Pre-consultation to seek views on a Successor Strategy to the New Strategic Direction for Alcohol & Drugs Phase 2

Consultation opened on 17 May 2019.

Consultation closes on 09 August 2019 at 17:00.

Summary

The Department of Health (DoH) is responsible for leading and co-ordinating action on Northern Ireland's substance misuse strategy on a regional and local basis.

Consultation Description

The current strategy – the New Strategic Direction for Alcohol & Drugs Phase 2 (NSD Phase 2) – was published and endorsed by the former NI Executive in 2012.

The NSD Phase 2 was recently reviewed, and a report has been published which looked at its outcomes, outputs, and stakeholder views on how successful this has been.

We are now seeking initial feedback from partners and the general public on what could come next. We want your views on the vision, focus and priorities of any new or successor strategy – should you believe one is needed. This will help to inform future developments in policy and practice.

Next Steps

Following this exercise, we will collate and analyse all views and inputs, and, if appropriate, begin the process of developing a new strategy. It will be for incoming Ministers and the Executive to agree any final strategy for publication. It is important to note that the NSD Phase 2 – and all the structures that support action and collaboration – will remain in place until any new strategy is put in place.

The Closing Date for responses is Friday 09 August 2019

Ways to respond: Respond Online

DoH website:
https://www.health-ni.gov.uk/consultations/nsd-pre-consultation

Email: HDPB@health-ni.gov.uk

Write to: Health Development Policy Branch
Room C4.22
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

INTRODUCTION	
Question 1	**What is your name?**
	Name: Dr Gerry Lynch, Chair of RCPsych NI & Vice Chair of RCPsych
Question 2	**What is your e-mail address?** *If you enter your email address then you will automatically receive an acknowledgement email when you submit your response.*
	E-mail: thomas.mckeever@rcpsych.ac.uk
Question 3	**Is your response being submitted on behalf of an organisation or as an individual?** (*please tick below as appropriate*)
	☑ **Organisation** *Please use text box below to state the name of your organisation etc?* ☐ **Individual**
	Royal College of Psychiatrists Northern Ireland

OVERVIEW	
Question 4	**From your experience and from the findings of the Review and other sources of evidence, does Northern Ireland still need a substance misuse strategy?** ☑ Yes ☐ No
Question 5	**Should any new substance misuse strategy continue to cover both alcohol and drug misuse?** ☑ Yes ☐ No If you wish, please explain your choice [*comments*] The new policy should consider using the term "drug use" as well as the term "drug misuse". The term "drug misuse" may cause some drug users to feel judged by a set of values which are alien to their own views. For example, people are more likely to see themselves as cannabis users rather than cannabis misusers. The use and abuse of alcohol and other drugs both result in equally important physical, psychological and social consequences for individuals, families and society as a whole. Increasingly polydrug use, often in conjunction with alcohol is becoming the norm, blurring any traditional notional distinction between these two categories of substance users. Although there are more deaths in NI from alcohol than drugs, the years of life lost from drugs may actually be greater - given the younger average age of deaths linked to drug use. Most alcohol or drug users are also nicotine dependent and are at increased risk of dying prematurely from a range of medical complications which are not captured in the current figures for alcohol or drug-related deaths. The new strategy should also include the treatment of nicotine addiction, which is mainly from burning tobacco products and which kills 50% of its long term users. **Northern Ireland Statistics and Research Agency (NISRA) Alcohol and Drug Deaths** https://www.nisra.gov.uk/statistics/cause-death/alcohol-and-drug-deaths

Question 6	**If it continues to be a combined alcohol and drug strategy, should these have an equal priority?** ☑ Yes ☐ No Please provide further information if appropriate. [*comments*] A combined alcohol and drug strategy encourages the development of a seamless service which can assess individuals who may have both alcohol and drug related problems - and then agree a treatment plan which meets their clients' needs.
Question 7	**What should the overall vision be for any future substance misuse strategy?** (*For example, a society where these is no substance misuse, or a society where no-one come to harm caused by substance misuse, or where people are supported to prevent and address substance misuse and to maintain recovery.*) [*comments*] The vision might be to ensure front line health and care staff have the core skills to make every contact count and be aware of the "All Our Health" guidance from Public Health England to help them:- • identify, prevent or reduce alcohol or drug-related harm • identify resources and services available in your area that can help people with alcohol or drug misuse **Alcohol: applying All Our Health Updated 7 February 2018** https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health **Misuse of illicit drugs and medicines: applying All Our Health 03 May 2019** https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health/misuse-of-illicit-drugs-and-medicines-applying-all-our-health **E-learning** Try our free e-learning aimed at supporting the Everyday Interactions toolkit https://www.rsph.org.uk/our-work/policy/wider-public-health-workforce/measuring-public-health-impact/e-learning.html The strategy might also aim to reduce the stigma associated with substance use by emphasising that substance use disorder is recognised as a mental disorder, which is strongly linked with adverse childhood experiences, trauma and other mental disorders including personality disorder – also poverty, social deprivation, suicide and self-harm.

