Joint Strategic Needs Assessment

Substance Use

(Drugs, Alcohol and Tobacco)

Partnership of Purpose

States of Guernsey
Public Health Services

Contents

Foreword

On the 9th November 2017, the Committee *for* Health & Social Care published A Partnership of Purpose: Transforming Bailiwick Health and Care. This programme of transformation provides a strategic direction for the future provision of Health and Care Services in Guernsey and Alderney. Central to this is a focus on prevention, early intervention and user-centred care.[1]

A critical and enabling foundation was to develop an evidence-base for informed decision-making in relation to service provision across the islands. To achieve this, the Committee *for* Health & Social Care instructed Public Health Services to conduct a suite of Joint Strategic Needs Assessments (JSNAs) to provide them with regular updates on the population's health and care needs. The first JSNA focused on the needs of the over 50s living in Guernsey and Alderney. This, the second JSNA, examines health and care needs in relation to substance use, including drug, alcohol and tobacco use.

There is considerable and wide-ranging harm caused by substance use in Guernsey and Alderney. The greatest overall harm suffered is from the consumption of alcohol. The majority of the adult population consume alcohol (89%) and the number of those who do so at a level that is considered damaging to health is higher than the prevalence of both tobacco and drug use.[2] The concern is for people who exceed the recommended drinking guidelines with regard to the effect of alcohol on their health, as well as the impact on the health and wellbeing of relatives and victims of crime and injury related to alcohol.

Lessons can be learned from tobacco control policy measures to further reduce alcohol harms. Governments worldwide take a strong position on smoking and advise against it, in any form or quantity. However for alcohol consumption, drinking 'safely' is a common term used and the UK alcohol guidelines are called 'low risk drinking' guidelines.[3] Low risk is a reference to direct physical and mental health harms and does not consider any wider societal impacts.

The smoking prevalence in the adult population in Guernsey and Alderney is 13%, lower than in Jersey (15%) and England (14.7%).[2][4][5] However, 16% of deaths in the over 35s locally are smoking-related, indicating that this is still a significant public health problem for Guernsey and Alderney.[6]

The biggest concern with the inappropriate use of drugs locally is the diversion of prescription medication. Despite best efforts to treat drug misuse as a health issue there remains a stigma associated with drug use that does not exist to the same extent in alcohol use or smoking. The illegal sourcing of drugs stops some from seeking help for fear of criminal sanctions.

This JSNA has adopted a holistic approach considering the impact of the wider determinants of health and wellbeing on substance use. It also looks at what we know about our current service provision and activity, as well as who is at risk and why. Examining the evidence of what works and mapping the unmet needs and service gaps is central to this process.

This JSNA will inform the development of a Combined Substance Use Strategy which will define our goals in relation to substance use and map the provision of services and prevention efforts for the next five years. Ownership of the implementation of the Strategy will rest with the different operational and political Committees that comprise the States of Guernsey and Alderney, Primary and Secondary Care Services and the voluntary and private sectors. This is a 'whole islands' issue and requires a 'whole system' response in line with the principles of the Partnership of Purpose.

We are very grateful to our key partner, The Health Improvement Commission, as well as to all the stakeholders from Primary and Secondary Care, the community and voluntary sector and, most importantly, to service users and their families, who gave their time to help develop this Joint Strategic Needs Assessment.

Deputy Al Brouard
President of the Committee for Health & Social Care

Introduction

Substance use contributes significant health, social and economic costs to our islands, including illness, injury, crime, violence, anti-social behaviour, and the breakdown of families and relationships. The aim of Health & Social Care Services is to improve the health and wellbeing of the population. This includes reducing harms associated with substance use and increasing the chances of sustained recovery.

This Joint Strategic Needs Assessment focuses on the use of alcohol, drugs and tobacco. Historically the States of Guernsey has considered drugs, alcohol and tobacco independently from one another, with strategies for each substance led by different areas of Government.

Tobacco Control Strategies have always been led by the Committee for Health & Social Care (CfHSC), or equivalent previous bodies. The current strategy, which runs from 2016–2020, together with the success of preceding strategies, has helped to ensure that tobacco smoking is now a minority activity in Guernsey and Alderney. The smoking prevalence in the adult population in Guernsey and Alderney is estimated to be 13%, a figure that is lower than in Jersey (15%) and England (14.7%). [2][4][5]

This success has resulted from the concerted efforts to implement the current and previous Tobacco Control Strategies, together with increasing public awareness of the harms associated with tobacco use. Legislative reform has banned advertising of tobacco products and banned smoking in public buildings, States-owned properties (excluding States-owned social housing). Currently Public Health is working with Jersey on new legislation to introduce standardised plain packaging of cigarettes. The changes have been slower than anticipated due to the complex considerations needed following the UK's decision to leave the European Union.

The first Drug Strategy, [7] was led by the Committee *for* Home Affairs (previously the Home Department) and was accepted by the States of Deliberation in 1999. Recognising the similarities between drug and alcohol use, a combined Bailiwick Drug and Alcohol Strategy was introduced in 2007. Combined Bailiwick Drug and Alcohol strategies continued periodically under the Home Affairs Committee until 2017 when the responsibility was transferred to the CfHSC, recognising further that the use of drugs and alcohol is a health issue and therefore more appropriately led by the health service. In 2018, the operational delivery of the Drug and Alcohol Strategy was transferred to The Health Improvement Commission, with the strategic direction remaining under Public Health Services within the CfHSC.

In 2018, the CfHSC decided that Guernsey and Alderney should have a Combined Substance Use Strategy to include drugs, alcohol and tobacco due to the ability of all three substances to cause dependence syndrome. The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defines dependence syndrome as:

"a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take the psychoactive drugs (which may or not have been medically prescribed), alcohol, or tobacco."[8]

The transfer of responsibility for the Bailiwick Drug and Alcohol Strategy to the CfHSC reflects a growing acceptance that reducing drug supply alone is not sufficient to tackle illicit drug use, and that an effective response also requires measures to reduce demand, such as prevention, treatment and rehabilitation. This emphasises the need for a balanced approach to tackling the harms caused by drugs, supporting people through treatment and recovery and restricting the supply of drugs. The same principles are applicable to tobacco control and alcohol use.

Figure 1 Timeline of Strategic Management of Drug and Alcohol Strategies

Key Data

Alcohol

Data from the Wellbeing Survey 2018 and the Guernsey and Alderney Healthy Lifestyle Surveys from 2008 and 2013 show that [2][9][10]

- the proportion of people who exceed the current low-risk guidance has increased over the past 10 years from around 20% in 2008 to 27% in 2018.

The Wellbeing Survey 2018 showed that: [2]

- 22% of people were classified as having 'risky' drinking behaviours and 5% as 'high risk' as defined by the AUDIT Tool. The Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organisation (WHO) to support the identification of hazardous and harmful patterns of alcohol consumption);
- 24% of people had drunk more than 14 units of alcohol in the last week (i.e. exceeding current guidance which is for men and women to drink no more than 14 units per week on a regular basis);
- people aged 35-64 were most likely to have drunk more than 14 units over the last week;
- low mental wellbeing is more prevalent in those with a 'high risk' drinking behaviour (36%) compared to people with low risk drinking behaviour (15%);*
- those aged 16-34 were most likely to be categorised as 'risky' or 'high-risk' drinkers;
- 14% of people said they intend to drink less alcohol over the next six months, increasing to 32% amongst people who reported drinking alcohol 4 or more times per week;
- males are more likely than females to drink frequently (more than twice a week), consume over 14 units and exhibit risky drinking behaviour;
- when asked if they agreed that "getting drunk is a perfectly acceptable thing to do," 51% of 16 to 24 years olds said it was, compared to less than 5% amongst all age groups over 55 years; and
- when asked if they agreed with the statement that "It is easier to enjoy a social event if you have had a drink of alcohol," the levels of support declined with increasing age from a high of 64% in 16 to 24 year olds, but remained at 31% amongst those aged 75 years and over.

*****_Riskiness of drinking behaviour was calculated using the AUDIT tool. Further detail on this can be found in the Glossary of Abbreviations and Technical Explanations._

Other data for Guernsey and Alderney showed that:

- in 2017, 2.4% of Emergency Department attendances at the Princess Elizabeth Hospital were thought to be alcohol-related, a figure that is similar to the UK;[11]
- between 2010 and 2015 there were on average six alcohol-related deaths in Guernsey/Alderney every year;[6][12]
- in 2018, 38% (225) of all types of assault (out of a total of 590) involved the perpetrator being under the influence of alcohol;(13);[13]
- alcohol consumption by the offender was a factor in sexual offences (17%) and criminal damage (10%), but less so in offences for theft (4%);[13]
- locally, alcohol was involved in 48% of police call outs to domestic abuse incidents;[14]
- 14% of secondary school children aged 12 to 15 reported drinking alcohol in the last 7 days, a decrease from 19% in 2016 and 35% in 2010;[15]
- there are 269 establishments that sell alcohol in Guernsey;[16] and,
- professionals interviewed as part of this JSNA overwhelmingly agree that alcohol consumption is the greatest concern in Guernsey and Alderney with regards to substance use.

Tobacco

Data from the Wellbeing Survey 2018 showed that: [2]

- 13% of people currently smoke tobacco;
- smoking is most prevalent in the under 55s, particularly in the 25 to 34 year olds where 21% of people smoke;
- smoking and vaping rates are similar for males and females;
- 30% of people identified as ex-smokers;
- 6% of people vape or use e-cigarettes;
- 32% of current vapers also smoke tobacco, 59% of current vapers are ex-tobacco smokers and 9% of current vapers have never smoked;
- 15% of current smokers have high risk drinking habits, compared to 3% who have never smoked tobacco;
- 19% of people who never smoked tobacco rated their health as fair, bad or very bad, compared to 31% of current smokers, i.e. smokers reported worse health, on average, than those who have never smoked;
- 36% of people who currently smoke tobacco said they intend to give up in the next six months, almost half of these were between 16 and 24 years of age;
- 36% of respondents reported having experienced a large amount of stress in the past 12 months (up from 25% in 2013); current smokers and vapers reported higher levels of stress relative to non-smokers; and,

- an unexpected but necessary bill of £100 was more likely to pose a problem for those who smoke than it would for people who have never smoked, suggesting that smoking is more prevalent among those with low household incomes.

Other data from Guernsey and Alderney found that:

- in 2019 the proportion of primary school students aged 10 and 11 who have never smoked stayed at 98%: among 12–15 year olds, never-smoking increased by 7% since the previous survey suggesting a reduction in smoking amongst secondary school children;[15]
- in 2018, 14% of fires in Guernsey and Alderney were caused by cigarette lighters and smoking materials;[17] and,
- 16% of deaths in individuals aged over 35 years are attributable to smoking tobacco.[6]

Drugs

The Wellbeing Survey 2018 showed that:[2]

- around 11% of people have used cannabis in the last 12 months, compared to 5% in 2013.[9]
- 4% of people have used illegal drugs other than cannabis in the last 12 months;
- 24% of people using cannabis reported using other illegal drugs;
- drug use was reported as being higher amongst 16–34 year olds, especially males: however, as the numbers participating in the Wellbeing Survey 2018 in this age group were small, this data should be interpreted with caution;
- the reported use of cannabis and other illegal drugs was higher among those who smoke, vape and have high risk drinking habits;
- the reported use of cannabis was higher among people who have a longstanding mental or emotional health condition, or have low mental wellbeing.

