Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16

Consultation Document

1st March 2013

This Document brings together the most up to date data on alcohol and drug misuse in Northern Ireland. It describes the evidence base outlining what is effective in addressing prevention, early intervention, treatment and rehabilitation.

Considerable detail is provided on the role and function of interventions across the four tiers of service delivery in order to ensure consistency of service provision. Such guidance will inform any future commissioning of PHA /HSCB services and help reform and modernise existing HSCT provision. It is also hoped that this guidance will inform the commissioning of services by other bodies.

Commissioning priorities for addressing alcohol and drug misuse which may guide those across organisations and sectors are offered. Specific guidance is also provided to commissioners in PHA and HSCB and to local Drug and Alcohol Co-ordination Teams regarding commissioning decisions over the next 3-5 years.

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1.0 BACKGROUND

1.0.1 Alcohol and drug misuse are major public health issues that impact on society at a variety of levels. The following points merit serious consideration;

1.0.2 Alcohol is 62% more affordable than it was 30 years ago and is more readily available in Northern Ireland than ever before. Since 1971, average alcohol consumption per person (UK) has doubled and alcohol-related harms are steadily rising, with rates of both primary and secondary admissions to general hospitals continuing to rise year on year in Northern Ireland.

1.0.3 It is estimated that approximately £680 million is spent annually in Northern Ireland to address alcohol misuse, including costs to healthcare, policing, probation and prison services, social services and as a result of work absenteeism. (Social costs of alcohol misuse in Northern Ireland for 2008/2009, DHSSPS).

1.0.4 On a population level it is essential to recognise that the majority of alcohol-related harm is not due to drinkers with severe alcohol dependence but attributable to the much larger group of drinkers whose consumption is harmful or hazardous leading to an increased risk of physical, psychological and social harm.

1.0.5 Drug misuse also impacts upon society and although the use of such substances remains low in comparison to alcohol misuse the need to reduce drug related harm is also a key public health priority. The arrival of new and emerging drugs of concern, so called “legal highs” and the increasing sale of prescribed medication over the internet presents a real challenge to society. The cost of increasing rates of Hepatitis B and C need to be addressed.

1.0.6 Currently PHA invests £6.5m in drug and alcohol services to support the implementation of the New Strategic Direction on Alcohol and Drugs. The NSD covers prevention right through to treatment and the PHA has lead responsibility for the implementation of the HSC agenda. Investment in drug and alcohol services also comes through the Mental Health Programme of Care. Approximately £8m is invested in locality based Community Addiction Teams. Whilst this investment is important it should be remembered that the £8m invested in locality Community Addiction Services represents on average 5% of the Mental Health Programme of Care. Given that the impact particularly of alcohol features across a wide range of settings it is important that all directorates within Health and Social Care invest in services to reduce the impact of alcohol related harm. This issue is beginning to be acknowledged as can be seen by the development of the Regional Enhanced Service on Alcohol Brief Interventions within Primary Care.

1.0.7 Further investment in other programmes of care is necessary. Such investment will prove to be valuable and cost effective. This commissioning framework will indicate where such investment can be best spent.

1.0.8 Whilst there are a range of services across Northern Ireland there is a disparity in access to particular services. This situation arose as a result of legacy funding arrangements prior to the implementation of RPA. The development of the Health and Social Care Board and the Public Health Agency has made it possible address

this situation and ensure that people in need of services have access to similar services irrespective of where they live.

2.0 STRATEGIC CONTEXT FOR COMMISSIONING ALCOHOL AND DRUGS SERVICES IN NORTHERN IRELAND

2.0.1 Meaningful, sustainable change in the levels of damage caused to society through misuse of alcohol and drugs can only be achieved through collaborative working across the public, private, community and voluntary sectors. The strategic context within which this document sits is one that recognises the need to tackle both the underlying causes of health inequalities and the specific issues relating to alcohol and substance misuse.

2.0.2 At the highest level, the Programme for Government seeks to address the challenges of disadvantage and inequality that afflict society. It focuses on improving people's health and well-being, enhancing community safety, improving outcomes for children and adults most at risk of harm and protecting and improving the environment in which we live. It gives consideration to the impacts of domestic and sexual violence.

2.0.3 The "People and Place – A strategy for Neighbourhood Renewal". Strategy (2003) targets those communities throughout Northern Ireland suffering the highest levels of deprivation. This cross government strategy aims to bring together the work of all government departments in partnership with local people to tackle disadvantage and deprivation in all aspects of everyday life. The impact of substance misuse forms part of the agenda.

2.0.4 Within a wider context of health policy in Northern Ireland Transforming Your Care (DHSSPS) proposes a radical shakeup of service provision in Northern Ireland over the next 3-5 years. Key to its implementation is a shift left towards more prevention and early intervention and increased emphasis on personal responsibility for health and for the management of health conditions. Emphasis is also placed on the need to streamline and join up services to ensure maximum impact with the resources available.

2.0.5 The new 10-year public health framework, Fit and Well – Changing Lives 2012 – 2022 (DHSSPS) provides overarching policy for action on improving public health and reducing health inequalities. It sets the strategic direction for addressing many of the wider social and environmental factors that influence substance misuse in our communities. Central to the new strategy framework is a focus on the most disadvantaged in society, in particular the most disadvantaged neighbourhoods and population groups, with an emphasis on community involvement in both the design and delivery of programmes based on local need. It recognises alcohol and drugs as both cause and effect of adverse life experience. The document provides the mechanism for collaborative working across government departments and across sectors to address the underlying causes and to ensure resources available to tackle the health and other impacts of substance misuse are used to maximum effect.

2.0.6 The 'New Strategic Direction for Alcohol and Drugs – Phase 2' (2011-16) describes the direction for alcohol and drugs initiatives which will be required over the next five years, encompassing the spectrum from prevention to treatment. A range of provider inputs are required, from both HSC and non-statutory sectors. It reflects the over-

arching view outlined in Fit and Well, that success in addressing alcohol and drug issues will require joined up working across government departments/agencies.

2.0.7 There are close links between people's experience of alcohol and drugs, and issues such as mental health, suicide, and sexual health. DHSSPS strategies such as the suicide prevention strategy, 'Protect Life', the Mental Health Promotion Strategy, and the Sexual Health and Well-being Strategy recognise the need for common approaches and joint planning.

2.0.8 The Hidden Harm Action Plan (DHSSPS) highlights the impact on children of the substance misuse of their parents and carers. The action plan challenges those who interact with, and provide services to children, to become aware and competent to respond to the needs of children and their families.

3.0 PURPOSE OF THE COMMISSIONING FRAMEWORK

3.0.1 A Regional Addiction Services Commissioning Framework for Northern Ireland was first proposed in the New Strategic Direction on Alcohol and Drugs, 2006-2011 but due to the impact of the Review of Public Administration, work on this area was delayed until 2010. The need for this framework is timely given the reform and modernisation agenda being undertaken through the Bamford Mental Health and Learning Disability Review and the publication of Transforming Your Care.

3.0.2 The PHA/HSCB has also recognised the need to provide clarity and direction on the commissioning of the NSD resource allocation post March 2014. Due to this matter the scope of this framework has been broadened to address all four tiers of service delivery as laid out in the New Strategic Direction on Alcohol and Drugs 2011-2016.

3.1 Aim

3.1.1 This framework outlines the key prevalence figures of alcohol and drug related harm in Northern Ireland. It brings together the current evidence base in relation to what is effective in tackling these issues. It is hoped that this information will inform organisations within and beyond the HSC who are involved in commissioning services to address this issue. Furthermore it provides information on the commissioning requirements and priorities for commissioners in PHA/HSCB and DACTS. The framework aims to deliver on the following outcomes;

- Improved consistency of service provision across the five HSCT areas;
- Improved understanding of what works and commissioning of services better informed by evidence based practice;
- A reformed and modernised service provision;
- Integration of PHA and HSCB commissioning plans and priorities.

3.2 Objectives

1. Outline the extent and level of substance misuse in Northern Ireland.
2. Review the evidence base for service delivery across each tier of service delivery.
3. Outline the key functions of service delivery across the four Tiers.
4. Outline outcome measures appropriate to each setting.
5. Identify the key priorities for service delivery for the next 3-5 years.
6. Provide guidance and direction for the development of the PHA NSD commissioning plan 2013–16.

7. Ensure that non PHA/HSCB commissioning bodies have access to appropriate advice to commission effectively.

   (PHA NSD Commissioning Plan 2013 – 16)

3.2.1 Locality Health and Social Well-being Improvement Teams in partnership with Drug and Alcohol Coordination Teams will be required to review existing provision of services in their area, identify gaps and agree local priorities for the PHA NSD Commissioning Plan 2013 – 16. These plans will be required to take account of the local priorities identified in this framework. When reviewing existing provision of services DACTS should also engage with organisations representing Section 75 groups to ensure the needs of these groups are met. Where barriers to access are found to exist DACTs should engage with the organisations to ensure these are addressed. Plans must be submitted to the PHA to inform the development of the PHA NSD Commissioning Plan. Following this the PHA will procure new services to support the implementation of the NSD 2011-2016. Contracts for these services will be awarded by 31st December 2013.

3.3 Themes

3.3.1 Central to this framework are a number of key principles which run across all four tiers of service delivery.

- Evidence Based Practice;
- Integration of harm reduction and recovery agendas;
- Partnership Working;
- Development of Integrated Care Pathways;
- Service User and Carer Involvement.

3.4 Constraints and assumptions

3.4.1 The development of this commissioning framework is being completed at a time when there is considerable pressure on the availability of public finances and as such this framework needs to clearly outline how best to secure maximum impact for the current investment by the HSCB/PHA. It is also acknowledged that this commissioning framework may well highlight the need for additional investment in services. Part of the challenge will however be to examine how to improve the current delivery of services and also to look at other cross cutting issues such as mental health and encouraging other stakeholders to see the reduction of drug and alcohol related harm as a key part of their work. These challenges are reflected in the “Transforming Your Care” agenda.

4.0 PRINCIPLES

4.0.1This document reflects the values and principles described in the NSD. These are:

- Services are positive, person-centred, non-judgmental and empowering;
- The rights of the individual to make health-related choices are balanced with the need to protect families and communities from any adverse effects of such choices;
- Addressing drug and alcohol issues is a shared responsibility and commitment, across government departments, sectors, professions, communities, and individuals;
- Each person has equal worth and rights regardless of differences in race, gender, age, ability, religious belief, political affiliation, cultural outlook, origin, sexual orientation, citizenship, nature, lifestyle, or geographical location;
- The commissioning process will support joint action through effective partnership at every level of implementation and encourage seamless service between sectors;
- Commissioning of services to address alcohol and drug related harm is based on a commitment to take action informed by evidence about what the problems are, what works, and by information on cost effectiveness. Appropriate evaluation and reviews are undertaken to ensure all programmes and initiatives are effective;
- There is commitment to continue consultation, engagement and communication with key stakeholders at every level;
- Local needs are identified and the appropriate resources effectively used by local stakeholders and organisations. Any local action takes into consideration plans already developed;
- The importance of the community dimension is recognised, and the work carried out by, and within, the community in addressing this issue, is supported;
- A sustained, long-term strategic approach, with measured shorter-term milestones, is taken;
- Commissioning of services takes account of value for money to ensure wise use of public resources, and strives to find ways to design services that are at the lowest cost consistent with appropriate and effective service;
- Commissioning of services takes account of and builds on the services already in place.

4.0.2 Organisations are obligated to share data (subject to any confidentiality/data protection issues) both at a regional/local and statutory/community level, that allows Commissioners to assess need, and help providers optimise care for clients.

5.0 PREVALENCE OF ALCOHOL AND DRUG RELATED HARM IN NORTHERN IRELAND

5.0.1 Summary of data (A full referenced version of this information is in Appendix A)

5.1 Young People

- The proportion of young people ever drinking alcohol, ever having been drunk, and ever having used drugs has been declining since 2000/2003 (according to YPBAS);
- Indicators of substance misuse among young people have been less equivocal:
    - Number of young people in treatment for alcohol and/or drug misuse has been declining from 2007 to 2012 (Census of treatment services);
    - According to DMD, numbers for under 18s in treatment have been increasing since 2008/9;
    - Alcohol-related hospital admissions for under 18s (any and primary diagnosis) have been decreasing since 2009/10 after an increase from 2005/6 onwards.
- One in twenty looked after children were identified as having a substance abuse problem, equating to about 84 individuals;
- Young people (<20) under the supervision of PBNI were more likely to have alcohol and/or drug issues relevant to offending (75%) than those aged 40 and over.

5.1.1 Number of drug–related deaths only for <25s (increasing since 2008; year of registration); no alcohol-related deaths for <25s

5.2 Adults

- Treatment-based figures show a steady increase in those receiving treatment or referral and assessment for alcohol and/or drugs, with the latest figures being:
    - Census of treatment services: around 6,000 (2012);
    - Referrals to addiction services: about 12,000 (2009/10);
    - Drug Misuse Database: around 3,000 (2011/12);
    - Drug Addict Index: 225 (2011; slight decline);
    - Needle and syringe exchange: around 16,000 visits.

5.3 Alcohol

- Alcohol is 62% more affordable than it was 30 years ago and is more readily available in Northern Ireland than ever before;

- Since 1971, average alcohol consumption per person (UK) has doubled;

- Alcohol-related harms are steadily rising, e.g. liver disease. Rates of both primary and secondary admissions to general hospitals continue to rise year on year in Northern Ireland. Alcohol-related hospital admissions have been increasing since 2001/2, standing at 12,000 for any alcohol-related diagnosis and at over 3,200 for primary alcohol-related diagnosis in 2010/11;

    - Alcohol related mortality (as per year of registration) has been stable since 2007 at around 280 deaths;

    - Although there is evidence that alcohol may reduce the risk of certain cardiovascular diseases, these effects are limited to men over the age of 40 and postmenopausal women who drink small amounts. NICE 2010, PH24.

- Alcohol referrals to HSCT Community Addictions Teams continue to grow year on year;

- £680 million (estimate) annual spend in Northern Ireland to address alcohol misuse, including costs to healthcare, policing, probation and prison services, social services and as a result of work absenteeism. (Social costs of alcohol misuse in Northern Ireland for 2008/2009, DHSSPS);

- Three-quarters of the adult population drink alcohol and the proportion of those drinking within sensible limits increased up to 2008 and remained stagnant since. Although the proportion of those binge-drinking at least once/week has decreased since 2005, the proportion classified as problem drinkers (CAGE) remains stable at around 1 in 10 and those drinking at harmful levels at 1 in 20; the latter equating to 47,000 individuals (ADP);

- About 170,000 adults in Northern Ireland drink at hazardous levels (males: 22-50 units, females: 15-35 units per week; estimates based on Adult Drinking Pattern Survey 2011 and Census data);

- Around 47,000 adults drink at harmful levels (males: 51+ units, females: 36+ units per week; estimates based on Adult Drinking Pattern Survey 2011b and Census data);

- A 60% increase in the number of alcohol misusing individuals in treatment is required to meet the recommended level of access recommended by NICE.

5.3.1Harmful drinking encompasses those with alcohol misuse and dependence, thus the 47,000 harmful drinkers can be considered as the base population for needing treatment. As neither referral statistics nor treatment statistics from the Census of treatment services allow distinction between service users with alcohol misuse or dependence, the recommended figure of treating 1 in 6 of those dependent on alcohol is applied to the whole subgroup of harmful drinkers. This provides an estimate of about 7,000 individuals requiring alcohol treatment in any one year. Figure of 4402 (alcohol only or alcohol and drugs from the treatment services census 2011-12) as the baseline.

5.4 Drug Misuse

- Over a quarter of the population (16-64) had ever used drugs, while the proportion of those having used within the last year reduced to 6.6%. Current use of any drug (last month) was reported as 3.3%. Last year and last month use of antidepressants increased since 2006/7, particularly for men and those aged 35-64 (Drug Prevalence Survey);

- Rate of referrals for drug treatment have trebled over the period 2001-2012;

- The emergence of new chemical substances so called “legal highs” has presented new challenges to all involved in trying to reduce drug related harm;

- The level of heroin use in Northern Ireland does not appear to be increasing and the number of new notifications to the Drug Addicts Index continues to fall;

- Drug-related mortality (as per year of registration) has been stable since 2007 at around 30 deaths;

- Drug seizure incidents and numbers of arrests have increased over the last three years (up to 4,000 and 2,500 in 2011/12, respectively).

5.5 Vulnerable Populations

- Prevalence rates of alcohol and drug misuse among high risk populations are higher than among the general population:

  a) LGB&T individuals show higher rates of (almost) daily drinking, hazardous drinking and drug use than the general population;

  b) Among homeless people, 66% scored 8 or higher on AUDIT, indicating hazardous and harmful drinking and their experience of drug use over the lifetime (69%), past year (40%) and past month (37%) was substantially higher than in the general population;

  c) Over 7 in 10 people supervised by PBNI had an alcohol or drug offending related score (about 3,100 individuals).

6.0 COMMISSIONING PRIORITIES

6.0.1 The majority of priorities outlined here will be commissioned as discrete services by the PHA/HSCB in consultation with DACTs. Some require existing frontline services, such as those that work with children and young people, to incorporate alcohol and drug misuse prevention/early intervention into their service delivery. Where this is required workforce training/capacity building will be provided.

6.0.2 DACTS are specifically required as laid out in the New Strategic Direction On Alcohol and Drugs 2011-2016 to put in place a community support service and youth treatment services. Details of the nature of these services are provided in the document. In addition, other organisations/sectors can make a significant contribution to delivering on these priorities and DACTs are required to work in partnership with these organisations to meet the additional local priorities as laid out in this framework.

6.0.3 Within the document there are three areas for commissioning that will be the focus for the PHA/HSCB: improving quality and consistency of tier one services against the evidence base, increasing the levels of brief intervention in hospital and primary care, and reconfiguring statutory core services.

6.1 Children, Young People and Families

6.1.1 Education and Prevention

Regional Commissioning Priorities

- Commission evidence-based parenting skills and family based programmes including Strengthening Families;
- Commission evidence-based life-skills training for young people;
- Support effective delivery of alcohol and drugs policies and social norm approaches in schools through joint working/commissioning with DE/ELBs.

Local Commissioning Priorities

- Ensure that a community support service is in place to deliver Tier 1 services across the Trust/LCG area. This package will include the following components:
    - Delivery of a three year integrated multi-agency education and prevention plan, in communities, workplaces and educational settings, to raise awareness of the impact of drugs and alcohol locally;
    - Evidence-based community mobilisation initiatives which will raise awareness and concern about alcohol related harm and to support policy implementation and change;

- Local media initiatives to raise awareness and increase acceptability of the interventions provided to address locally identified alcohol-related problems.

6.1.2 Early Intervention

Commissioning Priorities

- Build capacity of professionals and front line workers to address substance misuse issues among young people. This will be addressed through the workforce commissioning process to ensure that early intervention services are fit for purpose.

6.1.3 Youth Treatment

Regional Commissioning Priorities

- Commission the specialist substance misuse within CAMHS services in consultation with local Trusts/DACTs.

Local Commissioning Priorities

- Commission community based youth treatment services.

6.1.4 Hidden Harm

Regional Commissioning Priorities

- Ensure professionals know how to respond to both child protection issues and to situations where it is deemed the child is in need of support, as a result of parental substance misuse. (This will be addressed under the Workforce Training Plan).

Local Commissioning Priorities

- Commission treatment and support services for young people affected by parental substance misuse and their families, including intensive support for those families most affected, and ensure these services are linked to Family Support Hubs;

- Commission initiatives working between adult addiction service and children's services;

- Commission initiatives working between midwifery/health visiting and adult addiction services.

6.2 Adults and the General Public

6.2.1 Education and Prevention

Regional Commissioning Priorities

- Public education initiatives on alcohol and drugs (including prescription medication) should concentrate on the following areas;
    - Providing information about the risks of alcohol/drugs and the availability of help and treatment to reduce harmful use;
    - Supporting existing and new alcohol/drug policy measures;
    - Providing access to web-based information and self-help programmes.
- Public support should be mobilised for current and new government legislation which reduces alcohol and drug related harm.

Local Commissioning Priorities

- Ensure that a community support service is in place to deliver Tier 1 services across the Trust/LCG area. This package will include the following components:
    - Delivery of a three year integrated multi-agency education and prevention plan, in communities, workplaces and educational settings, to raise awareness of the impact of drugs and alcohol locally;
    - Evidence-based community mobilisation initiatives which will raise awareness about alcohol related harm and to support policy implementation and change;
    - Local media initiatives to raise awareness and increase acceptability of the interventions provided to address locally identified alcohol-related problems.

6.2.2 Early Intervention

Alcohol Screening and Brief Interventions

Regional Commissioning Priorities

- Ensure that early identification and brief advice programmes are delivered to 10% of the population at risk of hazardous or harmful alcohol consumption in any one year;
- Early identification and brief advice programmes should be delivered in the following priority areas;
    - Primary care;

- Emergency Departments;
- Maternity Units;
- Criminal Justice .

- For any new Alcohol Brief Intervention initiative introduced, the commissioning organisation should commission appropriate evaluation;

- Piloting of Alcohol Brief Interventions in other settings should be undertaken.

Local Commissioning Priorities

- Voluntary and Community sectors should be commissioned to provide extended brief interventions at locality level.

6.2.3 Substance Misuse Liaison Services

Regional Commissioning Priority

- The current level of alcohol liaison services should be enhanced to meet the national benchmark guideline of 4 WTE practitioners per 250,000 of the population. Current provision is 10 WTE across the region. An additional 18 posts are required.

6.2.4 Low Threshold Services

Regional Commissioning Priorities

- Pharmacy based Needle Syringe Exchange Schemes should be commissioned to meet the needs of local drug using populations;

- HSCB/PHA should consider joint commissioning initiatives with NIHE and Supporting People in the further development of low threshold services.

Local Commissioning Priorities

- Non Pharmacy based Needle Syringe Exchange Schemes should be commissioned where appropriate;

- Low threshold harm reduction services should be available in each HSCT area for those who misuse alcohol and drugs but are unable to access formal treatment services. (Such services may be stand alone or integrated within broader health services, homeless and or accommodation services).

6.2.5 Community Based Treatment and Support

Regional Commissioning Priorities

- Specialist services assisting GPs in managing patient withdrawal from prescribed drugs should be available in each HSCT area;

- Ensure Community Addiction Services are adequately resourced to meet the NICE target of 1 in 6 receiving treatment per year. This equates to a 60% increase in the number of alcohol misusing individuals in treatment using the figure of 4402 (alcohol only or alcohol and drugs from the treatment services census) as the baseline;

- A shared care substitute prescribing service should be available across all Trust areas, and patients should be managed as part of a shared care arrangement once their opioid substitute treatment has been sufficiently stabilised by Trust services. Patients should be managed in line with Northern Ireland Primary and Secondary Care Opioid Substitute Treatment Guidelines (Draft 2012);

- Interventions targeting people within the criminal justice system should be available in Northern Ireland;

- Contingency management (CM) schemes should be piloted in Northern Ireland.

Local Commissioning Priorities

- Adult voluntary/community treatment service(s) should be in place within each HSCT area working with statutory Community Addiction services within a stepped care approach;

- All those who are at risk of blood borne viruses attending Community Addiction Teams, or in other settings such as prisons, should be offered annual testing for HBV, HCV and HIV. Blood spot testing should be available for those in whom venous access is difficult or where further referral would be otherwise necessary;

- All opioid dependent clients attending Community Addiction Teams and in prison should be offered Naloxone to reduce the risk of overdose.

6.2.6 Inpatient and Residential Rehabilitation

- Inpatient and residential rehabilitation provision should be reconfigured in order to ensure a reduction in regional variation and ensure equity of access based on need;

    - A total of 500 in-patient/hospital based treatment stabilisation/detoxification episodes are required regionally;

    - A total of 200-300 residential rehabilitation episodes are required regionally.

- Consider the need for the development of a regional coordination role to ensure that inpatient and residential access is managed based on patient need and priority.

6.3 Capacity

6.3.1 Service User Involvement

Regional Commissioning Priorities

- Commission a Service User Network to enhance involvement of adult service users in the planning of alcohol and drug services.

Local Commissioning Priority

- Ensure commissioned alcohol and drugs services demonstrate effective user involvement.

6.3.2 Family Involvement

Regional Commissioning Priorities

- All treatment and support services need to deliver a consistent and agreed standard of support for families and as appropriate, opportunities for involvement in their relatives care.

Local Commissioning Priorities

- Treatment and Support Services should ensure that families receive an appropriate level of support.

6.3.3 Workforce

Regional Commissioning Priorities

- The following workforce programmes should be in place to support the implementation of the commissioning framework;
    - Basic and Foundation modules aimed at those with no or little knowledge and/or skills in addressing substance misuse
    - An accredited substance misuse course for those working on a daily basis in the substance misuse field;
    - Motivation Interviewing Training;
    - Specific knowledge of substance misuse and access to psychological skill based courses;
    - 3rd level education courses at both under graduate and post graduate level as required by the service area;

- Mentoring programmes which support the acquisition of new knowledge and skills should be piloted and evaluated to inform future content of workforce mentoring schemes;

- Services should have in place measures to ensure that staff are supported to deliver evidence based interventions through the following means;

    - Use of relevant evidence-based treatment manuals to guide the structure and duration of the intervention and ensure a consistent approach is delivered;

    - Regular clinical supervision for staff from individuals competent in both the intervention and supervision;

    - Routine use of outcome measurement tools and ensuring that the person who misuses alcohol/drugs is involved in reviewing the effectiveness of their treatment plan;

    - Routine monitoring of treatment engagement and adherence;

    - Monitoring to ensure that staff hold a current appropriate registration (as required) and / or qualification and have the knowledge and skills appropriate to the level of intervention offered (See Appendix B).

7.0 SECTION ONE: CHILDREN, YOUNG PEOPLE AND FAMILIES

7.1 Education and Prevention

7.1.1 In determining the commissioning priorities for children, young people and families, it is important to consider what affects or informs their behaviour in relation to alcohol and drugs. The reality is that children, by the time they begin to drink, already have knowledge, attitudes and intentions about alcohol. These have been formed from what they have been told, from the general structure of family living, and from observation of adults around them. As they get older children are influenced by society. This can include religion, sports clubs, community participation, school, culture and the media. As young people they become more independent and more are heavily influenced by peers and the peer culture they belong to. The key factors which can reduce consumption, and therefore alcohol and drug related harm, include delayed start of taking alcohol or drugs, ease of access to substances, parental drug and alcohol related behaviour, supervision, educational or sport related aspirations and social norms.

7.1.2 The challenge for commissioning at Tier 1 is to build a suite of interventions which are delivered as an integrated system rather than as a series of small disjointed programmes. For this reason commissioning decisions need to make it possible for prevention programmes to be delivered as part of a coherent package of activity, including campaigns, community development, community mobilisation and community support, across each DACT area. Evaluation of the process will be required to determine the effectiveness of the components and the effect of the multi-component approach.

7.2 Overview of the evidence

(A referenced version is available in Appendix C)

7.2.1 Children and young people are the population groups most often targeted by alcohol and drug education, primarily so in the school setting. Expert reviews summarising the bulk of evidence of all alcohol-related policy and interventions generally conclude that education and persuasion approaches are not effective at achieving and sustaining change in drinking behaviour. Others would suggest that expectations of substance use prevention efforts still showing effects years after the intervention are unrealistic considering the wider context of pressures to use substances.

7.2.2 Educational interventions have been defined as those that aim to raise awareness of the potential dangers of alcohol and other substance misuse (e.g. increase knowledge) so that young people are less likely to misuse alcohol and other substances. Aside from educational interventions, which are among the least successful approaches, interventions that aim to prevent alcohol and drug misuse also involve other approaches. For example, psychosocial approaches aim to develop psychological skills (e.g. peer resistance) through modelling, understanding, norm-setting and social skill practice, so that young people are less likely to misuse alcohol and other substances. It is suggested that the term alcohol/drug education is misleading and should be replaced with ‘prevention’.

7.2.3 This overview of the evidence of what works for this section focuses on the prevention of alcohol and drug use in terms of initiation of use and escalation of use.

7.3 School-based prevention

- For alcohol use, certain generic psychosocial and developmental programmes have shown effectiveness, particularly around drunkenness and binge drinking.;

- Effects of generic programmes were generally stronger and longer-lasting than those of alcohol-specific programs, and the former have the advantage of tackling a broader range of problem behaviours;

- There is some evidence of effectiveness of skills-based approaches for drug use among young people.

7.4 Family-based prevention

- Family-based prevention can be provided at universal level or targeted to specific at risk populations or those showing problems already;

- Universal family-based prevention typically takes the form of supporting the development of parenting skills including parental support, nurturing behaviours, establishing clear boundaries or rules, and parental monitoring. Social and peer resistance skills, the development of behavioural norms and positive peer affiliations can also be addressed with a universal family-based preventive program;

- Family-based interventions have shown to be effective in delaying initiation of alcohol use and reducing the frequency of drinking, even in the long-term. They show stronger and longer lasting effects than school-based programs. There is some evidence of effectiveness in relation to drug use but fewer studies have examined drug use as an outcome;

- The reviews specific to family-based interventions generally concluded that family-based interventions work. The Strengthening Families Programme for 10-14 year olds was generally mentioned as it had the longest follow-up period and had shown increasing effects;

- Effective parenting interventions focus on developing strategies to involve adolescents in family activities to maintain family bonds and manage conflict. Such interventions also include active parental involvement and emphasise the development of social skills and a sense of personal responsibility among young people.

7.5 Multi-component interventions

- Multi-component interventions are defined as those prevention efforts that deliver interventions in multiple settings i.e. in schools, with families, and in the community. Inconsistent conclusions were drawn by various reviewers. While some claim there is, overall, little evidence that multi-component interventions are more effective than

single component ones, others state that they can be effective and may achieve larger effects due to targeting multiple settings;

- There is supportive evidence that certain universal multi-component programmes are effective with some evidence that the family component is the main driver of effects. One advantage some of these programmes offer is their generic nature, which addresses multiple risk-taking behaviours. Despite small effects, this may have some merit in addressing a number of health issues through one programme.

7.6 Wider social context

- The broader social context in which young people's drinking and other risk-taking behaviour emerges is also important. It is recommended that prevention programmes must be accompanied by broader social change to address the impact of pricing, availability of substances, marketing, media, culture and social norms on risk behaviour, and efforts to reduce marginalisation, social exclusion and the vulnerability of young people during periods of transition.

Regional Commissioning Priorities

- Commission evidence-based parenting skills and family based programmes including Strengthening Families;
- Commission evidence-based life-skills training for young people;
- Support effective delivery of alcohol and drugs policies and social norm approaches in schools through joint working/commissioning with DE/ELBs .

Local Commissioning Priorities

- Ensure that a community support service is in place to deliver Tier 1 services across the Trust/LCG area. This package will include the following components:
    - Delivery of a three year integrated multi-agency education and prevention plan, in communities, workplaces and educational settings, to raise awareness of the impact of drugs and alcohol locally;
    - Evidence-based community mobilisation initiatives which will raise awareness and concern about alcohol related harm and to support policy implementation and change;
    - Local media initiatives to raise awareness and increase acceptability of the interventions provided to address locally identified alcohol-related problems.

7.7 Service Aims

7.7.1 To ensure that:

1. All children and young people have access to programmes that use skills based approaches. Programmes for younger children should be generic in nature.

2. Parents and families are supported so that parenting skills are improved and communication between family members is enhanced.

3. The environment in which young people live should support a delay of/decrease in their consumption of alcohol/drugs.

7.8 Outcomes

- Increase the proportion of young people who see taking illicit drugs and getting drunk as socially unacceptable;

- Reduction in the proportion of young people who get drunk;

- Reduction in the proportion of young people who drink on a regular basis;

- Reduction in the proportion of young people who take drugs on a regular basis.

7.9 Early Intervention and Treatment

7.9.1 Universal, targeted and specialist Youth Treatment Services are required under the New Strategic Direction (NSD) for Drugs and Alcohol. To facilitate this, a joint integrated approach is required between NSD and CYSP to focus on prevention, the early identification of problems and difficulties, and on effective intervention at the appropriate level to meet the needs of children and young people. This will enable better planning for the full range of service provision from early intervention through to highly complex presentations.

7.9.2 In the development of the structures for meeting the priorities of the Children Service's Plan, substance misuse services need to be an integral part of each Trust's Outcomes Group and their associated Family Support Hubs. (The purpose of an Outcomes Group is to carry out integrated planning and commissioning for children and young people in a geographical area, with specific emphasis on sharing resources across agencies to improve outcomes for all children and young people. A Family Support Hub is a multi-agency network of statutory, voluntary and community organisations that either provide early intervention services or work with families who need early intervention services). This will add to effective prevention and early intervention for children and young people and their families. It should also ensure better co-ordination and greater integration between and with other services, to provide comprehensive support to individual children, families and their local communities. It is important also that services developed and provided take account of the cultural context and environments where alcohol and drug misuse occurs and

ensure that prioritisation and targeting of services is given to children and young people who may be particularly at risk of alcohol and drug misuse problems.

7.9.3 Prevention, early intervention and greater integration are key parts of the 'shift left' agenda under Transforming Your Care. The implication of this, in relation to developments in substance misuse services, is that universal provision (i.e. generic and primary services), and targeted services should aim to identify and screen those with vulnerability to substance misuse and identify those with difficulties in relation to substance misuse. Universal and child and family services are concerned with educational improvement and attainment, maintenance of health and identification of risks and hazards to children, including child protection; therefore they have a role also in embedding advice and information concerning substance misuse within a general health improvement agenda as a core element of mainstream services.

7.10 Overview of the evidence

7.10.1 The evidence with respect to young people's substance misuse services indicates the need for integration of substance misuse services for families, children and young people into all systems that serve family and youth.