	Health Inequalities Annual Report 2019 INFORMATION ANALYSIS DIRECTORATE **https://www.health-ni.gov.uk/news/health-inequalities-annual-report-2019** "Alcohol and drug related indicators continue to show some of the largest health inequalities monitored in NI, with drug related and alcohol-specific mortality in the most deprived areas around four and a half times the rates seen in the least deprived". Advisory Council on the Misuse of Drugs (ACMD) **What are the risk factors that make people susceptible to substance use problems and harm**? https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/761123/Vulnerability_and_Drug_Use_Report_04_Dec_.pdf
Question 8	**Should a future substance misuse strategy have a set of Values & Principles?** For reference, you can find those outlined in NSD Phase 2 (Chapter 5, pages 33-35) ☑ Yes ☐ No The values and principles outlined in NSD Phase 2 are commendable. However, the strategy should reflect the growing calls for a public health approach - as opposed to a criminal justice response - to individuals who have become addicted to drugs. It is clearly important that the PSNI "is actively tackling the issue of the organised crime gangs and their involvement with illicit drugs" - but this information might be better placed in a PSNI report. (NSD Phase 2), Criminal justice responses, which lead to young people getting a criminal record for drug-related offences, significantly damage their subsequent employment and life chances - which in turn increases their risk for drug use in the future.

OUTCOMES and INDICATORS	
Question 9	**What overall outcome should we seek to achieve?** (*For example, should the outcome be focused on prevalence of use/misuse, reductions in harm, reduction in substance misuse related deaths, increasing numbers in recovery, etc*?) All of the outcomes mentioned above are important but a reduction in deaths associated with substance use should be a priority. With the notable increase in prescription drug misuse, dependence and associated harms - there needs to be emphasis on primary prevention of this. This should be through education to primary and secondary care and on-going monitoring of prescribing practices.
Question 10	**What indicators should we be measuring to demonstrate that we are working towards this overall outcome?** (*Examples of indicators include mortality figures, prevalence data, alcohol and other drug related crime, Blood Borne Virus Prevalence, etc.*) The National Drug Treatment Monitoring System (NDTMS) which is in place in England records a comprehensive range of outcome measures for drug and alcohol problems using a Core dataset , TREATMENT OUTCOME PROFILE and ALCOHOL OUTCOME RECORD **National Drug Treatment Monitoring System (NDTMS) Reference data Core dataset O (2018)** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815366/NDTMS_Reference_Data_CDS-O_14.03.pdf **TREATMENT OUTCOMES PROFILE Public Health England** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786739/TOP_form_v2_July_2018.pdf **ALCOHOL OUTCOMES RECORD** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733250/AOR_form_090818.pdf **National Drug Treatment Monitoring System** https://www.ndtms.net/ **Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS)** 1 April 2017 to 31 March 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf

	Remaining on a long term prescription of an opioid substitute treatment should not be viewed as a treatment failure, if this is helping the individual achieve stability in their lives. Important measures include • the number of individuals entering treatment, • waiting time to first appointment and to initiation of a specific treatment • retention in treatment • planned or unplanned discharges • measures of physical and psychological health • changes in alcohol or drug use, frequency of injecting/sharing drug paraphernalia, • BBV status • Hep B vaccination status • Parental status and safeguarding children • Access to LARC or other reliable contraception • Smoking status (nicotine products) • Housing • Debt / receiving appropriate benefits • Employment/ further education opportunities • Dental health • Engagements with Recovery Services, including local community and voluntary groups - AA, NA Smart Recovery etc Most, if not all of this information, is already being collected routinely in England through the National Drug Treatment Monitoring System. Information on parental status and safeguarding children has been added to the NDTMS **It is suggested that the NDTMS be adopted in Northern Ireland and replace the existing NI Drug Data Collection Systems.** ***It would be advisable for there to be co-ordinated outcome measures across the different tiers of treatment – Tier 2, 3 and 4 as well as the Prison Addiction Services.*** ***Data collected should be shared in a timely manner and critically evaluated to inform services of best practice.***
Question 11	**What do you believe the key focus of any new strategy should be?** *please tick as many of the options below that apply* ☐ **Regulation, Legislation & Enforcement** ☑ **Supply Reduction** ☑ **Prevention** ☑ **Early Intervention** ☑ **Harm Reduction** ☑ **Treatment & Support** ☑ **Recovery** ☑ **Other** (*please elaborate in box below*) *(a brief definition for each of these categories is provided in Annex)*

Please tell us more about why you feel that this should be.