Other data from Guernsey and Alderney show that:

- cannabis is the drug most frequently seized by the Guernsey Border Agency, accounting for 49% of seizures in 2018;[18]
- the percentage of secondary school children aged 12 to 15 who have been offered cannabis increased from 10% in 2010 to 18% in 2019;[15]
- hepatitis C is the most common bloodborne virus in the Bailiwick; 80% of infections are caused by injecting drug use;[19]
- prescription rates for fentanyl, morphine and oxycodone decreased by 16% between 2014 and 2018;[20]
- in April 2019, the most common offence in the prison population related to drug possession, accounting for 38% of the prison population;[13]
- 55% of children in Guernsey who are placed on the Child Protection Register face some risk from parental substance use;[21]
- in 2018, 71% of clients seen by the Community Drug and Alcohol Team (CDAT) were male with the majority of males and females seeking help for alcohol use;[22]
- in Guernsey and Alderney from 2001–2015, there were 33 registered deaths related to drug poisoning, averaging three deaths per year; the majority of drugs associated with these deaths were prescription medicines.[23]
- the use of dihydrocodeine in the OST programme was criticised by most service users and professionals, at the time of interview, however over the past two years the service has been overhauled.
- the diversion and illicit supply of medicines ('DISM', also known as 'prescription diversion') is perceived to be a problem by professionals in Guernsey; and
- there is no GP Shared Care Arrangement for stable patients with agreed care pathways.

*****_From here on referred to as methodone._

Recommendations

For services

This report demonstrates the need:

1. for accurate data collection, sharing and monitoring;
2. to ensure that prevention and early intervention is integral to service provision;
3. to provide a framework to support staff to undertake brief interventions and to record, collect and monitor data to enable evaluation of outcomes;
4. for the development of clear referral and treatment pathways;
5. a focus on partnership working;
6. for improvements in joined-up working and the development of integrated care pathways;
7. for consideration of the introduction of a Dual Diagnosis Service to support mental health problems that often co-exist with substance use;
8. for development of a greater understanding of Adverse Childhood Experiences (ACEs) and underlying trauma for people who use alcohol, drugs and tobacco;
9. for improved measures to prevent the diversion of prescription medicines;
10. for strengthened peer support services;
11. for a programme of methadone use as OST;
12. for services in prison to address substance use (drug, alcohol and tobacco) that are equitable to those available for non-prisoner services;
13. to consider how prisoners can reintegrate into the community more effectively and smoothly on release from prison;
14. for services in the community to target groups in which smoking is most prevalent, as well as for specific groups, for example pregnant women;
15. to continue with a programme of Hepatitis C treatment, working toward the goal of eliminating Hepatitis C from Guernsey and Alderney;
16. to evaluate if services for harm reduction, for example needle exchange, are meeting the needs of the community;
17. to promote a culture of recovery, rather than viewing stability as long-term OST use with no plan to become drug-free; and
18. to consider the wider determinants of health in the delivery of services for clients with issues relating to substance use.

For Government Policy

This report identifies the need for:

1. an understanding of how Government policy impacts the wider determinants of health and developing cross-Government policies to address them;
2. for the inclusion of a programme of 'Health in All Policies' to be rolled across all States of Guernsey and Alderney Committee areas;
3. consideration of the regulation of alcohol pricing through promotion bans and consideration of the introduction of Minimum Unit Pricing (MUP);
4. consideration of the lowering of the blood alcohol concentration (BAC) level above which motorists in Guernsey will be prosecuted for drink driving to align with Scotland and most other European countries;
5. legislation to ban smoking in vehicles carrying children;
6. the regulation of e-cigarettes, in line with the UK;
7. an understanding that the fear of criminal sanctions may act as a barrier for people wishing to access help;
8. a consideration of the approach to the sale of duty-free alcohol and tobacco on States of Guernsey property (including State-owned airlines and other transport); and,
9. consideration of the interaction of the Health and Justice System in relation to the management of people found to be in possession of small amounts of drugs for personal use.

For community awareness

This report highlights the need for:

1. improved awareness of the association of alcohol with domestic abuse and other crime;
2. improved awareness that sigma remains a significant issue with negative attitude from society, some professionals and self-stigmatisation acting as a barrier to accessing treatment, community services and other activities;
3. improved understanding of, and signposting to, the services available for people with drug and alcohol problems;
4. improved understanding of low risk alcohol guidelines and signs of alcohol dependence;
5. continued awareness-raising and education on the risks and harms of drugs, alcohol and tobacco for all young people;
6. increased knowledge on the interaction of ACEs and substance use; and,
7. improved understanding of the wider determinants of health and their influence on health and wellbeing.

Methodology

Scope of the Joint Strategic Needs Assessment

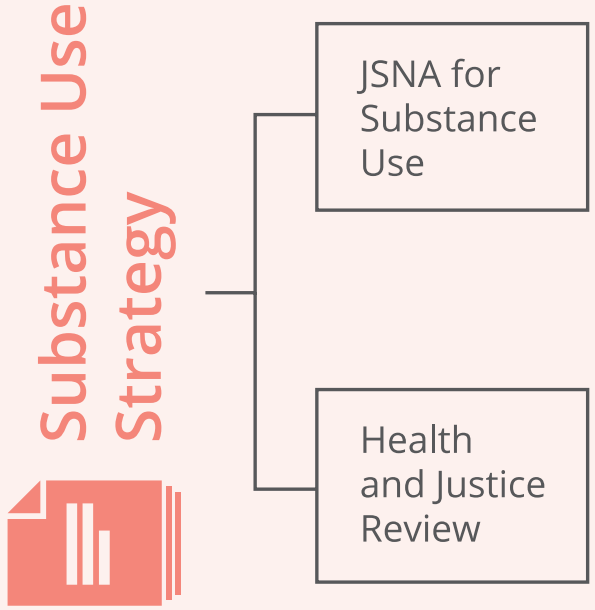
This JSNA focuses on alcohol, drugs and tobacco. It will be supported by more detailed subject-specific review of the interaction between the Health and Justice System in relation to possession of drugs for personal use ("Health and Justice Review").

These reports will be presented separately, but will both contribute to the development of a Combined Substance Use Strategy.

This JSNA considers:

- what we know, including an analysis of patterns and trends of substance use, including the identification of data gaps;
- who is at risk and why;
- current service provision and activity;
- evidence of what works; areas for strategic focus, including unmet needs and service gaps; and
- the impact of the wider determinants of health and wellbeing on substance use.

Figure 2 Components used in the Development of a Combined Substance Use Strategy



Project Steering Group

A Project Steering Group was established consisting of representatives from Public Health Services, The Health Improvement Commission, Primary and Secondary Care, other States of Guernsey Committees (for example the Committee *for* Home Affairs and the Committee *for* Employment & Social Security), as well as representation from the community and voluntary sector. This group provided strategic direction and oversaw the governance of the JSNA. Steering Group Members are detailed in Appendix A.

Data collection

A mixed methods approach to data collection was adopted.

Quantitative data collection consisted of:

- collation of pre-existing data and reports from both inside and outside of the States of Guernsey; and
- collection of data on existing services.

Qualitative data collection consisted of:

- focus groups;
- interviews with key stakeholder groups;
- interviews with service area teams; and
- interviews with individuals and their families.

Stakeholders were identified through a snowball approach. The project team initially wrote a list of relevant stakeholders. This was then discussed with Steering Group Members and expanded to ensure engagement with the appropriate breadth of individuals. In addition, when stakeholders were interviewed they were asked if there was any one else that they thought the project team should speak to, so identifying other possible stakeholders.

Individual and group interviews, focus groups and team meetings were conducted to capture the views and experiences of service users and their families, health and social care professionals, other States of Guernsey

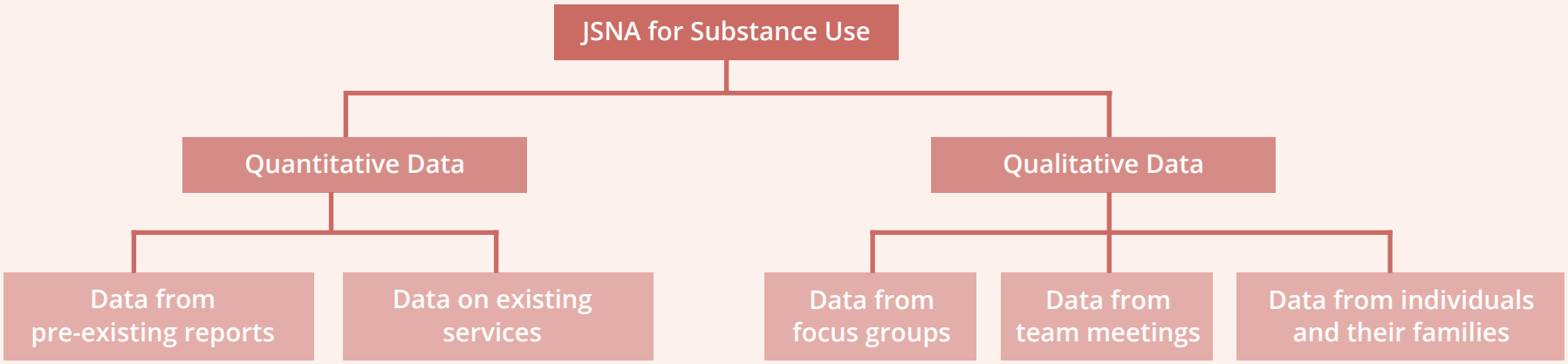
services and the third sector. Specific engagement with Alderney ensured that their views were represented. A full list of stakeholders can be found in Appendix B.

Semi-structured interviews were conducted and stakeholders were asked for information on what substances were being used and their experiences of the accessibility and effectiveness of treatment. Service users, professionals and families were also asked about the problems the community faces in relation to substance use.

Examples of questions include the following:

- What service do you provide and who to (age included)?
- Are you a standalone service or do work closely with others?
- What works well within the service?
- What could be improved?
- Are there any gaps in the service?

Figure 3 Data Sources



- What resources would be required to fill the gaps?
- Do you collect any data that would be beneficial to the Strategy?
- What is the demographic profile of people who use your service (e.g. age, sex)?
- Are there any particular issues the service would like to raise to be considered in the rewrite of the Strategy?

Information from these meetings and discussions was noted down by the researcher and the main points were extracted from these notes.

All participants were asked to either fill out a consent form or came out of choice to an advertised meeting. Participants were also made aware of how their data would be stored in line with the Data Protection (Bailiwick of Guernsey) Law 2017.

Output

The output of the JSNA is

- A summary of the key qualitative and quantitative data in relation to drug, alcohol and tobacco use;
- A map of currently available services;
- Recommendations to inform the development of a Combined Substance Use Strategy for drugs, alcohol and tobacco.