7.10.2 This model of providing substance misuse interventions within existing children's services with a targeted, specialist treatment service for those with more complex needs is reflected throughout the guidance from NICE and the NTA. NTA 2008 sets out a dual role for such a specialist treatment services:

- To support and enable universal and targeted children's and youth services to respond to substance misuse;

- To provide specialist substance misuse treatment for young people and their families, noting that the balance between these two activities should be determined by local need.

7.10.3 NICE/NTA guidance is that most young people can have their needs with respect to substance misuse met in universal or targeted services, but that specialist substance misuse treatment services should be provided for young people whose functioning is significantly impaired by their substance misuse.

7.10.4 NICE 2011 (II) recommends that all children and young people are referred to "a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs, if their alcohol misuse is associated with physical, psychological, educational and social problems and/or co-morbid drug misuse."

7.11 Early Intervention

Regional Commissioning Priorities

Commissioning Priorities

Build capacity of professionals and front line workers to address substance misuse issues among young people. This will be addressed through the workforce commissioning process to ensure that early intervention services are fit for purpose.

7.12 Role and function of early intervention services

7.12.1 Screening / Assessment

In commissioning effective youth treatment services it will be important to build capacity of the workforce working with children and young people. This will require that staff are able to talk about issues of alcohol and drug misuse with children and young people and can screen for alcohol and drug misuse problems using the regionally agreed Regional Initial Assessment Tool (RIAT) in conjunction with UNOCINI, where possible alcohol or drug misuse may be indicated. Staff will also need to understand and be able to deliver basic therapeutic interventions; know the pathways in to specialist services and supports and how to work within integrated care pathways to ensure comprehensive delivery of services.

7.12.2 Brief/Early Intervention

Lower risk substance misuse is increasingly dealt with within universal / targeted children's services. It is appropriate for staff in these services to provide early intervention to young people with lower risk substance misuse problems and specialist youth treatment services should provide support for these members of staff to deliver such interventions. (Brief summary of relevant evidence is available in Appendix D)

7.12.3 Referral to Specialist Youth Treatment Services

It will be necessary to agree referral pathways / procedures between children's services and the specialist youth treatment services and to develop a framework within which these services can offer support to practitioners and services within children's services; this may necessitate the development of agreed protocols setting out the roles and responsibilities of services / staff.

7.12.4 Keyworking/coordination

Where staff within universal/targeted children's services refer young people to a specialist youth treatment agency, these staff will also perform a keyworking/coordination role with respect to the range of agencies providing services/interventions to that young person.

7.13 Outcomes

- Commissioners will have clear commissioning specifications in place which are consistent with relevant national strategies, NICE guidance and best practice and the appropriate resources identified;

- Services provision demonstrates greater integration through both joint commissioning and joint providing initiatives;

- Providers have in place a range of stepped care interventions which reflect different levels of service provision (across Tiers 1–4). These will be supported by clear care pathways;

- There is a consistent application of the RIAT assessment tool by all staff engaging with children and young people vulnerable to substance misuse, that facilitates prevention and early intervention;

- Providers will routinely collect patient experience and clinical and care outcomes that contribute to the High Level outcomes identified in the Children Services Plan. Specific clinical and care outcomes should demonstrate a reduction in substance use; reduction in the physical harm associated with drug use; improvement in the psychological well-being of young engaging in substance abuse; improvement in family and social relationships; and, engagement with other health and social care services.

7.14 Young people's treatment services

Regional Commissioning Priorities

- Commission the specialist substance misuse within CAMHS services in consultation with local Trusts/DACTs

Local Commissioning Priorities

- Commission community based youth treatment services

7.15 General Service aims for young people's treatment services

7.15.1 Assessment and diagnosis, including provision of:

- Screening & Initial assessment – using regionally agreed and validated tools for early identification and assessment;

- Comprehensive assessment;

- Onward referral to CAMHS services upon identification or suspected signs of co-occurring complex physical or psychological conditions.

7.15.2 Interventions and therapies - undertaken on an individual or group basis:

- Young people should be provided with individual care plans that address the needs identified through assessment;

- Extended brief interventions;

- Specialist counselling;

- Formal psychological therapies – motivational enhancement therapy, cognitive behavioural therapy, relapse management therapy, family therapy.

7.15.3 Engagement with other services as appropriate through development of integrated care pathways and joint working with such services to ensure multi-agency planning and delivery of a coordinated care plan that meets the assessed need. This approach, which is in keeping with the Stepped Care Model, will enable more seamless and flexible access to services and ensure that children do not have to experience unnecessary transfers to different services to have their needs met.

7.15.4 Specialist substance misuse liaison service offering consultation, advice and outreach support to Social Services, criminal justice agencies, voluntary/community sector agencies, and other specialist provision (e.g. forensic) working with young people engaged in or at risk of substance misuse. Commissioned specialist youth treatment services should be required to build links with children's services to facilitate referral between the agencies and to provide support to children's services in increasing their capacity to respond to lower risk substance misuse among children and young people.

7.15.5 Where young people are transferring to adult services this should be done in a planned, managed way, applying formally agreed cross-sector transition protocols. This will involve the formulation of a transition plan for the young person that supports joint working in preparation for transition to adult addiction, adult mental health, or other appropriate services).

7.16 **Specific functions for young people's treatment services**

7.16.1 Young people's treatment services reflecting the aims and specific functions highlighted above should be available within each LCG area in Northern Ireland. There should be reasonable geographic access to such services.

7.16.2 Practice and day-to-day delivery should be underpinned by holistic working with young people and a recognition that substance misuse problems may affect or be affected by other issues in a young person's life.

7.16.3 Each young people's treatment service will provide a target level of treatment programmes / interventions per year. This will be determined on the basis of local need and evidence based practice.

7.16.4 Service delivery requirements:

- The target population for this service is: young people aged 11-17 who are misusing substances in a harmful way or are at significant risk of doing so as well as those young people who are affected by someone else's substance misuse;
- The required treatment inputs as reflected by the evidence base;
- The required specialist skills/competencies to deliver these inputs;
- Clear referral pathways including transition arrangements for those young people who are moving to adult substance misuse services;
- Preparation for treatment/process of engagement and a flexibility of response acknowledging the difficulties young people may have in sustaining engagement;
- Clear routes and smooth transition to other sources of support as necessary;
- Regular reviews with client and, where appropriate, with clients' families;
- Liaison with clients' families as appropriate, including provision of support whether directly or through referral to other services;
- Agreed care management protocols between referring agencies and treatment agencies that are understood by clients
- Provision of information regarding the service in a variety of formats.

7.16.5 Services must comply with existing HSC and RQIA governance requirements.

7.16.6 Young people should have their views taken into account. This is both in terms of the treatment they receive and the design and delivery of the service.

7.16.7 The service should be accessible to young people with a diverse range of needs (including Section 75 groups), in terms of its physical location, opening hours and having a range of gateways through which young people can access the service (including self-referral).

7.17 Child and Adolescent Mental Health Service (CAMHS)

7.17.1 It is necessary that there is greater integration between CAMHS and substance misuse provision. This will involve the development of a local youth treatment pathway that includes access to CAMHS in order to ensure a comprehensive service that addresses co-occurring substance addiction/misuse and mental health needs.

This will involve each service working towards having a number of dedicated staff who are specialists in the management of such young people. Intervention from CAMHS in this regard will require three levels of intervention:

7.17.2 Generic CAMHS staff should have the skills to work with children and young people with emerging substance misuse problems and provide psycho-social education.

7.17.3 Addiction specialists providing consultation and co-working alongside other frontline children services.

7.17.4 Provision of dedicated therapeutic care to children and young people with problems requiring specialised interventions and on those with co-occurring mental health problems.

7.18 General service aims for youth treatment services within CAMHS

7.18.1 Each locality CAMHS service model must encompass the following five service components.

7.18.2 Assessment and diagnosis, including provision of:

- Comprehensive assessment;
- Identification of medical psychiatric co-morbidities and co-existing conditions and where necessary arrange input from other services.

7.18.3 Interventions and therapies - undertaken on an individual or group basis:

- Young people should be provided with individual care plans that address the needs identified through assessment;
- Formal psychological therapies – motivational enhancement therapy, cognitive behavioural therapy, relapse management therapy, family therapy.

7.18.4 Engagement with other services as appropriate through development of integrated care pathways and joint working with such services to ensure multi-agency planning and delivery of a coordinated care plan that meets the assessed need. This approach, which is in keeping with the Stepped Care Model, will enable more seamless and flexible access to services and ensure that children do not have to experience unnecessary transfers to different service provision to have their needs met.

7.18.5 Specialist substance misuse liaison service offering consultation, advice and outreach support to Social Services, criminal justice agencies, voluntary / community sector agencies, and other specialist provision (e.g. forensic) working with young people engaged in or at risk of substance misuse.

7.18.6 Where young people are transferring to adult services this should be done in a planned, managed way, applying formally agreed cross-sector transition protocols. This will involve the formulation of a transition plan for the young person that

supports joint working in preparation for transition to adult addiction, adult mental health, or other appropriate services.

7.19 **Specific functions for youth treatment service within CAMHS**

7.19.1 CAMHS services reflecting the aims and specific functions highlighted above should be available within each LCG area in Northern Ireland. There should be reasonable geographic access to such services.

7.19.2 Practice and day-to-day delivery should be underpinned by holistic working with young people and a recognition that substance misuse problems may affect or be affected by other issues in a young person's life.

7.19.3 Each CAMHS service will provide a target level of treatment programmes / interventions per year. This will be determined on the basis of local need and evidence based practice.

7.19.4 Service delivery requirements:

- The target population for this service is: young people aged 11-17 who are misusing substances in a harmful way or are at significant risk of doing so as well as those young people who are affected by someone else's substance misuse.;
- The required treatment inputs as reflected by the evidence base;
- The required specialist skills / competencies to deliver these inputs;
- Clear referral pathways including transition arrangements for those young people who are moving to adult substance misuse or other adult services;
- Preparation for treatment/process of engagement and a flexibility of response acknowledging the difficulties young people may have in sustaining engagement;
- Clear routes and smooth transition to other sources of support as necessary;
- Regular reviews with client and, where appropriate, with clients' families;
- Liaison with clients' families as appropriate, including provision of support whether directly or through referral to other services;
- Agreed care management protocols between referring agencies and treatment agencies that are understood by clients;
- Provision of information regarding the service in a variety of formats.

7.19.5 Services must comply with existing HSC and RQIA governance requirements.

7.19.6 All young people's treatment providers, including CAMHS, will contribute to regional work to develop shared understanding of their obligations/requirements e.g. referral

thresholds, referral/handover process and actual service practice and service delivery.

7.19.7 Young people should have their views taken into account. This is both in terms of the treatment they receive and the design and delivery of the service.

7.19.8 The service should be accessible to young people with a diverse range of needs (including Section 75 groups), in terms of its physical location, opening hours and having a range of gateways through which young people can access the service (including self-referral).

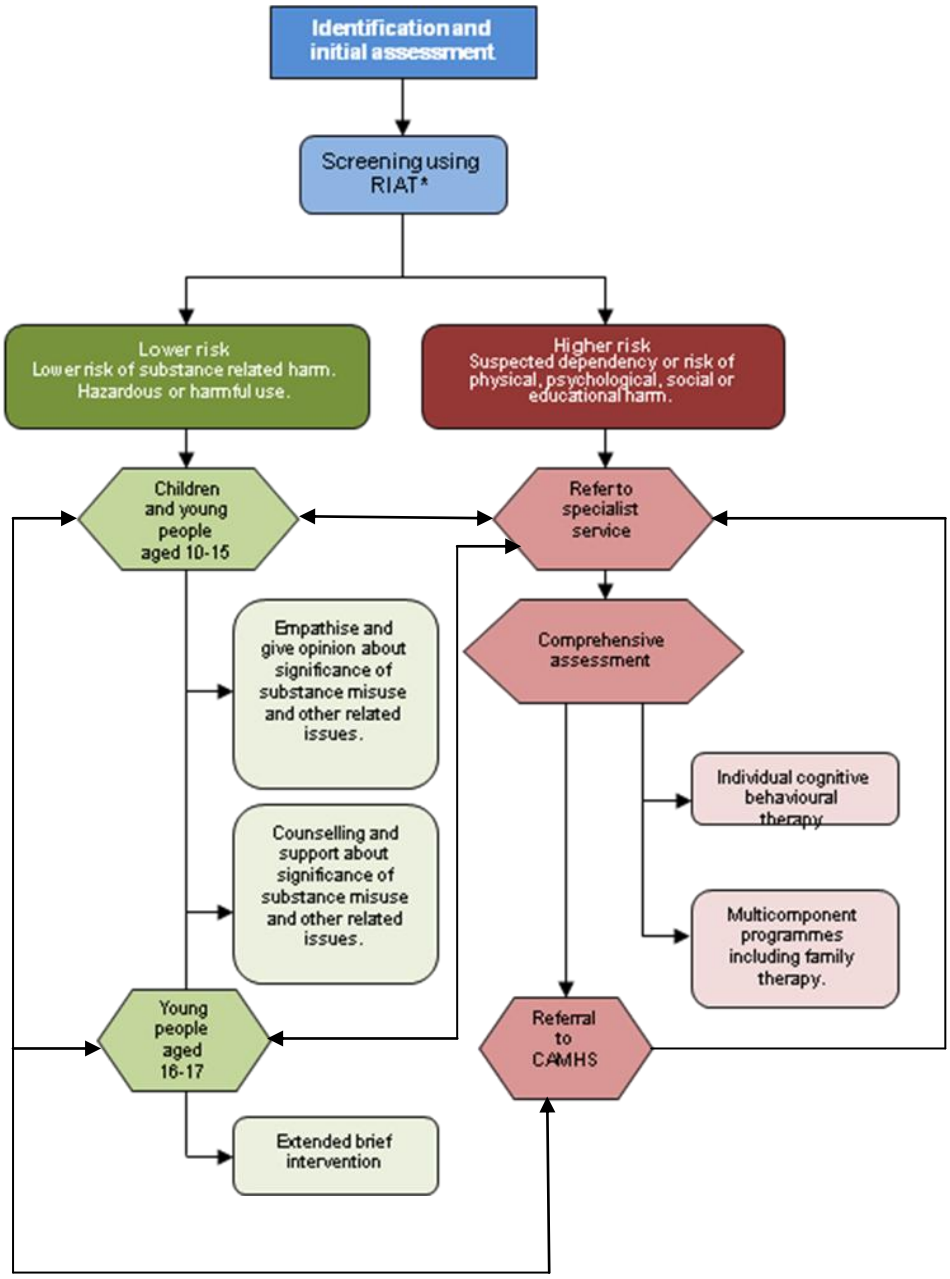
7.20 Care Pathways

7.20.1 In the provision of services it is important to distinguish between services for children and young people at:

- **lower risk of substance-related harm**, such as tailored empathy, counselling or short interventions delivered by trained professionals in targeted universal and specialist partner agencies. An example would be a young person who attends an accident and emergency department after drinking too much but who does not have any significant social, family, health or education problems;

- **higher risk of substance-related harm**, delivered by a specialist alcohol or substance misuse service. Most young people who enter specialist alcohol treatment have other, often multiple needs such as mental health issues, involvement with criminal justice, poor education attendance or unemployment.

7.20.2 The following flowchart shows the pathway for the identification, assessment, referral and intervention/treatment of children and young people aged 10 to 17 years who are at risk of alcohol related harm across both categories of risk:



* Regional Initial Assessment Tool

7.21 Hidden Harm

7.21.1 In 2003, the Advisory Council on the Misuse of Drugs (ACMD) published *Hidden Harm: responding to the needs of children of problem drug users*, which was the result of a three-year UK-wide inquiry. This report included 48 recommendations to Government, and the following six key messages:

- It is estimated that there are between 250,000 and 350,000 children of problem drug misusers in the UK – about one child for every problem drug misuser;
- Parental problem drug misuse can, and does, cause serious harm to children at every age from conception to adulthood;
- Reducing the harm to children from parental problem drug misuse should become a main objective of policy and practice;
- Effective treatment of the parent can have major benefits for the child;
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children;
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

7.21.2 This was followed by *Hidden Harm 3 Years On*: *Realities, Challenges and Opportunities (2007)* which looked at how the recommendations had been taken forward including work done in Northern Ireland.

7.21.3 The Northern Ireland policy response was written into the New Strategic Direction for Alcohol and Drugs 2006 –2011, with a requirement that a Hidden Harm Strategy for alcohol should be developed.

7.21.4 In 2007, the NSD Steering Group established a Hidden Harm working group to support the production of the Regional Hidden Harm Action Plan. The Regional Plan was released in October 2008.

7.21.5 In 2011 the Health and Social Care Board endorsed the Adult and Children's Services Joint Working Protocol developed by the Think Child, Think Parent, Think Family project board; this protocol is being implemented within all five Health and Social Care Trusts.

7.21.6 There is limited information available in Northern Ireland about the precise number of children born to and / or living with parental substance misuse. However, there are pockets of information, which indicate that this is an area of growing concern. It is estimated that there are approximately 40,000 children in Northern Ireland living with parental alcohol misuse. In 2007/08, 22% of problem drug misusers presenting for treatment were living with children, which equates to children of 412 adults. Approximately 40% of children on the child protection register are there as a direct result of parental substance misuse. Seventy percent of our "Looked After Children" are living away from home as a direct result of parental substance misuse. There are

increasing demands on our Children's Social Services as a direct result of rising referral rates related to parental alcohol and drug misuse, domestic abuse, and mental health issues.

7.22 Overview of the evidence

7.22.1 The evidence base with respect to interventions around parental substance misuse is not yet sufficiently developed to point to particular interventions as being more effective in improving outcomes than others, however the available research does point to certain approaches as being beneficial. These include:

- school-based programmes;
- play therapy;
- social and emotional support;
- group therapy;
- coping skills (emotion focused and problem-solving).

7.22.2 It is also important to remember that children and families often need help with problems other than the substance misuse, and that help should also continue beyond cessation of the alcohol or drug misuse (and resolution of, or improvement in, any other problems). Support pre- and post-cessation of substance misuse is crucial in increasing the likelihood of the maintenance of positive change.

7.22.3 The ACMD also recommends that multi-agency arrangements and protocols are in place to address parental substance misuse and that data is collected to ensure that children living with parental substance misuse are provided with appropriate services and to provide greater clarity on the extent of the problem.

7.22.4 ACMD 2007 also indicated the need for specialist maternity services and protocols in Northern Ireland.

<u>Regional Commissioning Priorities</u>

- Ensure professionals know how to respond to both child protection issues and to situations where it is deemed the child is in need of support, as a result of parental substance misuse. (This will be addressed under the Workforce Development Plan).

<u>Local Commissioning Priorities</u>

- Commission treatment and support services for young people affected by parental substance misuse and their families, including intensive support for those families most affected, and ensure these services are linked to Family Support Hubs;
- Commission initiatives working between adult addiction service and children's services;

- Commission initiatives working between midwifery/health visiting and adult addiction services.

7.23 Screening/Assessment

7.23.1 Screening for parental substance misuse should occur both within adult services addressing substance misuse issues and within services working with children and young people. These services should provide support to young people affected or support them in accessing appropriate support in line with the regional protocol.

7.24 Role and Function of Early Intervention Services

7.24.1 Treatment / support for those affected by parental substance misuse will typically involve a multiagency response.

7.24.2 Where the parent(s) with substance misuse issues is already in treatment, the agency providing this treatment has a responsibility to establish whether the individual has dependent children and whether these children are in need of support. The treatment provider should make appropriate referrals to support services and seek feedback from these services on whether the young person / family referred has engaged with the support service. Commissioners should ensure that this is reflected in the targets of those services providing substance misuse treatment to adults.

7.24.3 Where parental substance misuse is identified by an agency working with a young person / family around another issue, the following action should be taken:

7.24.4 In situations where Family and Childcare Social Workers consider that the parent / carer's substance misuse problems are not having a significant impact on the well-being of the children, they should

- Monitor the situation;
- Provide information to the parent(s) on where to access support/treatment;
- Seek to ensure that the child(ren) are linked to sources of support within the community which can help to mitigate against any negative impact due to parental substance misuse.

7.24.5 Where there is clear identified risk the Family and Childcare Social Worker must follow procedures as outlined in the Area Child Protection Committees' Regional Policy and Procedures (3.11 to 3.26).

7.24.6 In situations where Family and Childcare Social Workers consider that the parent / carer's substance misuse problem is having a significant impact on the well-being of the children, they should discuss this with the person concerned and seek their

consent to contact the appropriate substance misuse professional or the general practitioner to seek background information. Once the person gives consent, contact will be made with the relevant substance misuse professional. Commissioners should ensure that all services provided for young people / families have targets / monitoring in place to reflect this.

7.24.7 Family Support Hubs may provide a route for young people and families affected by parental substance misuse to access a range of support services. However, this depends on the range of agencies involved in a local hub and the range of services provided locally by these agencies. Where the local Family Support Hub cannot provide appropriate support services, treatment providers should still ensure that they refer the young person / family to an appropriate source of support.

7.25 Role and Function of Maternity Services

- An integrated approach is needed where maternity and/or other services are able to offer a comprehensive and integrated approach to both health and social care issues surrounding the pregnancy, and involve the woman in the decision making process as much as possible;

- Every maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug (and other substance) users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby. This should include the use of clear evidence based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals;

- Pregnant drug (and other substance) users should be routinely tested with their informed consent, for HIV, hepatitis B and hepatitis C, and appropriate clinical management provided including hepatitis B immunisation for all babies of drug injectors;

- Every maternity unit should have effective links with primary health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby;

- Commissioners should ensure that all maternity units have access to training and other support to ensure that the needs of pregnant substance users can be fully met.

7.26 Multiagency Working

7.26.1 The Regional Joint Service Agreement - Hidden Harm Protocol aimed at improving outcomes for children of problem drug and alcohol users should be implemented. This is most appropriately placed as additional guidance to UNOCINI to enable staff to make an informed judgement on the specific risks associated with substance misuse. Commissioners should consider how best to support the implementation of the protocol within their local area: e.g. through provision of training for staff or through provision of interventions to improve communication between services working with adults affected by substance misuse and services working with children and young people.

7.27 Outcomes

- Improved safeguarding and promoting the welfare of children and young people whose health or development may be being impaired as a consequence of parental substance misuse;

- Improved outcomes for children of substance misusing parents or carers, including children who may have caring roles in the family;

- Improved joint working between adult treatment services and children's services, providing an integrated approach to ensure that their functions are discharged having regard to the need to safeguard and promote children's welfare;

- Improved training and support to both the adult and children's workforce.

7.28 Role and function of Treatment services

7.28.1 Services working with families around parental substance misuse may provide a range of interventions; the intensity of these will be dependent on the extent of the problem. Interventions should focus on:

- minimising the harm experienced by young people as a result of parental substance misuse and, where possible, on

- reducing the parental substance misuse.

7.28.2 Services working with young people around parental substance misuse should:

- Provide psychosocial support as appropriate;

- Work to develop resiliency in young people;

- Provide opportunities for young people to interact with their peers, including outside of a therapeutic setting;

- Support young people to access practical help (e.g. help with clothing, household tasks, school attendance).

7.29 Outcomes

- Improved treatment outcomes for parents who misuse substances beginning with access to drug treatment through to support from family services and parenting practitioners;

- Improved access to adult drug and alcohol treatment services for parents using drugs or alcohol;

- Increased retention and compliance in treatment for drug and alcohol users who are parents;

- Improved training and support to both the adult and children's workforce;

- Ensure children and young people undertaking caring roles for their parents and siblings are supported and protected from inappropriate caring.

8 SECTION TWO : ADULTS AND THE GENERAL PUBLIC

8.1 Education and Prevention

8.1.1 It is now recognised that alcohol is a major public health issue and one that has to be addressed at a number of levels. The need for increased regulating in the alcohol market has become under increasing scrutiny. Likewise the existing laws applied to drug misuse continue to exist with very little appetite for any real changes in this matter. The emergence of “legal highs” has presented government with real challenges emphasising the need to have responsive legislation. Providing information to the general public on alcohol and drug related harm remains a key aspect of any strategy.

8.2 Overview of the evidence

8.2.1 The strongest evidence for measures which reduce alcohol related harm at a population level are those which attempt to regulate the alcohol market through pricing / taxation and restricting supply.

- Making alcohol less affordable is the most effective way to reduce alcohol related harm. Setting a minimum unit price for alcohol is the most effective way to do this. Increasing the duty on alcohol products is currently not effective as duty rates do not reflect the strength of alcohol products. In addition producers and retailers may well absorb the cost of any increase;

- Managing the availability of alcohol by restrictions on hours and days of sale and on the number and density of outlets, raising the minimum drinking age and training of bar staff (requires reinforcement with refresher courses) are all measures which have also shown to be effective. Specific measures can include;

    - enforcement - sales to underage drinkers/responsible sales;

    - banning alcohol price/drinks promotions;

    - action on alcohol advertising: there is evidence of small but consistent effects of advertising on the consumption of alcohol by young people;

    - Limiting the number of new licensed premises especially in areas where there is saturation and existing high levels of alcohol related crime.

8.2.2 NICE 2010 PH 24 did not review the evidence on wider dissemination of information on alcohol units and related health information. However, the report stated that these were important measures that needed to be tackled in conjunction with the recommendations on pricing and reducing supply. There are also a range of evidence/policy directives which support public information campaigns and action at a local level, in communities, workplaces and educational settings, when delivered in a coordinated manner. However, these measures need strong partnership working and sustained leadership at various levels of society.

8.2.3 Some of this work has also addressed drug misuse with broadly similar conclusions. However certain aspects within a community mobilization approach has particular risks when applied to drug misuse and one could argue remains the responsibility of law enforcement agencies. It is however also important that law enforcement responses to drug misuse do not alienate communities and exacerbate the harm caused by drug misuse.

8.2.4 It must also be borne in mind that people living in deprived areas are five times more likely to die from alcohol or drug related harm. In this sense the wider determinants of ill health, in particular poverty, unemployed and fractured/unstable communities all impact of the level of alcohol and drug related harm. Northern Ireland has a strong history of community development and the recent publication of the Working in Partnership, Community Development Strategy for Health and Well-Being 2012-2017, HSCB/PHA 2012 aims to strengthen communities in order to enhance their well-being.

Regional Commissioning Priorities

- Public education initiatives on alcohol and drugs (including prescription medication) should concentrate on the following areas;
    - Providing information about the risks of alcohol/drugs and the availability of help and treatment to reduce harmful use;
    - Supporting existing and new alcohol/drug policy measures;
    - Providing access to web-based information and self-help programmes.
- Public support should be mobilised for current and new government legislation which reduces alcohol and drug related harm.

Local Commissioning Priorities

- Ensure that a community support service is in place to deliver Tier 1 services across the Trust/LCG area. This package will include the following components;
- Delivery of a three year integrated multi-agency education and prevention plan, in communities, workplaces and educational settings, to raise awareness of the impact of drugs and alcohol locally;
- Evidence-based community mobilisation initiatives which will raise awareness and concern about alcohol related harm and to support policy implementation and change;
- Local media initiatives to raise awareness and increase acceptability of the interventions provided to address locally identified alcohol-related problems.

8.3 Role and function of Community Support Service

8.3.1 Service Aims

1. Support DACTs in the development of a local integrated education and prevention plan in communities, workplaces and educational settings to raise awareness of the impact of drugs and alcohol locally.

2. Support existing and develop new initiatives addressing alcohol and drug related harm in urban and rural areas. Such work should include a focus on night time economies where relevant and work closely with Policing and Community Safety Partnerships.

3. Advocate and promote adherence to existing laws concerning regulation (Media Advocacy).

4. Build capacity for non professionals to ensure they have access to information/resources on alcohol and drugs and can provide information and signposting to their communities.

5. Use local media to raise awareness of local drug and alcohol concerns.

6. Work on regional projects with other community support services where necessary.

8.3.2 Outcomes

- Increased awareness of treatment and support services available for those experiencing difficulties as a result of drug and /or alcohol misuse;

- Increased awareness of the recommended government guidelines on drinking sensibly;

- Reduction in the number of people drinking hazardously and harmfully;

- Increase in the number of people drinking sensibly;

- Reduction in the number of people reporting using drugs within the last year and last month.

8.4 Early Intervention Services

Alcohol Screening and Brief Interventions

8.4.1 In Northern Ireland, the majority of alcohol brief interventions are carried out in primary care. A pilot in the CAWT area has also carried out a number of ABIs in maternity services. There has been no thorough evaluation of ABIs carried out in Northern Ireland to date. In June 2012, a Regional Enhanced Service (RES) took effect which provides financial incentives for GPs to screen their patients using AUDIT and carry out an ABI or refer on as appropriate.

Defining brief intervention

8.4.2 Brief interventions tend to be carried out in general community settings and are delivered by non-specialist personnel such as general medical practitioners and other primary healthcare staff, hospital physicians and nurses, social workers, probation officers and other non-specialist professionals. They are directed at hazardous and harmful drinkers who are not typically seeking help for an alcohol problem.

8.4.3 Brief interventions can be divided into

- Simple brief interventions – structured advice taking no more than a few minutes;
- Extended brief interventions – structured therapies taking perhaps 20-30 minutes and often involving one or more repeat sessions.

8.4.4 Given levels of hazardous/harmful alcohol and/or illicit drug consumption outlined elsewhere in this framework, there is a clear need to markedly enhance the level of population-based early identification initiatives across both HSC (e.g. primary care) and other settings. National/European guidance identifies that such activities are cost efficient in terms of generating significant savings, e.g. earlier identification/future hospital admissions avoided. The provision of an agreed screening/brief interventions programme should be prioritised regionally.

8.5 Overview of the evidence

8.5.1 The strongest evidence for the delivery of Alcohol Brief Interventions is in primary care with some studies suggesting that impact may persist for periods up to two years after intervention and perhaps as long as four years. Evidence for delivering ABI's in Emergency Departments is also strong but implementation in this area has been difficult due to; existent workload pressures, that alcohol was not a priority, high staff turnover, and staff feeling forced to take on extra work.

8.5.2 Other areas where ABI'S where the evidence is promising includes; the criminal justice setting and prenatal care.

8.5.3 There is evidence to suggest that additional resources may be required to support frontline staff undertaking ABI's particularly in the delivery of structured brief advice.

8.5.4 Based on evidence, in relation to alcohol brief interventions with adults, the NICE Guidelines recommend the following:

- NHS professionals should routinely carry out alcohol screening as an integral part of practice;

    - The Alcohol-Use Disorders Identification Test (AUDIT) is effective in the identification of hazardous and harmful drinking in adults in primary care. The use of lower thresholds in conjunction with alcohol screening questionnaires was recommended for women;
    - The evidence for the effectiveness of shorter versions of AUDIT in adults in primary care was variable.

- AUDIT was reported to perform effectively among general hospital inpatients. Evidence was identified for the use of the following alcohol screening questionnaires among adults in emergency care settings: CAGE, AUDIT-C, FAST and Paddington. Where screening everyone is not feasible, NHS professionals should focus on groups that may be at increased risk from alcohol and those with an alcohol-related condition;

- Non-NHS professionals (in criminal justice / community and voluntary sector) should focus on screening groups that may be at an increased risk of harm from alcohol and people who have alcohol related problems;

- Professionals who have received the necessary training and work in healthcare, criminal justice, social services and higher education should offer those screened positively a session of structured brief advice on alcohol;

- They should use a resource based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy). It should take 5-15 minutes;

- Adults who have not responded to brief structured advice or who would benefit from an extended brief intervention should be offered extended brief intervention lasting 20-30 minutes, with follow-up and assessment, and where necessary up to 4 additional sessions or referral to a specialist alcohol treatment service.

Regional Commissioning Priorities

- Ensure that early identification and brief advice programmes are delivered to 10% of the population at risk of hazardous or harmful alcohol consumption in any one year;
- Early identification and brief advice programmes should be delivered in the following priority areas;
    - Primary care;
    - Emergency Departments;
    - Maternity Units;
    - Criminal Justice.
- For any new Alcohol Brief Intervention initiatives introduced, the commissioning organisation should commission appropriate evaluation;
- Piloting of ABI's in other settings should be undertaken.

Local Commissioning Priorities

- Voluntary and Community sector should be commissioned to provide extended brief interventions at locality level.

8.6 Role and function of services providing alcohol brief interventions

Primary care

8.6.1 Those working in primary care should ideally screen all adult patients using AUDIT, and provide a brief intervention with those scoring between 8 and 19 on AUDIT. Patients scoring 20 or over should be referred onwards as appropriate. However where this is not appropriate the following people should be targeted;

- with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders);
- with relevant mental health problems (such as anxiety, depression or other mood disorders);
- who have been assaulted;

- at risk of self-harm;
- who regularly experience accidents or minor traumas;
- who regularly attend GUM clinics or repeatedly seek emergency contraception.

8.7 Criminal Justice

8.7.1 Those working in criminal justice should recognise that their clients are a suitable target group for alcohol brief interventions and develop interventions as appropriate within their services. They should work with those in healthcare to ensure consistency of approach. They should also consider setting bail or release conditions which include going to a service provider for appropriate intervention or counselling.

8.8 Maternity

8.8.1 Those working in maternity care should screen pregnant women at the earliest opportunity, using an appropriate screening tool, e.g. AUDIT or TWEAK. Interventions should address not only drinking during pregnancy, but also drinking at hazardous or harmful levels prior to pregnancy, and promote health behaviours during pregnancy and beyond.

8.9 Emergency Departments

8.9.1 See Substance Misuse Liaison Section

8.10 Outcomes

- Reduction in the number of people drinking alcohol hazardously;
- Reduction in number of people drinking harmfully;
- Increase in the number of people drinking sensibly.

8.11 Substance Misuse Liaison Services

8.11.1 Alcohol and drug related harm is not adequately identified within a range of HSC settings, including general hospitals. This has direct consequences in terms of higher morbidity/mortality for individuals with hazardous/harmful alcohol consumption or who misuse drugs either illicit or prescription and, in turn, adds significant costs to the health (and other) services.

