Review of Mental Health Services and Support for Children and Young People in Northern Ireland, carried out by the Northern Ireland Commissioner for Children and Young People (NICCY). The aim of the Review was to assess the adequacy of mental health services and support for children and young people, using a children's rights framework. A central focus of the Review was to enable children and young people (and their parents and carers) to share their direct experiences of accessing, or trying to access, mental health services or support; identify barriers preventing children and young people accessing adequate support; highlight good practice and make recommendations for improving services.

Protect Life 2[81]

Protect Life 2 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.

The Road Safety Strategy[82]

The Department for Infrastructure's Road Safety Strategy to 2020 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. A new Strategy is currently being developed.

Problem Solving Justice

The Justice System frequently comes into contact with people suffering from alcohol and drug related harms, 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.

Operation DEALBREAKER

Every aspect of drug-related operational activity undertaken by the Police Service of Northern Ireland (PSNI) will be branded under the banner of Operation DEALBREAKER in order to demonstrate the organisational commitment and consistent approach to tackling illegal drugs and the associated criminality and funding. This will be interwoven with the ongoing work of the OCTF Drugs Sub Group and Community Safety Board.

PSNI intends as an organisation to effectively target the harm caused by illegal drugs, their supply, and use in Northern Ireland. It is only by understanding its operating environment and through working with partners and communities, that PSNI can effectively tackle the hugely complex and challenging arena of illegal drugs supply and substance use. The priorities identified are aligned with the overarching aims of the Policing Plan 2020-2025 and PSNI strategic priorities and vision for delivery. PSNI's approach will be co-ordinated to prevent and address the harm from drug use and will be targeted under five key pillars:

- Prevention and Early Intervention;
- Law Enforcement and Criminal Justice outcomes;
- Harm Reduction;
- Multiagency working – whole systems approach;
- Interdepartmental working within and external to PSNI.

Community Safety Framework[83]

The purpose of the Community Safety Framework is to ensure effective connectivity between the community safety work of the responsible agencies and provide an operational roadmap on how to collectively deliver the safer community objectives set out in the PfG and Community Plans, whilst providing the mechanism to respond proactively and reactively to operational need. The Framework recognises the ongoing relevance of many of the priorities, approaches and need for collaborative working among agencies, as set out in the previous "Building Safer, Shared and Confident Communities, A Community Safety Strategy for Northern Ireland 2012-17" which centred on reducing crime, anti-social behaviour (ASB), fear of crime, building community confidence and ensuring local solutions to local concerns.

Improving Health within Criminal Justice Strategy and Action Plan[84]

This joint Strategy and Action Plan between the Department of Justice and the Department of Health, seeks to address the health and social care needs of children, young people and adults at all stages of the criminal justice journey (as suspects, defendants and serving sentences) in Northern Ireland. In doing so, it aims to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour.

Stopping Domestic and Sexual Violence and Abuse[85]

The strategy is a cross Executive strategy led jointly by Health and Justice, including Education, Finance, Communities. Potential to cut across issues of mental health in relation to: prevention; protection; support for offenders; and at the point of reviewing cases of domestic homicide to learn lessons (Domestic Homicide Reviews).

Consultation on Establishment of a Regional Care and Justice Campus[86]

From 21 October 2020 to 15 January 2021, the Department of Health and Department of Justice ran a joint public consultation exercise on proposals to establish a regional Care and Justice Campus for children and young people. The Campus will provide facilities and services for the most vulnerable children who may require a period of secure accommodation because of their complex needs or offending behaviour. Work to analyse the consultation responses has been undertaken and the input received is being used to help shape proposals for the service design and key principles which will underpin the operation of the Campus.

Family & Parenting Support Strategy

The Department of Health is currently leading on the development of a Family & Parenting Support Strategy which, unlike previous family support strategies, will be implemented on a cross-departmental basis over the next 10 years. All Northern Ireland government departments will work together to support all parents in Northern Ireland to make family life as good as it can be and deliver improved outcomes for all children and young people. This will be achieved through an implementation plan intended to contribute to the following outcomes:

- Confident, competent, positive parenting;
- Resilient, stable and strong families where relationships are positive, healthy and nurturing;
- A society and culture which values and supports the role of parents and recognises the importance of strong families; and
- Support that meets the needs of families experiencing particular challenges.

Sexual Health Strategy[87]

Sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) cause a wide range of illnesses and can have long-term effects on people's lives. Sexual health is an important part of physical and mental health, as well as emotional and social wellbeing. DoH works with a wide range of organisations to prevent sexual ill health and promote sexual health among the population of Northern Ireland. The Department's survey of lifestyle choices and behaviour gathers information on a range of sexual health issues amongst young people and adults in Northern Ireland.

The 'Sexual Health Promotion Strategy and Action Plan (2008-13)' aims to improve, protect and promote the sexual health and wellbeing of the population of Northern Ireland. The 'Progress and Priorities: Addendum to the Sexual Health Promotion Strategy and Action Plan' extended the strategy with an updated action plan until December 2015. Implementation of the DoH sexual health promotion policy is led by the Public Health Agency through a regional Sexual Health Improvement Network (SHIN) of key stakeholders which includes voluntary organisations. It is expected that the Sexual Health Promotion strategy will be updated during the lifetime of this strategy.

Children’s Services Co Operation Act (Northern Ireland) 2015[88]

The Children’s Service Co-operation Act (the Act) received Royal Assent in December 2015. The aim of the Act is to improve co-operation amongst Departments and Agencies and places a duty on Children’s Authorities, as defined by the Act, to co-operate where appropriate as they deliver services aimed at improving the well-being of children and young people.

The Act requires the Executive to develop and adopt a strategy which sets the strategic direction with a view to achieving improvements in the well-being of children and young people in NI.

The Act is structured as follows;

- Well-being of children and young persons – a “purpose clause” used to define what is meant by well-being and what is intended by the Act.
- Co-operation to improve well-being – a duty on the NI Executive to make arrangements for co-operation to improve well-being.
- Children and young persons strategy – a duty on the NI Executive to bring forward a strategy to outline the priority outcomes for children’s well being.
- Sharing of resources and pooling of funds – an enabling power to allow Departments and Agencies to pool resources (should they choose) to deliver children’s services.
- Report on the operation of this Act – a duty on the NI Executive to report on the delivery of the strategy and how the lives of children and young people have improved.
- Programme for Government – a requirement that the Programme for Government (PfG) consider issues raised in the report on the operation of this Act.
- Guidance – a clause which details that the Executive Office may bring forward guidance on the implementation of this Act.
- Regulations relating to clause 4 – a clause which gives the Department of Finance the power to introduce regulations which would outline how Departments should act in the pooling of budgets.

ANNEX 3
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