Substance use in an ageing population

Substance use in an ageing population results in complex additional health needs. As of March 2018, Guernsey had a population of 62,307 with over 50s comprising 41.3% of the population, a 4.0% increase since March 2012.[24] The demographic distribution of Guernsey is typical for a developed nation and Guernsey faces similar challenges as other countries, such as the UK, if we do not adequately prepare to match services with increasing demand. This is especially important within health and care whereby people are more likely to require the use of these services as they age.

Alderney, a part of the Bailiwick of Guernsey, is an island of approximately 2000 inhabitants and, as of March 2018, had an old age dependency ratio of 0.68, meaning that for every 100 people of working age (between ages 16 and 64), there were 68 older people of dependent age (aged 65 and over). In March 2018, there were 739 people aged 65 and over living in Alderney.[25]

The planning of substance use services needs to take into account the requirements of the over 50s living in Guernsey and Alderney. Of note is that substance use in the over 50s is often underdiagnosed, misdiagnosed, undertreated or untreated. Symptoms may, instead, be attributed to dementia/Alzheimer's disease, depression or other problems common among older adults. In fact, substance use in the over 50s has been referred to as the 'invisible epidemic' as prevalence studies have focused mainly on younger people. It has also been suggested that older adults are more likely to hide their substance use problems and are less likely to ask for help than younger adults.[26]

Data from the Wellbeing Survey 2018 showed that 27% of people over 50 drink four or more times a week compared to only 12% of under 50s. However, although those who are over 50 years old drink more often, when

people aged under 50 years drink, they tend to drink alcohol in greater quantities or 'binge drink'. Again, the desire to change was identified in some over 50s with 10% wanting to drink less alcohol in the next six months.[2]

Data from the Emergency Department at the Princess Elizabeth Hospital showed that of a total of 16,413 Emergency Department attendances in 2017, 2.4% were thought to be alcohol-related, similar to the UK.[11][27] Almost a third of these suspected alcohol-related admissions occurred in individuals over 50 years of age and, of these, just over two thirds were in men. Information from the Mignot Memorial Hospital in Alderney showed that 3.6% of admissions were thought to be drug or alcohol related.[28] In relation to drug use, the over 50s are far less likely than under 50s to have used cannabis in the last year at 0-1%, compared to 11% of under 50s.[2]

Looking at patterns of substance misuse, the Community Drug and Alcohol Team are more likely to see clients under 50 years of age in relation to drug use, whereas those over 50 years of age are more likely to attend for alcohol use.[22]

The smoking prevalence in the adult population in Guernsey and Alderney is 13%, a figure that is lower than in Jersey and England (15% and 14.7% respectively). [2][4][5] Data from the Wellbeing Survey 2018 showed that 6% of over 50s and 5% of over 65s identified themselves as smoking every day, compared to 12% of under 50s. Over 50s are less likely to use e-cigarettes than under 50s.[2]

Although premature death from cardiovascular disease has decreased, diseases of the circulatory system are still our top cause of death, accounting for 31% of deaths in the 35+ age group.[6] Of the total deaths in individuals aged over 35 years, 16% were attributable to tobacco smoking.[6] Evidence from the UK suggests that the provision of smoking cessation services for older people should ensure that older smokers are not missing out on smoking cessation therapies and the health benefits of cessation at older ages.[29] This is supported by local data which showed that 3% of over 50s and 2% of over 65s would like to give up smoking tobacco, illustrating a small local pocket of need.[2] Local smoking cessation services and healthcare practitioners alike need to specifically consider asking older people if they would like to stop smoking and provide appropriate support, if indicated.

The wider determinants of health and wellbeing

The broad social and economic factors, that together influence and determine the quality of population health, are known as the 'wider determinants of health.' The mechanisms by which these determinants impact on mental and physical health are complex and inter-related, often developing over a long period of time.[30] Most experts are in agreement that the wider determinants of health influence the health of a population more strongly than the health care service itself.[31]

While it is not the remit of this report to consider the wider determinants of health in their entirety, it is important to consider some local data to demonstrate their association with substance use and so better understand how they support or hinder individuals in adopting healthy behaviours.

Figure 4: The wider determinants of health [32]

Societal and Intergenerational Harm

Health risk behaviour refers to behaviours which are widely recognised as adversely affecting health and increasing the risk of premature death. They often co-exist and are not evenly distributed across populations, demonstrating associations with income and educational attainment among other factors.[33]

Intergenerational harm, which refers to the adoption of risky health behaviours through family generations, can impact on the health and wellbeing of current and future generations. Figure 5 depicts ten factors that, if experienced during childhood, can adversely affect both the health and development of children. They are referred to as ACEs as already described. The neurodevelopment of children can be disrupted when they are exposed to chronic, stressful events such as these. As a result, their ability to cope with negative emotions may be impaired and over time, often during adolescence, they may adopt unhealthy behaviours as a coping mechanism. This can include substance misuse. These coping mechanisms contribute to the social problems, disease and premature deaths associated with substance use.

Parental substance use is itself identified as one factor that increases the vulnerability of a child to abuse and neglect.[34] This is seen locally where data tell us that the majority of children on the Child Protection Register are so due to parental substance use. In 2008, 83% of children

Figure 5: Childhood abuse, neglect and household dysfunction factors referred to as Adverse Childhood Experiences

on the Child Protection Register were there for this reason, although this figure has reduced to a low of 55% in 2018 (Table 1). These data represent the most serious cases of parental substance misuse known to services, and therefore likely underestimate the number of children affected by this problem across Guernsey and Alderney.

Table 1: Children on the Child Protection Register due to parental misuse of substances between 2008-2018[35]

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total no. of children on register	58	63	87	79	95	111	136	112	66	77	121
Parental drug/alcohol use	48	44	53	50	58	72	82	67	41	45	67
Proportion of children on the register due to parental drug/ alcohol use	83%	70%	61%	63%	61%	64%	60%	60%	62%	58%	55%

With regards to young people who commit offences, it has been recognised for some time that they almost always have the same needs as those children who are in need of care and protection provided by the Government[36], thus demonstrating the cycle of substance use, neglect and criminality. The reason and number of referrals to the Children's Convenor can be seen in Table 2. The most numerous of which are for allegedly committing a criminal offence. A small number of referrals received each year are for the misuse of substances but this is likely an underestimate of the true need.

Table 2: Number of referrals to the Children's Convenor for each referral category for the years 2014-2018 [37]

	2014	2015	2016	2017	2018
Misuse of alcohol, drugs or volatile substance	<5	<5	<5	5	6
Significant impairment to health or development	89	81	72	54	126
Physical or sexual abuse	12	9	5	7	22
Exposed to moral danger	<5	<5	<5	<5	13
Violent or destructive behaviour/ beyond parental control	32	24	6	12	20
Allegedly committed a criminal offence	178	284	190	210	215
Failure to attend school without good reason	24	19	11	18	8

Finances and Economic Impact

There is strong evidence that people who smoke are less likely to be able to afford an unexpected, but necessary, bill compared with people who have never smoked (Table 3). There is moderate evidence to demonstrate this for alcohol.[2]

Table 3: Ability to Afford Unexpected Expenses by Smoking Status and Drinking Risk Category.

	Tobacco		Alcohol	
	Never smoked	**Current smoker/vaper**	**Low risk audit**	**High risk audit**
Cannot afford an unexpected but necessary £100 expense	3%	18%	No significant difference	
Cannot afford an unexpected but necessary £1000 expense	17%	41%	13%	24%

The direct financial costs of substance use will typically be borne by the States of Guernsey, largely by the Committees for Health & Social Care, Home Affairs and Employment & Social Security. While it is not the remit of this report to explore the economic impact of substance misuse, it is useful to highlight data in relation to Years of Life Lost (YLL) and Years of Working Life Lost (YWLL).

YLL is a measure of premature mortality which is used to compare the mortality experience of different populations for all causes of death and/or particular causes of death, by quantifying the number of years not lived by individuals who die under a given cut-off age, usually 75 years of age. YWLL uses the same calculation but with an age cut off of 65 and can be used as an indicator of the economic impact of premature deaths.[6]

There are on average 31 lung cancer deaths per year in Guernsey and Alderney. These deaths contribute to 119 YLL per year and 26 YWLL per year. The average YWLL per year from alcohol-related deaths is 69 from just six deaths per year. There are approximately three drug poisoning deaths per year, which contribute 63 YWLL. This means that despite fewer people dying in Guernsey and Alderney every year from alcohol and drug poisoning compared with lung cancer, deaths tend to occur at a much younger age and thus have a much greater economic impact as well as a major negative impact on families, friends and the community. Other causes of death which are often associated with alcohol or drug use, and which have higher YWLL than lung cancer deaths, include chronic liver disease, accidents, suicide and undetermined injuries.[6]

Table 4: Average number of deaths per year and YWLL from selected causes of death[6]

Cause of death	Average no. of deaths per yer	YWLL average per year
Lung Cancer	31	119
Accidents	15	85
Suicide and undetermined injury	4	80
Alcohol-related	6	69
Drug poisoning	3	63
Chronic liver disease	5	32

Tenure and Home Ownership

There is good evidence to demonstrate that current smokers are less likely to own their home and more likely to live in affordable housing than those who have never smoked. There are no notable differences observed between the different types of housing tenure and alcohol consumption.

Table 5: Smoking Status and Drinking Risk Category by Housing Tenure.[2]

	Tobacco		Alcohol	
	Never smoked	**Current smoker/ vaper**	**Low risk audit**	**High risk audit**
Home ownership	60%	11%	No significant difference	
Private rental	52%	27%	No significant difference	
Affordable housing	29%	46%	No significant difference	

Alcohol

Alcohol use

When examining alcohol use from a public health perspective, it is important to consider both the total amount of alcohol that people drink, as well as drinking patterns. The concern is for drinkers themselves and the impact that alcohol consumption has on their health, the health and wellbeing of their relatives and the impact on victims of crime or injury related to their drinking.

The Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organization,[38] is a simple screening tool to identify individuals with harmful patterns of alcohol consumption. Alcohol harm is generally associated with two types of harmful drinking behaviours. High levels of regular alcohol consumption over a long period of time can lead to the development of certain cancers, heart disease, organ damage and poor mental health whereas short-term harms, such as injuries, unsafe sex or crime, are often the result of drinking a large volume of alcohol on one occasion, a pattern of consumption often referred to as 'binge drinking'.

Table 6 presents the AUDIT drinking risk categories and the percentage of adults in Guernsey and Alderney for each category. The results show that most adults in Guernsey and Alderney drink alcohol. The UK Chief Medical Officers' guidance on low-risk drinking recommends that in order to keep health risks from alcohol to a low level it is safest for men and women not to drink more than 14 units of alcohol per week on a regular basis, with two or three alcohol free days during a week. 64% of islanders consume alcohol within this limit but 27% exceed it.[2]

Abstinence has been stable while for other drinkers there was a reduction in low-risk drinking in 2018 compared to 2008. The difference was mainly driven by people moving into the first of the risky drinking groups ('risky' equating to moderate risk of harm).