8.11.2 The scale and magnitude of substance misuse related problems in Northern Ireland is significant. Direct costs of alcohol misuse to the HSC are estimated to be around £250 million per year. Around three-quarters of costs are incurred within the hospital setting (Emergency Departments = 27% of costs; In-patient wards = 33%; Out-patient/Other = 15%).

8.11.3 These costs, however, may be a significant under-estimate given that alcohol-related harm is frequently not detected even though it is a contributory factor in many attendances/admissions (local hospital statistics identify that fewer than 5% of admissions are alcohol related. However, national data indicates that around 70% of 'weekend' emergency department attendances are alcohol-related. The evidence around numbers who misuse drugs both prescription and or illicit is less clear. ,

8.12 Overview of the evidence

8.12.1 There is increasing evidence to support early identification and brief advice programmes delivered within general hospitals to identify at risk individuals. Department of Health (DoH London, July 2009) identified that substance misuse liaison services can generate considerable real cost savings achieved through: reduced length of stay, fewer re-attendances and lower readmission rates. They estimated that for every £1m invested at a population level up to 1,200 alcohol-related hospital admissions could be averted, equivalent to £1.7m savings or net £0.7m savings. In practical terms, one substance misuse liaison practitioner with salary costs equivalent to 30 'average' hospital admissions per year could save an estimated 150 admissions per year. Importantly, there is increasing evidence that these services bring about longer term reductions in substance misuse and consequently improved health status.

<u>Regional Commissioning priority</u>

- The current level of substance misuse liaison services should be enhanced to meet the national benchmark guideline of 4 WTE practitioners per 250,000 of the population. Current provision is 10 WTE across the region. An additional 18 posts are required.

8.13 Service Aims

8.13.1 The two main service aims are (a) identifying people with substance-related problems and provision of structured advice/interventions, and (b) reducing substance-related hospital admissions, reducing length of stay and reducing future re-attendances. Substance Misuse Liaison Networks should be established by each HSCT to ensure that an action plan for addressing alcohol and drug related harm is in place on acute trust sites. Terms of Reference should encompass relevant care pathway issues including self-harm, maternity/peri-natal health, mental health, CAMHS and also the interfaces with primary care and the community/voluntary sector.

8.13.2 Substance Misuse Liaison teams working within acute general hospitals will undertake the following:

8.14 Direct work

8.14.1 Undertake drug and alcohol-related case-finding and delivery of brief advice and structured brief interventions within the Emergency Department and general hospital setting.

8.14.2 Contribute to the management of patients identified with substance-related problems (i.e. assist with medical detoxification process) and/or arrange input from other medical services.

8.14.3 Liaise with community based and other specialist services and also work with other relevant services/teams, in particular those undertaking self-harm, child/family care and crisis related work also the community/voluntary sector.

8.14.4 This objective includes the development/implementation of policies, procedures and care pathways for the management of individual presenting with harmful/hazardous substance misuse and also dependent use.

8.15 Indirect work

8.15.1 Improving the capacity of Trust staff:

Individual liaison practitioners will inevitably target their direct service inputs upon Emergency Departments and admission/assessment wards. However, targeted strategies will miss a significant proportion of those with harmful/hazardous substance misuse, particularly those with more latent problems, i.e. individuals admitted to non acute wards, maternity services, etc. Highly targeted/specific strategies are noted in some national level documents, e.g. to address the top 30 most frequent repeat attenders.

8.15.2 Training the wider range of medical/nursing staff, particularly those undertaking assessment functions, to better identify patients with latent problems is therefore a vital component of the liaison practitioner's role. This training will enable hospital staff to provide brief advice (circa 5 minutes duration) and undertake appropriate

referral where necessary. This can be achieved through training which focuses upon identification (screening tools) and provision of brief advice and motivational skills training in the hospital setting.

8.15.3 Service provision models must take account of and reflect the regionally agreed integrated care pathway referenced elsewhere in this document and therefore ensure appropriate liaison arrangements are in place regarding other Tiers of service provision / other agencies.

8.16 Identification and Referral

8.16.1 Referrals from the Emergency Department and all in-patient wards will be accepted with medical, surgical, maternity and other admission/assessment wards likely to be the main referral source/priority.

8.17 Screening and assessment tools

8.17.1 An initial key task will be roll out, training and usage of the Audit / Audit-C tool – this will need to be incorporated within usual Trust assessment procedures at the time of Emergency Department presentation or ward admission.

8.18 Brief Advice & Structured Brief Interventions

8.18.1 Recent studies note the importance of intervening promptly at the 'treatable moment', i.e. at the time the practitioner 'detects' an individual with harmful/dependent use. This is where the practitioner endeavours to maximise the opportunity when a patient may be highly motivated to act on advice and change behaviour thereafter.

8.18.2 To maximise the likelihood of positive outcomes, it is therefore important that individuals identified with substance related problems receive structured advice, interventions and, if necessary, referred promptly to specialist community and/or Trust services.

8.18.3 Where longer term follow up and interventions are required, the process of referral to the receiving service/agency should be enacted ideally within 24 hours (max 48 hours). Otherwise, dis-engagement & non-attendance are more likely and the opportunity to intervene is lost.

8.18.4 Failure to provide advice, interventions and appropriate follow up could mean the individual re-presents later in an even worse condition/in a crisis – the opportunity costs are therefore high.

8.18.5 In terms of providing structured advice and interventions, Trusts services will:

- Identify and agree content of 'Brief Advice', i.e. the structured content lasting circa 5 minutes duration –there is a need to identify which staff will undertake and deliver this role;

- Identify and agree content of 'Brief Interventions', i.e. approx 30 minutes duration – in general this will be undertaken by the dedicated substance misuse liaison practitioners and potentially also other trained Trust staff, e.g. from mental health, maternity wards, cancer units, etc;

- Develop and deploy 'take away' resources following discharge (e.g. Advice packs);

- Identify and agree potential follow-up interventions (for post detoxification and/or higher risk clients), including telephone follow up post interventions (undertake re AUDIT / additional advice).

8.18.6 In general, moderate-severely dependent individuals will require onward referral to Trust specialist substance misuse services and in this respect the liaison practitioner has a key role in motivation and preparation (of the individual) for this next stage of care.

8.19 Outcomes

- Reduction in number of people attending and re-attending Emergency Departments for alcohol/drug related concerns;

- Increase in the number of patients receiving screening and brief interventions.

8.20 Low Threshold Services

8.20.1 Services described as low threshold are those which adopt a harm reduction approach. They make minimal demands on the patients and do not attempt to control their substance use. Low threshold services are accessible and have minimum criteria to restrict who can access. While low threshold services do not require that the client undergoes counselling or other healthcare interventions, these may be offered.

8.20.2 The following types of low threshold harm reduction services are currently provided in Northern Ireland

- Pharmacy based Needle Syringe Exchange Schemes;

- Drug and Alcohol Outreach Services;

- Drop-in/Day Services for Chronic Drinkers;

- Specialist health care support within specialist accommodation provision.

8.21 Overview of the evidence

8.21.1 In reviewing the evidence of effectiveness of low threshold services it is widely acknowledged that measuring the impact of such work through randomised control

trials has ethical and moral concerns and as such there was no research of this standard to consider.

8.21.2 However, there is a strong tradition of commissioning these services from a pragmatic social and health care point of view. The approach gained considerable ground in the mid 1980's with the emergence of human immunodeficiency virus (HIV) epidemics in many countries. In addition to this a considerable amount of good practice has emerged through the need to provide help and support to homeless people.

8.21.3 Broadly speaking the evidence and policy recommendations can be summarised as follows;

- Harm reduction interventions such as needle exchange, advice and information on safer injecting, reducing injecting and preventing overdose should be locally available;

- People with alcohol misuse problems unwilling or unable to consider receiving formal treatment should be able to access advice and information about drugs and alcohol and basic health care;

- Low threshold services play a key role in supporting people into treatment as part of a stepped care approach;

- Homeless people's substance misuse cannot be addressed without also addressing their housing problems.

<u>Regional Commissioning Priorities</u>

- Pharmacy based Needle Syringe Exchange Schemes should be commissioned to meet the needs of local drug using populations;

- HSCB/PHA should consider joint commissioning initiatives with NIHE and Supporting People in the further development of low threshold services.

<u>Local Commissioning Priorities</u>

- Non Pharmacy based Needle Syringe Exchange Schemes should be commissioned where appropriate;

- Low threshold harm reduction services should be available in each HSCT area for those who misuse alcohol and drugs but are unable to access formal treatment services. (Such services may be stand alone or integrated within broader health services, homeless and or accommodation services).

8.22 Role and function of Needle Syringe Exchange Schemes

General Service Aims

8.22.1 Reduce the transmission of blood-borne viruses (BBV) and other infections caused by sharing injecting equipment by providing;

- needles and syringes and other equipment used to prepare and take illicit drugs (for example, filters, mixing containers and sterile water);
- advice on safer injecting;
- encouragement to switch to non-injecting methods of drug taking;
- information on safe disposal of injecting equipment.

8.22.2 Signpost towards blood-borne virus testing, vaccination and treatment services.

8.22.3 Provide information on recovery services (for example, opioid substitution therapy (OST).

8.22.4 Provide other health and welfare services (including condom provision).

8.22.5 Reduce the risk of overdose through advice on how to avoid this, and through providing information on how they can obtain take-home Naloxone.

8.23 Specific Functions

- Provide people who inject drugs with needles, syringes and other injecting equipment. The quantity dispensed should not be subject to an arbitrary limit but, rather, should meet their needs. Where possible, needles and syringes should be made available in a range of sizes;
- Ensure people who use NSPs are provided with sharps bins and advice on how to dispose of needles and syringes safely;
- Encourage people using the scheme to return their used needles in the sharp boxes provided;
- Provide other injecting equipment associated with illicit drug use and encourage people who inject drugs to switch to other methods of drug use;
- Encourage people who inject drugs to stop using drugs (for example, opioid substitution therapy); and address their other health needs. Advise them where they can access these services;
- Offer advice and information on, and referrals to, services which aim to: reduce the harm associated with injecting drug use, including take-home Naloxone services;

- Ensure staff working in Pharmacy based schemes and more specialist schemes are competent to deliver the level of service offered;

- Engage with service users to increase the benefits which they can get from using needle exchange services.

8.24 Role and function of Low Threshold Harm Reduction Services

General Service Aims

8.24.1 Provide accurate, objective information about drugs and/or alcohol and their effects and support to individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels.

8.24.2 Provide care and support to those individuals who are not willing/able to access treatment services in order to reduce the level of drug and/or alcohol related harm reflecting a person centred approach to care.

8.24.3 Provide prompt and flexible access including out-of-hours, drop in provision where possible.

8.24.4 Ensure appropriate liaison and engagement with service users and their families.

8.24.5 Assess need comprehensively and match need with appropriate evidence based interventions and arrange input from other relevant agencies where necessary.

8.24.6 Work closely with statutory and non statutory providers to ensure that service users can access support in relation to housing, employment and education.

8.24.7 Work within a stepped care approach ensuring that where necessary clients can be referred for treatment where necessary.

8.25 *Specific Functions*

- Offer advice and information including basic drug and/or alcohol information including information and advice on safer injecting and overdose;

- Undertake screening and assessment of each individual accessing support;

- Provide or facilitate access to nursing support/interventions for the provision of;

    - Conducting healthcare assessments;

    - Wound care;

    - Sexual health screening, testing and providing related information;

    - Blood-borne virus testing, vaccination including pre and post test counselling and follow up;

    - Ensuring compliance with hepatitis C treatment.

- Offer needle exchange including provision for steroid users (Drug Outreach);

- Provide social and psychological support;

    - Consider providing contingency management schemes to improve physical healthcare for all people at risk of physical health problems (including transmittable diseases);

    - Provide opportunistic brief interventions focused on motivation to people in limited contact with services. These interventions should normally consist of two sessions each lasting 10–45 minutes exploring ambivalence about use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

- Provide or facilitate access to employment and training programmes;

- Provide or facilitate access to specialist accommodation.

8.26 Care Pathways

8.26.1 The development of a stepped care approach in which low threshold services are a key stakeholder is very important and arrangements for developing treatment service pathways are outlined elsewhere in this framework.

8.26.2 It is also essential that low threshold services develop strong partnership working arrangements with homeless services given the nature of the client group that these services work with.

8.27 Outcomes

- Reduction in the levels of Hepatitis B, C and HIV infections;

- Reduction in the number of people overdosing;

- Increase in the uptake of Hepatitis B and C testing and treatment;

- Reduction in alcohol use;

- Reduction in drug use;

- Improvement in mental and emotional health;

- Improvement in physical health;

- Improved relationship with family members.

8.28 Community Based Treatment and Support

8.28.1 Community based treatment and support is provided by Health and Social Care Trust Community Addiction Services and Voluntary/Community Service provision. This section will clarify the roles and responsibilities of both providers. In addition it will describe what arrangements need to be in place to ensure quality in delivery of psychological interventions and that a stepped care approach is in place to meet the needs of substance misusers.

8.29 Overview of the evidence

8.29.1 There is a considerable body of evidence from international studies which consistently show that treatment leads to improved outcomes namely; reductions in substance misuse and offending, in harmful behaviours associated with such use, and improvements in mental wellbeing and social functioning. Treatment for substance misuse includes both pharmacological and psychological support. The Drug Treatment Outcomes Research Study estimated that treatment was cost effective. For every £1 spent, an estimated £2.50 was saved and drug treatment was overall found to be cost beneficial in 80 per cent of cases.

8.29.2 There is also emerging evidence that support for the carers of substance users has an impact upon the substance user, including getting reluctant users into treatment, reducing their use and making better progress through treatment.

8.29.3 Criminal justice interventions also show positive results. This is critically important given the level of substance misuse within this population.

Regional Commissioning priorities

- Specialist services assisting GPs in managing patient withdrawal from prescribed drugs should be available in each HSCT area;
- Ensure Community Addiction Services are adequately resourced meet the NICE target of 1 in 6 receiving treatment per year. This equates to a 60% increase in the number of alcohol misusing individuals in treatment using the figure of 4402 (alcohol only or alcohol and drugs from the treatment services census) as the baseline;
- A shared care substitute prescribing service should be available across all Trust areas, and patients should be managed as part of a shared care arrangement once their opioid substitute treatment has been sufficiently stabilised by Trust services. Patients should be managed in line with Northern Ireland Primary and Secondary Care Opioid Substitute Treatment Guidelines (Draft 2012);
- Interventions targeting people within the criminal justice system should be available in Northern Ireland;

- Contingency management (CM) schemes should be piloted in Northern Ireland.

Local Commissioning Priorities

- Adult voluntary/community treatment service(s) should be in place within each HSCT area working with Statutory Community Addiction services within a stepped care approach;

- All those who are at risk of blood borne viruses attending Community Addiction Teams, or in other settings such as prisons, should be offered annual testing for HBV, HCV and HIV. Blood spot testing should be available for those in whom venous access is difficult or where further referral would be otherwise necessary;

- All opioid dependent clients attending Community Addiction Teams and in prison should be offered Naloxone to reduce the risk of overdose.

8.30 Role and Function of Statutory Substance Misuse services

8.30.1 In terms of service structure, there are two main components.

8.30.2 Medically managed day treatment units
- This is typically provided in a suitable community facility that is able to provide assisted alcohol and/or drug withdrawal and also capacity to provide post detoxification/withdrawal intensive care programmes of circa 2-3 weeks duration.
- *Community-based assisted withdrawal:*
- *Structured day programmes.*

8.30.3 Medically managed, or monitored, Community Addiction Services
- *Harm Reduction*
- *Substitute Prescribing Services*
- *Counselling and Psychological support.*

8.31 General Service Aims

8.31.1 Services should deliver the following:

8.31.2 Services provided must be in line with the recommendations arising from the recent HSC.Board/PHA review of Addiction services (2011). Service provision must explicitly take account of evidence based practice and guidance, i.e. NICE guidance (2011), National Treatment Agency (2006), Specialist Clinical Addiction Network (SCAN, 2006) and Department of Health (2009).

8.31.3 Ensure timely access to specialist substance misuse/addiction services for adults and their families in line with existing regional IEAP and elective care

targets/requirements. This includes management of those who “Did Not Attend” (DNAs) and vulnerable groups.

8.31.4 Provide care in accordance with the regional Integrated Care Pathway (ICP) and reflecting the stepped care approach, i.e. aligning need to interventions delivered at the lowest appropriate step (in the first instance) and 'stepping up' to more intensive/specialist services as clinically required.

8.31.5 Providers must work towards consistent implementation of the ICP in terms of referral/access criteria, undertaking assessment/diagnosis and provision of intervention/support services.

8.31.6 Assess need comprehensively and match need with appropriate evidence based interventions (i.e. reflecting evidence referenced under #1 above) and arrange input (with joint care planning) from other relevant agencies where necessary.

8.31.7 Coordinate care for people with complex needs, e.g. referrals from criminal justice, homeless people, pregnant women, older people, and people with co-morbidities such as mental health problems and/or liver disease. Ensure appropriate service provision and coordination of care for adults for who there are safeguarding concerns, in all settings.

8.31.8 Provide care and support that reflect a recovery ethos and ensure appropriate liaison and engagement with service users and their families.

8.31.9 Offer consultation, advice and outreach support to Tier 1/2 services and providers, including primary care, general mental health services and other appropriate providers (non statutory sector) that require assistance regarding the management of individuals under their care.

8.31.10 Assist in wider HSC efforts to raise general population awareness of substance misuse related harm and facilitate local development of early intervention initiatives (in particular screening and brief interventions). This includes substance misuse liaison services working within general hospitals (and in particular Emergency Departments).

8.31.11 Services should have capacity to manage clients with a learning disability.

8.32 Specific functions

8.32.1 Each locality Tier 3 service model must encompass the following <u>seven</u> service components.

8.32.2 In general, many of these functions require service delivery to be undertaken by professionally qualified staff who are supervised and appropriately regulated (i.e. subject to national regulatory body).

8.32.3 **Assessment and diagnosis**, including provision of:

a. Screening & initial assessment – using regionally agreed and validated tools for early identification and comprehensive assessment;

b. Comprehensive medical and psycho-social assessment/diagnosis;

c. Identification of medical/psychiatric co-morbidities and co-existing conditions (and where necessary arrange input from other teams/services).

8.32.4 **Interventions and therapies** - undertaken on an individual or group basis as appropriate:

a. Extended brief interventions with particular vulnerable groups;

b. Formal psychological therapies – motivational interviewing, cognitive behavioural therapy, relapse management therapy, counselling and Behavioural Couple's Therapy.

8.32.5 **Detoxification and stabilization** – assisting with / undertaking community/home based programmes (provision will reflect the ICP).

8.32.6 **Substitute Programmes:** substitute prescribing and intervention programme – provided in accordance with Northern Ireland Primary and Secondary Care Opioid Substitute Treatment (Draft) Guidelines October 2012.

8.32.7 **Prescribing:** provision and management of pharmacological interventions as part of the overall substance misuse treatment process.

8.32.8 **Specialist substance misuse liaison service** (provided in partnership with Tier 2 providers)

a. Substance misuse liaison service: working across a range of medical, surgical, Emergency Departments and other hospital interfaces. Offer consultation, advice and outreach support;

b. Child and Family Care / Social Work liaison – assisting with the wider range of teams/services across Trusts. Ensure appropriate liaison occurs with family support services and gateway services as laid out in HSCB Adult and Children's Services Joint Protocol: Responding to the needs of children whose parents have mental health and/or substance misuse issues. September 2011.

c. Criminal Justice intervention / liaison services and assisting with associated schemes (court diversion).

8.32.9 **Dual Diagnosis:** co-working individual cases with community mental health teams (where there are significant co-existing substance misuse and psychiatric conditions).

8.33 Outcomes

- Reduction in alcohol use/related harm;
- Reduction in drug use/ related harm;
- Improvement in mental and emotional health;
- Improvement in physical health;
- Improved relationship with family members;
- Increase in the uptake of Hepatitis B and C testing and treatment.

8.34 Role and Function of Voluntary Sector Service Provision

8.34.1 The voluntary and community sector often provides specialist services targeting specific and hard to reach groups. In Northern Ireland this is particularly the case in the development of Hidden harm services, youth treatment and low threshold services. These services are addressed elsewhere in this framework.

8.35 General Service Aims

8.35.1 Services should deliver the following:

1. Provide care and support that offer both a harm reduction and recovery ethos reflecting a person centred approach to care.
2. Provide formal psychological therapies – motivational interviewing, cognitive behavioural therapy, relapse management therapy, behavioural couple's therapy.
3. Ensure practitioners have the appropriate knowledge and skills to ensure they are competent to deliver effective interventions.
4. Ensure appropriate liaison and engagement with service users and their families.
5. Assess need comprehensively and match need with appropriate evidence based interventions and arrange input from other relevant agencies where necessary.
6. Work closely with statutory and non statutory providers to ensure that service users can access support in relation to housing, employment and education.
7. Work within a stepped care approach ensuring that where necessary clients can be referred for additional treatment where necessary.
8. Provide care and support that reflect a recovery ethos and ensure appropriate liaison and engagement with service users and their families.
9. Services should have capacity to manage clients with a learning disability.

10. Raise general population awareness of substance misuse related harm and facilitate local development of early intervention initiatives (in particular screening and brief interventions).

8.36 Specific Functions

8.36.1 All

- Screening & initial assessment – use a regionally agreed and validated tools for early identification and assessment of need. (Appendix C);
- Undertake an initial psycho-social assessment to inform an appropriate treatment;
- Onward referral to statutory Step 3 Services upon identification or suspected signs of co occurring complex physical or psychological conditions and in all cases injecting drug misuse;
- Ensure appropriate liaison occurs with family support services and gateway services as laid out in HSCB Adult and Children's Services Joint Protocol: Responding to the needs of children whose parents have mental health and/or substance misuse issues. September 2011.

8.36.2 Step 2

- Delivery of **low intensity** interventions undertaken on an individual or group basis as appropriate (maximum of six 20-30 minute sessions);
- Guided Self Help;
- Extended brief interventions: extended brief intervention lasting 20-30 minutes, with follow-up and assessment, and where necessary up to 4 additional sessions;
- Motivational interviewing;
- Relapse Management therapy;
- Provide advice on or facilitate access to education, employment and housing advice.

8.36.3 Step 3

- Delivery of **high intensity interventions** undertaken on an individual or group basis as appropriate
    - guided self help;
    - motivational interviewing;

- cognitive behavioural therapy*;
- relapse management therapy*;
- behavioural couple's therapy.

*(recommended level of **twelve** 50-60 minute sessions)

- Ensure appropriate liaison occurs with family support services and gateway services as laid out in HSCB Adult and Children's Services Joint Protocol: Responding to the needs of children whose parents have mental health and/or substance misuse issues. September 2011;
- Provide advice on or facilitate access to education, employment and housing advice;
- Criminal Justice intervention / liaison services and assisting with associated schemes (court diversion).

8.37 Outcomes

- Reduction in alcohol use/related harm;
- Reduction in drug use/ related harm;
- Improvement in mental and emotional health;
- Improvement in physical health;
- Improved relationship with family members.

8.38 Regional Impact Measurement Tool

8.38.1 As a condition of the funding received from the Public Health Agency, treatment services are required to complete and submit IMT returns quarterly to DHSSPS.

8.38.2 For adult treatment services progress against the following domains are measured.

1. personal responsibility.
2. social contact/networks.
3. managing physical health.
4. mental and emotional health.
5. daily lifestyle.
6. crime and community safety (includes involvement with the criminal justice system).

7. relationships.

8. alcohol consumption/dependency.

9. drug use/dependency.

10. accommodation.

8.39 Care Pathways

8.39.1 Given the complex nature of addressing a person's substance misuse, it is highly unlikely that one organisation can completely meet their needs.

8.39.2 Centre for Public Health Research noted that in England, local substance misuse treatment and support services have developed over time, being funded from a range of sources. Consequently, individual services often operated in isolation.

8.39.3 It is acknowledged that some good progress has been achieved in Northern Ireland resulting in closer working relationship between HSCT and voluntary services. To build on this and achieve a more integrated system of care, it is proposed that DACT's should play a key role in the establishment of partnerships at both a strategic and operational level.

8.39.4 At strategic level, the DACT's in partnership with the HSCT'S, PHA and HSCB should agree:

- the aims and objectives of an integrated service;
- the range of services that could or should be engaged;
- the arrangements for sharing information;
- the arrangements for multi-agency training to promote mutual understanding of roles, monitoring and evaluation arrangements;
- common or core assessment procedures and data sets;
- systems and protocols for referral and joint working.

8.39.5 See proposed care pathway below. The stepped care approach is similar to the 4 Tiers of Service Delivery outlined in the New Strategic Direction on Alcohol and Drugs 2011-2016.

8.39.6 A stepped care model defines and clarifies the service area, condition and threshold criteria and will inform both commissioning and service provision. This model describes services provided for over 18 years and is defined across four steps:

8.39.7 Step 1 ***Universal health and well-being /self help.***

8.39.8 Step-2 ***Targeted Intervention*** -This involves early detection and provision of preventative support to people and their families in need. Intervention at this step is provided to those people who are experiencing substance misuse difficulties with or without mental health/emotional difficulties; which are impacting the person's and/or families psychological / social / educational functioning. At this step structured self-help approaches, behavioural, and/or family support are provided to reduce the impact of such issues and prevent their escalation to greater/more significant difficulties.

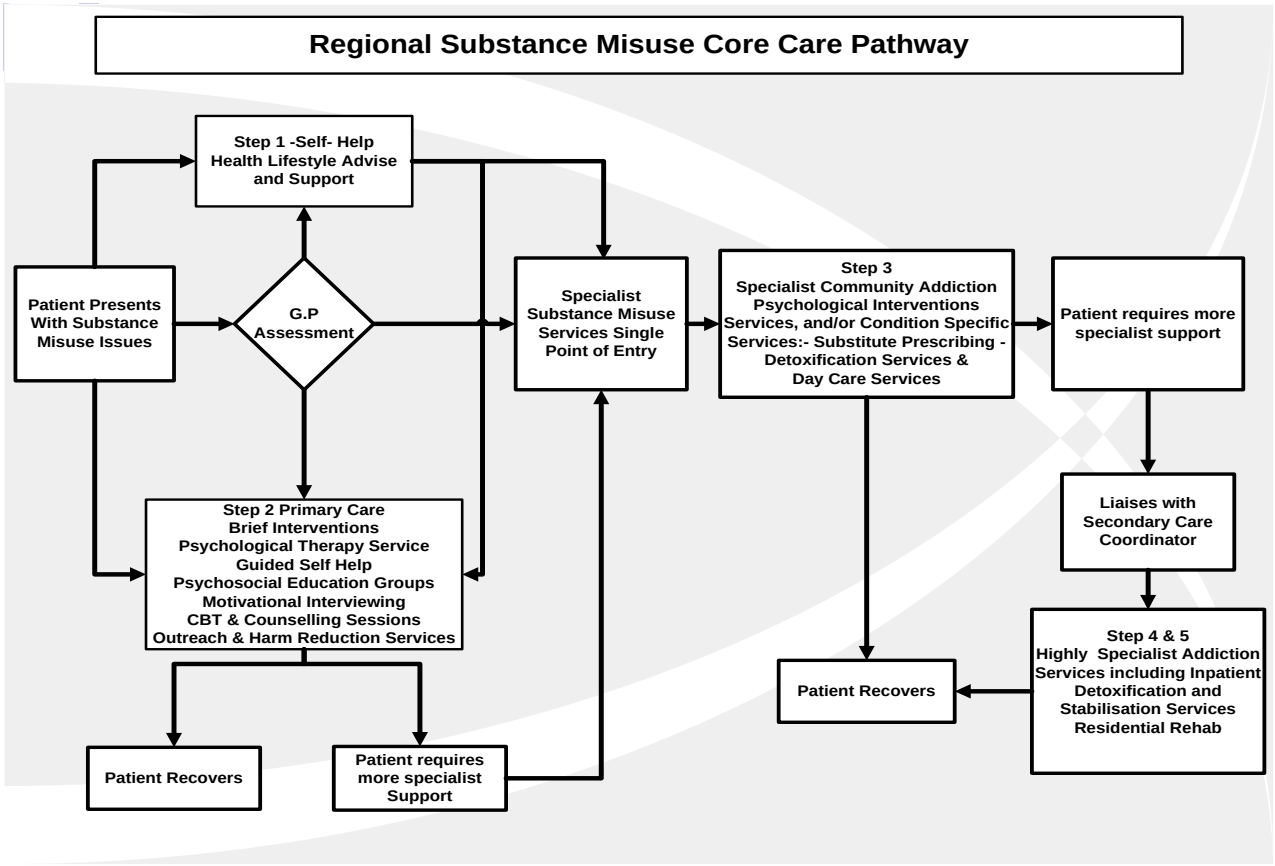
8.39.9 Step-3 ***Specialist Community Intervention*** - This involves specialist diagnostic assessment and the provision of psychological, and/or pharmacology therapy. Intervention at this step is provided to those experiencing moderate to severe substance misuse which is having a significant impact on daily psychological /social/ educational functioning. Intervention at this step is normally provided through specialist / specific multidisciplinary teams with some Psychological interventions provided by Community/Voluntary as well as Statutory services.

8.39.10 Step-4 ***Specialist Inpatient (detoxification).*** Care at this step is provided for those who are experiencing highly complex physical issues associated with their alcohol and /or drug misuse and require in-patient medically managed assisted withdrawal. At this level the person will require the input of community psychological interventions to continue post inpatient discharge.

8.40 Specialist Inpatient Rehabilitation

8.40.1 Care at this stage is for those who require a comprehensive 4-6 week inpatient rehabilitation programme which also provides support and family interventions/couples therapies.

Regional Substance Misuse Core care Pathway



8.41 Inpatient and Residential Rehabilitation Provision

8.41.1 Tier 4 provision should be targeted upon individuals with specific care needs and reflect the regionally agreed criteria for admission/referral. Service provision, regionally, should be based upon (a) 'medically managed' stabilisation/detoxification treatment services, i.e. HSC Trust provided and hospital based, and (b) rehabilitation services, primarily community/non-statutory sector based.

8.41.2 These services will primarily target individuals who misuse substances in a harmful or dependant way and where there is evidence of significant adverse impact upon daily psychological, social or physical functioning.

8.41.3 Future HSC/Trust Tier 4 provision will focus mainly upon the stabilisation/detoxification function and must reflect the Integrated Care Pathway (ICP). Provision will be based upon a total of 24 in-patient/hospital beds and reconfigured to be provided in fewer sites than is currently the case. A total of circa 500 in-patient care episodes will be provided per year. Services will encompass capacity to undertake comprehensive assessment and diagnosis, stabilization/detoxification and the provision of specialist psychological, systemic and/or pharmacology interventions.

8.41.4 Tier 4 rehabilitation provision, which, is overseen by contracts with the independent sector for defined services and activity, must again reflect the Integrated Care Pathway.

8.42 Overview of the evidence

8.42.1 The HSC.Board/PHA review of Tier 4 provision identified key NICE/SCAN/NTA guidance that most people with harmful/dependent substance misuse can be successfully cared for within community (Tier 3) settings.

8.42.2 Evidence does not show, *in general*, any additional benefit from hospital/residential-based interventions compared to community based programmes. For example, taking the overall heterogeneous 'alcohol misuse' population, the consistent finding is of comparable (or better) outcomes from community based as opposed to in-patient/residential based treatment.

8.42.3 Recent guidance from NICE provides criteria (treatment of Alcohol) to assist in determining which clients are likely to benefit from in-patient/residential services. In summary, NICE note that only a numerically small, discrete number of client groups are likely to benefit from Tier 4 services, i.e. compared to robust, adequately resourced, community based care options at Tier 3.

Regional Priorities

Inpatient and residential rehabilitation provision should be reconfigured in order to ensure a reduction in regional variation and ensure equity of access based on need.

- A total of 500 in-patient/hospital based treatment stabilisation/detoxification episodes are required regionally;
- A total of 200-300 residential rehabilitation episodes are required regionally.

- Consider the need for the development of a regional coordination role to ensure that inpatient and residential access is managed based on patient need and priority.

8.43 Regional Treatment Services Network Forum

8.43.1 A regional Integrated Care Pathway for substance misuse treatment should be established. This will be facilitated by the establishment of a regional 'Treatment Services Network' forum (this will focus upon implementation of the pathway, i.e. practice development, specialist training and outcome monitoring/ audit).

8.44 Service Aims: Inpatient Treatment

8.44.1 Services should deliver the following:

1. Services provided must be in line with the recommendations arising from the recent HSC.Board/PHA Review of Addiction Services (2011). Service provision must explicitly take account of evidence based practice and guidance, i.e. NICE guidance (2011), National Treatment Agency (2006), Specialist Clinical Addiction Network (SCAN, 2006) and Department of Health (2009).

2. Ensure timely access to specialist substance misuse/addiction services for adults and their families in line with existing regional IEAP and elective care targets/requirements. This includes management of those who "Did Not Attend" (DNAs) and vulnerable groups.

3. Provide care in accordance with the regional Integrated Care Pathway (ICP) and reflecting the stepped care approach.

4. Providers must work towards consistent implementation of the ICP in terms of referral/access criteria, undertaking assessment/diagnosis and provision of intervention/support services.
5. Assess need comprehensively and match need with appropriate evidence based interventions (i.e. reflecting evidence referenced under #.1 above) and arrange input (with joint care planning) from other relevant agencies where necessary.

6. Coordinate care for people with complex needs, e.g. referrals from criminal justice, homeless people, pregnant women, older people, people with co-morbidities such as mental health problems and/or liver disease. Ensure appropriate service provision and coordination of care for adults for whom there are safeguarding concerns, in all settings.

7. Provide care and support that reflect a recovery ethos and ensure appropriate liaison and engagement with service users and their families.