Broadening the base for the prevention and treatment of substance use disorders

Treatments for alcohol or drug-related problems are delivered by a range of identified community, voluntary and statutory services, depending on the complexity of each case and the intensity of required treatment. However, there are multiple opportunities for staff working in Primary Care, mental health services, Emergency Departments/acute hospitals, community pharmacists, criminal justice services and other settings to have a meaningful conversation about the possible negative effects of alcohol or drug use, including prescription drug use.

Some individuals who use performance enhancing or image enhancing drugs or who engage in chemsex - are unlikely to attend an Addiction Clinic - and some thought should be given as to how best to engage with these groups.

There are other groups who are likely to come into contact with young people or adults, who may have substance use issues and who could help signpost people to support services These groups include teachers, community workers, social workers, housing officers, services for looked after children, health visitors, sexual health, family planning services etc. The use of apps or online resources could support this approach.

The current separation between Tier 2 and Tier 3 addiction services is somewhat arbitrary - and closer integration - and ideally co-location of this community service - would be helpful in reducing duplication of services and in ensuring the best use of resources.

Consideration should be given on how best to co-ordinate Tier 4a and Tier 4b services to optimise equitable access across the region for all patients requiring this level of treatment.

For individuals who are not yet ready to engage with structured treatments or who have difficulty accessing services, an assertive outreach approach is required to deliver harm reduction strategies - including Needle Exchange Services (NES) and Take Home Naloxone (THN).

Guidance on optimising OSTs is also available from Public Health England (2014) and by the *Drug misuse and dependence: UK guidelines on clinical management* (2017)

- Short waiting time before initiation on to OST
- Prescribe OSTs within the recommended therapeutic range
- OSTs prescribed in conjunction with psychosocial treatment
- Monitoring of treatment and increasing or decreasing intensity of treatment depending on progress
- Flexibility in supervising daily doses in a pharmacy for individuals who are in employment or have other important commitments
- Maintaining individuals in treatment until they feel ready to gradually reduce their OST.
- Mental and/or physical health problems addressed - including

treatment for BBVs

The British Society of Gastroenterology and Public Health England have produced guidance on setting up Alcohol Care Teams, which should be developed across Northern Ireland.

Alcohol: applying All Our Health Public Health England Updated 7 February 2018

https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health

Misuse of illicit drugs and medicines: applying All Our Health Published 3 May 2019

https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health/misuse-of-illicit-drugs-and-medicines-applying-all-our-health

Optimising opioid substitution treatment: turning evidence into practice Public Health England Published 1 January 2014
https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/optimising-opioid-substitution-treatment-turning-evidence-into-practice

Drug misuse and dependence: UK guidelines on clinical management (2017)
https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

Alcohol treatment services should be delivered in line with NICE Clinical Guidelines CG 115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

All Trusts should be providing a community assisted alcohol withdrawal service for selected patients.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Clinical guideline Published: 23 February 2011
https://www.nice.org.uk/guidance/cg115/resources/alcoholuse-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-dependence-pdf-35109391116229

Optimising opioid substitution treatment: turning evidence into practice Public Health England Published 1 January 2014
https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice/optimising-

	opioid-substitution-treatment-turning-evidence-into-practice **Drug misuse and dependence: UK guidelines on clinical management** (2017) https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

EVIDENCE and PARTNERSHIP WORKING	
Question 12	**Are you aware of any other sources of evidence, research or studies that would support action to address substance misuse and your proposed outcomes and indicators?** Please provide titles of and links to evidence as appropriate. [See previous comments] Public Health England has compiled a very helpful library of resources relating to the assessment, treatment and recovery. **Alcohol and drug misuse prevention and treatment guidance** **https://www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance** Other helpful references are to be found throughout this response.
Question 13	**Who needs to be involved if we are to effectively address substance misuse, and address the outcomes and indicators you proposed?** This question has been addressed in other responses.

ACTIONS and GAPS	
Question 14	**Were there any gaps in the previous strategy that need to be addressed?** [*comments*] **1. Addressing nicotine addiction** Over 60% of opioid dependent patients smoke tobacco products - yet this is not a focus for treatment in most addiction services. Medications to support quit attempts, such as Varenicline, are rarely prescribed by addiction services. This is not surprising - as smoking cessation services unfortunately sit outside of NI addiction services. This can result in situations where an individual may successfully stop drinking following a period of treatment - only to still die prematurely due to tobacco related diseases. It is also time for the PHA to review the role of e-cigarettes - and vaping to be reconsidered as a harm reduction measure for those individuals who have not managed to stop burning tobacco products. Any concerns about the potential for harm associated with vaping are accepted by most experts to be less than for burning tobacco products.

A recent survey of e-cigarettes among young people in the UK published by ASH in 2018 found the "use of e-cigarettes remains very low among young people (11-18 year olds) in Great Britain" and "E-cigarette use is confined almost entirely to those who currently or have previously smoked tobacco cigarettes."