Table 6: AUDIT risk category for the adult population in Guernsey and Alderney[2][9][10]

AUDIT drinking risk category	Population (%)		
	2008	2013	2018
Abstainer	8%	10%	9%
Low-risk (low risk of harm from drinking behaviour)	72%	62%	64%
Risky (Moderate risk of harm)	17%	25%	22%
High-risk 1 (Drinking that will eventually result in harm, if not already done so. May be dependent)	3%	2%	3%
High-risk 2 (Definite harm, likely to be dependent on alcohol)	0%	1%	2%

The Wellbeing Survey 2018 showed that men were more likely to exceed the 14 units per week recommendation than women and were more likely to be in the risky and high risk categories. There was also some evidence that drinking behaviour is related to age with younger adults (aged under 35 years) tending to drink more at their home and at the weekend, compared to the over 35s.[2]

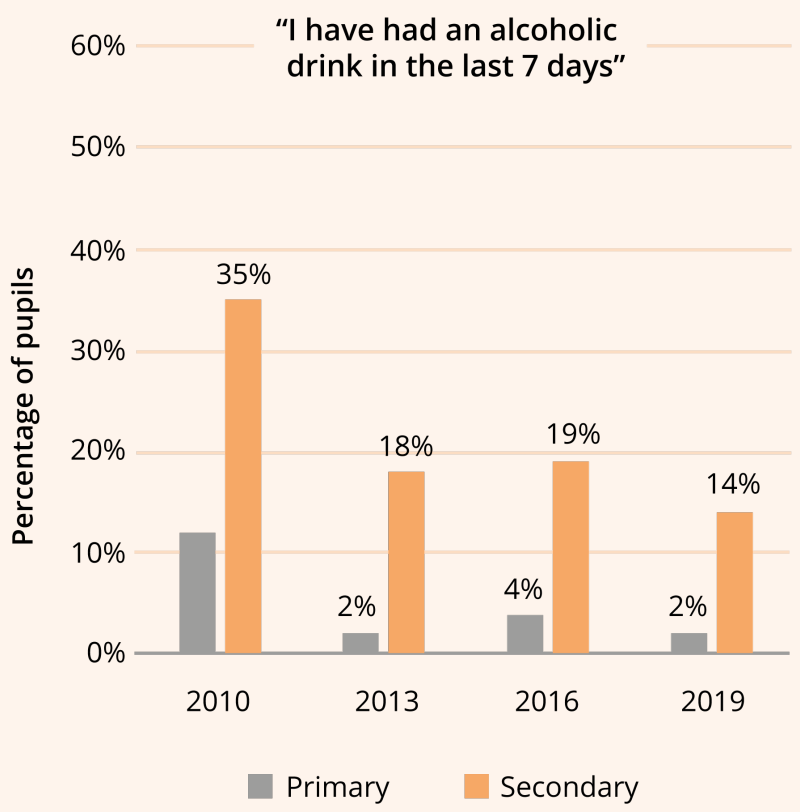
Alcohol consumption per capita in Guernsey describes the volume of pure alcohol consumed in litres per year by residents who are aged 16 years or over. The alcohol consumption per capita has been stable in the range 10.62 to 10.86 from 2014 to 2018 (Table 7). In Jersey, alcohol consumption per capita in 2018 was 11.8 litres[39], remaining at a similar level since 2015. In the United Kingdom, during the period 2010 to 2016, alcohol consumption per capita has fallen by nearly a litre from 12.3 litres to 11.4 litres.[40] Although the Jersey and UK figures remain higher than in Guernsey, they are not directly comparable due to the calculation of alcohol consumption per capita in these jurisdictions using a threshold of residents aged 15 years and over compared to 16 years and over in Guernsey.

Table 7: Alcohol consumption per capita in Guernsey and Alderney (litres).[39]

Children and young people aged 10 to 15 who drink alcohol mostly do so over the course of a weekend and usually at home or the home of a friend or relative. They primarily source alcohol from friends and their parents or carer. 14% of secondary school children aged 12–15 reported drinking alcohol in the last seven days, a decrease from 19% in 2016 and 35% in 2010 (Figure 6).[15]

Attitudes to Alcohol Consumption

Figure 6: Alcohol Consumption in Secondary School Children in the Seven Days prior to Survey



To gauge societal attitudes to drinking in Guernsey and Alderney respondents in the Wellbeing Survey 2018, were asked to what extent they agreed or disagreed with the following statements:

"Getting drunk is a perfectly acceptable thing to do"

"It is easier to enjoy a social event if you have had a drink of alcohol"

Only one in five (19%) people responded that they thought that getting drunk was a perfectly acceptable thing to do. However, there was a polarisation of attitudes between younger and older people. Whilst 51% of respondents aged 16–24 years agreed or strongly agreed with this statement this declined incrementally with age (Figure 7).[2]

Figure 7: Agreement with the statement "Getting drunk is a perfectly acceptable thing to do" by age, displaying 'agree/strongly agree' responses.

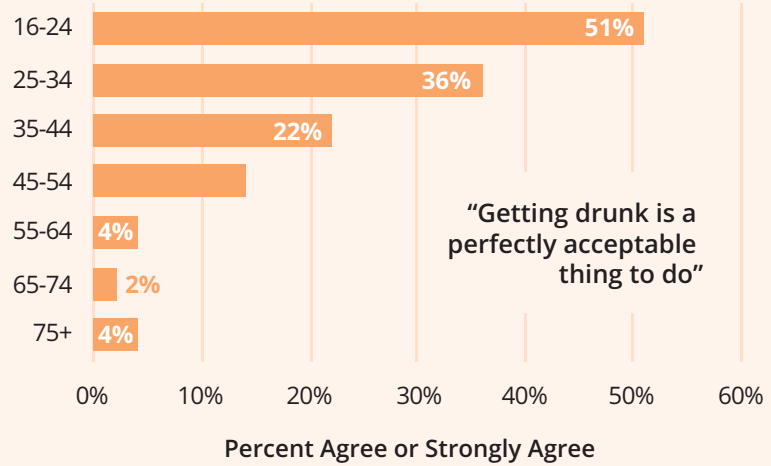
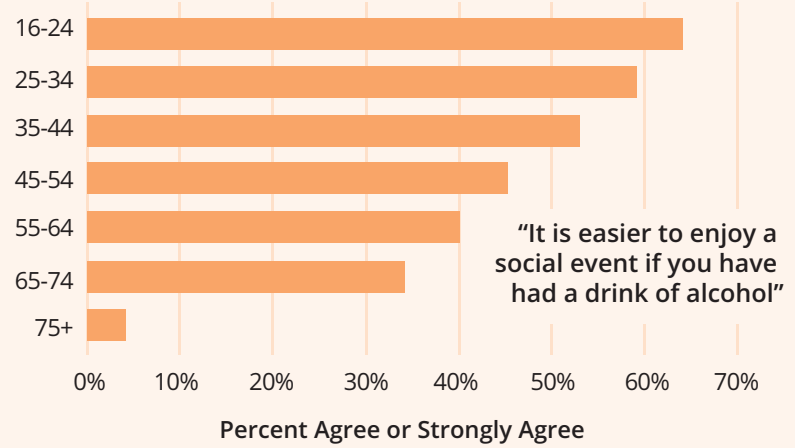


Figure 8: Agreement with the statement "It is easier to enjoy a social event if you have had a drink alcohol" by age, displaying 'agree/strongly agree' responses



A slightly different picture emerges with regard to alcohol as an aide to enjoy social events. Whilst support for this statement was highest among males and the younger age group there was not the steep drop off with age as there was for the "getting drunk" question, as indicated in Figure 8. These results give an indication that alcohol has a role in how we interact socially with other people and holds value in our local culture across all age groups.

Alcohol Availability

Table 8 shows the type and number of alcohol licences issued in Guernsey during 2019.[16]

Table 8: The type and number of alcohol licenses issued in Guernsey during 2019

Licence Code	Licence Description	Licences Issued
Category A	Bar, restaurant or cafe licence	129
Category B	Residential licence	3
Category C	Hotel licence	41
Category D	Club licence	22
Category E	Nightclub licence	3
Category F	Port (on-sales) licence	1
Category G	Passenger vessel licence	0
Category H	General off	0
Category I	General off licence	71
Category J	Airport duty free	2
Total		**272**

Data from 2016 to 2018, provided by the Guernsey Border Agency, on alcohol importations show the volumes of alcohol imported into the Bailiwick (Table 9).

Table 9: Importation volume of alcohol type: 2016, 2017 and 2018[18]

Alcohol type	Volume Imported (millions of litres)		
	2016	2017	2018
Spirits ABV*	0.28	0.30	0.31
Wine	2.25	2.26	2.14
Cider	1.01	1.06	1.14
Beer	4.51	4.46	4.64
Total	8.05	8.08	8.23

* Alcohol by Volume

Minimum Unit Pricing (MUP), as the name suggests, sets a minimum price below which a unit of alcohol cannot be sold. MUP is specifically targeted at addressing the cheapest alcohol which is most likely to be favoured by the heaviest drinkers. Research conducted in Guernsey in 2019 illustrated that, were a MUP set at 50p, it would affect 49% of products. This would increase the cost of the cheapest products, typically cheap ciders by around 20%. Only by increasing the MUP to 70p would the majority of the products sampled in the research be affected. However, local research illustrated that special offers were the main cause of low price alcohol.[41]

Alcohol Morbidity and Mortality

Alcohol harms both physical and mental health and is a global public health issue. The NHS advises that 10 to 20 years of regularly drinking more than 14 units a week can lead to:

- cancers of the mouth, throat and breast;
- stroke;
- heart disease
- liver damage;
- bowel cancer; and
- pancreatitis.[42]

Alcoholic beverages have been classified by the International Agency for Research on Cancer, since 1988, as carcinogenic to humans.[43] A carcinogen is a substance that can cause cancer. Alcohol consumption is particularly associated with colorectal cancer, which describes bowel and colon cancers. It also increases the risk of mouth cancer, pharyngeal (upper throat) cancer, oesophageal (food pipe) cancer, laryngeal (voice box) cancer, breast cancer, and liver cancer. Deaths from alcohol – related conditions and also from colorectal cancer in Guernsey and Alderney are illustrated in Tables 10 and 11.