8. Services should have capacity to manage clients with a learning disability.

8.45 Specific functions

8.45.1 The Tier 4 service model must encompass the following specific functions:

8.45.2 **Assessment and diagnosis**, including provision of:

- Screening & initial assessment – using regionally agreed and validated tools for early identification and comprehensive assessment;

- Comprehensive medical and psycho-social assessment/diagnosis;

- Identification of medical/psychiatric co-morbidities and co-existing conditions (and where necessary arrange input from other teams/services).

8.45.3 **Interventions and therapies** - undertaken on an individual or group basis as appropriate:

- Specialist counseling;

- Formal psychological therapies – motivational interviewing, cognitive behavioural therapy, relapse management therapy, behavioural couple's therapy.

8.45.4 **Detoxification and stabilization provision**;

8.45.5 **Substitute Programmes**: substitute prescribing and intervention programme – provided in accordance with Northern Ireland Primary and Secondary Care Opioid Substitute Treatment (Draft) Guidelines October 2012;

8.45.6 **Prescribing**: provision and management of pharmacological interventions as part of the overall substance misuse treatment process;

8.45.7 **Dual Diagnosis**: managing those with co-existing substance misuse and psychiatric conditions).

8.46 Outcomes

- Number of people detoxed;
- Number of people maintaining abstinence 6 months after inpatient treatment;
- Number of people stabilised on Substitute Prescribing;
- Number of people remaining stabilised on Substitute Prescribing after 6 months.

Service Aims: Residential provision

8.46.1 With regard to Tier 4 rehabilitation provision, an overall regional contract will be drawn up for defined levels of service activity and which reflects the Integrated Care Pathway. Service providers will be identified through the appropriate regional procurement/tendering processes.

8.47 General Service Aims

8.47.1 Services should deliver the following:

1. Services provided must be in line with the recommendations arising from the recent HSC.Board/PHA Review of Addiction Services (2011). Service provision must explicitly take account of evidence based practice and guidance, i.e. NICE guidance (2011), National Treatment Agency (2006), Specialist Clinical Addiction Network (SCAN, 2006) and Department of Health (2009).

2. Ensure timely access to specialist substance misuse/addiction services for adults and their families in line with existing regional IEAP and elective care targets/requirements. This includes management of those who “Did Not Attend” (DNAs) and vulnerable groups.

3. Provide care in accordance with the regional Integrated Care Pathway (ICP) and reflecting the stepped care approach.

4. Providers must work towards consistent implementation of the ICP in terms of referral/access criteria, undertaking assessment/diagnosis and provision of intervention/support services.

5. Assess need comprehensively and match need with appropriate evidence based interventions (i.e. reflecting evidence referenced under #1 above) and arrange input (with joint care planning) from other relevant agencies where necessary.

6. Coordinate care for people with complex needs, e.g. referrals from criminal justice, homeless people, pregnant women, older people, people with co-morbidities such as mental health problems and/or liver disease. Ensure appropriate service provision and coordination of care for adults for whom there are safeguarding concerns, in all settings.

7. Provide care and support that reflect a recovery ethos and ensure appropriate liaison and engagement with service users and their families.

8. Assist in wider HSC efforts to raise general population awareness of substance misuse related harm and facilitate local development of early intervention initiatives (in particular screening and brief interventions).

9. Services should have capacity to manage clients with a learning disability.

8.48 Specific functions

8.48.1 The Tier 4 rehabilitation service model must encompass the following specific functions:

- Assessment, including provision of:
    - Initial assessment – using regionally agreed and validated tools for comprehensive assessment.
- Delivery of formal psychological therapies undertaken on an individual or group basis as appropriate:
    - motivational enhancement therapy, cognitive behavioural therapy, relapse management therapy, behavioural couple's therapy.
- Facilitate access to follow on accommodation where appropriate.

8.49 Outcomes

- Number of people showing a reduction in alcohol use/related harm;
- Number of people showing a reduction in drug use/related harm;
- Improvement in mental and emotional health;
- Improvement in physical health;
- Improved relationship with family members.

9.0 SECTION THREE: CAPACITY

9.1 Service User and Family Involvement

9.1.1 Service user involvement

A national project carried out by the Joseph Rowntree Foundation with 126 service users found that service users highlighted two activities as central to making user involvement work. These are:

1. People being able to mutually support to each other and work together to change things.

2. Having their experience, views and ideas heard.

9.1.2 The project also found the following:

- Service user organisations and individual service users are often isolated. Funding which is not secure and has a low profile will only be able to offer limited involvement for service users;

- Service users see effective user networking as crucial for positive participation. What is needed is a national database of service user organisations, controlled by service users, and a national user-led network, with enough money and staff, which offers support, information exchange, improved communication, contacts, advice on good practice and a national voice;

- Service users feel that their knowledge is generally not valued or taken seriously by professionals, policy makers, and services. The closed culture of health and social care services, and their own lack of resources, makes it harder for them to develop and share their knowledge;

- Service users see user-led training and education, a commitment to change in services, the inclusion of diverse service user perspectives and more support for service user networking as key to strengthening service user knowledge and enabling it to have greater impact on policy and services.

9.2 Defining service users

9.2.1 The definition of a service user has been debated generally. Traditional definitions have sometimes focused only on people who are current or past service users, and who use this experience to help shape services. However, there is a shift towards the term “experiential experts”. This term acknowledges the valuable experience that someone who has had experience of drug and alcohol misuse can bring, regardless of whether they have been or are using or shaping services. Including experiential experts in

service user groups ensures that those who are excluded from or who have excluded themselves from services have their voices heard. Throughout this paper, the term *service users* will also refer to experiential experts.

Regional Commissioning Priorities

- Commission a Service User Network to enhance involvement of adult service users in the planning of alcohol and drug services.

Local Commissioning Priority

- Ensure commissioned alcohol and drugs services demonstrate effective user involvement.

9.2.2 A series of workshops with service users in Northern Ireland during 2011-2012, aimed at identifying service users' needs, supported the above findings. The workshops brought service users together to agree a model for service user involvement in Northern Ireland. The model is outlined below.

9.3 Northern Ireland model for service user involvement

9.3.1 The following model was proposed by and agreed on by service users:

9.3.2 Establishment of a steering group with local service user representation to oversee the development of the model.

9.3.3 Development of five local networks (co-terminous with Trusts and DACTs) coordinated by a Network Support Service. The local networks would feed into one regional network.

9.3.4 The specific services provided by the network support service will be agreed by the steering group, but would be likely to include the following:

- Organise local network meetings;
- Support new service user groups in the area;
- Support service users to represent their own views and the views of other service users on relevant groups (e.g. Drug and Alcohol Coordination Teams; Naloxone Steering Group; Substitute Prescribing Steering Group; Bamford Drug and Alcohol Subgroup);
- Provide information to service user groups (e.g. on relevant consultations or fundraising opportunities);

- Provide support and advice around fundraising (not including actual fundraising activity);

- Provide support and advice to services working in the substance misuse field on developing service user participation;

- Coordination of training provision.

9.4 Outcomes

- Service users are proactively involved in the identification, assessment and planning of care for their mental health needs;

- Service users are proactively involved in the implementation of the New Strategic Direction on Alcohol and Drugs 2011-2016.

9.5 Family Involvement

9.5.1 There is emerging evidence that support for the families and carers of substance users has an impact upon the substance user, including getting reluctant users into treatment, reducing their use and making better progress through treatment.

9.5.2 NICE recommends that services should provide the following support to carers;

- Encourage families and carers to be involved in the treatment and care of people who misuse substances to help support and maintain positive change;

- When families and carers are involved in supporting a person who misuses substances, discuss concerns about the impact of substance misuse on themselves and other family members, and:

    - provide written and verbal information on substance misuse and its management, including how families and carers can support the service user offer a carer's assessment where necessary;

    - negotiate with the service user and their family or carer about the family or carer's involvement in their care and the sharing of information; make sure the service user's, families and carer's right to confidentiality is respected.

- When the needs of families and carers of people who misuse substances have been identified: offer guided self-help, usually consisting of a single session, with the provision of written materials provide information about, and facilitate contact with, support groups (such as self-help groups specifically focused on addressing the needs of families and carers);

- If the families and carers of people who misuse substances have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, consider offering family meetings. These should:
    - provide information and education about alcohol misuse;
    - help to identify sources of stress related to alcohol misuse;
    - explore and promote effective coping behaviours;
    - usually consist of at least five weekly sessions.
- All staff in contact with parents who misuse alcohol and who have care of or regular contact with their children, should:
    - take account of the impact of the parent's drinking on the parent–child relationship and the child's development, education, mental and physical health, own alcohol use, safety, and social network;
    - be aware of and comply with the requirements of the Children Act (2004).

Regional Commissioning Priorities

- All treatment and support services need to deliver a consistent and agreed standard of support for families and as appropriate, opportunities for involvement in their relatives care.

Local Commissioning Priorities

- Treatment and support services should ensure that families receive an appropriate level of support.

9.6 Outcomes

- Improvement in family relationships;
- Increased retention in treatment services;
- Improvement in the mental health of family members.

9.7 Workforce Development

9.7.1 It is estimated that Northern Ireland has some 100,000 people working for government agencies such as healthcare, teachers, Police and Prison Service and nearly 30,000 working in the voluntary sector, many of whom may have contact with people with substance misuse. There is a clear link between skilled and competent staff and improved treatment outcomes and high quality services.

9.7.2 Historically, the delivery and content of training courses and the target audiences has differed across Northern Ireland, resulting in widely different investments, outcomes, and numbers of people trained. A need was identified to develop a regional approach to training which would allow more equitable access to training and alignment to standards across the region, as well as preventing duplication.

9.7.3 Consultation with stakeholders led to eight recommendations on the development of a Northern Ireland workforce development plan. It should:

- take a regional approach;
- be multidisciplinary;
- be free at point of delivery;
- be open to everyone;
- have a short course duration where appropriate;
- meet budgetary constraints;
- be needs led;
- meet the training needs of professionals working with vulnerable populations.

9.7.4 The workforce development priorities will help ensure those working with people who misuse substances have the knowledge and skills and confidence to carry out the work outlined in the Commissioning Framework.

9.7.5 The framework has confirmed the need to equip a wide number of non specialist staff with the skills and knowledge to provide people with information about the potential impact of drug and alcohol use and offer brief advice, support and signposting where relevant. Specific knowledge and skills based courses have been identified through this framework together with those groups and settings that are best placed to carry out these interventions. These groups will be prioritised and are detailed in table below.

Area	Training issue /topic	Target audience
Prevention / Education	Social Media	Professionals delivering Drug and Alcohol Prevention initiatives
	Media Advocacy	DACT's
	Groupwork Facilitation Skills	Professionals delivering drug and alcohol prevention initiatives
Hidden harm	Hidden harm protocol	Addiction services Family and childcare services Voluntary and community sector agencies working on substance misuse Voluntary and community sector agencies working with children in any capacity
Youth treatment	Brief interventions	Youth services
	General alcohol / drugs	Youth services
	Psycho-social Interventions	Specialist youth treatment services
Alcohol brief intervention	Alcohol brief intervention	GPs Criminal Justice Emergency Departments and other hospital staff including midwives Other groups identified as appropriate
	Extended brief interventions	Practice nurses Voluntary and community sector agencies
Low threshold services	First aid and Naloxone administration	Community Addiction Teams Agencies who work with injecting drug users
	Working with injecting drug users	Agencies who work with injecting drug users, including NSP providers
	Substitute prescribing	OST providers, including GPs, pharmacists, CATs
	Working with chronic drinkers	Agencies who work with chronic drinkers
Adult treatment	MI	Professionals who come into contact with substance mis-users to receive introductory training. All workers in substance misuse services trained to a standard level of competency.
	CBT	Introductory course/skills based training for those who already have a counselling accreditation
	Behavioural Couples Therapy	Introductory course/skills based training for those who already have a counselling accreditation
	Relapse Management	All workers in substance misuse services trained to a standard level of competency.
	Providing support to family members	All workers in substance misuse services trained to a standard level of competency.
All Sectors	Appropriate mental health training	Agencies who work with substance misusers

9.7.6 However, there is also a wider need to provide basic information to all staff working in a range of sectors about drug and alcohol misuse. In addition to this, the need to provide an accredited substance misuse qualification as outlined in the model proposed in the workforce consultation paper is still relevant particularly for new staff working in the field.

9.7.7 The commissioning framework has identified a number of key psychological interventions which have a strong evidence base namely;

- Motivational Interviewing;
- Cognitive Behavioural Therapy;
- Behavioural Couples Therapy;
- Relapse Management.

9.7.8 It is not within the remit of the PHA to ensure that staff working within drug and alcohol services are competent in the delivery of all of these interventions. The PHA will concentrate on ensuring that staff working in substance misuse services receive an agreed level of training in Motivational Interviewing and Relapse Management. Introductory courses in CBT and BCT will be provided but it will be the responsibility of services to ensure that their staff obtain the necessary qualifications to practice these therapies.

9.7.9 There are additional workforce development needs which cannot be met by specific drug and alcohol training. This includes the need for staff who work with substance misusers to have access to timely and appropriate support and supervision within their workplace, as well as for them to be able to work within an organisational culture which supports them in carrying out the work outlined in this Commissioning Framework.

<u>Regional Commissioning Priorities</u>

- The following workforce programmes should be in place to support the implementation of the Commissioning framework;
    - Basic and Foundation modules aimed at those with no or little experience of working in drugs and alcohol;
    - An accredited substance misuse course for those working on a daily basis in the substance misuse field;
    - Motivation Interviewing Training;

- Specific knowledge of substance misuse and access to psychological skill based courses;
- 3rd level education courses at both under graduate and post graduate level as required by the service area.

- Mentoring programmes which support the acquisition of new knowledge and skills should be piloted and evaluated to inform future content of workforce mentoring schemes;
- Services should have in place measures to ensure that staff are supported to deliver evidence based interventions through the following means;
  - Use of relevant evidence-based treatment manuals to guide the structure and duration of the intervention and ensure a consistent approach is delivered;
  - Regular clinical supervision for staff from individuals competent in both the intervention and supervision;
  - Routine use of outcome measurement tools and ensuring that the person who misuses alcohol/drugs is involved in reviewing the effectiveness of their treatment plan;
  - Routine monitoring of treatment engagement and adherence;
  - Monitoring to ensure that staff hold a current appropriate registration (as required) and / or qualification and have the knowledge and skills appropriate to the level of intervention offered (See Appendix B).

10. KEY SOURCES OF EVIDENCE

Children, Young People and Families

Education & Prevention and Early Intervention (See Appendix C)

Young People's Treatment

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Early Intervention

Alcohol Screening and Brief Interventions

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http://www.nta.nhs.uk/uploads/psychosocial_toolkit_june10.pdf

Centre for Public Health Research: Integrated care pathway for alcohol services: From guidance to local delivery. 2009
http://www.alcohollearningcentre.org.uk/_library/projects/files/ChaMPs-Integrated_care_pathway_for_Alcohol_Services_148.pdf

INPATIENT/REHABILITATION

Alcohol-use disorders Diagnosis, assessment and management of harmful drinking and alcohol dependence, National Clinical Practice Guideline 115 (NICE, 2011)
http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-cg115

Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service – Specialist Clinical Addiction Network consensus project (SCAN, 2006)
http://www.drugsandalcohol.ie/17842/1/SCAN_Inpatient_Consensus_project_document_FINAL.pdf

National Treatment Agency: Models of care for treatment of Adult alcohol & Drug misusers: Update (NTA, 2006)
http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf

Signs for improvement – Commissioning interventions to reduce alcohol-related harm (Department of Health, July 2009)

http://www.skillsforhealth.org.uk/component/docman/doc_view/129-ad-commissioning-guidelines.html

SERVICE USER AND CARER INVOLVEMENT

Making user involvement work: supporting service user networking and knowledge. Joseph Rowntree Report 2006
http://www.jrf.org.uk/publications/making-user-involvement-work-supporting-service-user-networking-and-knowledge

Recovery from drug and alcohol dependence: an overview of the evidence. ACMD Advisory Council on the Misuse of Drugs. December 2012
http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/acmdrecovery

APPENDIX A

11.0 Extent of Substance Misuse in Northern Ireland

11.1 Substance use prevalence based on population surveys

- Adult Drinking Pattern Survey
- Drug Prevalence Survey
- Northern Ireland Crime Survey
- Young Person's Behaviour and Attitude Survey
- Primary School Survey

11.2 Treatment-based population estimates with alcohol and/or drug misuse

- Census of drug and alcohol treatment services
- Referrals to addiction services
- Drug Misuse Database
- Drug Addict Index
- Needle and Syringe Exchange
- Prescribing data for tranquilisers/sedatives and antidepressants

11.3 Substance-related harm: hospital admissions and mortality

- Alcohol-related hospital admissions
- Alcohol liaison nurses
- Alcohol-related mortality
- Drug-related mortality

11.4 High risk populations

- LGB&T
- Homeless
- Looked After Children
- Hidden Harm

11.5 Criminal justice system

- PSNI drug seizure statistics
- PBNI

Alcohol

Estimating alcohol use and misuse based on the Adult Drinking Pattern Survey 2011
http://www.dhsspsni.gov.uk/adult_drinking_patterns_in_northern_ireland_2011.pdf

NI Health Survey
http://www.dhsspsni.gov.uk/health_survey_northern_ireland_-_first_results_from_the_2010-11_survey.pdf) - same trends as in ADP but less methodologically robust

Census of drug and alcohol treatment services 2012
http://www.dhsspsni.gov.uk/census_bulletin_march_12.pdf

YPBAS 2010
http://www.dhsspsni.gov.uk/young_persons_behaviour_and_attitude_survey__ypbas__2010_-_secondary_analysis.pdf

Alcohol related mortality
http://www.nisra.gov.uk/demography/default.asp30.htm

Illicit and Prescription Drugs

Drug prevalence survey
http://www.dhsspsni.gov.uk/bulletin_1-_ni_prevalence_rates.pdf
http://www.dhsspsni.gov.uk/bulletin_2.pdf

Northern Ireland Crime Survey
http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/northern-ireland-crime-survey-s-r/nics_2008-09_drugs_bulletin.pdf

Drug Misuse Database
http://www.dhsspsni.gov.uk/dmd_bulletin_2011-12.pdf

Drug Addicts Index
http://www.dhsspsni.gov.uk/addicts_index_report_2011.pdf

Needle and Syringe Exchange
http://www.dhsspsni.gov.uk/nses_annual_bulletin_2009-10.pdf

Drug related mortality
http://www.nisra.gov.uk/demography/default.asp30.htm

High risk populations

LGBT All partied out?
http://www.publichealth.hscni.net/sites/default/files/TRP-AllPartiedOut-FinalReport-Mar12.pdf

Criminal Justice

Drug seizure statistics for all reports
http://www.psni.police.uk/index/updates/updates_statistics/updates_drug_statistics.htm *monthly updates next due 19 Sept for up to Aug '12*

Last quarter 4-6/12
http://www.psni.police.uk/apr_-_jul_2012_monthly_bulletin_published_22.8.12.pdf

Year 11/12
http://www.psni.police.uk/annual_statistics_report_drug_seizures_2011.12.pdf

New Trends

Information on drugs seized at music festivals:
http://www.guardian.co.uk/uk/2012/may/21/music-festivals-drugs
http://www.guardian.co.uk/news/datablog/2012/may/21/festival-drugs-data

All population estimates calculated with 2011 Census figures, release phase 2:
http://www.ninis2.nisra.gov.uk/public/Theme.aspx
http://www.nisra.gov.uk/Census/pop_2_2011.pdf

11.1 SUBSTANCE USE PREVALENCE BASED ON POPULATION SURVEYS

Adult Drinking Pattern Survey

11.1.1 Information on alcohol use levels is available from the Adult Drinking Pattern Survey (ADP), the most robust survey of alcohol use in Northern Ireland, for the period 2002 to 2011 (Table 1). Over this period there was an increase in the proportion of those who drink alcohol and those who drink sensibly, while the rate of those drinking above weekly sensible but below dangerous levels and those binge drinking decreased. The prevalence of drinking above dangerous levels and being identified as problem drinkers (based on CAGE) has stayed stable. There is variation in prevalence by Board/Trust area.

Table 1. Alcohol use prevalence from 2002 to 2011 for NI and by Board/Trust area (%)

	Year	Drink alcohol	Within weekly sensible limits	Above sensible but below dangerous limits	Above weekly dangerous limits	At least one binge per week	CAGE problem drinker
All	***2002***	***70***	***-***	***-***	***-***	***-***	***7***
	2005	***73***	***71***	***23***	***6***	***38***	***10***
	2008	***72***	***76***	***19***	***5***	***32***	***10***
	2011	***74***	***77***	***18***	***5***	***30***	***9***
By Board / Trust area							
EHSSB	2005	81	67	26	7	-	-
	2008	78	72	20	8	34	-
BHSCT	2011	76	74	17	9	31	11
SEHSCT	2011	77	80	17	3	21	8
NHSSB	2005	67	76	20	4	-	-
	2008	69	79	17	5	31	-
NHSCT	2011	74	76	19	5	33	14
SHSSB	2005	67	78	16	6	-	-
	2008	67	80	17	3	27	-
SHSCT	2011	68	80	18	2	33	5
WHSSB	2005	71	64	31	6	-	-
	2008	72	77	19	5	33	-
WHSCT	2011	78	75	19	6	33	6

Source: Adult Drinking Pattern Surveys for 2002, 2005, 2008, 2011
Note: - figures not available

Estimating alcohol use and misuse based on the ADP 2011

11.1.2 Based on the ADP 2011, almost three-quarters of the adult Northern Ireland population (aged 18-75) drink alcohol; this equates to about 942,000 people. Of these, the majority (77%) drink within sensible limits, 18% drink at hazardous levels, and 5% drink at harmful levels (ADP, 2011). An overview by gender, age, and HSCT area is shown in Table3.

Table 2. Overview of estimated population for levels of alcohol consumption

Weekly limits			Drinking level	Number of individuals
Sex	**Units**			
M	Up to 21	Below sensible limits	Sensible levels	725,000
F	Up to 14			
M	22-50	Above sensible but below dangerous limits	Hazardous levels	170,000
F	15-35			
M	51+	Above dangerous limits	Harmful levels	47,000
F	36+			

Source: Population estimates based on prevalence rates from ADP 2011 and Census 2011 figures

11.1.3 Almost one-third of adults binge drink (i.e. drink more than twice the recommended daily intake, (males=10+ units, females=7+ units per drinking occasion), equating to almost 283,000 adults who binge drink at least once a week. This figure suggests that also those who drink within sensible limits drink at times at a level that can harm them.

11.1.4 Using CAGE, 9% of the drinking population, about 85,000 individuals, can be considered as problem drinkers. This is almost twice the rate (1.8 times) of those identified as drinking at harmful levels. Please note particularly the discrepancy for the Northern Trust where there was a very high perception of problems related to alcohol despite an average rate of harmful drinking.

11.1.5 A more detailed overview of prevalence rates and related population estimates by gender, age group and HSCT area is shown in Table 3.

For the full ADP 2011 report see
http://www.dhsspsni.gov.uk/adult_drinking_patterns_in_northern_ireland_2011.pdf

Table 3. Alcohol use and misuse: population estimates based on the Adult Drinking Pattern Survey 2011 (adults aged 18-75)

		Population estimate	Drink alcohol	Within weekly sensible limits	Above sensible but below dangerous limits	Above weekly dangerous limits	At least one binge per week	CAGE caseness
All	**%**		*74*	*77*	*18*	*5*	*30*	*9*
	n	1,273,138	942,122	725,434	169,582	47,106	282,636	84,790
Males	**%**		78	74	19	7	35	11
	n	626,051	488,320	361,357	92,781	34,182	170,911	53,715
Females	**%**		72	80	17	3	25	8
	n	647,087	465,903	372,722	79,203	13,977	116,475	37,272
18-29	**%**		82	69	24	8	50	14
	n	300,293	246,240	169,906	59,098	19,699	123,120	34,474
30-44	**%**		81	82	15	3	29	7
	n	373,947	302,897	248,376	45,435	9,087	87,840	21,203
45-59	**%**		75	76	18	6	27	10
	n	347,850	260,888	198,275	46,960	15,653	70,440	26,089
60-75	**%**		59	77	19	4	13	7
	n	251,048	148,118	114,051	28,142	5,925	19,255	10,368
BHSCT	**%**		76	74	17	9	31	11
	n	250,368	190,280	140,807	32,348	17,125	58,987	20,931
NHSCT	**%**		74	76	19	5	33	14
	n	325,901	241,167	183,287	45,822	12,058	79,585	33,763
SEHSCT	**%**		77	80	17	3	21	8
	n	244,218	188,047	150,438	31,968	5,641	39,490	15,044
SHSCT	**%**		68	80	18	2	33	5
	n	247,540	168,327	134,662	30,299	3,367	55,548	8,416
WHSCT	**%**		78	75	19	6	33	6
	n	205,111	159,986	119,990	30,397	9,599	52,796	9,599

Note: population estimates based on Census 2011; binge F=7+, M=10+ units

Drug Prevalence Survey

11.1.6 The Drug Prevalence Survey measures use of illegal drugs and select prescription drug classes and data is available for the period 2002/03 to 2010/11.

Illegal drug use

11.1.7 Table 4 shows the prevalence of any illegal drug use across the three surveys for different time periods. Although drug use prevalence seems to have declined since 2006/07, the reduction was only significant for last year use overall, among males, and those aged 15-64.

Table 4. Trend in any illegal drug use in Northern Ireland (%) – Drug Prevalence Survey

		2002/03	2006/07	2010/11
All 16-64	**Life time**	20.0	28.0	27.3
	Last year	6.4	9.4	6.6*
	Last month	3.4	3.6	3.3
Males	**Life time**	26.7	33.9	32.3
	Last year	9.7	13.7	9.2*
	Last month	5.7	4.9	5.1
Females	**Life time**	13.5	22.1	22.4
	Last year	3.1	5.2	3.9
	Last month	1.1	2.4	1.6
15-34	**Life time**	30.9	40.2	36.9
	Last year	11.6	17.3	11.8*
	Last month	6.1	5.9	5.7
35-64	**Life time**	11.5	19.3	20.4
	Last year	2.2	3.7	2.7
	Last month	1.2	2.0	1.7

Source: NACD & PHIRB (2011)
*Note: "any illegal drug" refers to amphetamines, cannabis, cocaine powder, crack, ecstasy, LSD, magic mushrooms, poppers and solvents; * significant change (p<0.5) compared to 2006/07*

11.1.8 Last month prevalence for any illegal drug use (overall) suggests that around 40,000 individuals are current drug users; three-quarters of them are males, two-thirds are aged 15-34, and most (60%) live in Belfast and the South Eastern HSCT area. Prevalence rates for selected substances vary, with cannabis being the most commonly used drug (by about 32,000 individuals in last month). Please note, individual users may have used more than one illegal drug in the last month.

Table 5. Last month prevalence of illegal drug use (2010/11) – extrapolation of drug user numbers

		Population Census 2011	Any drug	Cannabis	Cocaine (crack)	Amphetamine	Ecstasy
All	**%**		3.3	2.7	0.5	0.3	0.3
	n	1,192,440	39,351	32,196	5,962	3,577	3,577
Males	**%**		5.1	4.4	0.9	0.5	0.5
	n	591,018	30,142	26,005	5,319	2,955	2,955
Females	**%**		1.6	1.1	0.2	0.2	0.1
	n	601,422	9,623	6,616	1,203	1,203	601
15-34	**%**		5.7	4.6	0.6	0.3	0.6
	n	496,192	28,283	22,825	2,977	1,489	2,977
35-64	**%**		1.7	1.3	0.5	0.4	0.1
	n	696,248	11,836	9,051	3,481	2,785	696
BHSCT	**%**		6.3	4.7	1.4	0.6	0.8
	n	234,582	14,779	11,025	3,284	1,407	1,877
NHSCT	**%**		2.1	1.3	0.4	0.7	0.4
	n	302,663	6,356	3,935	1,211	2,119	1,211
SEHSCT	**%**		4.0	3.6	0.8	0.2	0
	n	225483	9,019	8,117	1,804	451	0
SHSCT	**%**		1.3	1.1	0	0	0
	n	234,529	3,049	2,580	0	0	0
WHSCT	**%**		3.5	3.5	0.2	0	0.5
	n	195,183	6,831	6,831	390	0	976

Source: Drug Prevalence Survey 2010/11, NACD & PHIRB (2012)
Note: population estimates based on Census 2011; 'any illegal drug' includes cannabis, heroin, crack, cocaine, amphetamines, ecstasy, LSD, magic mushrooms, solvents, and poppers

11.1.9 Table 6 shows last year prevalence and estimated user numbers for heroin, methadone, mephedrone, legal highs, and anabolic steroids. The Drug Prevalence Survey is not suitable to estimate numbers of heroin users as the prevalence rate for several demographic categories is zero. While the largest number of users of methadone was identified for the NHSCT, it was BHSCT for mephedrone, and BHSCT and SEHSCT for legal highs and anabolic steroids.

Table 6. Last year prevalence of heroin, methadone, mephedrone, legal highs, and anabolic steroids – extrapolation of drug user numbers

		Population Census 2011	Heroin	Methadone	Mephedrone	Legal highs	Anabolic steroids
All	***%***		*0.1*	*0.4*	*1.1*	*1*	
	n	1,192,440	1,192	4,770	13,117	11,924	
Males	**%**		0.2	0.6	1.9	1.6	
	n	591,018	1,182	3,546	11,229	9,456	
Females	**%**		0	0.3	0.3	0.3	
	n	601,422	0	1,804	1,804	1,804	
15-34	**%**		0.1	0.8	2	2	
	n	496,192	496	3,970	10,916	9,924	
35-64	**%**		0.1	0.2	0.3	0.2	
	n	696,248	696	1,392	2,089	1,392	
BHSCT	**%**		0.4	0.4	2	1.4	1.2
	n	234,582	938	938	4,692	3,284	2,815
NHSCT	**%**		0	0.6	0.8	0.4	0.5
	n	302,663	0	1,816	2,421	1,211	1,513
SEHSCT	**%**		0	0.3	0.7	1.4	1.2
	n	225,483	0	676	1,578	3,157	2,706
SHSCT	**%**		0	0.5	0.8	0.8	0.8
	n	234,529	0	1,173	1,876	1,876	1,876
WHSCT	**%**		0	0.3	1.3	1.1	0.4
	n	195,183	0	586	2,537	2,147	781

Source: Drug Prevalence Survey 2010/11
Note: population estimates based on Census 2011 figures; prevalence rates for anabolic steroids were only available for HSCTs

Prescription drug use

11.1.10 The Drug Prevalence Surveys provide prevalence for three groups of prescription/over the counter drugs: other opiates (i.e. opiate pain killers excluding heroin, methadone), sedatives/tranquillisers and antidepressants). Table 6 shows that use of these drugs is higher in women than men, and among older as compared to younger adults. From the 2006/7 to the 2010/11 survey, an increase in antidepressant use for the past year and last month was noted overall, among males, and those aged 35-64. Table 7 shows extrapolated numbers of prescription drug users based on Census 2011 data and DPS prevalence.

Table 6. Trend in use of selective medication: Drug Prevalence Survey data by gender and age band

		Other opiates			Sedatives/tranquillisers			Antidepressants		
		2002/03	2006/07	2010/11	2002/03	2006/07	2010/11	2002/03	2006/07	2010/11
All 16-64	**Life time**	18.0	20.2	15.6*	-	20.2	20.7	-	21.0	21.9
	Last year	8.0	8.4	6.4*	-	9.2	11.0	-	9.1	12.0*
	Last month	4.1	4.9	3.6	-	7.1	8.0	-	7.5	10.2*
Males	**Life time**	16.4	17.4	13.9	-	18.1	17.2	-	13.4	15.3
	Last year	6.9	8.0	5.8	-	8.2	9.3	-	5.8	8.9*
	Last month	3.1	5.1	3.3	-	5.7	7.3	-	4.2	7.6*
Females	**Life time**	19.5	23.0	17.4*	-	22.3	24.1	-	28.4	28.4
	Last year	9.0	8.7	7.0	-	10.2	12.7	-	12.4	15.2
	Last month	5.2	4.7	3.8	-	8.4	8.7	-	10.7	12.8
15-34	**Life time**	17.9	14.4	13.0	-	11.7	13.6	-	13.6	13.6
	Last year	7.5	7.1	5.6	-	4.6	6.4	-	5.8	7.1
	Last month	3.3	3.6	2.9	-	2.3	3.6	-	4.2	5.0
35-64	**Life time**	18.0	24.7	17.6*	-	26.5	25.8	-	26.6	28.0
	Last year	8.3	9.3	6.9*	-	12.6	14.3	-	11.7	15.7*
	Last month	4.8	5.8	4.0*	-	10.7	11.2	-	10.9	14.0*

Source: NACD & PHIRB (2011)
*Note: * significant change to 2006/07; changes in the definition of other opiates were made from 2006/07 to 2010/11*

Table 7. Last month prevalence of use of selective medications (2010/11) – extrapolation of prescription drug user numbers

	Population Census 2011	Other opiates		Sedatives & tranquilisers		Antidepressants	
		%	n	%	n	%	n
All	1,192,440	*3.6*	42,928	*8.0*	95,395	*10.2*	121,629
Males	591,018	3.3	19,504	7.3	43,144	7.6	44,917
Females	601,422	3.8	22,854	8.7	52,324	12.8	76,982
15-34	496,192	2.9	14,390	3.6	17,863	5.0	24,810
35-64	696,248	4.0	27,850	11.2	77,980	14.0	97,475
BHSCT	234,582	5.5	12,902	8.9	20,878	10.8	25,335
NHSCT	302,663	2.4	7,264	7.1	21,489	9.5	28,753
SEHSCT	225,483	5.3	11,951	9	20,293	11.5	25,931
SHSCT	234,529	3.1	7,270	7.8	18,293	10.2	23,922
WHSCT	195,183	1.6	3,123	7.5	14,639	9.2	17,957

Source: Drug Prevalence Survey 2010/11

11.1.11 Further information on sedatives/tranquillisers and antidepressants is available from the Drug Prevalence Survey (2010/11).

http://www.dhsspsni.gov.uk/bulletin_6_-_sedatives_or_tranquillisers_and_anti-depressants.pdf

- 69% of current sedative/tranquilliser users and 94% of current antidepressant users took them daily or almost daily (current = last months; up from 66% and 87% in 2006/7, respectively)

- The vast majority of current users got their sedatives/tranquillisers (95%) and their antidepressants (99%) on prescription (e.g. males and 15-34 year olds more likely to have gotten sedatives from someone else, 4.4% and 13.9%%, respectively).