Worryingly the same survey found "An increasing proportion of young people incorrectly believe that E-Cigarettes are as harmful as Tobacco Cigarettes."

Smoking cessation and smokefree policies: Good practice for mental health services NCSCT (2018)
https://www.ncsct.co.uk/usr/pub/Smoking%20cessation%20and%20smokefree%20policies%20-%20Good%20practice%20for%20mental%20health%20services.pdf

The Stolen Years- The Mental Health and Smoking Action Report ASH 2016
http://ash.org.uk/information-and-resources/reports-submissions/reports/the-stolen-years/

Use of e-cigarettes among young people in Great Britain ASH: August 2018
http://ash.org.uk/home/

Smoking rates remain too high in people with mental health problems and e-cigarettes should be considered as an option for patients to use during any admission to a psychiatric hospital.

> "People with mental health problems are more likely to smoke and smoking is the single largest contributor to their 10-20 year reduced life expectancy. A recent UK study highlighted that men and women living with schizophrenia in the community have 20.5 and 16.4 year reduced life expectancies respectively.
>
> "A third (33%) of people with mental health problems and more than two thirds (70%) of people in psychiatric units smoke tobacco. Reductions in smoking rates in the general population over the last 20 years have not been matched in these mental health populations."

Better care for people with co-occurring mental health and alcohol and drug use conditions Public Health England (2018)
https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services

2. The unmet needs of pregnant drug or alcohol users

Pregnant women who misuse substances (alcohol and/or drugs) often have complex social factors, co-existing physical and mental health problems and may have experienced domestic violence during their lifetime (NICE 2010, 2014). They may find it difficult to actively engage with antenatal or other treatment services and they may be wary of involvement with Childcare Services.

The most recent MBRRACE-UK REPORT published in November 2018 made the following observations:-

”Specifically, it highlights yet again that a number of women died by suicide after a pregnancy or postnatal loss, or after removal of their infant into care. For some women, pre-existing mental health conditions were exacerbated when their child was removed, and it is essential that care for the mother increases rather than decreases in these circumstances. On too many occasions the mother was forgotten once services were appropriately reassured that her child was safe.” (Foreword)

“There is very clear evidence that the care of vulnerable women, particularly those who misuse drugs and alcohol, and in prevention of thromboembolism can be improved”. (vi)

The **MBRRACE-UK REPORT** (2018) highlighted the major role played by alcohol or drug related problems in maternal deaths by suicide, unintended overdose or medical complications. **The report stated seventy-one women had died by suicide during pregnancy or up to one year after pregnancy in 2014-16 in the UK and Ireland. During the same period there were 43 women whose deaths were related to drug and alcohol misuse.**
The report also highlighted some deaths from medical complications where a medical diagnosis was delayed or overlooked due to alcohol or drug use.

Unfortunately these vulnerable women are likely to find themselves excluded from specialist perinatal psychiatric services in the UK, except where substance use may co-exist with another mental disorder.

The current **Royal College of Psychiatrists Report on Perinatal Mental Health Services (CR197),** published in 2015 and due for revision in 2019 specifically stated that “this report does not cover the care of pregnant women with alcohol and substance misuse.”

Similarly the **NHS Perinatal Mental Health Care Pathways (2018) advises** “if harmful or dependent drug or alcohol use is identified in pregnancy or the postnatal period, the woman should be referred to a specialist drug/alcohol service for advice and treatment.”

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, 1st November 2018
NHS Perinatal Mental Health Care Pathways (2018)
https://www.npeu.ox.ac.uk/mbrrace-uk

Alcohol use in pregnancy can cause a variety of serious adverse outcomes, but there are particular concerns about the life changing effects of Foetal Alcohol Syndrome or Foetal Alcohol Spectrum Disorders (FASD), conditions which are often misdiagnosed or not considered .

Although there are specialist midwives supporting smoking cessation in all NI Trusts, only the SHSCT has a specialist midwife supporting abstinence from alcohol during pregnancy and the postnatal period. No NI Trusts have a specialist midwife in post to support women with a substance use disorder.

The role and number of specialist midwives providing support for smoking cessation could be expanded to include alcohol and drug use - including prescription drug use.

SIGN 156 Children and young people exposed prenatally to alcohol- A national clinical guideline Scottish Intercollegiate Guidelines Network January 2019
https://www.sign.ac.uk/assets/sign156.pdf

McQuire C, Mukherjee R, Hurt L et al. Screening prevalence of foetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study. Preventive Medicine Volume 118, January 2019, Pages 344-351

https://www.sciencedirect.com/science/article/pii/S0091743518303323?via%3Dihub

3. **The needs of homeless drug users and the lack of longer term drug and alcohol residential units or half-way houses in N .Ireland**

Northern Ireland has an emerging problem with homeless or roofless drug users. Some are visible on our streets while others are clustered in hostels, often with other addicts, while others revolve between short periods in prison or police custody before being released back to yet another hostel. Not all these individuals are ready to commit to abstinence, but they do need ready access to a range of healthcare service and outreach workers - who can deliver harm reduction measures.