Table 10: Alcohol-related deaths in the Bailiwick for the periods 2010-2012 and 2013-2015[6][12]

	3 Year total Alcohol-related deaths	Average no. of Alcohol-related deaths per year
2010-2012	19	6
2013-2015	19	6

Table 11: Colorectal cancer deaths for the periods 2010-2012 and 2013-2015[6][12]

	Colorectal cancer deaths over 3 year period	Average no. of Colorectal cancer deaths per year
2010-2012	49	16
2013-2015	47	16

Data from the Emergency Department at the Princess Elizabeth Hospital showed that of a total of 16,413 Emergency Department attendances in 2017, 2.4% were thought to be alcohol-related, a similar proportion to the UK.[11][27] Almost a third of these suspected alcohol-related attendances occurred in individuals over 50 years of age and, of these, just over two thirds were men.[44] Information from the Mignot Memorial Hospital in Alderney showed that 3.6% of admissions were thought to be drug or alcohol related.[28]

The Wellbeing Survey 2018 asked respondents about their life satisfaction (now and in the future), loneliness, and levels of emotional support and social exclusion. In evaluating the results as a whole, what should be noted is that several subgroups emerge with poorer results than the average —those living in affordable housing, those aged 16–24 and those who reported drinking alcohol to levels of high risk (see table 12). This illustrates the interaction of alcohol and broader issues of health and wellbeing.[2]

Table 12: Emotional Health and Wellbeing: Association with high-risk drinking scores

	Lower life satisfaction scores	Low Mental Wellbeing	Loneliness	Feeling lonely, isolated, lacking companionship	Feeling excluded from activites and events
Occupants of affordable housing	✓	✓	✓	✓	✓
Young people (16-24)*		✓	✓	✓	✓
Those with hight risk drinking scores		✓	✓	✓	
Those reporting a mental/emotional health condition	✓		✓		

**this should be interpreted with caution due to small sample size*

Furthermore, individuals who reported drinking at levels that are classed as 'high risk' (as measured by the 'AUDIT' score):

- were more likely than low risk drinkers to have 'low mental wellbeing' (36% compared to 15%);
- were more likely to be intensely emotionally lonely (34% compared to 15% of all respondents); and,
- were more likely to feel lonely, isolated or lacking in companionship (42% compared to 26% among abstainers and 15% among low risk drinkers).[(2)]

However, the impact of substance use on health and wellbeing also cannot be considered in isolation. The Wellbeing Survey 2018 also looked at stress.

Self-reported factors associated with experiencing large amounts of stress included:

- living in affordable housing or renting privately;
- being a current smoker or vaper;
- drinking to a level of high risk;
- having caring responsibilities; and,
- living with obesity. [(2)]

The Wellbeing Survey 2018 also found that males in Guernsey and Alderney are more likely to drink frequently (more than twice a week), consume over 14 units of alcohol a week and exhibit risky drinking behaviour as measured using AUDIT score. [(2)]

Tobacco

Tobacco

Tobacco use is the single largest avoidable cause of premature death globally.[45] Negative health effects for smokers and, those who involuntarily inhale tobacco smoke (known as passive smokers), are numerous and come at a high risk (Table 13).

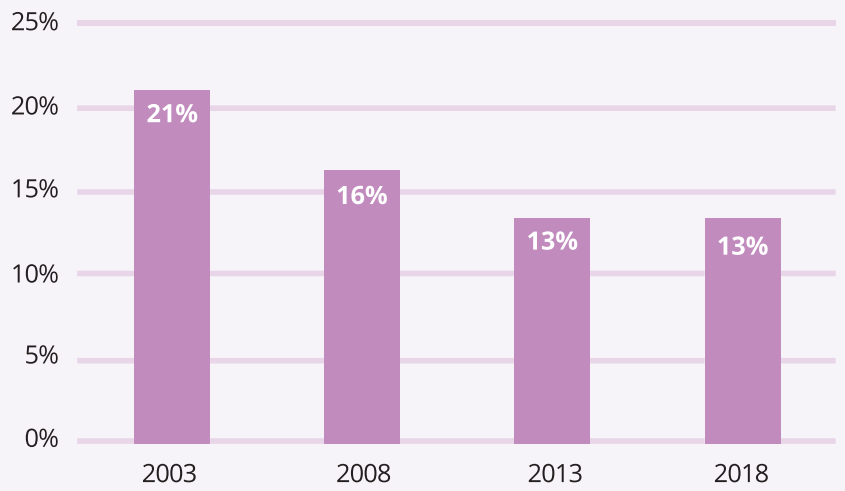
Table 13: Health Risks to Smokers and Passive Smokers[46]

Smokers	Passive Smokers
Nicotine addiction	In babies: increased risk of low birth weight and cot death
Increased risk of cancers (including lung, bladder, oral, oesophageal, stomach and pancreatic)	In children: increased risk of middle ear infections, bronchitis and asthma
Increased risk of vascular disease (including coronary heart disease, stroke and abdominal aortic aneurysm)	In adults: increased risk of heart disease, stroke, and lung cancer
Chronic lung disease e.g. COPD	Irritation to the eyes and airways
Increased risk of cataracts, hip fracture and periodontal disease	
Increased risk of stillbirth in pregnant women	

Tobacco Use

The adult smoking prevalence in Guernsey and Alderney is calculated every five years. Various fiscal, legislative and awareness raising measures have helped to reduce the smoking prevalence over the past few decades but the most recent data tells us that it has remained at approximately the same level amongst adults since 2013 (Figure 9).[2] It is possible that this plateau represents reaching a point where those who continue to smoke are the most dependent for which conventional tobacco control measures are ineffective and new approaches are needed.

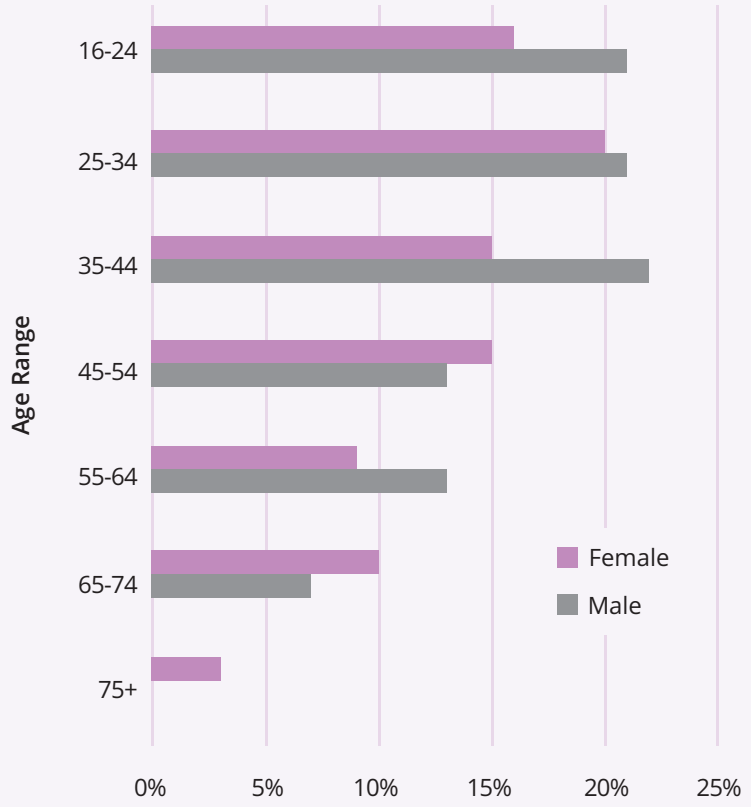
Figure 9: Percentage of the Population who are Current Smokers in Guernsey and Alderney[2]



As stated, results from the Wellbeing Survey 2018 shows no change in smoking prevalence from 2013 remaining at 13%. A further 30% of people reported that they used to smoke but no longer do so. As expected, smokers and ex-smokers were more likely to rate their health as bad or very bad, compared to non-smokers. Furthermore 15% of current smokers have high risk drinking habits, compared to 3% of people who have never smoked tobacco.[2]

The Wellbeing Survey 2018 showed that there was a higher prevalence of smoking in the under 55s. Overall smoking rates were similar in males and females. Amongst women, smoking rates were highest at 20% (one in five people) in the 25 to 34 age group. For men, rates were highest, at 22%, amongst the 35 to 44 year age group. Also noteworthy is that the smoking rate was 21% in the 16 to 24 year age group. However, as previously noted, this data needs to be interpreted with caution due to the relatively small numbers in this age group participating in the survey (Figure 10).[2]

Figure 10: Percentage of the population in Guernsey and Alderney Smoking by Age and Gender[2]



Although the average prevalence of tobacco smoking in Guernsey and Alderney is lower than comparison jurisdictions at 13%, smoking status is strongly age-dependant with higher rates among younger islanders. Recent data from Health & Social Care's Maternity Services, confirms that smoking prevalence among women having babies locally, and those they live with, is considerably higher than the all-age average, typically between 16 and 23% (Table 14). Many women give up smoking on discovering that they are pregnant, however, more commonly, women who were smokers before they conceived continue to smoke throughout pregnancy. Approximately one in five women report that they live with someone who smokes. This undoubtedly increases the risk to those who successfully quit smoking during pregnancy of resuming the habit after giving birth. It also means that one in five babies born in the islands goes home to a household where they may be exposed to second-hand smoke.[47]

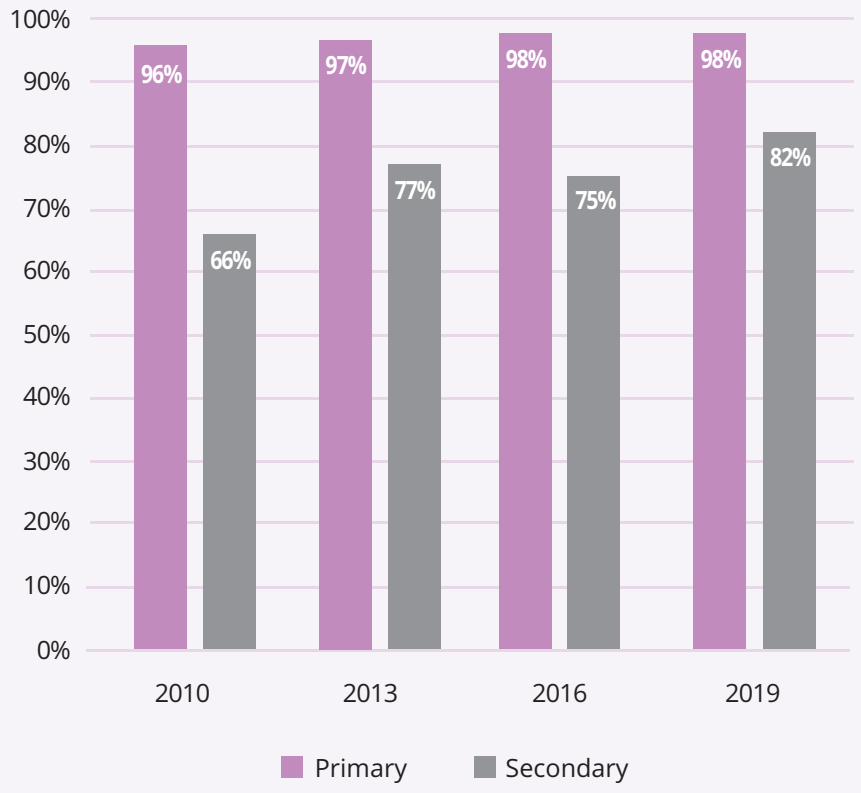
Table 14. Smoking prevalence of pregnant women and those in their households, 2017–19 [47]*

	Year of booking		
	2017	2018	2019
Smoker at booking	13%	11%	11%
Quit smoking prior to booking	8%	10%	7%
Total smokers pre-pregnancy	21%	21%	18%

* based on information gathered at ante-natal 'booking' appointments (the first contact pregnant women have with Maternity Services during pregnancy which typically takes place at about 8 to 10 weeks gestation).

Primary school students aged 10 and 11 who have never smoked remained at 98%, whereas, encouragingly, secondary school students aged 12 to 15 who have never smoked increased by 7% (Figure 11).