Table 8. Use of sedatives/tranquillisers and antidepressants by social class, work status and marital status (Drug Prevalence Survey 2010/11)

	Sedatives & tranquilisers			Antidepressants		
	Lifetime	Last year	Last month	Lifetime	Last year	Last month
National Statistics Socio-Economic Classification						
N	2,527	2,529	2,527	2,530	2,528	2,529
Managerial/professional	19.9	8.8	5.0	20.1	9.5	8.0
Intermediate occupations	24.2	11.2	8.0	23.1	12.2	10.5
Small employers/own account workers	18.4	10.4	8.4	16.8	10.0	9.2
Lower supervisory/ technical occupations	20.3	12.7	9.9	23.1	13.3	9.8
Semi-routine, routine occupations	24.0	14.5	11.5	27.3	15.7	13.9
Never worked, long-term unemployed	26.5	15.4	11.1	32.7	22.2	16.7
Not classified	3.9	1.4	0.5	2.9	0.5	0.0
Work status						
N	2,534	2,533	2,533	2,535	2,532	2,533
In paid work	15.5	5.8	3.1	16.2	6.7	5.4
Not in paid work	35.0	23.6	19.3	37.8	25.1	22.0
Other	3.9	1.5	0.5	2.9	0.5	0.0
Marital status						
N	2,532	2,529	2,529	2,534	2,531	2,529
Single	17.1	8.8	6.0	17.2	9.8	7.9
Married	19.2	9.1	7.0	18.4	9.2	8.1
Co-habiting	21.1	9.3	4.3	20.5	10.6	6.8
Separated	33.6	22.1	17.0	54.0	35.4	31.3
Divorced	42.9	28.0	22.0	60.3	32.2	27.5
Widowed	36.1	29.5	23.0	31.1	23.0	19.7
A civil partner in a legally recognised civil partnership	-	-	-	0.0	0.0	0.0

Source: NACD & PHIRB (2012)

For the Drug Prevalence Survey 2010/11 bulletins see

http://www.dhsspsni.gov.uk/bulletin_1-_ni_prevalence_rates.pdf, http://www.dhsspsni.gov.uk/bulletin_2.pdf http://www.dhsspsni.gov.uk/bulletin_6_-_sedatives_or_tranquillisers_and_anti-depressants.pdf

Northern Ireland Crime Survey

11.1.12 The NICS is a representative, continuous, personal interview survey of the experiences and perceptions of crime of adults (16-59 years) living in private households throughout Northern Ireland. Across the period 2003-2009 lifetime drug use has remained stable, yet last year and last month use showed a significant decline (Toner & Friel, 2010; Table 9).

11.1.13 Findings from NICS 2008/09 suggest that around a quarter (27.5%) of people aged 16-59 have used illicit drugs at least once in their lifetime compared to 36.8% in England and Wales (British Crime Survey 2008/09). Adults in Northern Ireland also displayed lower last year (6.7% v 10.1%) and last month (3.8% v 5.9%) prevalence rates compared to people in England and Wales.

Table 9. Prevalence of drug misuse (%) in Northern Ireland and England and Wales

	NICS						BCS
	2003/4	**2005**	**2006/7**	**2007/8**	**2008/9**	**Statistically significant change 2003/04 to 2008/09**	**2008/9**
Lifetime	27.4	26.2	27.3	24.6	27.5		36.8
Last year	9.7	8.2	8.4	6.8	6.7	** decrease	10.1
Last month	6.2	4.9	4.3	3.8	3.8	** decrease	5.9
Unweighted base	*2,121*	*2,381*	*2,390*	*2,494*	*2,204*		*28,232*

Source: Toner & Friel (2010)
1. Results exclude don't knows and refusals.
2. Statistical significance of change at the 5% level (two-tail test) is indicated by a double asterisk (**).
3. Unweighted base refers to lifetime drug misuse. Other bases will be similar.

11.1.14 Cannabis has the highest prevalence across all three time frames.
Males were generally more likely to have used drugs compared to females, particularly over the lifetime. Those most likely to have taken drugs in the last months: were aged 20-24, spent at least one night/week visiting a pub, lived in the social rented sector, were single, lived in Belfast, and resided in the 20% most deprived areas (Toner & Friel, 2010).

Table 10. Prevalence of drug misuse (adults 16-59) by drug type and gender, 2008/9

	Lifetime prevalence			Last year prevalence			Last month prevalence		
	Male	**Female**	***All***	**Male**	**Female**	***All***	**Male**	**Female**	***All***
Any drug	***33.6***	***22.0***	***27.5***	***8.9***	***4.7***	***6.9***	***5.3***	***2.6***	***3.8***
Amphetamines	9.4	5.5	*7.4*	0.4	0.7	*0.6*	0.1	0.1	*0.1*
Cannabis	25.0	16.7	*20.6*	7.0	3.2	*5.0*	4.2	1.5	*2.8*
Cocaine	6.2	3.2	*4.6*	1.5	0.7	*1.1*	0.7	0.4	*0.5*
Crack	0.5	0.6	*0.6*	0.0	0.0	*0.0*	0.0	0.0	*0.0*
Ecstasy	9.7	6.4	*7.9*	1.1	1.1	*1.1*	0.6	0.5	*0.5*
Heroin	0.7	0.9	*0.8*	0.2	0.0	*0.1*	0.0	0.0	*0.0*
LSD	5.7	3.2	*4.4*	0.4	0.4	*0.4*	0.3	0.2	*0.2*
Magic Mushrooms	7.3	3.1	*5.1*	0.2	0.2	*0.2*	0.1	0.2	*0.1*
Methadone	0.5	0.4	*0.4*	0.2	0.0	*0.1*	0.2	0.0	*0.1*
Tranquillisers*	3.5	2.8	*3.1*	1.1	0.9	*1.0*	0.4	0.6	*0.5*
Amyl Nitrite	8.1	5.6	*6.8*	1.2	0.6	*0.9*	0.4	0.3	*0.3*
Steroids	0.4	0.2	*0.3*	0.0	0.0	*0.0*	0.0	0.0	*0.0*
Glue	4.0	1.9	*2.9*	0.4	0.1	*0.2*	0.3	0.1	*0.2*
Methamphetamine	0.3	0.1	*0.2*	0.1	0.0	*<0.1*	0.1	0.0	*<0.1*
Ketamine	1.5	0.6	*1.0*	0.4	0.3	*0.4*	0.2	0.2	*0.2*

Source: Toner & Friel (2010)
http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/northern-ireland-crime-survey-s-r/nics_2008-09_drugs_bulletin.pdf
*Note: *use without prescription*

11.1.15 Survey respondents were asked whether they have ever taken any diazepam/valium which was not prescribed by a doctor (this was repeated for last year, last month). In contrast to the Drug Prevalence Survey findings indicating higher use of sedatives/tranquillisers in women and older adults, the NICS shows that non-prescribed tranquilliser use was more common in men (except for last months) and younger age groups.

Table 11. Tranquilliser misuse by demographic measures (NICS, 2008/09)

	All 16-59	**M**	**F**	**16-19**	**20-24**	**25-29**	**30-34**	**35-44**	**45-54**	**55-59**
Life-time	3.1%	3.5%	2.8%	0.5%	7.0%	6.6%	5.0%	1.7%	2.1%	3.0%
	2,204	979	1,225	120	162	234	282	652	502	252
Last year	1%	1.1%	0.9%	0%	3.3%	2.5%	1.2%	0.5%	0.3%	0.8%
	2,190	972	1,218	119	159	232	277	651	501	251
Last month	0.5%	0.4%	0.6%	0%	1.9%	0.4%	0.8%	0.5%	0.2%	0.4%
	2,190	972	1,218	119	159	232	277	651	501	251

Note: Unweighted bases provided

11.1.16 There is substantial variation in the three drug prevalence indicators across policing districts. The Belfast area (policing districts A and B) has the highest rate of lifetime, last year, last month drug use.

Table 12. Prevalence of drug use by policing district (NICS, 2008/9)

Policing district		Lifetime %	Last year %	Last month %	Unweighted base
All		*27.5*	*6.7*	*3.8*	*2,204*
A, B	Belfast (N&W, S&E)	45.3	13.5	8.7	348
C	Ards, Cregagh, Down, N Down	23.8	6.5	3.2	383
D	Antrim, C'fergus, Lisburn, N'abbey	31.3	9.6	5.2	353
E	Armagh, Banbridge, Craigavon, Newry & Mourne	26.0	4.2	2.1	348
F	Cookstown, Dungannon & S Tyrone, Fermanagh, Omagh	17.6	1.9	1.2	219
G	Foyle, Limavady, Magherafelt, Strabane	25.8	4.8	3.9	299
H	Ballymena, Ballymoney, Larne, Moyle	19.6	5.1	1.7	254

Young Person's Behaviour and Attitude Survey (YPBAS)

11.1.17 The YPBAS collects information on substance use and various other topics from post-primary pupils in years 8-12 via self-completion questionnaires in classroom settings. Over the period 2003-2010 lifetime prevalence of alcohol (full drink) and drug use has been declining (Table 13). A decrease in lifetime experience of drunkenness has been observed from 2000 to 2010. The most commonly used substances in the 2010 survey were cannabis (7%, 6%, 3%) and solvents (7%, 4%, 2% for lifetime, last year, last months, respectively).

Table 13. Trend in lifetime alcohol use, drunkenness and drug use: 1997-2010

	Ever drunk alcohol			Ever been drunk[1]			Ever used any drugs		
	All	**Males**	**Females**	***All***	**Males**	**Females**	***All***	**Males**	**Females**
1997	*79*	82	76	*54*	56	51			
2000	*57*	60	54	*61*	61	62			
2003	*60*	61	59	*56*	56	57	*23*	26	20
2007	*55*	56	55	*55*	51	58	*19*	19	19
2010	*46*			*52*[2]			*15*	17	12

Note: 1997 HBSC survey "Have you ever tasted an alcoholic drink?"; 2000-2003 YPBAS "Have you ever taken an alcoholic drink (not just a taste or sip)?"; Ever used any drugs: includes drugs or solvents;

[1] *of those who had ever drank alcohol*

[2] *secondary analysis resulted in 23% ever drunk for whole sample (25% boys, 22% girls)*
http://www.csu.nisra.gov.uk/survey.asp96.htm

For headline bulletin, top line results tables and secondary analysis see

http://www.csu.nisra.gov.uk/YPBAS%202010%20Headline%20bulletin.pdf, http://www.csu.nisra.gov.uk/YPBAS%202010%20Topline%20Results%20(Weighted).pdf, http://www.dhsspsni.gov.uk/young_persons_behaviour_and_attitude_survey__ypbas__2010_-_secondary_analysis.pdf

Primary School Survey

11.1.18 Survey of primary pupils in years 5-7 was undertaken in 2006. There was high awareness of alcohol among them (95%). Almost one in five had been offered alcohol. Two in five primary pupils reported ever having tried alcohol, with the proportion increasing with age. Half of pupils (51%) reported having taken one sip, 30% a few sips, and 19% more than a few sips. Thirteen percent of all pupils said they currently used alcohol. However, the majority of children still held quite negative views about alcohol. When trying alcohol for first time, 85% were supervised by parent or looked after by someone else. Overall, the majority (86%) said their parent/supervisor knew they were drinking; the proportion of supervisors not knowing increased with age. Parents and the home environment in general are a critical context for children's alcohol use. Further information from this survey is summarised in Table 14.

Table 14. Alcohol and primary school children (2006)

	All	Gender		FSM		Other variation
		Boys	Girls	Yes	No	
Aware of alcohol	95%	95%	96%			
Offered alcohol	**18%**	**22%**	**14%**			
By parent	39%					
By other known adult	19%					
Ever tried	**40%**					**P5: 32%, P6: 40%, P7: 49% BELB; 43%, SEELB: 45%, NEELB: 44%, SELB: 34%, WELB: 35%**
Given by parents	56%			44%	72%	NEELB: 63%, BELB=SELB: 48%
By other known adult	12%					
Took themselves	13%			18%	12%	BELB: 19%, NEELB: 7%
1st drink: home	**57%**	**54%**	**60%**			
Drank alcohol at time of survey	34%	36%	32%	36%	24%	BELB: 33%, WELB: 33%, NEELB: 33%, SELB, 42%, SELB: 28%
Been in trouble due to drinking	13%	16%	9%			

Source: http://www.dhsspsni.gov.uk/ps_report__jan_07.pdf

11.2 TREATMENT-BASED ESTIMATES OF SUBSTANCE USING POPULATION

Census of drug and alcohol treatment services

11.2.1 Table 15 shows the numbers of individuals in treatment for substance misuse by treatment type, sex and age. The most recent census of drug and alcohol treatment services was on 1st March 2012. Overall, 5,916 individuals were in treatment which is relatively unchanged to the previous census in 2010. However, there was some change by subcategory, with increases in drug related treatment for females and a decline in those under 18.

Table 15. Number of individuals in treatment on census days in 2005-2012 by treatment type, gender and age

		1st March 2005		1st March 2007		1st March 2010		1st March 2012		*Change 2010-12*
		n	%	n	%	n	%	n	%	%
Total		*5064*		*5583*		*5846*		*5916*		*+1*
Treatment type	Drugs only	1030	20	1118	20	1294	22	1514	26	*+17*
	Alcohol only	3074	61	3476	62	3328	57	3111	53	*-6*
	Drugs + alc.	960	19	989	18	1224	21	1291	22	*+5*
Sex	Males	3292	65	3686	66	4244	73	4066	69	*-4*
	Females	1772	35	1897	34	1602	27	1850	31	*+15*
Age	Under 18	271	5	847	15	644	11	398	7	*-38*
	18 or over	4793	95	4736	85	5202	89	5518	93	*+6*

Source: Reports on Census of drug and alcohol treatment services
http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm

11.2.2 Treatment provision by HSSB/HSCT level is shown in Table 16. There has been substantial change in treatment between the Trust areas since the previous census in 2010, ranging from an almost 50% decrease in SEHSCT and more than a 50% increase in SHSCT. While BHSCT and NHSCT had the highest number of individuals in drug treatment, SHSCT ranked highest on alcohol treatment and BHSCT for mixed alcohol and drug cases.

Table 16. Individuals in treatment for alcohol and/or drug problems by area: 2005-2012

		EHSSB		NHSSB	SHSSB	WSSB
2005	Drugs only	412		257	92	230
	Alcohol only	1002		706	624	476
	Alc + drugs	340		145	147	215
	Total	***1754***		***1108***	***863***	***921***
2007	Drugs only	310		286	196	146
	Alcohol only	1104		1037	796	455
	Alc + drugs	210		59	328	258
	Total	***1624***		***1382***	***1320***	***859***
		BHSCT	**SEHSCT**	**NHSCT**	**SHSCT**	**WHSCT**
2010	Drugs only	348	253	417	100	140
	Alcohol only	577	771	761	544	483
	Alc + drugs	347	228	171	145	174
	Total	***1272***	***1252***	***1349***	***789***	***797***
2012	Drugs only	467	170	430	172	201
	Alcohol only	558	332	579	887	567
	Alc + drugs	502	173	85	181	247
	Total	***1536***	***675***	***1094***	***1240***	***1015***
Change 2010-12		*+21%*	*-46%*	*-19%*	*+57%*	*+27%*

Source: Census of alcohol and drug treatment services

11.2.3 Of those in treatment at the 2012 Census (5,916), the majority were male (69%), 18 or older (93%), and in treatment for alcohol problems (53%). There was some variation by substance use category and demographics/service variables.

- Fewer females were in treatment for alcohol and drug problems, while more under 18s were;
- While service users in BHSCT were almost evenly split between all three substance misuse categories, SHSCT catered more for those with alcohol problems and NHSCT had the highest proportion of those with drug problems but the least of those with mixed drug and alcohol problems;
- Residential treatment was taken up more by those with alcohol problems and less by drug users;
- Statutory services treated fewer users with alcohol and drug problems, while more of them were treated by non-statutory services. For drug users the relationship was the opposite.

Table 17. Census of substance misuse treatment services 1st March 2012

Treatment	Alcohol only		Alcohol and drugs		Drugs only		N
	%	n	%	n	%	n	
All	*53*	*3,111*	*22*	*1,291*	*25*	*1,514*	*5,916*
Male	51	2,056	24	968	26	1,042	4,066
Female	57	1,055	17	323	26	472	1,850
Under 18	23	91	53	210	24	97	398
Over 18	55	3,020	20	1,081	26	1,417	5,518
BHSCT	36	558	33	502	31	476	1,536
NHSCT	53	579	8	85	39	430	1,094
SEHSCT	49	332	26	173	25	170	675
SHSCT	72	887	15	181	14	172	1,240
WHSCT	56	567	24	247	20	201	1,015
Prison		32		-		-	184
HIS		156		-		-	172
Residential	67	94	23	33	10	14	141
Non-residential	52	3,017	22	1,258	26	1,500	5,775
Statutory*	56	2,260	14	546	30	1,205	4,011
Non-statutory	45	851	39	745	16	309	1,905

Source: **http://www.dhsspsni.gov.uk/census_bulletin_march_12.pdf**, ** includes prison*

Extrapolating Treatment Need

11.2.4 An alcohol needs assessment in England showed that only 1 in 18 (5.6%) dependent drinkers received treatment (Alcohol Needs Assessment Research Project (ANARP, 2005). DH (2009) suggested that treatment access levels should be 15% (1 in 6/1 in 7) of the local dependent population. No equivalent figures are available for Northern Ireland.

11.2.5 In the absence of a reliable estimation of the rate of alcohol dependence, the rate for problem drinking (CAGE) and for harmful drinking from the 2011 ADP were used to calculate the potential population with treatment need. CAGE based estimate suggests a substantially larger in-need population than the harmful drinking based estimate. Using current treatment figures (2012 Census), these suggest that about 9% of the in-need population are treated for alcohol problems which varies substantially across HSCT areas. Please note that it is not possible to distinguish what proportion of those in treatment for alcohol or drugs and alcohol problems suffer from alcohol dependence. If a 15% target of treating those with alcohol dependence was applied, over 7,000 individuals would need treatment within a year.

Table 18. Extrapolation of treatment need and coverage

	Treated for alcohol or alcohol and drugs	In need population: CAGE (ADP 2011)			In need population: drinking above harmful limits (ADP 2011)		
	n	N	% being treated	Target 15%	N	% being treated	Target 15%
All	*4,402*	84,791	5.2	12,719	47,106	9.3	7,066
Male	3,024	53,715	5.6	8,057	34,182	8.8	5,127
Female	1,378	37,272	3.7	5,591	13,977	9.9	2,097
18+	4,101	84,791	4.8		47,106	8.7	
BHSCT	1,060	20,931	5.1	3,140	17,125	6.2	2,569
NHSCT	664	33,763	2.0	5,065	12,058	5.5	1,809
SEHSCT	505	15,044	3.4	2,257	5,641	9.0	846
SHSCT	1,068	84,16	12.7	1,262	3,367	31.7	505
WHSCT	814	9,599	8.5	1,440	9,599	8.5	1,440

Note: treated numbers from 2012 Census of treatment services: any alcohol treatment; N= prevalence of CAGE caseness and harmful drinking, taken from ADP 2011, and multiplied with age-matched population figures from 2011 Census (see Table ...); % = numbers treated divided by N; Target 15% = 15% of N; age range for ADP 2011: 18-75, treatment service figures include all ages

2.2. Referrals to addiction services

Table 19. Number of referrals to addiction services by HSCT 2007-2010

	2007/08	2008/09	2009/10	
	n	n	n	Rate per 100,000
BHSCT	1,720	2,122	2,464	734
NHSCT	2,162	2,590	2,894	631
SEHSCT	1,849	1,762	1,843	531
SHSCT	1,722	1,845	2,460	686
WHSCT	2,205	2,108	2,314	773
Total	**9,658**	**10,427**	**11,975**	**665**

Source: Hospital systems
Note: Figures refer to referred and assessed.

Drug Misuse Database

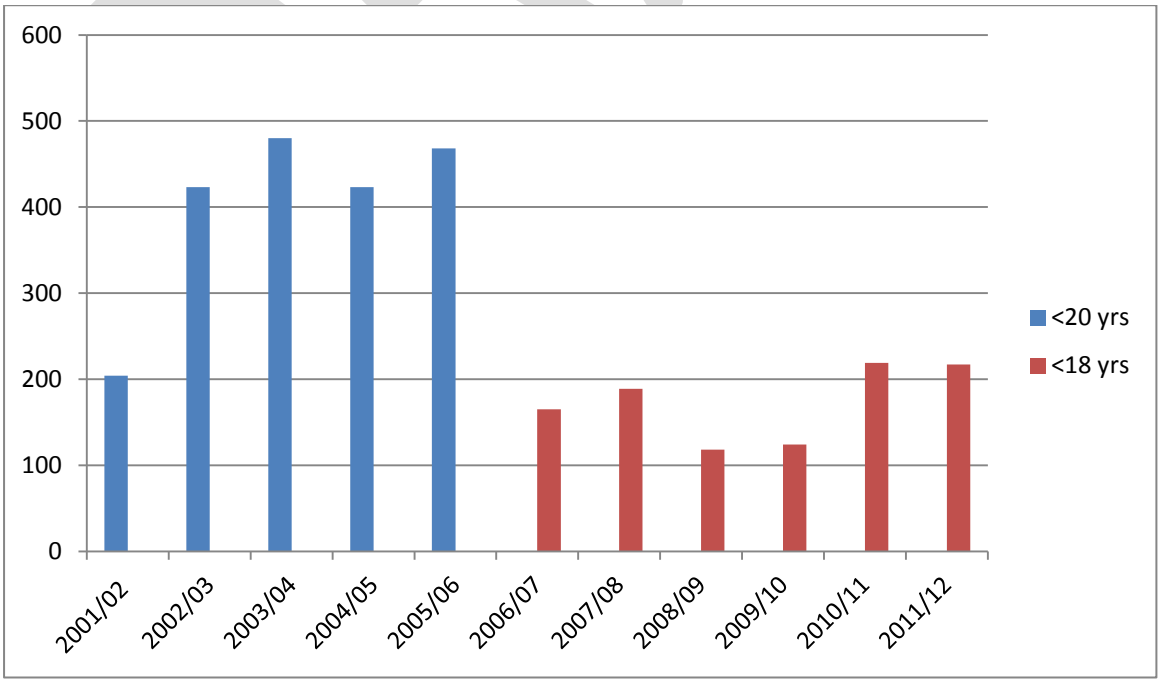
11.2.6 The DMD collects information on individuals who present to substance use services for the first time or for the first time in six months or longer. Table 20 shows DMD information over the period 2001/2 to 2010/11. Overall numbers of presentation nearly tripled over this period, with the proportion of men, being close to three-quarters, remaining stable. Introduction of benzodiazepine-specific care saw an increase in the proportion of women presenting as well as a change in top three main drugs presented with. The proportion of young people presenting to services has remained relatively stable, though there has been a change in age categories (from under 20s to under 18s) in reporting in 2006/7 which prevents direct comparison of those periods (see Figure 1).

11.2.7 Misuse of a single drug was observed in under half of the cases, indicating that polydrug use is common. Concomitant misuse of alcohol in the presenting drug users seems to be increasing. Although cannabis remained the main drug, there has been a shift away from heroin and other opiates towards benzodiazepines and cocaine, and recently to mephedrone.

11.2.8 There is substantial variation in local activity. The Eastern area/BHSCT and SEHSCT have seen a steady increase, the Southern and Western area have had an increase after a recent dip in activity. In the Northern area activity fluctuated and has recently been decreasing.

11.2.9 In general, it cannot be established that changes in patterns of presenting drug users were due to changes in drug taking behaviour and drug using populations or due to changes in outreach practice.

Figure 1: Number of young people in registered for drug treatment (2001-2012)



Source: Drug Misuse Database; there was a change in definition of age group in 2006/07

Table 20. Summary of information from Drug Misuse Database: period 2001-2011

		2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
N presented		969	1,438	1,527	1,907	1,754	1,559	2,140	1,843	2,102	2,781	3,133
N consent		***916***	***1,368***	***1,409***	***1,746***	***1,666***	***1,464***	***1,984***	***1,755***	***2,008***	***2,593***	***2,999***
n new		-	-	-	+337	-80	-202	+520	-229	+253	+585	
% male		74%	75%	76%	76%	72%	77%	69%	72%	72%	72%	75%
% young[a] (n)		22% (204)	31% (423)	34% (480)	24% (423)	29% (468)	11% (165)	9% (189)	7% (118)	6% (124)	8% (219)	7% (217)
Eastern [b]	B	471 (79)	603 (91)	665 (100)	812 (122)	908 (136)	744 (111)	1,286 (191)	926 (277)	1,184 (353)	1,364 (406)	1,239 (356)
	SE								176 (52)	243 (71)	342 (99)	430 (124)
Northern		158 (37)	189 (44)	164 (38)	255 (58)	153 (35)	176 (40)	227 (50)	183 (40)	130 (28)	109 (24)	129 (28)
Southern		34 (11)	125 (40)	136 (43)	145 (45)	136 (42)	132 (39)	102 (30)	89 (26)	48 (14)	230 (64)	243 (68)
Western		253 (90)	357 (127)	337 (117)	386 (134)	307 (106)	334 (114)	221 (75)	234 (79)	226 (76)	301 (101)	318 (108)
Statutory		69%	61%	53%	60%	58%	69%	73%	74%	72%	64%	63%
% single drug		44%	45%	45%	46%	47%	41%	47%	45%	49%	46%	43%
% drug + alc		-	-	-	-	31%	37%	35%	37%	34%	42%	38%
Top 3 main drugs		Cann 34% Her 21% Oth op 14%	Cann 47% Hero 15% Oth op 9%	Cann 52% Her 12% Ecst 8%	Cann 46% Her 14% Benzo 10%	Cann 49% Benzo 14% Her 10%	Cann 46% Benzo 14% Coc 10%	Cann 35% Benzo 31% Coc 10%	Cann 39% Benzo 22% Coc 11%	Cann 42% Benzo 23% Coc 9%	Cann 40% Benzo 19% Meph 8%	Can 41% Benz 24% Coc 7%

Note: [a] change in age categories from <20 to <18 in 2006/7; [b] change from HSSB to HSCT in 2008/9, HSSB/HSCT numbers presented (rate per 100,000 population)

11.2.10 Over the period April 2011 to March 2012, 3,123 individuals presented to services; 124 did not provide consent for use of their data, leaving 2,999 substance users in the analysis. Over two-fifths of service users used one drug (43%), while 27% used two drugs, 14% used three drugs, 8% used four drugs, and 7% used five drugs. 38% reported alcohol use being a problem. There is local variation what the main drug of use is among those presenting for treatment, possibly depending on what services are available.

Table 21. Main drug and all drugs of misuse of clients presented for treatment 2011/12 (DMD)

Drug	Used as main drug in %			All drugs in %
	Overall	Males	Females	
Cannabis	41	**48**	**18**	58
Ecstasy	2	2	1	14
Cocaine	7	**8**	**3**	24
Heroin	6	6	4	8
Other opiates	7	7	8	15
Benzodiazepines	24	**16**	**45**	42
Codeine & paracetamol	2	**1**	**4**	6
Solvents	1	1	1	3
Mephedrone/ Methedrone	5	5	4	15
Other hypnotics	3	**2**	**8**	8
Other stimulants	2	2	1	9
Other drugs	1	1	2	8

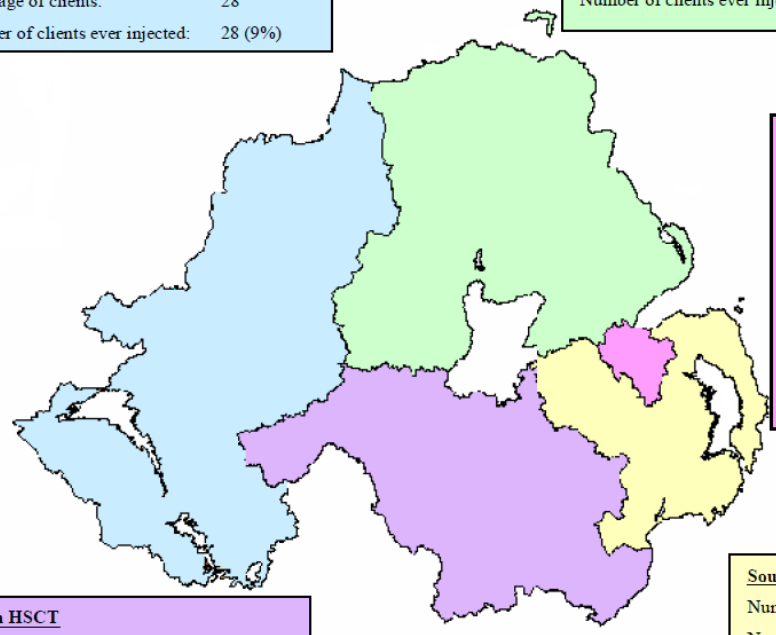
Variation in main drug by HSCT				
BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
Cannabis 36%	Cannabis 42%	Cannabis 28%	Cannabis 56%	Cannabis 64%
Benzos 33%	Heroin 20%	Benzos 44%	Cocaine 8%	Other drugs 12%

Note: Other opiates = methadone, buprenorphine; BHSCT and SEHSCT have benzodiazepine-specific services

11.2.11 The most commonly proposed actions included: 87% assessment, 54% counselling, 47% education/information, 14% detoxification, 14% mentoring. About one-quarter (24%) had previously been treated.

Figure 2.

Map showing summary statistics for each Health and Social Care Trust [1]



Western HSCT

Number of clients:	318 (11%)
Number of clients reporting main drug to be:	
• Cannabis	204 (64%)
• Mephedrone/Methedrone	30 (9%)
• Other Opiates	21 (7%)
• Cocaine	15 (5%)
• Benzodiazepines	9 (3%)
Mean age of clients:	28
Number of clients ever injected:	28 (9%)

Northern HSCT

Number of clients:	129 (4%)
Number of clients reporting main drug to be:	
• Cannabis	54 (42%)
• Heroin	26 (20%)
• Other Opiates	19 (15%)
• Benzodiazepines	11 (9%)
Mean age of clients:	27
Number of clients ever injected:	31 (24%)

Belfast HSCT

Number of clients:	1,239 (41%)
Number of clients reporting main drug to be:	
• Cannabis	442 (36%)
• Benzodiazepines	407 (33%)
• Cocaine	73 (6%)
• Other Opiates	60 (5%)
Mean age of clients:	35
Number of clients ever injected:	74 (6%)

Southern HSCT

Number of clients:	243 (8%)
Number of clients reporting main drug to be:	
• Cannabis	135 (56%)
• Mephedrone/Methedrone	31 (13%)
• Cocaine [2]	19 (8%)
• Heroin	15 (6%)
• Other Opiates	15 (6%)
Mean age of clients:	29
Number of clients ever injected:	14 (6%)

South Eastern HSCT

Number of clients:	430 (14%)
Number of clients reporting main drug to be:	
• Benzodiazepines	191 (44%)
• Cannabis	122 (28%)
• Other Opiates	32 (7%)
• Cocaine	16 (4%)
• Mephedrone/Methedrone	16 (4%)
Mean age of clients:	39
Number of clients ever injected:	21 (5%)

[1] This map excludes returns received from prisons.

[2] The services available across all Trust areas vary and this may be reflected in the main drugs of misuse. For example, in areas where benzodiazepine projects exist, there are greater proportions of individuals presenting to services with benzodiazepine misuse, than in areas where no such projects exist.

Source: DMD 2011/12

Drug Addict Index

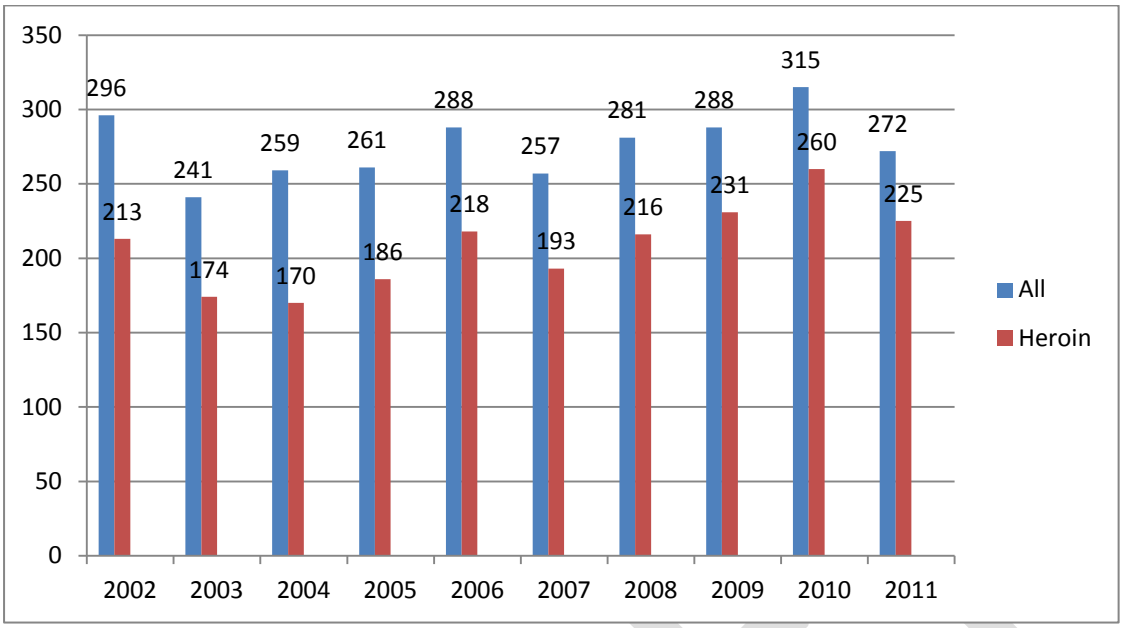
11.2.12 On 31 December 2011, 272 persons were registered with DAI, 43 persons fewer than in the previous year. The vast majority were re-notifications (n=240), with 32 new cases. 74 individuals were removed from the DAI due to addiction ceased/no evidence of ongoing addiction (31%), whereabouts unknown (47%), death (11%), and not resident in Northern Ireland (11%).