There is a glaring shortage of accommodation in Northern Ireland for young people with substance use disorders. Some of these young men and women would benefit from a placement in a drug or alcohol residential placement or a half-way house for 6 months or longer - but this is not available in Northern Ireland. This needs to be addressed.

The Queen's Nursing Institute, London has published very helpful resources on the delivery of high quality healthcare to homeless people

https://www.qni.org.uk/nursing-in-the-community/homeless-health-programme/homeless-health-resources/

4. **Access to treatment for alcohol and drug problems within the prison service**

This is an important area which needs to be addressed within the new strategy. Prison medical services face unique challenges and must be adequately resourced to deliver treatments for substance use disorders safely - and seamlessly link with community services at the point of committal and release from prison.

Enhanced community treatment and monitoring services for those involved in the Criminal Justice System may lead to reduced incarceration and / or early release.

Safer Prescribing in Prisons Guidance for clinicians Second edition RCGP January 2019
https://www.rcgp.org.uk/-/media/Files/Policy/2019/RCGP-safer-prescribing-in-prisons-guidance-jan-2019.ashx?la=en

5. Services for problem gamblers

NSD-2 did not include any discussion about the care of problem gamblers despite the serious harms associated with gambling disorders, including an increased risk of suicide.

Gamblers Anonymous are active in Northern Ireland but GAMCARE does not offer support to residents of Northern Ireland.

At present Dunlewey Substance Advice Service offer community based treatment for problem gamblers.
A 12 week residential programme for problem gamblers is offered by Cuan Mhuire (NI) Limited, 200 Dublin Road, Newry, followed by a two year after care service.

There is a pressing need to protect young people from the emergence of gambling via the internet, interactive television and mobile phone.

There is an expectation that some of the large bookmaker chains will be allocating funding to help problem gamblers. It is important that Northern Ireland gets its fair share of any such funding streams which may become available in the future.

A network of services should be set up - building on the existing services - to improve access to treatment services.

Addiction Psychiatrists may have a role in prescribing Naltrexone to problem gamblers, an opioid antagonist which is licensed to treat both opioid and alcohol dependence.

The Royal College of Psychiatrists has recommended the following:-

> "Treatment services for problem gambling should have parity of esteem with other mental disorders, in particular alcohol, drug and tobacco addiction, and should be a core element of addictions treatment provision within the NHS".

Naltrexone, an opioid antagonist which is licensed to treat both opioid and alcohol dependence, may also be effective in the treatment of gambling disorders - although this is an off-license indication.
In the future it is expected that there will be individuals seeking treatment for gaming disorders.

A losing bet? Alcohol and gambling: investigating parallels (2013) Royal College of Psychiatrists Alcohol Concern
https://www.rcpsych.ac.uk/docs/default-source/members/divisions/wales/wales-a-losing-bet.pdf?sfvrsn=934b3d6c_2

Gambling with our health Chief Medical Officer for Wales Annual Report 2016/17
https://gov.wales/sites/default/files/publications/2019-03/gambling-with-our-health-chief-medical-officer-for-wales-annual-report-2016-17.pdf

RAPID EVIDENCE REVIEW OF EVIDENCE-BASED TREATMENT FOR GAMBLING DISORDER IN BRITAIN. ***Dr Henrietta BOWDEN-JONES, Professor Colin DRUMMOND. Royal College of Psychiatrists 2016***
https://www.rcpsych.ac.uk/docs/default-source/members/faculties/addictions-psychiatry/addictions-resources-for-specialists-rapid-evidence-for-gambling.pdf?sfvrsn=736e144a_2

.

6. **Encouraging Primary Care to become more actively engaged in the assessment and treatment of the spectrum of substance use disorders**

While the workload pressures and recruitment issues facing primary care are very challenging, it is clear that GPs have particular skills in the management of the complex comorbidities which are often present in individuals with substance use disorders - but they do need additional support to take on this work.

It is hoped that more GPs can be encouraged to prescribe OSTs following completion of the necessary training and with the support of addiction services.

The NHS Long Term Plan (2019) boldly sets out to "boost 'out-of-hospital' care - and finally dissolve the historic divide between primary and community health services" - to be replaced by a "**fully** integrated community-based health care. This will be supported through the on-going training and development of multidisciplinary teams in primary and community hubs". This integrated approach would help ensure that the physical health care needs of drug or alcohol users who are in contact with Addiction Services are being fully addressed. Non-detection and under treatment of physical health contribute significantly to the high levels of morbidity and mortality in this group.