Figure 11: Percentage Responses from Primary and Secondary School Children when responding to "I have never smoked"



Information on parents' and carers' smoking rates is important. Infants and young people are particularly vulnerable to the detrimental effects of second-hand smoke because of their physical stage of development and due to their lack of control over their environment. As part of the Young People's Survey 2019, children where asked about their parents'/ carers' smoking habits and the results have remained broadly similar between 2010 and 2019, as illustrated in Figure 12. These young people may also be exposed to second-hand smoke in their home and cars. It is important to note that reported smoking among parents and carers ranges from 27% to 33%. This is considerably higher than the overall prevalence for Guernsey and Alderney (13% as reported in the Guernsey and Alderney Wellbeing Survey 2018). However, in the Wellbeing Survey, amongst women, smoking rates were highest at 20% (one in five people) in the 25 to 34 age group and for men, rates were highest, at 22%, amongst the 35 to 44 year age group, ages which will inevitably be reflective of many parents in Guernsey and Alderney. Despite this, the reported smoking prevalence from the Young People's Survey 2019 needs to be interpreted with caution as there is a possibility that children and young people over report parental smoking and for double counting in the case of multiple siblings.

Tobacco Availability

The amount of tobacco imported to the island has been decreasing for 10 years and the number of retail and wholesale outlets have more than halved since 2015. This has meant that importation has declined from just over 43,000kg in 2008 to around 23,500kg in 2018, a reduction of 46% (Figure 13). Tobacco importation has increased since 2018 to 35,049kg in 2020. [18]

Figure 12: Percentage Responses from Primary and Secondary School Children when responding to "My parent(s)/carer(s) smoke" illustrating the number of parents / carers that do smoke

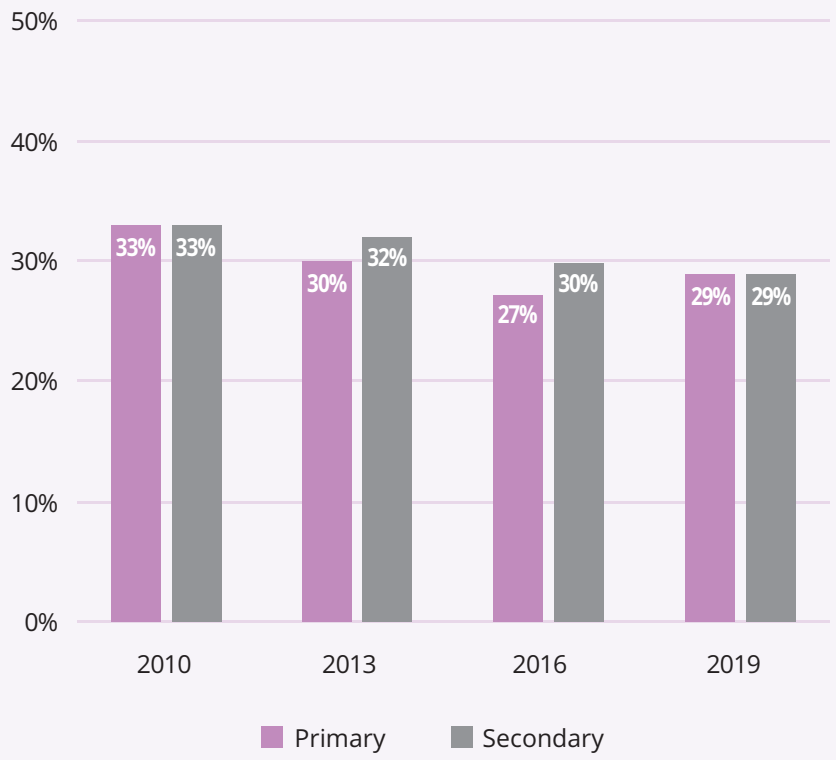
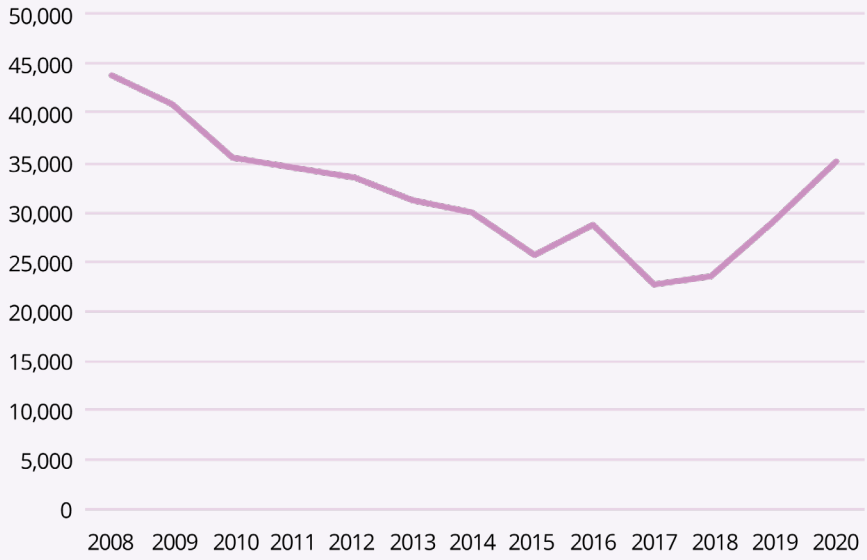


Figure 13: Tobacco Importation (kgs)



The number of licences issued to sell tobacco has also decreased year-on-year from a total of 167 in 2015 to 44 in 2018 – a 74% reduction (Table 15).[18]

Table 15: Tobacco licenses issued annually by the Office of Environmental Health and Pollution Regulation[48]

Licenses issued to sell tobacco				
	Retail	**Wholesale**	**Indirect/ Internet**	**Total**
2014	10	1	0	**11**
2015*	160	4	3	**167**
2016	102	4	1	**107**
2017	90	3	1	**94**
2018	43	1	0	**44**

*The legal requirement for a licence to sell tobacco was enacted on 24th November 2014 through The Tobacco Products (Guernsey) Ordinance, 2014.

Tobacco Morbidity and Mortality

Morbidity associated with smoking tobacco is wide reaching and often coexists with other health problems.

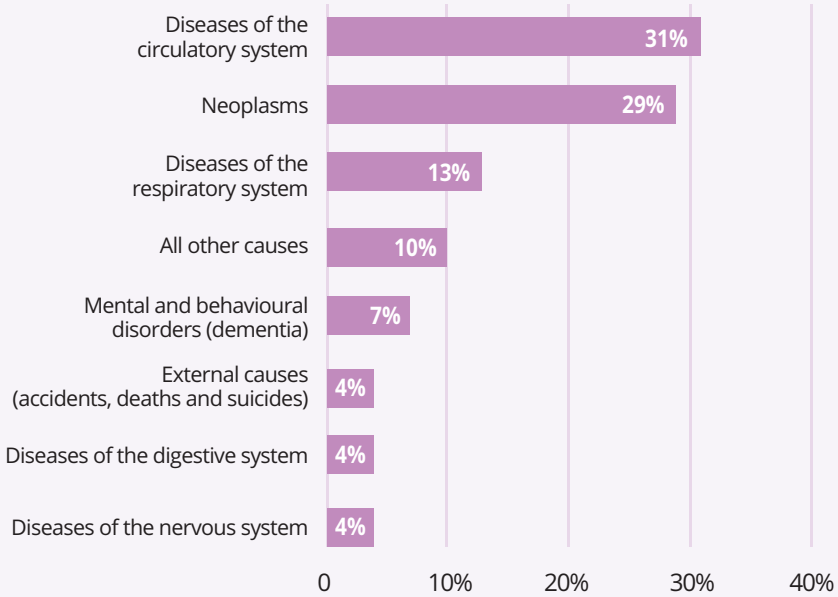
The Wellbeing Survey 2018 indicated poorer health and wellbeing in smokers. For example, compared with those who never smoke, tobacco smokers are more likely to have:

- high-risk drinking behaviours (15% of smokers compared to 3% who have never smoked tobacco);
- report experiencing a large amount of stress (50% of current smokers compared to 34% who have never smoked or who have given up smoking); or,
- rate their overall health as fair, bad or very bad (32% of smokers compared to 19% who have never smoked tobacco). [2]

Research has shown that loneliness and social isolation is as harmful to health and wellbeing as smoking 15 cigarettes a day.[49] Loneliness can be social, occurring when someone misses a wider social network, or emotional, when someone misses a close or intimate relationship.[50] Islanders who smoke or vape, are more likely to be both intensely emotionally and socially lonely compared with those who have never smoked.

The association between smoking and cardiovascular complications and certain cancers is well documented and Figure 13 demonstrates that these are the leading causes of death in Guernsey and Alderney. Examples of diseases of the circulatory system are strokes and heart attacks and neoplasms are cancers.

Figure 14: Leading causes of death in Guernsey and Alderney 2013-15[6]



The Guernsey and Alderney Health Profile 2012- 2015 states that:

"In recent years the calculation and application of the Smoking Attributable Fractions (SAF) for several diseases and causes of death where smoking is a contributory factor, has allowed a better estimate on the impact of smoking on health to be made. In the Guernsey and Alderney Health Profile 2013–2015 SAFS were used in conjunction with smoking prevalence data to estimate the number of local deaths that could reasonably be attributed to smoking. During this period, 54 male and 32 female deaths were attributable to smoking."[12]

Table 16: Deaths in Guernsey / Alderney attributable to smoking[6][12]

Period	% caused by smoking	Deaths over 3 year period	Average no. of deaths per year	Estimated deaths per year	
				Male	Female
2010-2012	16%	261	87	51	36

Rates of cancer incidence and mortality for Guernsey and Alderney are collated by Public Health England's National Cancer Registration and Analysis Service and analysed on behalf of the Channel Islands. The last report was published in 2017 which showed that lung cancer is the fourth

most common cancer in Guernsey and Alderney and the second most common cause of cancer deaths.[51] The number of lung cancer deaths in Guernsey and Alderney from 2010 to 2015 is illustrated in Table 17.

Table 17: Lung cancer deaths for the periods 2010-2012 and 2013-2015[6][12]

Lung cancer deaths (all ages)		
	Deaths over 3 year period	Average no. of deaths per year
2010-2012	113	38
2013-2015	92	31

Although premature death from cardiovascular disease has decreased, diseases of the circulatory system are still our top cause of death, accounting for 31% of deaths in the 35+ age group. Overall 16% of deaths in the over 35s were smoking-related (Table 18).[6]

Table 18: Cardiovascular disease mortality attributed to smoking in Guernsey/Alderney, Jersey and England for the period 2013-2015[6][12]

Jurisdiction	Timeframe	Cardiovascular disease mortality attributed to smoking
Guernsey/Alderney	2013-2015	10%
Jersey	2013-2015	14%
England	2014	13%

The respiratory disease mortality attributed to smoking is illustrated in Table 19.

Table 19: Respiratory disease mortality attributed to smoking in Guernsey/Alderney, Jersey and England for the period 2013-2015[6][12]

Jurisdiction	Timeframe	Respiratory disease mortality attributed to smoking
Guernsey/Alderney	2013-2015	44%
Jersey	2013-2015	43%
England	2014	37%

In 2018 14% of fires in Guernsey and Alderney were caused by cigarette lighters and smoking materials.[17]

Vaping and E-cigarettes

What are e-cigarettes?