Table 22. Key findings on registered cases from DAI for 2011

		n	% (N=272)
Substances used	**Heroin**	225	83
	Methadone	50	18
	Cocaine	18	7
Injecting behaviour (N=195 known)	**yes**	108	55
Gender	**Male**	215	79
	Female	57	21
Age	**<29**	70	26
	30-39	121	44
	40+	81	30
Duration of registration	**Within last year**	32	12
	1-5 yrs	140	51
	6-9 yrs	49	18
	10+ yrs	51	19
Trust area	**BHSCT**	108	41
	NHSCT	83	32
	SEHSCT	23	9
	SHSCT	39	15
	WHSCT	9	3

Source: DHSSPS (2010)
http://www.dhsspsni.gov.uk/nses_annual_bulletin_2009-10.pdf)

Figure 3: Number of addicts registered on Drug Addict Index: overall and those using heroin (2002-2011)



Source: **http://www.dhsspsni.gov.uk/addicts_index_report_2011.pdf**

Needle and Syringe Exchange

11.2.13 The last report on NSE showed that 15,828 visits were made, with the vast majority being by male clients (86%) and over half being 31 years or older (53%; 26% aged 26-30; DHSSPS, 2010, **http://www.dhsspsni.gov.uk/nses_annual_bulletin_2009-10.pdf**). The highest number of visits occurred in BHSCT (41%) and NHSCT (35%; SEHSCT: 3%, SHSCT: 5%, WHSCT: 16%). The highest number of syringes was issued in NHSCT (53,120), followed by Belfast (49,075) and WHSCT (35,945; SHSCT: 8,695; SEHSCT: 6,790).

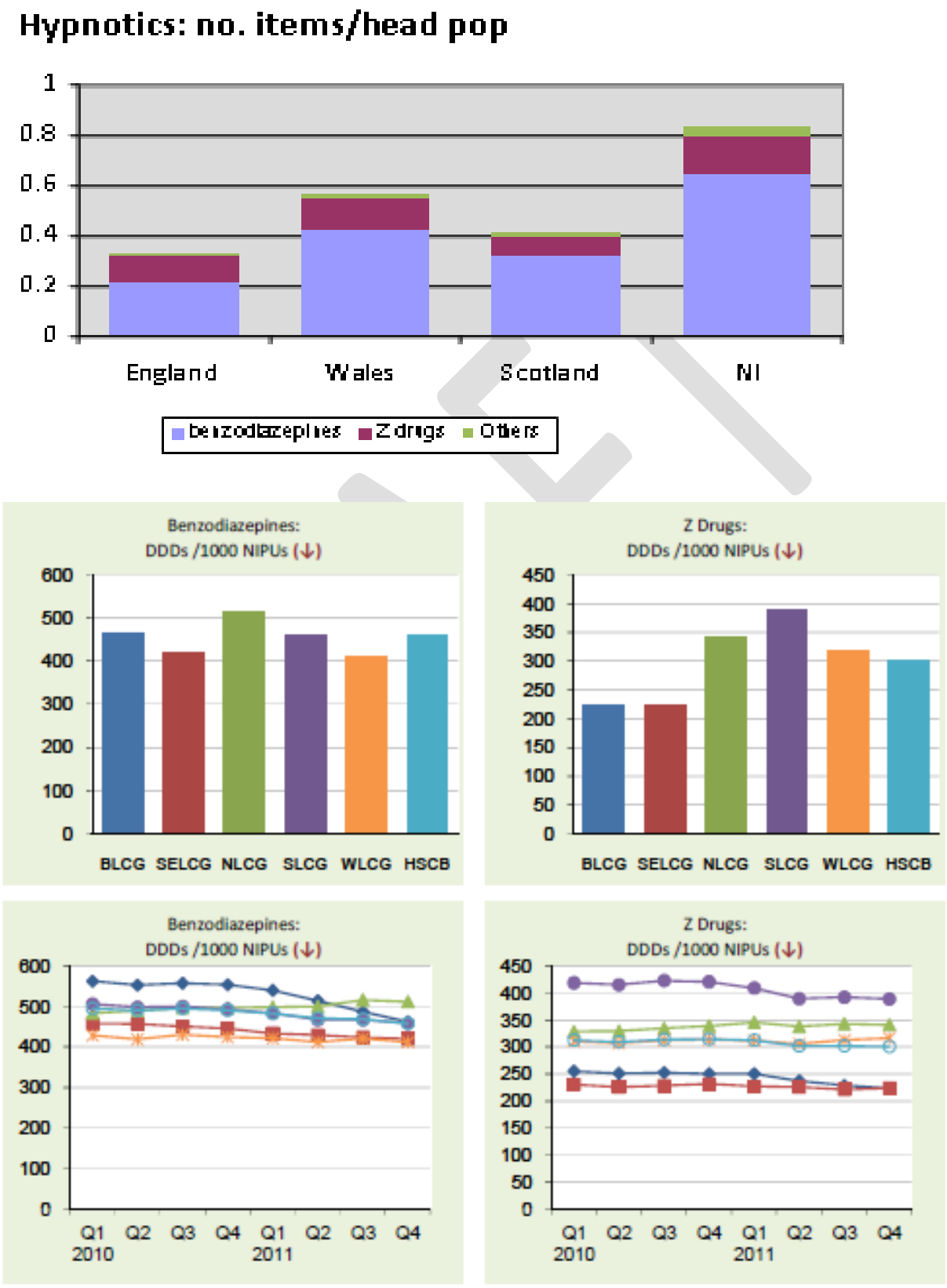
Table 23. Figures from needle and syringe exchange (2002-2010)

	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10
No. of visits	6,043	7,508	7,440	8,797	9,997	11,387	13,389	15,828
Change to year before		*+24%*	*-1%*	*+18%*	*+14%*	*+14%*	*+18%*	*+18%*
No. of syringes issued	67,516	82,731	86,056	85,801	97,684	116,935	153,700	153,625
Cin bins issued (% returned)	-	-	-	-	-	15268 (54%)	17,668 (53%)	20,126 (51%)

*Source: DHSSPS (***http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health/stats-drug-alcohol.htm***)*

Prescribing Data: Tranquillisers/Sedatives and Antidepressants

Figure 4. HSCB prescribing data (from presentation by Emma Quinn)

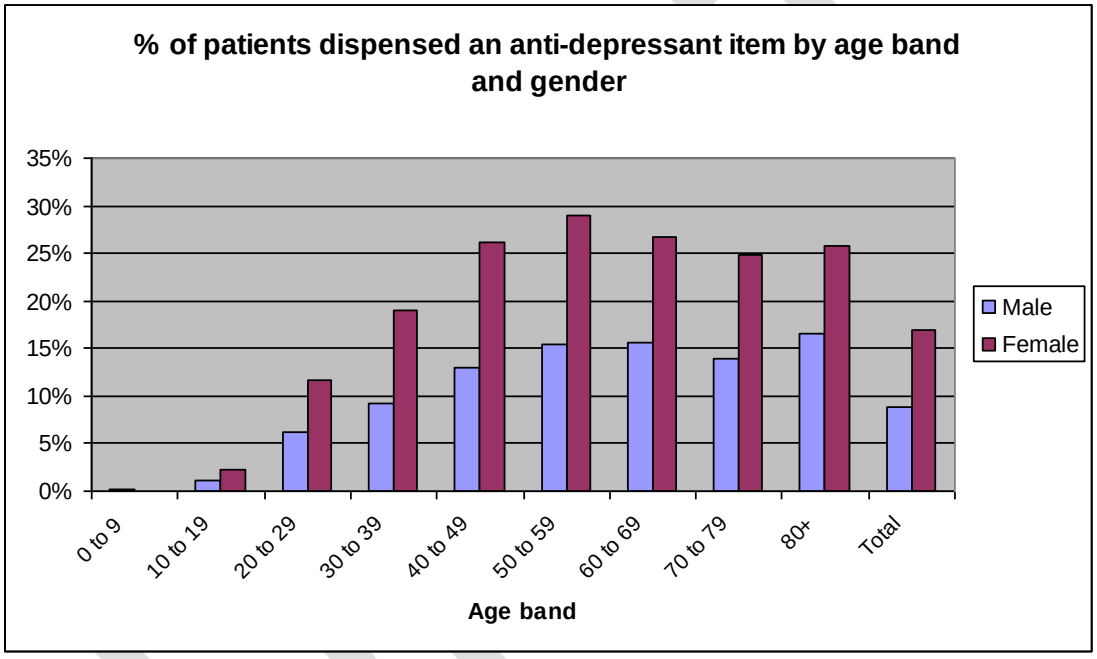


Antidepressant (AD) prescribing

Analysis of dispensing data (EPES analysis 2010)

11.2.14 In 2010, 1,785,099 antidepressant prescriptions were issues covering 1,909,605 items. Overall, ADs accounted for 5.4% of all dispensed items. In this period 248,276 patients were dispensed an AD, with 15.4% having been dispensed one item. There is wide variation in dispensing rates by Super Output Area (ranging from 2.67% in Stranmillis 2 to 24.24% in Shankill 2). A summary of the findings is presented in Table 24. Table 25 shows comparison data for the four UK regions.

Figure 5. Percentage of patients that were dispensed an antidepressant item by age and gender



Source: EPES 2010 antidepressant prescribing data (McLaughlin, 2012)

Table 24. Antidepressant prescribing in Northern Ireland in 2010: Number of items and prescriptions and number and percentage of patients dispensed to by age and gender

Age Band	Male					Female				
	Total no. of items	Total no. of prescript.	No. patients disp. AD items	Total regist. popul.	% patients disp. AD items	Total no. of items	Total no. of prescript.	No. patients disp. AD item	Total regist. popul.	% patients disp. AD items
0 to 9	171	171	144	127,808	0.11%	109	106	102	121438	0.08%
10 to 19	6,191	5,954	1,551	128,801	1.20%	10,552	10,142	2,683	122,722	2.19%
20 to 29	45,990	43,551	8,701	142,018	6.13%	82,398	77,720	16,209	139,037	11.66%
30 to 39	85,026	78,857	12,773	138,300	9.24%	171,061	158,420	25,412	133,761	19.00%
40 to 49	133,233	123,487	18,692	142,986	13.07%	267,193	245,945	36,171	138,420	26.13%
50 to 59	127,069	118,199	17,441	113,033	15.43%	239,248	221,937	31,769	109,826	28.93%
60 to 69	96,729	91,429	13,661	87,244	15.66%	175,001	166,003	24,104	90,129	26.74%
70 to 79	47,681	46,000	7,319	52,288	14.00%	109,364	105,215	15,692	63,149	24.85%
80+	27,634	26,923	4,054	24,536	16.52%	87,296	84,938	11,792	45,811	25.74%
Total	569,724	534,571	84,336	957,014	8.81%	1,142,222	1,070,426	163,934	964,293	17.00%

Source: EPES antidepressant analysis (2010)

Table 25. Antidepressant prescriptions by UK regions 2009-2011

	2009			2010			2011		
	Prescriptions	Population	per head	Prescriptions	Population	per head	Prescriptions	Population	per head
NI	1,722,746	1,788,900	**0.96**	1,919,733	1,799,400	**1,07**	2,118,159	1,799,400	**1.18**
England	39,139,530	51,809,700	**0.76**	42,787,966	52,234,000	**0.82**	46,677,813	53,012,500	**0.88**
Scotland	4,008,875	5,194,000	**0.77**	44,312,117	5,222,100	**0.83**	4,662,366	5,254,800	**0.89**
Wales	3,182,344	2,99,300	**1.06**	3,471,005	3,006,400	**1.15**	3,806,140	3,063,500	**1.24**

Source: **http://www.bbc.co.uk/news/uk-wales-19289669**

11.3 SUBSTANCE-RELATED HOSPITAL ADMISSIONS AN MORTALITY

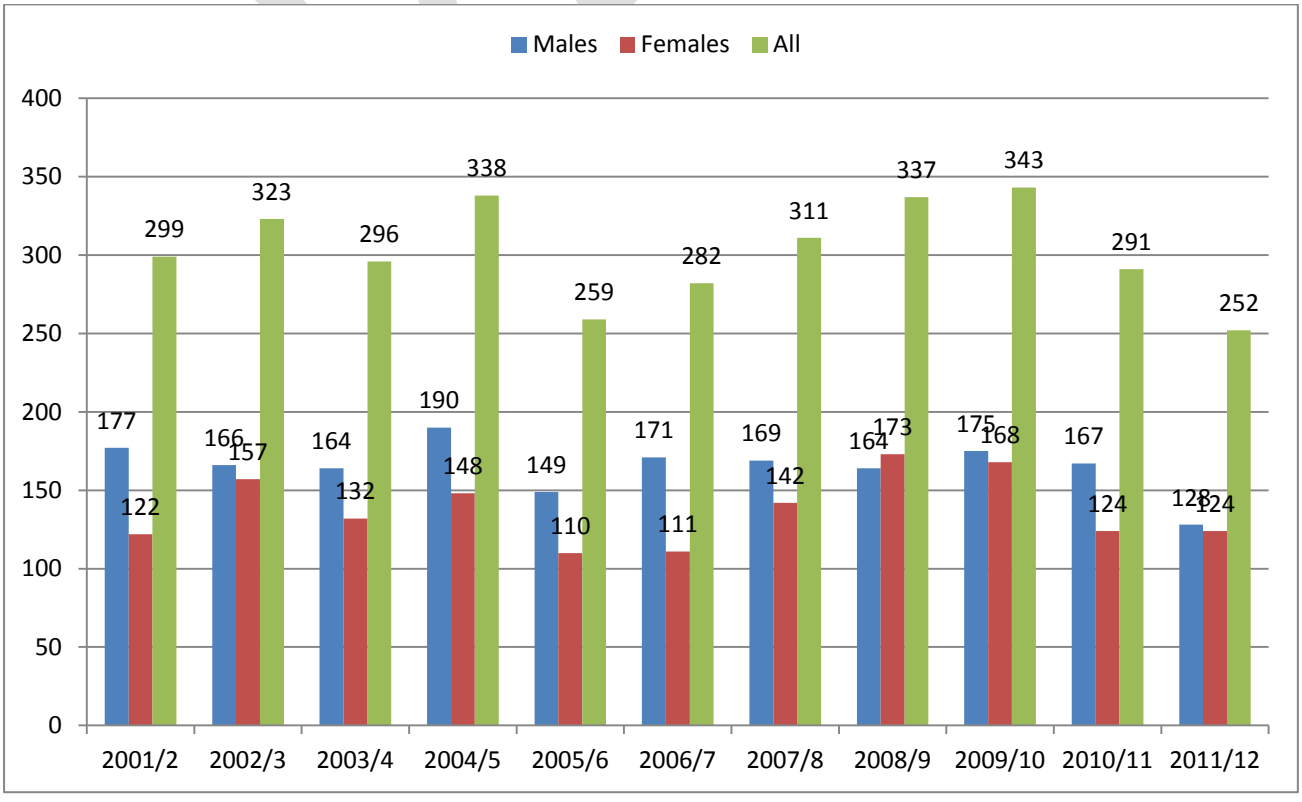
Alcohol related hospital admissions

Table 26. Admissions to HSC hospitals with an alcohol related diagnosis from 2000/01 to 2010/11

	Primary alcohol related diagnosis			Any alcohol related diagnosis		
	Male	Female	All	Male	Female	All
2001/02	1990	741	2731	6689	2713	9402
2002/03	2015	733	2748	6612	2749	9361
2003/04	1933	745	2678	6738	2655	9393
2004/05	2199	821	3020	7207	2973	10180
2005/06	2234	770	3004	7031	2921	9952
2006/07	2013	777	2790	7009	2817	9826
2007/08	2508	836	3344	8207	3174	11381
2008/09	2448	868	3316	8270	3257	11527
2009/10	2523	952	3475	8235	3308	11543
2010/11	2367	855	3222	8585	3431	12016

Note: Deaths and discharges were used to denote admissions; this figure should not be used to denote individuals as a person may be admitted to hospital more than once in a year or across a number of years; ICD-10 codes used to identify alcohol related admissions are listed below

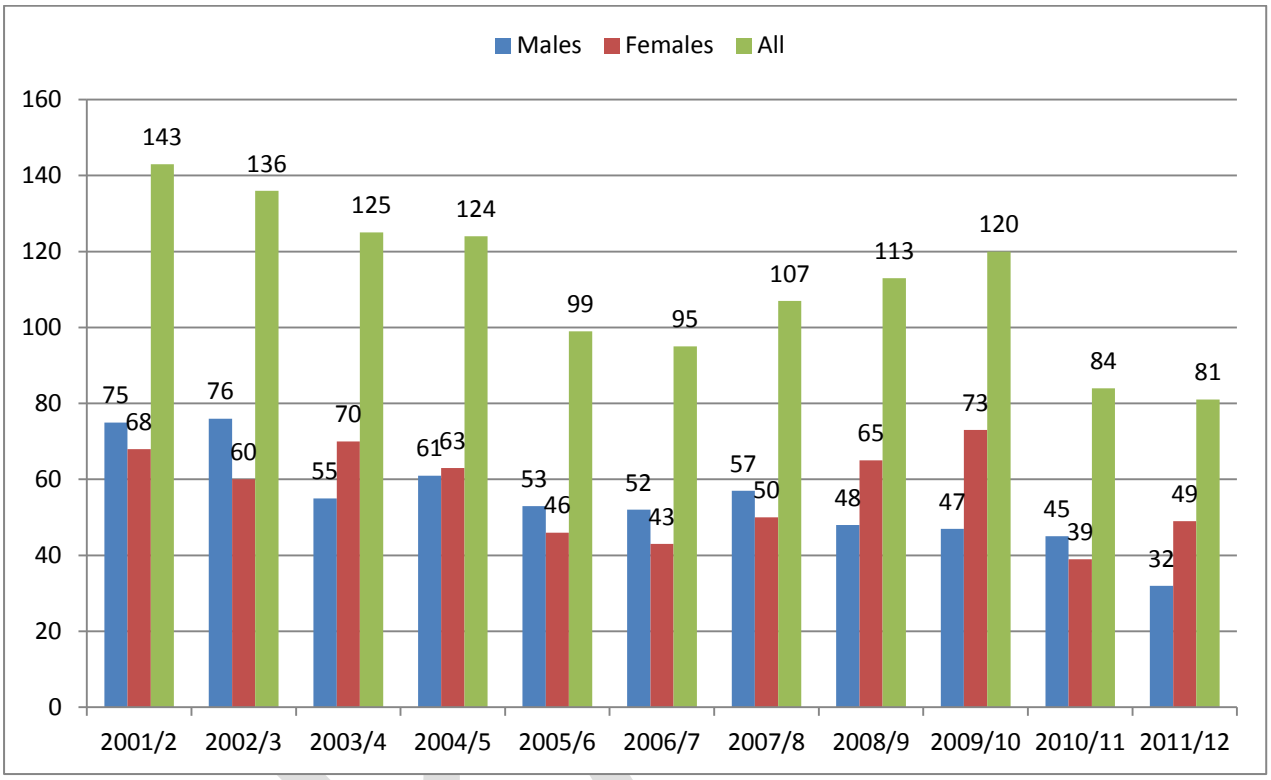
Figure 6. Admissions to HSC hospitals with any alcohol-related diagnosis for under 18s



Note: see Table 26

11.3.1 The majority of young people admitted to hospital with a primary alcohol-related diagnosis had a diagnosis of mental and behavioural disorders due to use of alcohol - acute Intoxication (F100).

Figure 7. Admissions to HSC hospitals with a primary alcohol-related diagnosis for under 18s



Note: Deaths and discharges were used to denote admissions; this figure should not be used to denote individuals as a person may be admitted to hospital more than once in a year or across a number of years; ICD-10 codes used to identify alcohol related admissions are listed in Appendix

Alcohol Related Mortality

Table 27. Alcohol related mortality 2001-2011: a) by HSCT and b) by gender

Registration Year	Health and Social Care Trust					Total
	Belfast	Northern	South Eastern	Southern	Western	
2001	75	50	28	29	24	**206**
2002	88	50	35	24	41	**238**
2003	71	39	43	33	28	**214**
2004	70	39	58	41	47	**255**
2005	83	49	50	39	25	**246**
2006	69	59	41	29	50	**248**
2007	89	60	43	43	48	**283**
2008	86	67	50	38	35	**276**
2009	75	58	56	40	54	**283**
2010	73	53	42	50	66	**284**
2011[P]	75	51	51	38	37	**252**
Total (2001-2011)[P]	**854**	**575**	**497**	**404**	**455**	**2,785**

Registration Year	All Persons	Sex	
		Male	Female
2001	**206**	131	75
2002	**238**	165	73
2003	**214**	132	82
2004	**255**	174	81
2005	**246**	171	75
2006	**248**	173	75
2007	**283**	199	84
2008	**276**	185	91
2009	**283**	187	96
2010	**284**	191	93
2011[P]	**252**	177	75
Total (2001-2011)[P]	**2,785**	**1,885**	**900**

Source: NISRA
Note: 2011 preliminary data

Table 28. Alcohol related mortality 2001-2011 by deprivation quintile: 2005-2011

Cause of Death	Deprivation Quintile[1] Least Deprived 1	2	3	4	Most Deprived 5
Alcohol related deaths	**165**	**247**	**285**	**444**	**731**
All deaths	17,697	18,779	20,440	22,195	22,262
Rate per 100,000 population	*7*	*10*	*11*	*17*	*31*

Source: NISRA
Note: 2011 preliminary data

Drug-related mortality

Table 29. Drug related deaths 2001-2011 by HSCT

Registration Year	Health and Social Care Trust: Belfast	Northern	South Eastern	Southern	Western	Total
2001	13	8	9	3	2	**35**
2002	24	14	11	7	12	**68**
2003	11	17	8	7	9	**52**
2004	13	9	8	10	8	**48**
2005	28	24	14	13	5	**84**
2006	27	16	17	9	22	**91**
2007	25	24	12	12	13	**86**
2008	32	23	11	12	11	**89**
2009	28	17	13	17	9	**84**
2010	29	21	19	17	6	**92**
2011[P]	32	18	15	21	16	**102**
Total (2001-2011)[P]	**262**	**191**	**137**	**128**	**113**	**831**

Source: NISRA
Note: 2011 preliminary data

Table 30. Number of deaths due to drug misuse 2001-2011 by HSCT

Registration Year	Health and Social Care Trust					Total
	Belfast	Northern	South Eastern	Southern	Western	
2001	9	4	7	2	1	**23**
2002	15	5	5	4	3	**32**
2003	8	10	3	4	7	**32**
2004	4	2	2	6	3	**17**
2005	12	13	9	6	2	**42**
2006	17	10	6	4	12	**49**
2007	14	12	8	5	9	**48**
2008	24	12	7	6	4	**53**
2009	14	14	5	10	3	**46**
2010	22	15	13	9	4	**63**
2011[P]	19	10	9	12	8	**58**
Total (2001-2011)[P]	**158**	**107**	**74**	**68**	**56**	**463**

Source: NISRA
Note: 2011 preliminary data

Table 31. Drug related deaths by deprivation 2005-2011

Cause of Death	Deprivation Quintile[1]				
	Least Deprived 1	2	3	4	Most Deprived 5
Drug related deaths	**59**	**85**	**78**	**153**	**253**
All deaths	17,697	18,779	20,440	22,195	22,262
Rate per 100,000 population	*3*	*3*	*3*	*6*	*11*
	Deprivation Quintile[2]				
	Least Deprived 1	2	3	4	Most Deprived 5
Deaths due to drug misuse	**34**	**50**	**44**	**94**	**137**
All deaths	17,697	18,779	20,440	22,195	22,262
Rate per 100,000 population	*1*	*2*	*2*	*4*	*6*

Source: NISRA
Note: 2011 preliminary data

Table 32. Drug related deaths where individual substances were mentioned on death certificate 2001-2011

Substance	Registration Year											Total (2001-2011)[P]
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011[P]	
Heroin/Morphine*	4	3	11	-	9	12	10	6	9	16	17	**97**
Methadone*	1	1	-	1	1	2	1	1	1	3	4	**16**
Cocaine*	-	2	2	-	1	1	3	6	4	3	4	**26**
All amphetamines*	1	3	1	1	8	2	5	4	3	2	4	**34**
MDMA/Ecstasy*	1	3	1	1	7	2	5	3	3	1	2	**29**
Mephedrone*[3]	-	-	-	-	-	-	-	-	-	1	2	**3**
All benzodiazepines*	15	14	17	12	21	26	29	35	27	40	36	**272**
Temazepam*	9	3	7	5	3	4	8	6	1	3	1	**50**
Diazepam*	7	8	7	9	19	20	21	28	22	35	33	**209**
All antidepressants	9	16	11	12	19	25	20	27	27	22	19	**207**
Dothiepin	5	6	7	7	4	4	4	6	4	-	1	**48**
Amitriptyline	4	5	2	3	8	9	7	8	9	8	4	**67**
Paracetamol (includes dextropropoxyphene or propoxyphene mentioned without paracetamol)	1	13	8	8	18	14	8	4	4	4	5	**87**
Codeine not from compound formulation*	5	6	2	4	6	9	16	14	8	17	15	**102**
Dihydrocodeine not from compund formulation*	6	12	3	3	9	14	9	11	17	10	9	**103**
Tramadol	-	3	-	2	6	11	11	11	8	13	17	**82**

Death can be counted more than once, for each substance that was listed on the death certificate

11.4 HIGH RISK POPULATIONS

Lesbian, gay, bisexual and transgender persons (LGB&T)

11.4.1 The most recent and so far largest survey of LGB&T community in Northern Ireland was conducted with 941 individuals in 2012 (Rooney, 2012). Survey respondents were 15 to 64 years old, 319 were women and 40 identified as transgendered.

11.4.2 Alcohol: A larger proportion of LGB&T individuals drink alcohol than in the general population; although it needs to be noted that the latter includes older respondents who are less likely to drink alcohol. Among LGB&T people, women are more likely to drink alcohol and drink more frequently (Rooney, 2012), in contrast to the pattern in the general population (DHSSPS, 2011).

Table 33. Percentages of individuals engaging in alcohol consumption in the LGB&T community and the general population

	APO 2012 (ages 15-64)			ADP 2011 (ages 18-75)		
	All	**Males**	**Females**	**All**	**Males**	**Females**
Drink alcohol	91	89	93	74	78	72
Drink daily or most days	13	12	14	6	8	5
				Psychiatric morbidity survey, England 2007		
Hazardous drinking (AUDIT)	57	59	55	24	33	16

Note: APO 2012 – All partied out? Survey (Rooney, 2012); ADP 2011 – Adult Drinking Pattern Survey 2011 (DHSSPNI, 2011)

11.4.3 Drugs: LGB&T individuals (62%) are three times more likely to have taken any illicit drug over their lifetime than was reported in the Drug Prevalence Survey 2010/11 (22%; NACD & PHIRB, 2011). Transgendered people were the subgroup with the highest level of any drug use. Similar to the general population, CNS depressant drugs (cannabis, sedatives, antidepressants) and opiates were used more frequently than "'recreational' drugs associated with the nightclub scene (Rooney, 2012, p.10); the exception were poppers. While use of all drugs was higher among LGB&T individuals, use of drugs associated with the nightclub scene was disproportionately higher among LGB&T persons. For example, the factor that LGB&T people were more likely to have used selective drugs compared to the general population, was 1.5 for sedatives, 1.7 for antidepressants, 4.7 for cannabis, 8 for cocaine, 13 for ecstasy, 30 for mephedrone, and 160 for poppers[1].

[1] Please note that men who have sex with men frequently use poppers as they relax muscles that make anal sex easier. They are legally sold in many gay bars and nightclubs, yet it is illegal to advertise them for human consumption.

Table 34. Prevalence of drug use in LGB&T and Northern Ireland populations aged 15-64 (%)

DRUG	LIFETIME			LAST YEAR			LAST MONTH		
	APO	NI	TRANS	APO	NI	TRANS	APO	NI	TRANS
Any illegal drug[7]	62	22	74	37	7	53	28	3	40
Cannabis	56	24	66	27	5	42	14	3	26
Poppers	46	9	63	25	1	34	16	0.1	21
Opiates	40	29	55	30	6	50	22	4	42
Sedatives	38	21	47	22	11	34	12	8	24
Anti-depressants	37	22	50	22	12	37	17	10	34
Ecstasy	29	9	45	10	1	21	4	0.3	16
Cocaine	29	7	42	12	2	19	4	0.5	11
Amphetamines	22	6	32	4	1	13	1	0.3	5
Legal highs	21	2	40	10	1	23	3	0.2	10
LSD	17	5	24	2	0.2	8	0.2	0.0	0
Mephedrone	12	2	11	7	1	3	3	0.1	0

Source: APO Survey (2012) and NACD & PHIRB (2011) Drug Prevalence Survey 2010/11

11.4.4 In terms of gender differences in the LGB&T community, females were more likely than males to have used cannabis (lifetime: 61% vs 50%, last year: 29% vs 25%, last month: 16% vs 12%) which is in contrast to the general population. Otherwise the gender pattern in the LGB&T population is similar to the one in the general population (females higher for opiates and antidepressants; about similar levels for sedatives; males higher for illicit drugs) – particularly for more recent use.

11.4.5 Comparing the rates of use of antidepressants, poppers, sedatives, cannabis, and opiates for males and females by age group showed some differences between the LGB&T and general population.

Table 35. LGB&T females and males use of drugs

Compared to the general population ...	LGB&T females' use of	LGB&T males' use of
Antidepressants	Peak in youngest aged 15-24 (40%)	
Poppers		Around 40% in ages 15-44, then decreasing
Sedatives	Peak in 15-24, followed by 55-64 (u-shaped curve; general population: linear increase with age)	Peak in 25-34 (25%) and decreasing with age (in contrast to general population)
Cannabis	Decreasing with age but levelling off at age 35+ (around 17%)	Peak in 15-24 (46%) and linear decrease with age as in general population

Opiates	Peak in 15-24 (40%)	Around 30% in 15-44, then decreasing

11.4.6 **Problems associated with substance use**: Over the past 12 months, 8% of respondents reported withdrawal symptoms, 8% reported blackouts or flashbacks, and 4% mentioned medical problems. There were no gender differences but higher proportions of transgender individuals experienced these problems (23%, 20%, and 10%, respectively). The influence of substances was reported to have been a factor in suicidal thoughts (30%), suicide attempts (7%) and self-harming (15%). Again, all prevalences were higher among transgendered people (47%, 25%, and 35%, respectively). Alcohol and drug use were seen very much as a coping mechanism in a homophobic society (stigma, prejudice), which causes emotional and psychological distress, and resulting from the club and bar culture as the only opportunity for social activities.

Homeless People

11.4.7 A report by Deloitte (2004) explored substance use among homeless people, for which 154 individuals, ranging from 16 to 60+ years in age, were interviewed.

11.4.8 Alcohol use:

- 106 (69%; 57 males, 49 females) drank alcohol at least once a month;
- 39 drank at least once a week (25%; 26 males, 13 females);
- 48 were not drinking at time of interview (n=44: abstinent period ranging from 3 weeks to 10 years; n=4 never drank alcohol);
- 101 (95%) had 3 or more alcoholic drinks on a typical day when drinking;
- 70 (66%; 48 males, 22 females) scored 8+ on the AUDIT, indicating hazardous and harmful drinking.

11.4.9 A medium level of alcohol problems (AUDIT scores 8-15) were experienced by 64% of females and 31% of males, while 69% of males and 36% of females experienced a high level of alcohol problems (scores 16+). More 26-59 year olds reported high levels of alcohol problems.

Table 36. Prevalence of AUDIT scores by gender and age: absolute numbers (Deloitte, 2004)

AUDIT score	<8	8-15	16-19	20-29	30-39	*Total 8+*
All	*36*	*29*	*14*	*16*	*11*	***70***
Males	9	15	10	14	9	***48***
Females	27	14	4	2	2	***22***

16-17	1	3	6	2	1	***12***
18-25	15	16	5	6	1	***28***
26-59	18	10	3	8	9	***30***
60+	2	0	0	0	0	***0***

11.4.10For 15 individuals their alcohol use was the main reason for becoming homeless, while five said that continuing alcohol use was the main reason for remaining homeless.

*11.4.11**Drug use**:* Over two-thirds (69%) had lifetime experience of drug use, while 40% and 37% would have used drugs in the past year and past month, respectively.

Table 37 Drug use among homeless people (Deloitte, 2004)

N=154	**Lifetime**		**Last year**		**Last month**	
	n	**%**	**n**	**%**	**n**	**%**
All	*106*	*69%*	*62*	*40%*	*57*	*37%*
Males	61		40		39	
Females	45		22		18	

11.4.12 The most commonly used drugs for lifetime use were cannabis, ecstasy and amphetamines; this changed to cannabis, benzodiazepines, and ecstasy for recent and current use (33%, 14% and 12%; multiple responses). Prevalence by gender for the four most commonly is shown in Table 38. The strongest gender difference shows for benzodiazepines, with twice as many homeless males compared to homeless females having used them, a pattern in contrast to that in the general population. Similar to other surveys and prescribing data, benzodiazepine use is highest among homeless people aged 26-59.