There is a key role also for Primary Care in the primary prevention of prescription drug misuse and early detection and treatment of substance misuse problems through effective focussed screening and brief intervention.

The NHS Long Term Plan (2019)

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

7. **Ensuring mental health services do not exclude individuals with co-occurring mental health and alcohol/drug use conditions'**

Public Health England produced very helpful guidance for Commissioners and service providers on this important topic in 2018:-

> "Evidence, presented below, tells us that people with co-occurring conditions are often unable to access the care they need. It is not uncommon for mental health services to exclude people because of co-occurring alcohol/drug use, a particular problem for those diagnosed with serious mental illness, who may also be excluded from alcohol and drug services due to the severity of their mental illness".
>
> "This is everyone's job - meeting co-occurring alcohol/drug and mental health needs should be core business for both alcohol, drug and mental health services, supported by wider health and social care services"
>
> **Better care for people with co-occurring mental health and alcohol and drug use conditions Public Health England (2018)**
> https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services

8. **Preparing for future threats**

The NI Drug and Alcohol Monitoring and Information System (DAMIS) acts as an early warning system about emerging trends in drug and alcohol misuse. This is welcome but the new strategy should also plan for future threats based on drug trends in the rest of the UK or Ireland.

Public Health England prepared "Guidance for local areas on planning to deal with fentanyl or another potent opioids" (2018)

> "Make further efforts to ensure quick,attractive and easy access to treatment, especially for people who are reluctant to engage. Services can improve engagement and retention in treatment through, for example, flexible and responsive services, optimized pharmacological and psychosocial interventions and contingency management (modest incentives to reinforce changes in behaviour). Consider the range of medications that is provided. Consider enhanced targeted outreach to engage particular populations such as people who have never engaged in treatment or those who have tried it before but dropped out"

Fentanyl also presents a risk to first responders who arrive on the scene where Fentanyl has been used or is being prepared for distribution.

> ***Guidance for local areas on planning to deal with fentanyl or another potent opioid Public Health England (2018)***
> https://www.gov.uk/government/publications/fentanyl-preparing-for-a-future-threat

Fentanyl: safety recommendations for first responders Evidence-based recommendations to protect first responders from exposure to fentanyl Public Health England 23 August 2018
https://www.gov.uk/guidance/fentanyl-safety-recommendations-for-first-responders

An additional risk is the possible emergence of etizolam use in Northern Ireland, a drug which is currently the **"**"street benzodiazepine" most commonly associated with drug related deaths in Scotland.

Drug –related deaths in Scotland National Records of Scotland Published 16 July 2019
https://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/2018/drug-related-deaths-18-pub.pdf

9. Services for individuals with Alcohol Related Brain Injury

There remain no clear treatment pathways for the treatment and care of individuals with ARBD. The current situation is that no identified services take responsibility for overseeing the care of this vulnerable group.

Alcohol-related brain damage in Northern Ireland- Treatment, not just care College Report CR212 Royal College of Psychiatrists April 2018

10. Responding to overprescribing and misuse of prescription drugs

Although HSCB has been very active in highlighting the abuse potential of opioids, benzodiazepines and gabapentenoids over many years, the prescribing rate for these classes of drugs remains too high across Northern Ireland. Patients who have been prescribed high dose of opioid medications (often at the direction of a Pain Clinic) and who show no evidence of addictive behaviours, are now being advised that the Faculty of Pain Medicine now feel these medications are doing more harm than good and are of limited value in treating chronic non-cancer pain. Unfortunately, there are no bespoke services to assist these patients reduce or withdraw from opioids and hence they may be referred to Addiction Services as the only available option.
At the same time there are patients whose journey into addiction began after they had been prescribed an opioid, gabapentenoid or benzodiazepine - which was subsequently continued for much too long and often in escalating doses.

The development of closer links between Addiction Services and Pain Clinics would be highly desirable.

The HSCB has developed and supported services to encourage the de-prescribing of benzodiazepines - and a similar approach should be adapted to the prescribing of opioids and gabapentenoids.

Opioids Aware: Resource at a Glance
https://www.rcoa.ac.uk/node/28715

11. Services for young people under the age of 18 years old.

The assessment and treatment of young people under the age of 18 is outside the remit of adult addiction services, but it is essential that their needs are addressed with age specific services. Particular efforts should be made to support those young people who have been excluded from school, are in the care system or are in contact with the criminal justice system. Young people with untreated or undertreated ADHD are particularly at risk of developing a substance use disorder.

Unfortunately young people with substance use disorders who are 18 to 21 years old and sometimes older, often do not fit well into a service where they may be vulnerable to exploitation or otherwise be adversely influenced by some older drug users.

Consideration should be given to setting up a bespoke addiction service within an adolescent mental health service with a flexible age range.