Electronic cigarettes, also known as vapourisers, vapes or electronic nicotine delivery systems (ENDS), are battery-powered devices that deliver nicotine by heating a solution of nicotine, flavouring, additives and propylene glycol and/or vegetable glycerine (glycerol).

There is no tobacco in e-cigarettes. As these products contain nicotine and are sometimes used as a smoking cessation aid, information on vaping and e-cigarettes is included in this JSNA.

When an e-cigarette is used, a sensor detects air flow and activates a heating element (the 'atomiser') which heats the liquid in the cartridge so that it evaporates. The vapour delivers the nicotine to the user. E-cigarettes were developed to mimic the action of smoking, including nicotine delivery, without the toxic effect of tobacco smoke.

When a person smokes a conventional tobacco cigarette, smoke is inhaled into the lungs and then exhaled (this is second hand smoke). Smoke is also emitted from the burning tip of the cigarette (also second-hand smoke), releasing toxins into the air. As there is no combustion involved in the use of e-cigarettes there is no smoke. Vapour is released into the air only when the user exhales.

There are three main types of e-cigarettes or vapourisers:

- "Cig-a-like" product: This first generation of e-cigarettes were designed to resemble tobacco cigarettes. Some have a light at the end that glows when the user draws on the device, to resemble a lit cigarette. These are either non-rechargeable disposable models or an electronic cigarette kit that is rechargeable and includes replaceable pre-filled cartridges.
- 'Tank' models (also known as vape pens): A re-chargeable e-cigarette with a tank or reservoir that has to be filled with liquid nicotine. Tank models that have now become Electronic cigarettes (also known as vapourisers) are more commonplace and allow the user to choose from a broader range of nicotine strengths and flavourings.
- 'Mods' (or advanced personal vaporisers): A more complex tank model which can be manually customised by, for example, adjusting the voltage on the device.[52]

Are e-cigarettes safe?

In the second quarter of 2019, headlines around the world reported on an outbreak of serious lung disease across the United States of America, which was reported to be associated with vaping. By the 22nd October 2019, 1,604 cases had been reported to the Center for Disease Control (CDC) from 49 US states. There were 34 deaths. The US has an estimated 9 million e-cigarette users in the country. The group affected by this lung disease is very specific. The outbreak appears to be largely amongst young men (70% of cases), with an average age of 24 years. Almost half of the affected patients (46%) were under 21 years of age. In most cases THC-containing products had been used by patients experiencing lung injury. Tetrahydrocannabinol (THC) is one of at least 113 cannabinoids identified in cannabis. The specific substance or substances causing the lung injury have not yet been identified though a limited number of suspected chemicals are being investigated. The implicated products are being obtained off the street or from other informal sources (e.g. friends, family members or illicit dealers). The outbreak does not appear to be associated with long term use of regulated nicotine e-cigarettes, which have been used in the US for over ten years.[53]

Events in the US have been considered by Public Health England. They have highlighted that this problem is not linked to long-term use of regulated nicotine vaping products. If it were, there would be many more cases of ill-health in vapers across the demographic spectrum. Furthermore, e-cigarettes containing nicotine are more tightly regulated in the UK than in the US as the Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for overseeing the tobacco regulations. The main chemicals under suspicion in the US, such as THC and Vitamin E acetate oil, are not permitted in e-cigarettes in the UK.[53]

E-cigarettes are not regulated in Guernsey and Alderney and so, similarly to the US, we cannot be confident that we will not be affected by street products. Local regulation would provide some assurance.

Public Health England Advice on vaping and e-cigarettes

PHE advice on smoking and e-cigarettes

- **For smokers:** You should stop smoking completely. Getting expert support combined with using an e-cigarette doubles your chances of quitting successfully.
- **For people who vape nicotine:** if you are still smoking, you should stop and switch completely to vaping, then come off nicotine when you are confident you won't relapse to smoking.
- **If you have never smoked:** Don't vape.
- **For people who vape CBD:** although CBD is less tightly regulated, if you experience symptoms or are concerned you should stop.
- **For people who vape THC:** if you are vaping THC (or an unknown liquid which could contain THC) it can be hazardous. These are the products most implicated in the US outbreak. If you feel unwell or have any difficulty breathing after vaping THC, go to A&E and tell them precisely what the product was you were using.[53]

Local data on vaping and e-cigarette use

Local data reports that 6% of adults in Guernsey and Alderney vape (use e-cigarettes). Vaping was also shown to be more prevalent amongst younger people than older people. Of those who vape 32% are also current smokers, 59% are ex-smokers and 9% have never smoked tobacco products.[2] This last figure is particularly important. It reveals that some people have taken up vaping as a behaviour itself and not as a way of quitting tobacco products, although the numbers are small.

Drug Use

Drug use

A drug is any substance (with the exception of food and water) which, when taken into the body, alters the body's function, either physically and/or psychologically. Drugs may be legal (e.g. alcohol, caffeine and tobacco) or illegal (e.g. cannabis, ecstasy, cocaine and heroin).[54] For the purpose of this report, any reference to drugs is describing illegal and prescription drugs and considers drug use as the use of a drug that is not consistent with legal or medical guidelines.

Types of Drugs used

The Wellbeing Survey 2018 provides detailed information on local drug use. Respondents were asked to indicate their use of cannabis and any other illegal drugs within the last month and year. 11% of people reported that they had used cannabis within the last year, while 4% had used other illegal drugs. In both cases, use was higher in men than women and was strongly related to age with highest levels of use among the youngest age groups.[2]

Results from the Wellbeing Survey 2018 do, however, need to be interpreted with caution. This is because the age group where drug use was reportedly greatest (16-24s) is also the age group where the fewest responses were received. This reduces the level of confidence that the findings are a good representation of the general population.[2]

However, taken at face value, cannabis use has increased by 6%, up from 5% in 2013 to 11% in the 2018 survey. This is potentially corroborated by findings from the Young People's Survey 2019. Since much of this difference was driven by change among the 16-24s, the group where there is most statistical uncertainty, we must again view this result with caution.[2]

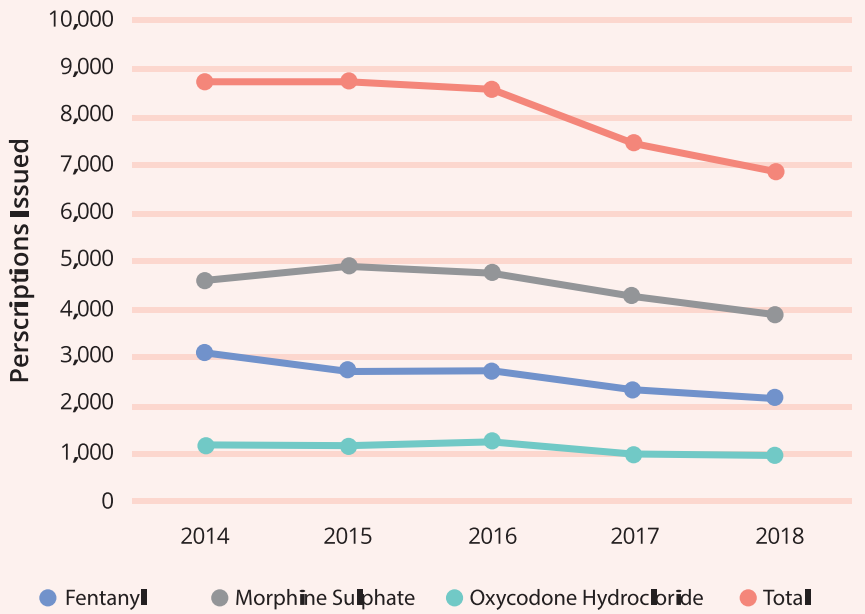
Management of chronic pain, particularly musculoskeletal pain, remains an important source of opioid prescribing and increased opioid prescribing gives rise to the possibilities of dependency or prescription diversion. The need for greater monitoring of opioid prescribing in

chronic pain, for which there is little evidence of clinical benefit, has been identified. This highlights the importance of exploring alternative pain management strategies to manage the heavy burden of chronic pain. Recent research has shown that between 1998 and 2016, opioid prescriptions increased by 34% in England (from 568 to 761 per 1000 patients). However, encouragingly there was a decline in prescriptions from 2016 to 2017 in England.[55]

Locally, the combined prescription rates for opioids in the Bailiwick, including fentanyl, Morphine Sulphate and Oxycodone Hydrochloride, have decreased markedly in the past five years (Figure 15). This is encouraging as the use of these drugs can lead to physical dependency and tolerance. It is important to use a holistic approach to pain management by exploring all treatment options.

New psychoactive substances (NPS), often misleadingly referred to as 'legal highs', pose a challenge to government, local authorities healthcare services and the criminal justice system. In 2014 legislation in the Bailiwick was strengthened to ban the importation of these substances by making it illegal to import any substance that is designed for the purpose of recreational drug use in Guernsey. This has meant that Guernsey has not faced similar problems to that experienced in other jurisdictions in relation to the use of NPS.

Figure 15: Number of prescriptions issued for Fentanyl, Morphine and Oxycodone Hydrochloride for the years 2014-2018 in Guernsey and Alderney[20]



Although a wide range of illegal drugs are seized at Guernsey's borders, the drug most frequently seized is cannabis in both herbal and resin form, as illustrated in Table 20.

Table 20: Drug importation seizures by Guernsey Border Agency for the years 2016 to 2018 [56]

CLASS A Compound/Drug	No. of seizures 2016	2017	2018
Cocaine	3	5	6
Heroin	0	0	2
MDMA (tablet)	8	9	4
MDMA (powder)	1	11	7
Methamphetamine	3	0	0
LSD	1	1	
Canabis Oil	3		1
Class A Total	**16**	**26**	**16**

CLASS B Compound/Drug	No. of seizures 2016	2017	2018
Amphetamine (powder)	1	2	1
Dihydrocodeine	0	1	0
Cannabis Plant			1
Canabis Resin	34	56	19
Herbal Cannabis	5	68	44
CBD Capsules / Pills			5
CBD Liquid			12
Mephedrone	2	0	0
Class B Total	**42**	**127**	**82**

CLASS C Compound/Drug	No. of seizures 2016	2017	2018
Steroids	4	7	6
Steroids (vials)	7	5	9
Benzodiazepines	4	0	
Ketmaine	1	0	
Diazepam	2	8	10
Buprenorphine (tablets)	0	1	
Other Class C medication			3
Class C Total	**18**	**21**	**28**

OVERALL TOTAL | 2016 - **76** | 2017 - **174** | 2018 - **130**

Prisoners entering Les Nicolles Prison are tested for drug use on admission. Cannabis is the drug that is detected most frequently, reflecting the data from Guernsey Border Agency, illustrated in Table 21. This is followed by benzodiazepines and opiates. amphetamine, cocaine, methadone and methamphetamine are occasionally identified.[56]

Drug related Morbidity and Mortality

Table 21: Drugs that prisoners tested positive for on admission to prison in 2018[56]

Drugs	Frequency
Cannabis	Most Frequent
Benzodiazepines	
Opiates	
Buprenorphine	
Amphetamine	
Cocaine	
Methadone & Methamphetamine	Least Frequent

There is some evidence to demonstrate that the number of secondary school aged pupils who have been offered cannabis is increasing (Table 22).