Table 38. Most commonly used drugs by homeless people by gender (Deloitte, 2004)

	Lifetime		**Last year**		**Last month**	
	% Male	**% Female**	**% Male**	**% Female**	**% Male**	**% Female**
Cannabis	97	98	64	44	57	36
Ecstasy	66	62	38	22	25	9
Amphetamines	57	44	28	18	15	4
Benzodiazepines	62	31	43	20	26	13

Note: males: n=61; females: n=45

11.4.13 Drug dependence was assessed with the 10-item Drug Abuse Screening Test (DAST), using a cut-off score of 3 to determine a drug abuse problem in the last 12 months. All 61 drug users scored over 3, with more males (80%) scoring 6 or higher than females (52%). Among drug users:

- 69% never or only sometimes thought their drug use was out of control;

- 61% never or only sometimes wished they could stop using drugs;
- 75% did not worry or only worried a little about their drug use;
- 38% would not find it difficult to go without drugs.

11.4.14 Injecting drug use (ever) was reported by 13 homeless people, with three having injected drugs during the last four weeks. All three had engaged in either sharing spoon/filter, giving injecting equipment to someone else or used others' equipment.

11.4.15 Those who had used alcohol and drugs were asked about engaging in activities that put their health and safety at risk due to their substance use. Men were more likely to be involved in risk behaviours, except for self-harm. Younger homeless people (aged 16-17) had higher levels of self-harm (62%). Suicidal and criminal behaviour increased with older age groups, while those aged 18-25 had highest proportion of engaging in unsafe sex (43%).

Table 39 Risk behaviours related to substance use: overall and by gender

	All drug and alcohol users (N=134)		% Males (N=74)	% Females (N=60)
	n	%		
Suicidal behaviour	52	39	45	32
Unsafe sex	50	37	40	33
Criminal behaviour	48	36	50	18
Self-harm	44	33	32	33

Reference: Deloitte (2004). *Research into homelessness and substance misuse*.

Looked after children

11.4.16 Of the 1,675 children looked after at 30 September 2010, 5% (76) were identified as having a substance abuse problem; similar to the corresponding figure for England (4%).

11.4.17 Substance abuse was more common among older children with 16% of children looked after aged 16 and over identified as having a problem. All children identified as having a substance abuse problem were offered intervention and less than half of these (39%) accepted intervention.[16]

11.4.18 Department of Health, Social Services and Public Safety (2012). Children in Care in Northern Ireland 2009/10 Statistical Bulletin **http://www.dhsspsni.gov.uk/microsoft_word_-_2_oc20910bulletin.pdf**

Hidden Harm

11.4.19 Parental substance misuse is an important factor for children and young people being involved with social services. About 40% of children and young people registered on the Child Protection Register and about 70% of those being looked after have this status due to parental substance misuse (percentages from Hidden Harm Strategy). Table 40 extrapolates how many cases by HSCT area may be affected by parental substance misuse. Figures 8 and 9 provide trend data on how many children/young people are on the Child Protection Register and looked after by HSCT.

Table 40 Estimated number of children on Child Protection Register and looked after as a direct effect of parental substance misuse

	All	BHSCT	SEHSCT	SHSCT	NHSCT	WHSCT
Children on Child Protection Register						
N as 31 March 2012	*2,127*	474	529	363	458	303
Estimate: 40% as a direct effect of parental substance misuse	*850*	190	212	145	183	121
Looked after children						
N as 31 March 2012	*2,644*	653	512	420	634	425
Estimate: 70% as a direct effect of parental substance misuse	*1851*	457	358	294	444	298

Source: DHSSPS (2012; **http://www.dhsspsni.gov.uk/children_s_social_care_statistics_for_northern_ireland_2011-12.pdf)**

Figure 8 Children on the Child Protection Register by Trust at 31 March (2007-2012)

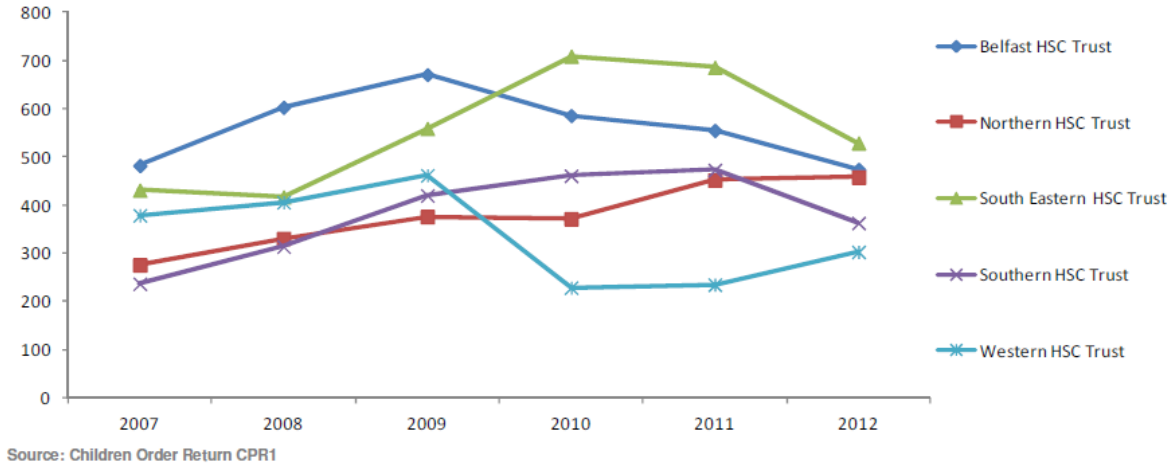
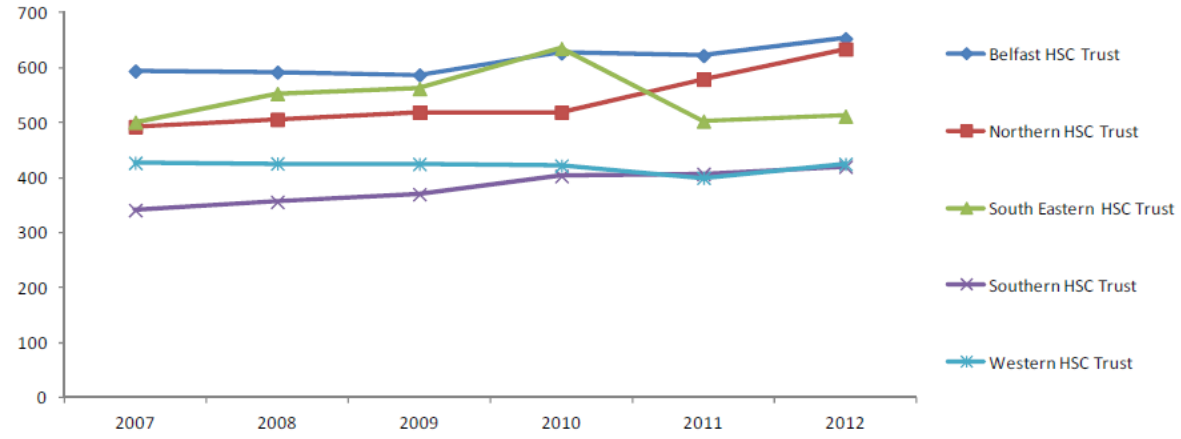


Figure 9 Looked after children by Trust at 31 March (2007-2012)



Source: Health and Social Care Board Corporate Parenting Returns and Children Order Return LA1

11.5 CRIMINAL JUSTICE SYSTEM

Police recorded drug seizures and arrest statistics

11.5.1 The annual report on police recorded drug seizure statistics for 2011/12 showed an increase in both drug seizure incidents (up by 10%) and number of individuals arrested for drug related offences (up by 4%) compared to the previous year (PSNI, 2012).

Table 41 Table Drug seizure incidents and arrests in NI 2009/10-2011/12

	2009/10	2010/11	2011/12	% change 10/11 to 11/12
Drug seizure incidents	3,319	3,564	3,920	10.0%
Numbers of arrests	2,250	2,435	2,543	4.4%

Source: PSNI (2012)

11.5.2 Overall, there was substantial variation in the rate of change in both the number of seizure incidents and arrests by policing district. The largest increases were seen in districts F, A and C (arrests only).

Table 42 Drug seizure incidents and arrests by police district and region 2010/11-2011/12

Policing district		No. of seizure incidents			No. of arrests		
		10/11	11/12	% change	10/11	11/12	% change
A	Belfast: N&W	420	516	22.9	231	264	14.3
B	Belfast: S&E	552	571	3.4	345	341	-1.2
C	Ards, Cregagh, Down, N Down	446	484	8.5	221	265	19.9
D	Antrim, C'fergus, Lisburn, N'abbey	445	518	16.4	380	421	10.8
	Urban region	***1,863***	***2,089***	***12.1***	***1,177***	***1,291***	***9.7***
E	Armagh, Banbridge, Craigavon, Newry & Mourne	548	646	17.9	307	320	4.2
F	Cookstown, Dungannon & S Tyrone, Fermanagh, Omagh	387	515	33.1	227	285	25.6
G	Foyle, Limavady, Magherafelt, Strabane	356	314	-11.8	327	292	-10.7
H	Ballymena, Ballymoney, Larne, Moyle	410	356	-13.2	397	355	-10.6
	Rural region	***1,701***	***1,831***	***7.6***	***1,258***	***1,252***	***-0.5***

Source: PSNI (2012)

11.5.3 Although larger drug seizures were generally made in urban areas, most mephedrone was seized in rural areas (primarily in policing district G: Foyle, Limavady, Magherafelt, Strabane).

Table 43 Hotspots for selected seized drugs

Selected drug type seized	Policing district
Amphetamine powder	D: Antrim, C'fergus, Lisburn, N'abbey
Cannabis resin	D: Antrim, C'fergus, Lisburn, N'abbey C: Ards, Cregagh, Down, N Down
Cannabis herbal	B: Belfast: South & East
Cannabis plants	C: Ards, Cregagh, Down, N Down E: Armagh, Banbridge, Craigavon, Newry & Mourne D: Antrim, C'fergus, Lisburn, N'abbey
Cocaine powder	A: Belfast: North & West D: Antrim, C'fergus, Lisburn, N'abbey
Ecstasy tablets	D: Antrim, C'fergus, Lisburn, N'abbey B: Belfast: South & East
Mephedrone powder	G: Foyle, Limavady, Magherafelt, Strabane
Opiate powder	A: Belfast: North & West

Note: areas with largest amount of drug seized in terms of numbers or weight (PSNI, 2012)

Probation Board for Northern Ireland caseload profile regarding alcohol and drugs

11.5.4 On 31 October 2011, PBNI had a caseload of 4,291 people. Individuals get rated in terms of an alcohol and drug Offending Related Score (ORS). Information on those scoring positively (i.e. alcohol or drugs being slightly, fairly, or very relevant to offending) during their latest Assessment, Case Management and Evaluation exercise are summarised in the table below. Over 7 in 10 people supervised by PBNI had an alcohol or drug offending related score (over half of females and 3 in 4 males), with this proportion only being lower in individuals aged 40 and older. Alcohol only ORS increased with age, while it declined for mixed alcohol and drug ORS with age and drug only ORS being most common among those aged 25-39.

Table 44 Alcohol and drugs ORS profile of PBNI caseload at 31 October 2011

	N	Any alcohol	Any drug	Alcohol + drug	Alcohol only	Drug only	Any alcohol or drug
All	4,291	*2,695*	*1,606*	*1,217*	*1,478*	*389*	***3,084***
		63%	*37%*	*28%*	*34%*	*9%*	***72%***
Males	3,855	65%	39%	30%	35%	9%	**74%**
Females	436	47%	23%	14%	33%	8%	**56%**
<20	401	67%	49%	41%	26%	7%	**75%**
20-24	1,097	71%	46%	38%	32%	8%	**78%**
25-29	778	65%	47%	33%	32%	13%	**78%**
30-39	934	61%	40%	28%	34%	13%	**74%**
40-49	676	57%	20%	14%	43%	6%	**63%**
50+	405	47%	7%	4%	42%	3%	**49%**

Additional Information:

Population in need of treatment: English evidence

11.5.5 An alcohol needs assessment in England showed that only 1 in 18 (5.6%) dependent drinkers received treatment (Alcohol Needs Assessment Research Project (ANARP, 2005)**http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122239.pdf.**

11.5.6 This study found that

- 26% of adults aged 16-64 have an alcohol use disorder (36% males, 16% females);
- 3.6% of adults aged 16-64 were dependent drinkers (6% males, 2% females);
- Two-thirds of those referred never enter services and 40-60% of those entering alcohol treatment will drop out within a couple of sessions.

11.5.7 **Method used:** Psychiatric morbidity survey 2000 prevalence rate is based on AUDIT which was used to identify hazardous and harmful drinking (scores 8-15) and alcohol dependence (score =16+) **http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf**

11.5.8 Cross validation was conducted: estimates based on AUDIT scores 8-15 overlapped with those exceeding weekly sensible limits (General Household Survey) and those exceeding harmful levels of weekly alcohol use with those scoring 15+ on AUDIT. NICE alcohol treatment guidance recommends an

AUDIT score of 15+ as the cut-off for comprehensive assessment . **http://www.nice.org.uk/nicemedia/live/13337/53191/53191.pdf).**

11.5.9 Alcohol Concern quotes that 2008/9 figures from the National Treatment Agency suggest that 1 in 13 problem drinkers accessed treatment support; however this figure includes non-dependent drinkers (in Alcohol Concern, 2010).

11.5.10 (For more up-to-date treatment figures see **http://www.nta.nhs.uk/uploads/natmsstatisticalrelease201011.pdf** but it does not provide proportions.)

11.5.11 DH (2009) suggested that treatment access levels should be 15% (1 in 6/1 in 7) of local dependent population **(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104854.pdf).**

11.5.12 The 2007 Psychiatric Morbidity Survey provides the latest English figures for alcohol misuse and dependency: **https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf** p.151ff for alcohol

11.5.13 Alcohol related hospital admissions – ICD 10 codes

The following ICD-10 codes (as used by Scotland) have been used to identify alcohol related admissions:

E244 Alcohol-induced pseudo-Cushing's syndrome

E512 Wernicke's encephalopathy
F10 Mental and behavioural disorders due to use of alcohol

G312 Degeneration of nervous system due to alcohol

G621 Alcoholic polyneuropathy
G721 Alcoholic myopathy
I426 Alcoholic cardiomyopathy
K292 Alcoholic gastritis
K70 Alcoholic liver disease
K860 Alcohol-induced chronic pancreatitis

O354 Maternal care for (suspected) damage to fetus from alcohol

P043 Fetus and newborn affected by maternal use of alcohol

Q860 Fetal alcohol syndrome (dysmorphic)

R780 Finding of alcohol in blood

T510 Ethanol
T511 Methanol
T519 Alcohol, unspecified
X45 Accidental poisoning by and exposure to alcohol

X65 Intentional self-poisoning by and exposure to alcohol

Y15 Poisoning by and exposure to alcohol, undetermined intent

Y573 Alcohol deterrents
Y90 Evidence of alcohol involvement determined by blood alcohol level

Y91 Evidence of alcohol involvement determined by level of intoxication

Z502 Alcohol rehabilitation
Z714 Alcohol abuse counselling and surveillance

Z721 Alcohol use

APPENDIX B

12.0 Organisations providing counselling* and / or support/advice** services must incorporate the following principles of good practice: Appendix 1

12.1 All counsellors should be accredited or working towards accreditation with the British Association for Counselling and Psychotherapy (BACP)/ the Irish Association for Counselling and Psychotherapy (IACP)/ British Association for Behavioural & Cognitive Psychotherapies (BABCP).

12.2 Whilst it is also recognised that not all counsellors / therapists will have achieved a professionally recognised qualification, it is essential that those providing direct care (who have not obtained qualifications) are supervised by a qualified supervisor in line with point 3.1 above.

12.3 All counsellors/therapists should receive supervision from an appropriate qualified supervisor who is experienced and practising in line with their professional body's standards and code of ethics.

12.4 All clients should have their care reviewed by the counsellor responsible for their care in accordance with needs and assessed risks.

12.5 The delegation of authority to other staff members should only occur when the following measures have been considered:

12.6 Appropriate assessment of client has occurred supported by organisation policies and procedures

12.7 Specific circumstances have been considered e.g. setting and availability of adequate resources

12.8 Member of staff is competent and has received appropriate training to undertake task

12.9 Records are maintained of delegation process

12.10 Process for ongoing monitoring and support is established.

12.11 Providers of specific counselling services, must keep full, accurate and up to date records of the background, experience, qualifications, accreditation status and supervision arrangements of all the counsellors/therapists working at their organisation.

12.12 All counsellors/therapists should have received Applied Suicide Intervention Skills Training (ASIST)/ Mental Health First Aid / Safetalk training or equivalent as agreed by HSCB / PHA.

12.13 All staff delivering or supporting the delivery of counselling and / or support/advice services should be confident in the use of helpline services including Lifeline and ensure that all such referrals are relevant, timely and appropriate.

12.14 Organisations providing counselling and / or support/advice services must have:

a) confidentiality protocols in place and make all staff aware of these protocols and have an understanding of their application.

b) information sharing protocols in place which aim to improve communication between statutory and voluntary organisations regarding the delivery of care when appropriate. All staff must be informed of these protocols and have an understanding of their application.

c) adequate systems to record information in place to support monitoring and evaluation internally and by the HSCB/PHA.

12.15 «Name_in_CAPS_Acronym» must follow the procedures for the identification, reporting, reviewing and responding to Serious Adverse Incidents (SAI) as outlined in HSCB protocol for the management of SAIs, April 2010.

12.16 Where a SAI involving a client/service user of «Name_in_CAPS_Acronym» is reported by a Health and Social Care Trust, «Name_in_CAPS_Acronym» will participate and co operate fully as will its staff in the multi-disciplinary review of that incident where aspects of the service provided by «Name_in_CAPS_Acronym» are also likely to be reviewed.

12.17 Where the SAI is confined to «Name_in_CAPS_Acronym» and is not related to services provided by a Health and Social Care Trust, «Name_in_CAPS_Acronym» will report the SAI directly to PHA. «Name_in_CAPS_Acronym» will be responsible for convening the multi-disciplinary review and producing the required report within the specified timescale.

APPENDIX C

13.0 Evidence To Support Commissioning In Education And Prevention For Children And Young People

13.1 Evidence of effectiveness supports specific programmes which are listed in the following overview. Most of the systematic reviews included in this evidence review focused on universal programmes.

	Primary school age	**Post-primary school age**
Recommended universal programmes		
School setting	Good Behaviour Game Seattle Social Learning Project	Life Skills Training Unplugged
Family-based		Strengthening Families Programme 10-14
Multi-component	Seattle Social Learning Project (school and parents)	
Promising universal programmes		
School		SHARP
Family		Preparing for the Drug Free Years Family Matters STAR Focus on Families
Multi-component	Linking the Interests of Families and Teachers Communities that Care	Keepin' it REAL Be under your own influence PROSPER
Promising selective or multi-tier programmes		
Family selective	Strengthening Families Programme (Kumpfer model) Coping Power program	Strengthening Families Programme (Kumpfer model)
Multi-tier		Adolescent Transitions Program/Family Check-Up

13.2 With regard to at-risk groups for substance misuse and those already engaging in substance misuse, three NICE public health guidance documents

(nos 4, 7, 24; see summary below) make specific recommendations. These generally involve work with parents/carers (parenting skills, family functioning), even including family therapy where appropriate, motivational interviewing for parents/carers, and, for young people, brief intervention or substance misuse treatment, referral to other relevant services (please see section for youth treatment). The ATP/Family Check-Up offer such tiered approaches to substance misuse and antisocial behaviour/delinquency.

13.3 Any programme implementation needs to be accompanied by a thorough evaluation.

Overview of recommendations from relevant NICE Public Health Guidance

NICE PH 4 (2007). Community-based interventions[1] to reduce substance misuse among vulnerable and disadvantaged children and young people[2]	**NICE PH 7 (2007). Interventions in schools to prevent and reduce alcohol use among children and young people**	**NICE PH 24 (2010). Alcohol-use disorders: preventing the development of hazardous and harmful drinking**
R1: any vulnerable / disadvantaged <25 • Local service model that defines role of local agencies and practitioners, referral criteria and referral pathways **R2:** any vulnerable / disadvantaged <25 • Screening and assessment of those misusing/at risk of misusing substances • Work with parents/carers, education welfare services, CAHMS, school drug advisers or other specialists – provide support, refer children/young people to appropriate services	**R1:** children and young people in school • alcohol education – age relevant: knowledge, attitudes, skills , media, advertising and social influences; • 'whole school' approach • signpost parents/carers for parenting skill training **R2:** children and young people in school thought of drinking harmful amounts of alcohol • Offer brief one-to-one advice and follow-up appointment or referral to external services • Direct referral (without one-to-one advice) • Where appropriate involve parents/ carers in consultation and any referral	**R7:** screening young people aged 16-17 • AUDIT or abbreviated versions • Key groups: had accident/minor injury; regularly attending GUM clinics or seek emergency contraception; involved in crime or other antisocial behaviour; truant on a regular basis; at risk of self-harm; LAC; involved with safeguarding agencies **R8:** extended brief interventions with young people aged 16-17 • Those that screened drinking hazardously or harmfully • Those actively seeking treatment for alcohol problem: physical and mental assessment; if appropriate refer for treatment • Intervening with those

R3: vulnerable/disadvantaged aged 11-16 • Family-based programme of structured support over 2 or more years: at least 3 brief MI each year for parent/carers, assess family interaction, offer parental skills training, encourage parents to monitor their children's behaviour and academic performance, include feedback • Offer more intensive support (e.g. family therapy) if needed **R4:** children aged 10-12 who are persistently aggressive and disruptive • Children offered group-based behavioural therapy over 1-2 years (before and during transition to secondary school) • Offer parents/carers group-based training in parental skills **R5:** vulnerable/disadvantaged <25 with problematic substance misuse • Offer one or more motivational interviews		below age 16 years generally requires efforts to include parents/carers

[1] interventions or small-scale programmes delivered in community settings such as schools and youth services

[2] <25: whose family members misuse substances; with behavioural, mental health or social problems; excluded from school and truants; young offenders; LAC; homeless; involved in commercial sex work; from some BME groups

Sources: **http://www.nice.org.uk/nicemedia/live/11379/31939/31939.pdf**
http://www.nice.org.uk/nicemedia/live/11893/38407/38407.pdf
http://www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf

NICE PSHE guidance has been suspended **http://guidance.nice.org.uk/PHG/0**

Alcohol and drug education: review of the evidence

Terminology and conceptual clarity

13.4 Children and young people are the population groups most often targeted by alcohol and drug education, primarily so in the school setting. Expert reviews summarising the bulk of evidence of all alcohol-related policy and interventions (e.g. Alcohol and Public Policy Group, 2010; Anderson & Bamberg, 2006; Anderson et al., 2009; WHO, 2009) generally conclude that education and persuasion approaches are not effective at achieving and sustaining change in drinking behaviour. Others would suggests that expectations of substance use prevention efforts still showing effects years after the intervention are unrealistic considering the wider context of alcohol and drug use (i.e. pressures to use substances; Velleman, 2009, p.30).

13.5 Educational interventions have been defined as those that "*aim to raise awareness of the potential dangers of alcohol* [and other substance] *misuse (e.g. increase knowledge) so that young people are less likely to misuse alcohol* [and other substances]" (Foxcroft & Tsertsvadze, 2011, p.3). Aside of educational interventions, which are among the least successful approaches (see meta-analysis by Tobler et al., 2000), interventions that aim to prevent alcohol and drug (mis)use also involve other approaches. For example, psychosocial approaches "*aim to develop psychological skills (e.g. peer resistance) through modelling, understanding, norm-setting and social skill practice, so that young people are less likely to misuse alcohol* [and other substances]" (Foxcroft & Tsertsvadze, 2011, p.3). Thus the term alcohol/drug education is misleading and should be replaced with 'prevention'. More recently, Strang et al (2012) concluded: "*The collective value of school, family, and community prevention programmes is appraised differently by different stakeholders*." (p.71).

13.6 This overview of the evidence of what works focuses on the prevention of alcohol and drug use in terms of initiation of use and escalation of use. Education components as part of treatment for alcohol and drug problems are not considered here. Also, secondary prevention approaches (i.e. reducing high levels of use) for adults often involve motivational interviewing and brief intervention; again these are not included in this overview.

Sources of evidence

13.7 Several sources of evidence were consulted:

- The Cochrane Library of systematic reviews was searched for reviews related to alcohol and drug prevention, resulting in 8 systematic reviews;

- NICE website for evidence reviews prepared for school-based alcohol prevention and PSHE, resulting in 4 evidence reviews

- WHO: 1 review;

- Reference lists of identified systematic and expert reviews, medical and alcohol and drug journals: 9 reviews.

13.8 The above mentioned expert reviews (Alcohol and Public Policy Group, 2010; Anderson & Bamberg, 2006; Anderson et al., 2009; WHO, 2009) were excluded as they generally only repeated findings from systematic reviews and some of their references have since been updated (e.g. Cochrane review by Foxcroft et al., 2002) or the original source has already been included in this overview.

13.9 An overview of the selected reviews is presented in Table 1, categorising the reviews by setting of interventions considered in them and which substance they primarily focused on. 'Alcohol' and 'drugs' refer to reviews that primarily focused on these substance classes as outcome measures (irrespective of intervention outcomes having been measured in the other substance class). Some alcohol-related reviews will also report on drug-related outcomes of interventions. 'Substance' refers to reviews that included interventions targeting drugs and/or alcohol. 'Multiple' includes reviews which examined interventions that targeted multiple risk behaviours beyond substance use (here: substance use and sexual activity).

13.10 The vast majority or reviews focused on interventions addressing alcohol use and many targeted children and young people. Two reviews examined interventions for college/university students (Moreira et al., 2010, Scott-Sheldon et al., 2012), while Spoth et al. (2008) and Jackson et al. (2010) concluded that young people/adults (particularly when not in college/university) are an under-investigated group with few if any interventions available or tested. One review focused on pregnant women (Stade et al., 2009).

Table 1 Overview of reviews by setting and focus

	Alcohol	Drugs	Substances	Multiple
School	**Foxcroft & Tsertsvadze, 2011a**; *Jones et al., 2007, 2009a, b*	**Faggiano et al., 2008**		
Further/higher education	**Moreira et al., 2010** Scott-Sheldon et al., 2012			
Family	**Foxcroft & Tsertsvadze, 2011b** Smit et al., 2008		Petrie et al., 2007	
Community			**Thomas et al., 2011**	
Health	**Stade et al., 2009**			
Multi-component	**Foxcroft & Tsertsvadze, 2011c**			
Any setting	Foxcroft, 2006 *Jones et al., 2010* (non-school) Spoth et al., 2008 Velleman, 2009	**Gates et al., 2009** (non-school); Strang et al., 2012	Stead et al., 2007	Jackson et al, 2010; 2011

Note: **Cochrane reviews** in bold print; *NICE evidence reviews* in italics;

13.11 Many of the children and young people focused reviews included the same interventions. However, judgements made about these interventions (as effective, promising or not worthwhile) vary across reviews, at times depending on what follow-up data of evaluations were used. More recent reviews may have included longer follow-up findings. Moreover, different reviewers had different inclusion criteria and may have weighted evidence differently. The following sections summarise the findings from the various reviews by setting and/or population group.

Findings

13.12 A more detailed description of the review and the main findings reported are summarised in Table A1 in the Appendix.

a. School-based prevention

13.13 For alcohol use, certain generic psychosocial and developmental programmes have shown effectiveness, particularly around drunkenness and binge drinking (Foxcroft & Tsertsvadze, 2011a; Jones et al., 2007, 2009a, b; Velleman, 2009). Effects of generic programmes were generally stronger and longer-lasting than those of alcohol-specific programmes, and the former have the advantage of tackling a broader range of problem behaviours (Foxcroft & Tsertsvadze, 2011a). There is some evidence of effectiveness of skills-based

approaches for drug use among young people (Faggiano et al., 2008; Strang et al., 2012; Velleman, 2009).

Table 2

Level of evidence	Program	Reviews recommending program
Most promising	Life Skills Training (Botvin)	Foxcroft & Tsertsvadze, 2011a Jones et al., 2007, 2009a Strang et al., 2012 Velleman 2009
	Unplugged	Foxcroft & Tsertsvadze, 2011a
	Good Behaviour Game	Foxcroft & Tsertsvadze, 2011a Jones et al., 2009b Strang et al., 2012
Some Evidence	SHAHRP (alcohol only)	Foxcroft & Tsertsvadze, 2011a Jones et al., 2007
No evidence of effectiveness	Project DARE, Project Alert, Project TND, Project SMART	Foxcroft & Tsertsvadze, 2011a Jones et al., 2007; 2009a

Note: Unplugged : **http://www.eudap.net/Research_Publications.aspx;** GBG: **http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3188824/; http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=201; http://evidencebasedprograms.org/wordpress/1366/good-behavior-game/**

b. Family-based prevention

13.14 Family-based prevention can be provided at universal level or targeted to specific at risk populations or those showing problems already (see review by Petrie et al., 2007). Universal family-based prevention "*typically takes the form of supporting the development of parenting skills including parental support, nurturing behaviours, establishing clear boundaries or rules, and parental monitoring. Social and peer resistance skills, the development of behavioural norms and positive peer affiliations can also be addressed with a universal family-based preventive program*." (Foxcroft & Tsertsvadze, 2011b, p. 3).

13.15 Family-based interventions have shown to be effective in delaying initiation of alcohol use and reducing the frequency of drinking, even in the long-term. They show stronger and longer lasting effects than school-based programmes (Foxcroft, 2006; Foxcroft & Tsertsvadze, 2011b; Jones et al. 2010; Petrie et al., 2007; Smit et al., 2008; Spoth et al., 2008; Velleman, 2009). There is some evidence of effectiveness in relation to drug use but fewer studies have examined drug use as an outcome (Gates et al., 2009; Petrie et al., 2007; Strang et al., 2012).

13.16 The reviews specific to family-based interventions (Foxcroft & Tsertsvadze, 2011b; Petrie et al., 2007; Smit et al., 2008) generally concluded that family-

based interventions work. SFP 10-14 was generally mentioned as it had the longest follow-up period and had shown increasing programme effects. Many other programmes were mentioned positively and would deserve further examination of their content and findings (see specific reviews). Petrie et al. (2007) stressed that effective parenting interventions focussed on developing strategies to involve adolescents in family activities to maintain family bonds and manage conflict. Moreover, such interventions also included active parental involvement and emphasised the development of social skills and a sense of personal responsibility among young people.

Table 3

Level of evidence	Program	Reviews recommending program
Most promising	Strengthening Families Programme SFP 10-14	Foxcroft 2006 Jones et al., 2007, 2010 Petrie et al., 2007 Smit et al., 2008 Stead et al., 2006 Strang et al., 2012 Velleman 2009
Some Evidence	Preparing for the Drug-Free, Years/Guiding Good Choices, Strong African American Families (SFP adaptation), Adolescent Transition Program, Family Matters, STARS, Coping Power Program	*Not all programmes were mentioned in every review*: Foxcroft & Tsertsvadze, 2011a Jones et al., 2007, 2010; Petrie et al., 2007 Smit et al., 2008 Spoth et al., 2008 Velleman, 2009

c. Multi-component interventions

13.17 Multi-component interventions "are defined as those prevention efforts that deliver interventions in multiple settings" (Foxcroft & Tsertsvadze, 2011, p. 3), i.e. in schools, with families, and in the community. Inconsistent conclusions were drawn by various reviewers. While some claim there is, overall, little evidence that multi-component interventions are more effective than single component ones (Foxcroft & Tsertsvadze, 2011; Gates et al., 2009; Strang et al., 2012), others state that they can be effective and may achieve larger effects due to targeting multiple settings (Jackson et al., 2010; Spoth et al., 2008; Velleman, 2009). There is supportive evidence that certain universal multi-component programmes are effective (Foxcroft & Tsertsvadze, 2011c); with some evidence that the family component being the main driver of effects (see Spoth et al., 2008; Velleman, 2009). One advantage some of these programmes is their generic nature which addresses multiple risk-taking behaviours and, despite small effects, may be of public health importance (Foxcroft & Tsertsvadze, 2011c). Others have highlighted the costs of sustaining community-based multi-component interventions and their effects (Giesbrecht & Haydon, 2006).

Table 4

Level of evidence	Program	Reviews recommending program
Most promising	Seattle Social Development Project	Foxcroft & Tsertsvadze, 2011c Jackson et al., 2010, 2011 Jones et al., 2007, 2009b Velleman 2009
Some Evidence	*Be under your own influence*	Foxcroft, 2006 Foxcroft & Tsertsvadze, 2011c Jones et al., 2007, 2009a, 2010
	Linking the Interests of Families and Teachers Program Communities That Care PROSPER *Keepin' it REAL*	Foxcroft & Tsertsvadze, 2011c Jones et al., 2007, 2009a, 2010 Velleman, 2009
Inconsistent evidence	Project Northland Midwestern Prevention Project	Jones et al., 2009a, 2010 Stead et al., 2006

d. Lack of evidence of effectiveness: young people's substance use

13.18 Evidence of effectiveness can be missing due to two reasons: 1) there is a lack of evidence as too few studies were conducted and/or findings were inconsistent; 2) studies found no effects of the intervention in the desired direction.

13.19 No or negative effects for:

- Media campaigns as stand-alone interventions (Jackson et al., 2010; Jones et al., 2009a; Spoth et al., 2008);

- Project DARE and Project ALERT (Foxcroft & Tsertsvadze, 2011a; Jones et al., 2009a; Rhule, 2005).