12. Training and workforce issues

Since the NSD-2, non-medical prescribers with Opioid Substitute Treatment Services have been appointed, which is a welcome development.

There are challenges for the addiction services workforce when trying to meet the often complex mix of co-occurring mental health and alcohol and drug use conditions commonly seen in individuals under their care.

While it is important that all members of an addiction service have shared core skills, the service also needs to recognise the unique skills of professionals from psychiatry, nursing, social work, occupational therapy or psychology - and use these to best effect. The role of service users in developing services and in promoting recovery is also important.

Addiction Services are struggling to respond to clinical need in a timely fashion. It is important that Addiction Services have the right number of staff with the right skill mix – delivering treatment and support as close to our Service Users as is possible.

The Role of Nurses in Alcohol and Drug Treatment Services
A resource for commissioners, providers and clinicians Public Health England RCN (2017)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652963/Role_of_nurses_in_alcohol_and_drug_services.pdf

Service user involvement - A guide for drug and alcohol commissioners, providers and service users Public Health England 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669061/Service-user-involvement-a-guide-for-drug-and-alcohol-commissioners-providers-and-service-users.pdf

The role of addiction specialist doctors in recovery orientated treatment systems- A resource for commissioners, providers and clinicians RCGP RCPsych 2015

Alcohol and other Drug Use: The Roles and Capabilities of Social Workers Prof Sarah Galvani March 2015 Manchester Metropolitan University
https://www2.mmu.ac.uk/media/mmuacuk/content/documents/hpsc/research/Alcohol-and-other-drug-use-report.pdf

Staff in addictions treatment services require effective training and supervision in the core evidence based psycho-social treatments. Consideration should be given to providing training at a regional level. Supervision should be provided by someone suitable, skilled and experienced in this specific area.

Are you aware of evidence-based actions that would meet these gaps?

Public Health England has published an extensive collection of resources on **Alcohol and drug misuse prevention and treatment guidance** which can be accessed through the GOV.UK website. These "provide Information and other resources to support commissioners, service providers and others providing alcohol and drug interventions".

Alcohol and drug misuse prevention and treatment guidance (last updated 12 June 2019)
https://www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance

Estimating the social return on investment of treating substance-misusing parents: a guide to collecting local data PHE 2016
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669625/benefits-of-treatment-families.aspx.pdf

Local Health and Care Planning: Menu of preventable interventions. Public Health England 2016 Menu of preventative interventions Public Health England 2016 November 2016
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683016/Local_health_and_care_planning_menu_of_preventative_interventions_DM_NICE_amends_14.02.18__2_.pdf

Quality and Productivity: Proven Case Study

Alcohol care teams: reducing acute hospital admissions and improving quality of care
Provided by: The British Society of Gastroenterology and Bolton NHS Foundation Trust

Originally published: February 2011
Last updated: February 2016
Publication type: Quality and productivity example

	https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?id=2603 **Financial case for action on liver disease- Escalating costs of alcohol misuse, obesity and viral hepatitis Foundation for Liver Research & Lancet Commission UK Liver Disease Crisis (2017)** http://www.liver-research.org.uk/liverresearch-assets/financialcaseforactiononliverdiseasepaper.pdf **Royal Society for Public Health – Measuring public health impact al College of Public Health Measuring public health impact** https://www.rsph.org.uk/our-work/policy/wider-public-health-workforce/measuring-public-health-impact.html **Everyday interactions- Measuring the public health impact of healthcare professionals** Public Health England Royal College for Public Health 2017 https://www.rsph.org.uk/uploads/assets/uploaded/2c2132ff-cdac-4864-b1f1ebf3899fce43.pdf
Question 16	**Are you aware of any innovative approaches or low-cost / no-cost actions that would make a difference?** There are opportunities to make substantial savings in the health and social costs of alcohol or drug use by setting up acute care teams in hospital and by redirecting funding from criminal justice services into addiction treatment services. This would take some initial funding, but they represent excellent "invest to save" projects.

ACTION and GAPS (continued)	
Question 17	**Have you any views on where existing or additional resources should be prioritised?** *please tick as many of the options below that apply* ○ **Regulation, Legislation & Enforcement** ○ **Supply Reduction** ○ **Prevention** ○ **Early Intervention** ○ **Harm Reduction** ◉ **Treatment & Support**