Too few studies, with inconsistent effects:

- Drinking age laws (Spoth et al., 2008: quality of the evidence, inconsistent findings);

- Mentoring (Thomas et al., 2011: only 4 RCTs found with inconsistent effects);

- Whole school approaches (e.g. Gatehouse Project; Healthy School and Drugs; Jackson et al., 2010; Jones et al., 2009a).

13.20 Overall, there seemed to be a lack of evidence for older adolescents/young adults, particularly those not in further or higher education, and for specific at-risk populations such as children in care, children not attending school, young people in the criminal justice system (Spoth et al., 2008; Velleman, 2009).

e. University and college students

13.21 Two systematic reviews examined social norm and expectancy challenge interventions (Moreira et al., 2010; Scott-Sheldon et al., 2012). The Cochrane review on social norm interventions showed that those delivered by web or computer feedback were effective in reducing a variety of outcome measures (drinking norms, drinking frequency and quantity, binge drinking, alcohol-related harm, peak blood alcohol concentration; Moreira et al., 2010). Individual face-to-face feedback was also effective but for fewer outcome measures (drinking frequency, binge drinking). However, these effects were primarily only in the short-term (up to 3 months), while few lasted into the medium-term (4-16 months). There was a lack of effect and evidence for group-based face-to-face and mailed feedback. Contradictory results were found for two social marketing campaign studies which had long follow-up periods (3 years). Variation in alcohol outlet density around selected campuses may have moderated programme effects.

13.22 The meta-analysis on expectancy challenge interventions showed their effectiveness in reducing positive alcohol expectancies, quantity consumed, and frequency of heavy drinking in the short-term (up to 1 month; Scott-Sheldon et al., 2012). Due to their short-lived effects, the usefulness of such interventions for changing college students' alcohol use has been doubted. The best time to employ such interventions may be just prior to "*periods when students are more likely to engage in at-risk drinking behaviour ... to maximise their utility*" (Scott-Sheldon et al., 2012, p.403)

f. Pregnant women

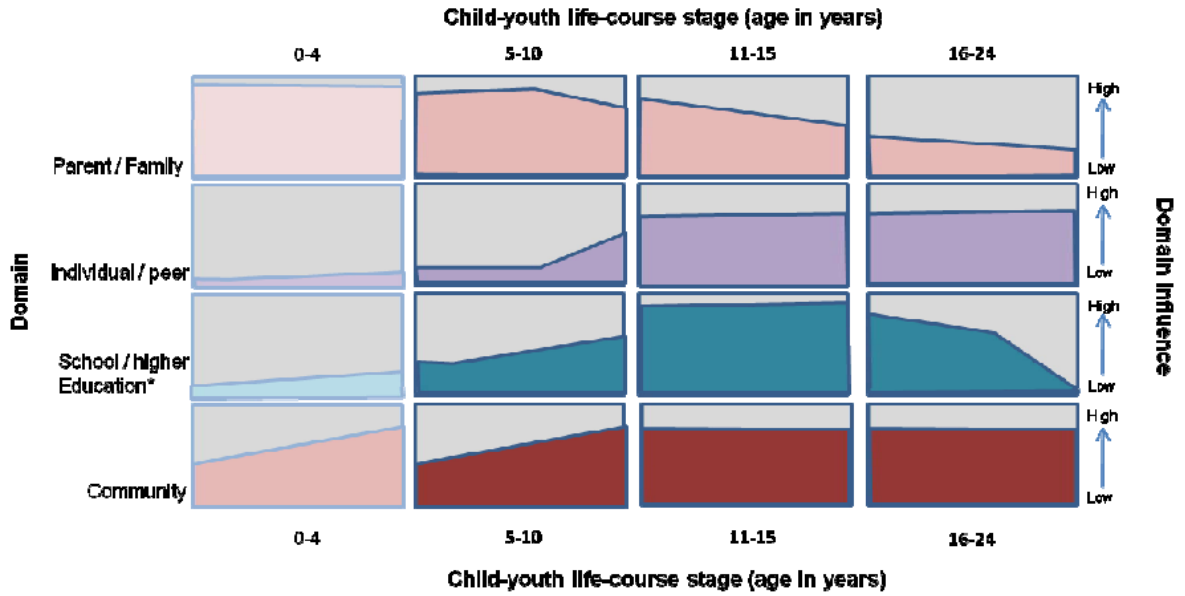
13.23 A Cochrane review on psychological and/or educational interventions for pregnant women, including only four RCTs, concluded that there was little evidence of the effects of such interventions on the health of women and babies (Stade et al., 2009). The interventions were very diverse and showed only weak and inconsistent effects on alcohol consumption. The lengthy assessment of alcohol use may have had an impact in itself. Drinking levels decreased with progressing pregnancy in both intervention and control

groups. In comparison to smoking in pregnancy there was a lack of studies for drinking and pregnancy.

Integrating the findings from the different reviews

13.24 Jackson et al. (2010) draw attention to transition points and critical periods[2] as key concepts of life-course epidemiology. Risk and protective factors fall into four key domains – individual, family, school, community – with their impact on developing risk behaviours changing across the child-youth stage of the life-course (in terms of relative impact). The pre-adolescent period and the transition from primary to secondary school represent a critical period. "In short, truly primary preventive interventions for risk behaviours in adolescence should ideally be applied at much earlier ages." (p.82).

Figure 1 Schematic representation of the contribution of each domain to the development of youth risk behaviour, with block-colour graphs representing the variation in importance from low to high (from Jackson et al., 2010)



13.25 Overall, family-based interventions seem to have the best evidence of effectiveness, with some school-based programmes (particularly those addressing skills and that are generic) and those that bridge school and family domains also being supported. However, these interventions are effective at particular stages in development and several reviews drew conclusions around this. For example, the strongest evidence for family-based interventions is for pre-teen and early adolescents (Petrie et al., 2007); primary school children respond better to programmes combining school and family-based components while alcohol and drug education programmes are not effective (Jones et al., 2009b):

[2] Transition points "mark a change in social, psychological, or physiological states", while critical periods are "a limited time-window in which an exposure can have a profound adverse or protective effect on development and disease, or behaviour, outcome" (see Jackson et al., 2010, p.82).

- Early childhood interventions (e.g. Family Nurse Partnership, Perry Preschool Program) were considered "*not sufficient to prevent all risk behaviour in young people*" (Jackson et al., 2010, p.62);

- Primary school level: Seattle Social Development Project, Good Behaviour Game, Linking the Interests of Families and Teachers (Foxcroft & Tserstsvadze, 2011a, Jackson et al., 2010; Jones et al., 2007, 2009a, b);

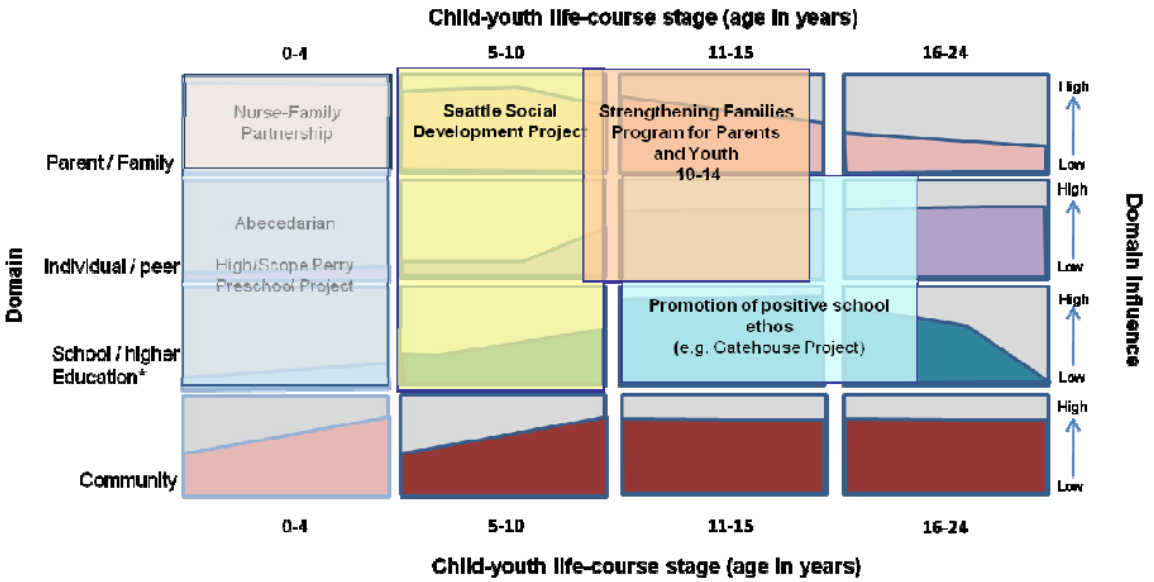
- Transition primary to/early period of secondary/post-primary school: Strengthening Families Programme SFP 10-14 (Foxcroft & Tserstsvadze, 2011a, Jackson et al., 2010; Jones et al., 2007, 2009a, 2010; Petrie et al., 2007);

- Secondary/post-primary level: Life Skills Training, interventions promoting positive school ethos (e.g. Gatehouse Project) (Foxcroft & Tserstsvadze, 2011a, Jackson et al., 2010; Jones et al., 2007, 2009a.

13.26 Communities That Care and PROSPER (both multi-component approaches in the United States) are good examples of cross-domain approaches that attempt to address multiple risk behaviours (see community support review for further detail).

Jackson et al. (2010) suggest the following combination of programmes sequentially ordered across the child-youth part of the life course:

Figure 2 Known effective, or promising interventions, interventions to reduce multiple risk behaviour in young people, schematic representation of domain influence on risk behaviour (in Jackson et al., 2010)



To target or not to target: the case for universal intervention

13.27 All the above specified prevention programmes (in this section) are universal programmes for whole populations. Foxcroft and Tserstsvadze (2011a, b) outline that even the small effects these universal programmes produce can be of public health significance. Several conditions are discussed in the literature according to which a universal approach should be used:

- If the condition/risk behaviour is highly prevalent and its costs are high; an intervention addressing it is relatively inexpensive and has proven its effectiveness (see Spoth et al., 2008);

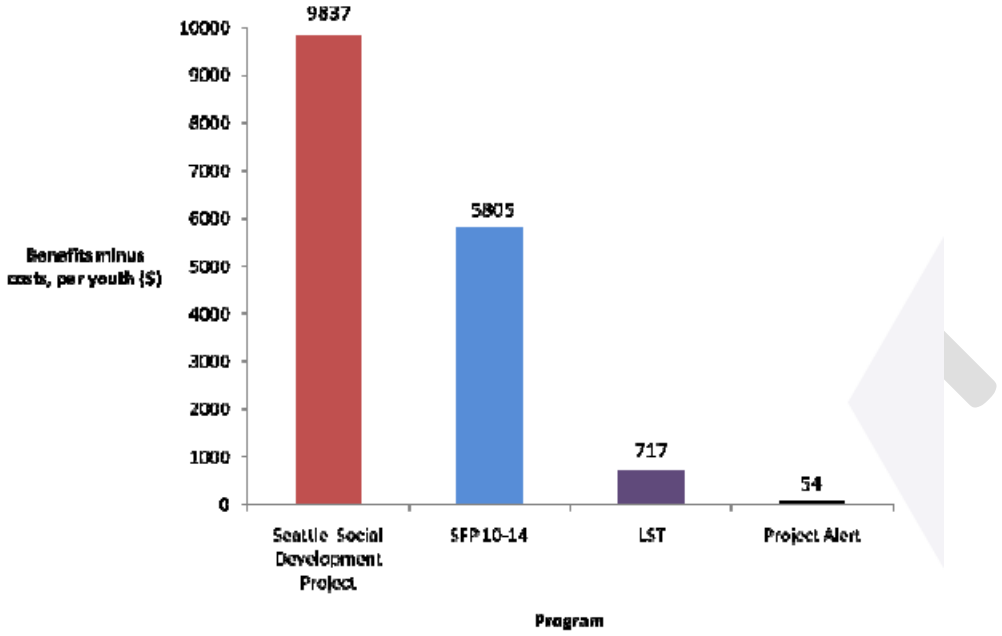
- If the risk factors for developing a problem are not easily identified, are diffuse in the population and cannot easily be targeted by an intervention (see Foxcroft and Tserstsvadze, 2011b);

- When the prevention paradox operates, "*i.e. more problems within a population arise from those at lower levels of risk than those at higher levels of risk*" (Foxcroft and Tserstsvadze, 2011b).

13.28 For example, both SSDP and SFP 10-14 have shown respectable outcomes in intention to treat analysis. For different outcomes numbers needed to treat

(NNT) ranged between 6 and 10 for either program[3], compared to 16-36 for individual-focused, school-based interventions (Jackson et al., 2010). Also economic benefit analysis would also favour the SSDP and SFP 10-14 programmes (Figure 3).

Figure 3 Economic benefit of 4 USA-based programmes demonstrated to be effective in reducing multiple risk behaviour in the short- and/or long-term (in Jackson et al., 2010)



13.29 For example, taking family-based intervention, which were the best supported by evidence, either as stand-alone or part of multi-component approaches, Velleman argues for their universal implementation, opposing NICE guidance (2007; for vulnerable and disadvantaged youth). "*Almost all of the research reviewed ... on family factors ... shows that these are vital, and yet many parents and families will be less than perfect on every one of those family factor dimensions. ... At present there is a dichotomous division between 'problem families' and 'non-problem families'; but in reality there is an immense continuum along which families and parents will lie, with a relatively arbitrary cut-off deciding on who is 'a case', 'a problem family'.* ***In reality, almost all families and parents have deficits on at least some of these family factors****, and parenting skills training and family management intervention strategies are the things most likely to delay adolescent alcohol initiation and prevent later misuse*." (p.37; emphasis in bold added).

13.40 However, there are instances where selective (early intervention) and indicated (treatment) interventions are necessary. In specific high-risk subgroups the relative importance of the four key domains will follow a

[3] SFP NNT=9 in Foxcroft et al., 2002 for initiation of drinking, drinking without permission, initiating drunkenness

different pattern which needs address by the type and scope of interventions delivered (Jackson et al., 2010). Several of the reviews also included selective and indicated interventions (e.g. Petrie et al., 2007; Spoth et al., 2008; Velleman, 2009).

Some thoughts on implementation

13.41 When selecting interventions, Foxcroft and Tsertsvadze (2011b) state that *"[T]those interventions that show persistence of effects over several years are more useful than those interventions that show immediate or short-term effects but no evidence of any longer-term duration of impact over several years."* (p.3). Programmes highlighted in this overview as promising or best supported by evidence, particularly those listed in section 4, are those with the longest follow-up whilst still maintaining effects. However, Velleman (2009) would argue that intervention effects in the short- and medium-term, particularly those delaying the initiation of drinking, are useful and not too much weight should be placed on "*interventions relative to ongoing factors within society*" (p.30).

13.42 Most of the studies included in the various reviews originate in the United States, some in Europe and Australia. This means that even effective programmes may not easily translate to the UK/Northern Ireland context due to cultural and contextual differences. Cultural adaptation may be necessary but attention needs to be paid regarding the depths of changes made (i.e. how much change in content is allowable to still qualify as a replication?, see Spoth et al., 2008). Cultural adaptations and issues around programme fidelity may threaten the integrity of programmes and their effects.[4]

13.43 In addition, there are issues around delivery, recruitment and exposure rates which impact on the success of interventions. For example, family interventions showed the strongest effect when they were offered at group level and not only to individual families who were allocated to the intervention (Smit et al., 2008). As intake in post-primary schools in Northern Ireland is not tied to catchment areas and pupils and their families in one classroom may not make up each others' peer network outside school, this proposes a new challenge to getting group coverage with family-based approaches and to achieve saturation in programme attendance in localities.

13.44 Any implementation of a programme should be followed up with a thorough evaluation and continued monitoring to further build the evidence base (Jones et al., 2009a, b, 2010; Velleman, 2009).

The broader context

13.45 Both Velleman (2009) and Jackson et al. (2010) highlight the importance of the broader social context in which young people's drinking and other risk-taking behaviour emerges. Jackson et al (2010) recommend that prevention

[4] Such problems have emerged with adaptations of SFP where format and/or content of delivery have been changed in other studies and, thus, generally no effects have been found.

programmes *"must be accompanied by broader social change (to address the impact of pricing availability of substances, marketing, media, culture and social norms on risk behaviour) and efforts to reduce marginalisation, social exclusion and the vulnerability of young people during periods of transition."* (p. 86).

13.46 Velleman (2009) identifies that an integrated, planned and implemented community prevention system is needed, that *"draws together what is known about effective parenting programmes, organisational change programmes in schools, classroom organisation, management and instructional strategies, classroom curricula for social and emotional competence promotion, multi-component programmes based in schools, community mobilisation, community/school policies, enforcement of laws relating to underage purchasing and selling alcohol to intoxicated people, altering community and cultural norms so that drunken comportment behaviour is not tolerated (and certainly not encouraged), and how to effect price, availability and accessibility, and to implement them in a planned fashion."* (p.43).

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Table A1. Summary of reviews

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Cochrane reviews					
Foxcroft & Tsertsvadze, 2011a	SR, U	<18, A	School	Psychosocial and/or educational interventions 53 trials of universal school-based preventions programmes • generic programmes (39) • alcohol-specific programmes (11) • alcohol+ (3)	• 15 generic and 6 alcohol-specific programmes had positive effects on alcohol use (mainly drunkenness or binge drinking) • Duration of intervention effect longer in generic compared to alcohol-specific/other programmes (persistent effects) • Generic: those based on psychosocial or developmental approaches more likely to report significant effects over several years ○ **LST** (life skills) ○ **Unplugged** (social skills and norms) ○ **Good Behaviour Game** (development of behaviour norm and peer affiliation) • Advantage of generic programmes: potentially impacting on broader set of problem behaviours; evidence supports generic programmes over alcohol-specific programmes

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Foxcroft & Tsertsvadze, 2011b	SR, U	<18, A	Family	Family-based psychosocial and education interventions: 12 trials	• 9 trials had positive effects on alcohol use; follow-ups varied between 2 mths and 8 yrs • ISFP more pronounced impact on several alcohol use measures than PDFY compared to CG • Strong African American Families (adaptation of SFP), Family Matters promising • Not effective: Orebro Prevention Project; Dartmouth Prevention Project • **Overall, evidence supports effectiveness of family-based programmes**; some family-based psychosocial and developmental programmes effective in particular settings

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Foxcroft & Tsertsvadze, 2011c	SR U	<18, A	**Multi-component**	Interventions delivered in multiple settings: 20 trials	• 12 trials with significant reductions on alcohol use; duration of impact ranged from 3 mths to 3 yrs in 8/12 trials • **Inconclusive evidence re benefits of additional components** – insufficient evidence • Psychosocial developmental orientation potentially more advantageous than alcohol-specific programmes due to impacting on broader set of risk behaviours • **Some particular multi-component psychosocial and developmental interventions effective** in particular settings (attention to programme content and delivery context needed)

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Faggiano et al., 2008	SR, U	Primary & 2nd-ary pupils D	School	32 trials (29 RCTs, 3 controlled prospective studies)	• Skills-based programmes had positive effects on both final outcomes (e.g. marijuana use, hard drug use) and mediating variables (drug knowledge, decision-making, self-esteem, peer pressure resistance • **Skills-based programmes appear to be effective in deterring early stage drug use;** yet there was very little long-term follow-up
Gates et al., 2009	SR	<25, D	Non-school settings	17 studies • Education & skills training (2) • Family interventions (8) • Brief interventions/motivational interviewing (2) • Multi-component community (5)	• Lack of evidence that non-school interventions are effective in preventing/reducing drug use among young people (insufficient evidence) • **PDFY, ISFP and Focus on Families** may be helpful in preventing drug use • MI had short-term effect on cannabis use • Multi-component community interventions too diverse to draw conclusion on effectiveness • No differences found for education and skills training • **Motivational interviewing and some family interventions may have some benefit**

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Thomas et al., 2009	SR	13-18, A+D	**Community**	Mentoring interventions (formal mentoring) – 4 RCTs	• Reduction of initiation of alcohol use (2 RCTs) and drug use (1 RCT); no adverse effects – due to young ages, low rates of use thus limiting effectiveness • Too few studies; only focused on structured formal mentoring and mainly on minority youth, those living in poverty, with experience of abuse/showing mental or behavioural problems, ages 10-16

Moreira et al, 2010	SR	College students A	College & university	Social norm interventions: universal, targeted to particular groups, social marketing campaigns; 22 RCTs • Individual face-to-face feedback often containing MI elements	• Intervention delivered by web or computer or via individual face-to-face sessions (for some outcomes) more effective than a control intervention (e.g. a leaflet with drinking related advice) for reducing alcohol misuse in college/university students – effects in short-term (up to 3 mths), some lasting to medium-term (4-16mths) • Lack of effect and evidence for group-based face-to-face feedback and mailed format • Contradictory results from 2 social marketing campaign studies (had longest follow-up: 3 yrs), possibly due to variation in alcohol outlet density around selected campuses

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Stade et al., 2009	SR	Pregnant women, A	Health care	Psychological and/or educational interventions; 4 RCTs	• Education and counselling interventions may encourage abstinence during pregnancy; but weak and inconsistent findings re alcohol consumption • **Overall, very little evidence of the effects of psychological and educational interventions health of women and babies** • Too diverse interventions, involving information and MI or counselling with follow-ups; often difficult to assess what CG received (some had information provision), lengthy alcohol use assessment might have had impact in itself • Although recruited women had consumed some alcohol since start of pregnancy (screened 'at risk'), low levels of alcohol use were reported and drinking levels decreased with progression of pregnancy in both intervention and control groups • Lack of evidence compared to smoking in pregnancy

WHO reviews

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Foxcroft, 2006	Rapid review, U	<18, A	Any	Follow-up on the 2002 Cochrane review (Foxcroft et al., 2002) 23 studies: 18 new studies, 5 reporting new results (since 2002)	• 12 studies evidence of ineffectiveness; 7 studies with some statistically significant findings but compromised by poor methods, high attrition, inappropriate analysis or effect sizes of questionable public health relevance • 4 studies with provisional evidence of effectiveness: 1 study for ***"Be under your own influence"*** (media-based intervention) and 3 studies for **SFP 10-14** (including adaptation Strong African American Families)

NICE/LMJU reviews

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Jones et al., 2009a	SR, U	11-19, A(+D)	School	Review of reviews and individual studies with various research designs Focus on school-based substance use prevention programmes	• Strong evidence that **LST** (Botvin) can produce **long-term reductions (>3 yrs) in alcohol use** • Alcohol-specific programmes: mixed short-term effects, limited medium- to long-term effects (e.g. SHARP) • **Inconsistent or no effects**: DARE, Going Places, Lion's Quest SFA, All Stars Senior, Project Alert, Project SMART, Project TND, NARCONON drug education curriculum; possibly harmful: Adolescent Decision Making Programme • **Possible positive effects of school-based plus additional components**: Healthy School and Drugs Project (whole school + parents), *Keepin it REAL, Be under your own influence*/All Stars (school + media) • Mixed and inconsistent effects by brief behavioural interventions (e.g. STARS for Families, Project SPORT) • Multi-component: Midwestern Prevention Project no effect on alcohol use and inconsistent effects of Project Northland • Inconsistent evidence on effectiveness of counselling and peer support

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Jones et al., 2009a (cont'd)					• Curriculum-based general health education programmes: no impact and in some cases negative impact on sexual health and alcohol use (e.g. All Stars, Gatehouse Project); those with intensive community element may have positive impact (e.g. Aban Aya)

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Jones et al., 2010	SR, U	5-19, A(+D)	**Community Family (i.e. non-school)**	Review of reviews and individual studies with various research designs Focus on substance use prevention programmes in non-school settings	• **Strong evidence that SFP** can produce long-term reductions (>3 yrs) in alcohol use and heavy alcohol use • Inconsistent evidence for effects from interventions/ programme delivered in social, health and community settings on alcohol-related attitudes and values and alcohol use • Moderate evidence that specific family-based programmes have effect on health outcomes related to alcohol use (7/11 RCTs positive effect on alcohol use): SFP, SAAF • Inconsistent evidence of parent-focused interventions on alcohol-related attitudes and values and insufficient and inconsistent evidence re health and social outcomes related to alcohol use among young people • Moderate evidence that interventions/ programmes involving wider community and mass media have no effect on young people's alcohol use • Programmes targeting alcohol use and sexual health: ○ no evidence supporting effectiveness of programmes/interventions delivered in social and community settings (on attitudes, value, and behaviour) ○ interventions / programmes delivered to parents did not provide additional long-term benefits beyond those conferred through programmes targeting young person directly •

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Jones et al., 2007	SR, U	<18	School	Review of reviews and individual studies with various research designs Focus on school-based substance use prevention programmes	• SR evidence that **ISFP and Botvin's LST** can produce long-term reductions (>3 yrs) in alcohol use • Evidence for 2 classroom-based, teacher-led programmes targeting 12-13 year olds: using life skills approach (**LST**) or harm reduction through skills-based activities (**SHARP**) – medium- to long-term reductions in alcohol use and risky drinking behaviour possible • No medium- or long-term effects for classroom-based programmes taught by adult health educators (Project Alert, Project SMART, Project TND) and uniformed police officers (DARE) • Inconsistent and insufficient evidence of effectiveness of normative education programmes led by external contributors • Brief interventions, targeting 12-13 year olds and involving nurse-led consultations (e.g. STARS for Families) produce short- but no medium-term reductions in heavy drinking • No effects on reducing drinking behaviour by counselling programmes, peer support and teacher training • Evidence that social development approaches (combining curriculum and parents), starting in childhood, have long-term impact: **SSDP, LIFT**; short-term effects of Healthy School and Drugs Project and classroom-based plus media: *Keepin it REAL*, *Be under your own influence*

Other reviews

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Jackson et al., 2011	SR	5-25, A+D+SH	Any	Interventions preventing substance use and risky sexual behaviour; f-up: 6 months + 18 studies, n=13 kept	• Most promising approaches target underlying risk and protective factors in multiple domains • **SSDP** (non-RCT), FOK plus ImPACT (selective sample); Aban Aya (high attrition) • (**SFP 10-14** mentioned, no SH data)
Jackson et al., 2010	SR	<26, A+D+SH	Any	Interventions preventing substance use and risky sexual behaviour Review of reviews and RCTs: • Multiple risk behaviours: 0 reviews, 8 RCTs, + SSDP, 4 early life programmes; • Single risk behaviours: 22 reviews	• Particularly promising: **SSDP** (NNT=6-10), • **SFP 10-14** (NNT=6-10) • Gatehouse Project worthy of further investigation • Early childhood intervention not sufficient to prevent all risk behaviour in young people • Any approach to recognise key transition points and critical periods of development within child-youth life course; accompanied by broader social change • Integrated cross-domain approach: e.g. Communities That Care
Petrie et al., 2007	SR	Parents with kids <18, A+D	Parenting	Any parenting programme where children had no established drug, alcohol, or smoking habit and parents did not receive treatment for own addictions to alcohol or drugs • 20 studies (16 RCTs, 3 CBAs, 1 CT)	• **Strongest evidence: pre-teen and early adolescent children (e.g. ISFP, PDFY, Midwestern Prevention Programme, Coping Power programme**) • Effective interventions focussed on developing strategies to involve adolescents in family activities to maintain familial bonds and manage conflict

Review authors **Petrie et al., 2007** (Cont'd)	Type	Targeted	Setting	Found studies	Conclusions / recommendations • Most studies complex interventions; parenting only one aspect - most effective interventions: i) Emphasized development of social skills and sense of personal responsibility among young people, as well as addressing issues relating to substance use and ii) Include active parental involvement • Transition from primary to secondary school effective time to intervene
Scott-Sheldon et al., 2012	M-A	College students	College/	Expectancy challenge (EC) interventions in experiential or didactic format • 14 studies (19 interventions)	• Overall EC interventions effective at reducing positive alcohol expectancies, quantity of alcohol consumed, and frequency of heavy drinking for as long as one month post-intervention • Quantity consumed and heavy drinking frequency not sustained at longer follow-ups (<6mths post-intervention)
Smit et al., 2008	M-A, U	<16, A	Family	18 articles on 9 RCTs	• Family interventions effective in delaying alcohol initiation and reducing frequency of alcohol consumption among young people; effects maintained over time • Effects strongest when all families within a group targeted (vs individual randomisation) • **ISFP and PDFY longest follow-up**

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Spoth et al., 2008	S-R	<10, 10-15, 16-20+, A	Any	41 interventions with follow-up test at least 6 mths after post-test/end of programme • <10 yrs: n=18 • 10-15 yrs: n=13 • 16-20+ yrs: n=10	• Distinguished interventions (universal, selective, indicated) by most promising (n=12) and mixed/emerging (n=29) evidence for alcohol outcome (see table below) • Only one preschool programme (FNP) shown effect on teen drinking • Considerable promise of family interventions for ages 10-15 (e.g. SFP 10-14, PDFY): small group format stronger effects than home-based interventions • Advances in school-based prevention (e.g. GBG) • Multi-domain interventions: most of the effective <10 programmes; promising model = combining 2 different interventions with proven efficacy; important parent programme component • No evidence-based policy interventions that have shown delay in alcohol use initiation; inconsistent findings for raising drinking age law • No stand-alone media interventions targeting alcohol use found as having strong evidence

Review authors	Type	Targeted	Setting	Found studies	Conclusions / recommendations
Stead et al., 2006	SR	Any, A+D, smoking, physical activity		Social marketing interventions = those which adopted specified social marketing principles in their development and implementation - 54 studies: • 21 school-based programmes • 22 multi-component community interventions • 5 primarily mass media-based • 2 restricting youth access to substances (retailer/ server) • 1 smoking cessation • 15 alcohol, 13 drugs, 21 smoking	• Social marketing can form effective framework for behaviour change interventions - some formative consumer or audience research: ○ to gain deeper understanding from the perspective of the consumer; ○ to provide insights into target group attitudes and behaviour, and/or ○ to pre-test or pilot intervention ideas with target participants • Majority of alcohol, drug and smoking prevention programmes effective in short-term, with only few sustaining effects into medium- and long-term • **SFP** having increasing effect over time; in Project Northland family-focused component effective in influencing wider precursors of problem behaviour
Strang et al., 2012	Expert review	Any, D	Any	Review of reviews on effective interventions around illicit drugs; SR of additional RCTs	• 3 interventions aimed at drug use prevention with supportive evidence: **SFP 10-14, social and life skills training, Good Behaviour Game** • No evidence of effectiveness: multi-component community, information about adverse drug effects only, mass media, DARE • Motivational interviewing and brief interventions as secondary prevention – cost-effective but not consistent effects on drug use • The collective value of school, family and community prevention programmes is appraised differently by different stakeholders.

Velleman, 2009	Expert review	Children & Young People A	Any	Review of reviews and individual interventions	• **Family-based interventions have best evidence of efficacy, longest lasting effects, especially SFP** • Family-based prevention approach: effect sizes 2-9 times greater than those focusing solely on the child • Some, though less strong, evidence for interventions based around altering peer influence can work • Multi-component interventions: especially those with family components, effective • Too few interventions based on media and cultural representations – not possible to come to tentative conclusion • Major lack of robust UK-based evaluations – more UK research required: medium-term, longitudinal studies of a range of family, school-based, community-based programmes • Need to change drinking norms among young people, adults (in general, their parents), society • Need for universal prevention programme starting children are young, not when families start considering how to prevent teen drinking • Improving enforcement of restrictions on alcohol purchasing for young people: test purchasing, policing underage sales – penalties for retailers, age checks at purchase, parental monitoring of income and expenditure among children • Need for an integrated, planned and implemented

Velleman, 2009					community prevention system – drawing together: ○ Effective parenting training programmes, ○ Organisational change programmes in school, ○ Classroom organisation, management and instructional strategies, ○ Classroom curricula for social and emotional competence promotion, ○ Multi-component programmes based in schools, ○ Community mobilisation, ○ Community/school policies, ○ Enforcement of laws relating to underage purchasing and selling alcohol to intoxicated people, ○ Altering community and cultural norms – not tolerating drunken, comportment behaviour ○ How to effect price, availability and accessibility

Note: SR ... systematic review, M-A ... meta-analysis, U ... universal programmes, A ... alcohol, D ... drugs, RCT ... randomised controlled trial, BBA ... Controlled Before and After study, CT ... controlled study

Table A2. Interventions with most promising and mixed/emerging evidence on alcohol outcomes according to Spoth et al. (2008)

	Most promising	**Mixed/emerging evidence**
<10	LIFT, Raising Health children, SSDP, NFP, Preventative Treatment Programme	Classroom-centred intervention, FAST, Fast Rack, First Steps to Success, GBG, I can problem solve, Olweus Bullying Program, Perry Preschool, PATHS, Schools and Families Educating Children, Second Step, Incredible Years, Triple P,
10-15	Keepin' it REAL, Midwestern Prevention Project/Project STAR, Project Northland, SFP 10-14,	Bicultural Competence Skills Program, Family Matters, Families that Care: Guiding good choices (formerly PDFY), Healthy Schools and Drugs, LST, New Beginnings, Project Alert, SHARP, SODAS City
16-20+	Project Toward No Drug Abuse, Yale Work and Family Stress Project, Mississippi Alcohol Safety Education Programme and Added Brief Individual Intervention	Athletes Training and Learning to Avoid Steroids, Brief Motivational Intervention in ED, Communities Mobilizing for Change on Alcohol, Community Trials Interventions to Reduce High-Risk Drinking, Problem Drinking in Workplace, Raising minimum drinking age law

APPENDIX D

14.0 At a minimum the following areas should be covered in a comprehensive assessment:

- Substance use, including consumption: historical and recent patterns of use (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer);
- dependence (using, for example, SADQ or Leeds Dependence Questionnaire (LDQ);
- alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ]);
- other drug misuse, including over-the-counter medication;
- physical health problems;
- psychological and social problems;
- cognitive function (using, for example, the Mini-Mental State Examination (MMSE);
- readiness and belief in ability to change.

(NSD funded services should ensure that their assessment also covers the domains within the Regional Impact Measurement Tool)