	○ **Recovery** ○ **At-Risk Population Groups** (eg *Young People, Older People, Homeless People, Pregnant Women, Single Parents, People Living in Areas of Multiple Deprivation, People Living in Rural Areas*) ○ **Other** (*please elaborate in box below*) *(a brief definition for each of these categories is provided in Annex)* **Please tell us more about why you feel that this should be?**
	(Only one box can be ticked) While any new strategy should aim to prevent or at least address substance use disorders at an early stage using community and voluntary resources, there are particular pressures to prioritise the comprehensive care of individuals with substance use disorders who are homeless or revolving through various hostels and/ or prison. There is a need for a homeless team which can comprehensively address substance use, physical and mental health and housing problems as a one-stop shop. Treatment is unlikely to be successful unless other factors can be assessed - such as access to decent housing, assistance with employment, training, education, social prescribing, purposeful activities linked to recovery projects, supports for families and childcare, longer term rehabilitation. **End of life care for people with problematic substance use** **https://endoflifecaresubstanceuse.com/** **Royal Society for Public Health – Measuring public health impact al College of Public Health Measuring public health impact** **https://www.rsph.org.uk/our-work/policy/wider-public-health-workforce/measuring-public-health-impact.html** **Everyday interactions- Measuring the public health impact of healthcare professionals** Public Health England Royal College for Public Health 2017 https://www.rsph.org.uk/uploads/assets/uploaded/2c2132ff-cdac-4864-b1f1ebf3899fce43.pdf

ACTION and GAPS (continued)	
Question 18	**Substance misuse does not have an equal impact on society. Do you believe the strategy should prioritise any of the at-risk population groups below?** *please tick as many of the options below that apply* ○ **Young People** ○ **Older People** ○ **Homeless People** ○ **Pregnant Women** ○ **Single Parents** ○ **People Living in Areas of Multiple Deprivation** ○ **People Living in Rural Areas** ○ **Other** (*please elaborate in text box below*) **What evidence do you have to support this view?**
	Only 1 of the above boxes can be ticked in this box but pregnant women and homeless people should both be prioritised for treatment for reasons previously stated.

FINAL COMMENTS	
Question 19	**Have you any other comments you wish to make at this stage?** The continuing upward trend in drug related deaths particularly in Scotland and the beginnings of prescribing medicinal cannabis (albeit a purified form of CBD) in the UK is heightening debate about whether cannabis use or indeed all illicit drugs should be decriminalised. Other harm reduction measures such as drug consumption rooms are under active consideration - but efforts to set these up in both Glasgow and Dublin have faltered. At present a change in the Misuse of Drugs Act (1971) would be required before drug consumption rooms could be opened in the UK. Reasons given for the failure to set up a drug consumption room in Dublin included the Health Service Executive (HSE) objecting to the proposed site, despite the initial proposal being made by the HSE. The Garda were also unclear if there would be an “amnesty zone” around the drug consumption room within which people could carry illicit drugs without fear of arrest.

	Supervised injectable opioid treatment may have a role for heroin users who have not responded to optimised opioid substitute treatments - but comes at considerable cost. Both drug consumption rooms and supervised injectable opioid treatment need to be placed within an urban setting and would not be cost effective in a rural setting. It is unlikely that they would be staffed or open 24 hours per day. These remain live issues which will have to be considered during the lifetime of this policy. Consider further development of specific services for families (after pilot in Southern trust) to prevent harm to children and keep families together. Further expansion of Substance Misuse Liaison Nurses accessing patients with addiction problems in the acute and mental health services, would allow earlier and more effective interventions to these difficult to engage and treat groups.

THIS IS THE END OF THE QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire.

Definitions for Question 11 & Question 17:

Regulation, Legislation & Enforcement

These can mean societal and criminal justice measures aimed at reducing the harms associated with alcohol and drug misuse, ranging from by-laws about drinking in public places to alcohol licensing (opening hours of licensed premises etc.) and drink-driving legislation through to enforcement of the Misuse of Drugs Act.

Supply Reduction

This is about reducing the supply of illicit drugs including prescription medicines, or addressing the irresponsible sale of alcohol, particularly underage sales. Measures include the disruption of organised criminal gangs involved in the manufacture and distribution of illicit substances, and tackling the online sale of counterfeit medicines.

Prevention / Early Intervention

These are about encouraging awareness and developing ways to support and empower individuals, families and communities in the acquisition of knowledge, skills and attitudes leading to a reduction of risk factors and to the development of protective factors in respect of alcohol and drug misuse.

Harm Reduction

This refers to policies, strategies and programmes designed to reduce the harmful consequences of substance misuse. Examples include measures such as provision of needle exchange (to prevent the spread of blood-borne viruses), substitute prescribing, and naloxone (to reverse the effects of overdose).

Treatment & Support

The provision of a comprehensive range of evidence-based treatment, rehabilitation and aftercare for patients and families (including detoxification, rehabilitation, substitute prescribing and therapeutic counselling) involving GPs, Community Pharmacists, Community Addiction Services and the Voluntary & Community Sector.

Recovery

The principle of placing a service user's needs at the centre of their treatment and care. Recovery might involve developing the skills to prevent relapse, or actively engaging in meaningful activities and building self-esteem, with the ultimate goal of moving on from problem alcohol/drug use.