Table 22: Percentage of secondary school pupils who have been offered cannabis [15][57][58][59]

	2010	2013	2016	2019
Secondary pupils aged 12 to 15 who have been offered cannabis	10%	9%	17%	18%

Use of cannabis or other illegal drugs was higher in those who smoke, vape or have high risk drinking habits. Those who use cannabis were also more likely to have a longstanding mental or emotional health condition, or have low mental wellbeing.[2]

There were 375 presentations to the Emergency Department during 2018, where drug misuse was recorded as part of the diagnosis. These attendances included, but were not limited to, general drug use, overdoses and self-harm, seizures, soft tissue injury from injecting and suspected body packing (internal concealment of drugs for importation). Some of these attendances also involved alcohol.[11]

Bloodborne viruses, such as HIV, Hepatitis B virus (HBV) and Hepatitis C virus (HCV), can be transmitted through the sharing of needles and injecting paraphernalia relating to injecting drug use (IDU). HCV is the most common bloodborne virus in Guernsey and Alderney, with injecting use accounting for more than 80% of infections. There are around 40 people living with HIV in Guernsey and Alderney, none of whom are current injecting drug users. No cases of HBV infection have been documented locally as acquired through injecting drug use.[19] During the period 2001–2015 there were 33 registered deaths related to drug poisoning in Guernsey and Alderney, averaging three deaths per year. In the majority of cases the drugs associated with these deaths were prescription medicines.[23]


ml

Substance use and criminality

Assault, sexual offences and criminal damage

Guernsey Police gather data on recorded crime and during their investigation of an assault record whether alcohol and/or drug consumption was involved in the incident. In 2018 a total of 590 crimes were recorded for all types of assault. The perpetrators of violence in 225 (38%) of these crimes were under the influence of alcohol. Drug use by the offender was recorded in fewer than five cases. [13]

Alcohol consumption by the offender was also a factor in other crimes including sexual offences (17%) and criminal damage (10%) but less so in offences for theft (4%). Drug use by offenders in these categories is lower than that of the recorded assault crimes. Alcohol and drug use by the victim of these crimes is low. [13]

Domestic Abuse

Domestic abuse is a crime taken seriously by the States of Guernsey, evidenced by the Committee for Home Affairs Domestic Abuse Strategy 2016-2020.[14] Women's Aid describe domestic abuse as

'an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer. It is very common. In the vast majority of cases it is experienced by women and is perpetrated by men.' [60]

The number of yearly police attendances to domestic abuse incidents and the percentage that involve alcohol use by the perpetrator can be seen in Table 23.

Table 23: Police call outs to domestic abuse incidents and association with alcohol use[14]

	Total Police Call Outs	Alcohol use by perpetrator	Proportion of call outs with perpetrator alcohol consumption
2013	682	310	45%
2014	635	265	41%
2015	601	216	36%
2016	632	181	28%
2017	618	297	48%

It is likely that the domestic abuse incidents reported to the police represent only the most serious incidents with many more going unreported. Domestic abuse may also be witnessed by children, a recognised adverse childhood experience. In 2018, 224 children were referred to a Multi-Agency Risk Assessment Conference (MARAC) as a result of domestic abuse in the home (Table 24). **(63)**

Table 24: Domestic abuse cases referred to MARAC and number of children involved [61]

	Number of domestic abuse referrals to MARAC	Number of children involved
2017	165	209
2018	177	224

When considering the age profile of domestic abuse perpetrators known to have substance use issues, drug use is mostly associated with offenders under 40 years of age. However, alcohol use is significantly more prevalent that drug use in all age categories.

Drink Driving

The effects of alcohol on driving can include:

- reduced ability to judge speed and distance
- false sense of confidence and increased tendency to take risks
- reduced co-ordination and concentration
- slower reaction times
- impaired vision and impaired perception of obstacles.[62]

The number of motorists breathalysed and convicted of drink driving in Guernsey and Alderney since 2010 can be seen in Table 25. There had been a downward trend in the number of motorists convicted of this offence between 2010 and 2016, but an increase in recent years.

The level of permissible blood alcohol concentration (BAC) in Guernsey aligns to that of England, Wales and Northern Ireland (up to 80mg per ml of blood). However, this is higher than that of Scotland, and most other European Countries, who have set 50mg per ml as their limit. [62]

Table 25: Number of motorists breathalysed and convicted for drink driving by year [13]

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Breathalysed	763	935	746	797	763	950	851	692	581
Convicted	123	116	91	97	68	96	65	76	89
% Convicted	16	12	12	12	9	10	8	11	15

Offences resulting in prison sentences

Table 26 shows the different offence categories committed by members of the prison population at Les Nicolles, the most numerous of which are drug offences. It is likely that this reflects the fact that most drugs which are used are either illegal substances or prescription medicines that have been obtained illicitly. Given the association of alcohol and crime as described above, it is expected that some prisoners convicted of other offences, particularly those involving violence, were under the influence of alcohol when they committed the crime which resulted in their incarceration.

An external review commissioned by the Committee for Health & Social Care, through Public Health Services, has considered the current approach used in the Bailiwick regarding the interaction of the health and justice system for the possession of drugs for personal use. This review will be considered, together with information from this JSNA, when developing a Combined Substance (Drugs, Alcohol and Tobacco) Use Strategy.

Table 26: Offence category of Guernsey Prison population as at 18th April 2019[16]

Offence category	Number in Prison (%)
Breach of supervision	1 (1%)
Drugs	38 (38%)
Fraud	0 (0%)
Miscellaneous	2 (2%)
Property	5 (5%)
Public order	2 (2%)
Sexual	25 (25%)
Driving	4 (4%)
Violence	22 (22%)
Total	**99 (100%)**

Substance Use and the COVID-19 pandemic

Substance Use and the COVID-19 pandemic in the Bailiwick

The first case of COVID-19 was diagnosed on 9th March 2020 in an individual who had recently returned to Guernsey from Tenerife. Initial cases seen in the first wave of infection in Guernsey were mostly travel-related or identified among close contacts of known cases following contact tracing. The Bailiwick risk profile initially increased with the identification on 23rd March 2020 of the first case of infection where viral transmission was from an unidentified community source. This led to the Bailiwick going into full lockdown on 25th March 2020.

With the implementation of comprehensive border controls, there was a dramatic reduction in the number of travel-associated cases in the Bailiwick. The last travel-associated case identified in the first wave of infection (Wave 1: 9th March–30th April 2020) became symptomatic on the 5th April, 10 days after lockdown was implemented, which is within the known incubation period (2–14 days) for this virus. No further cases were detected until 6th September 2020. The detection of a case on 6th September 2020 was not surprising as it followed the introduction of a policy of testing incoming travellers and the case was identified as a returning traveller who tested positive whilst in self-isolation. A small cluster of cases was identified in Guernsey in October 2020, which was quickly controlled by the Bailiwick's 'Test, Trace and Isolate' policy.

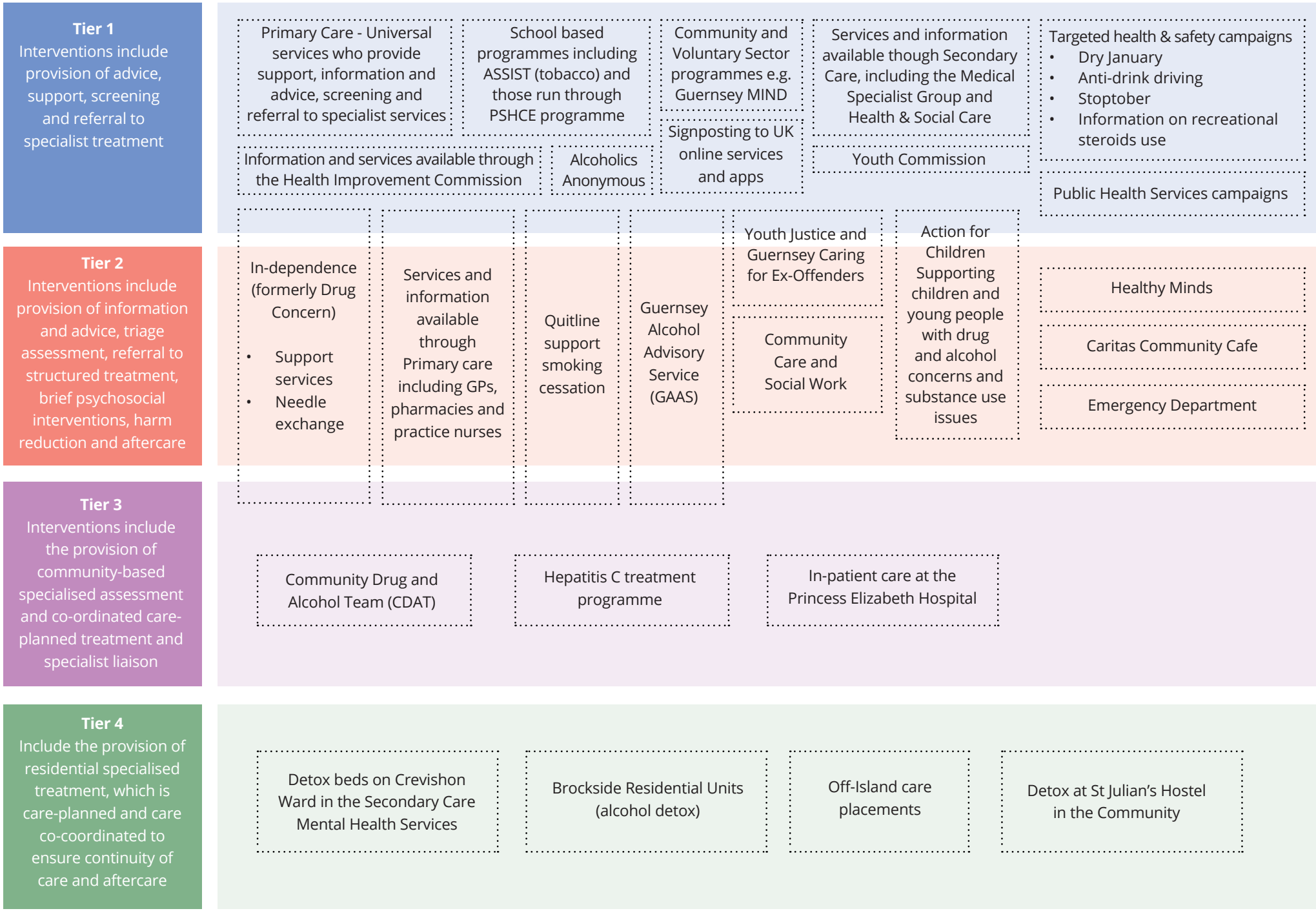
On the 22nd January 2021 four cases of unexplained community seeding of SARS-CoV-2, the virus that causes COVID-19, were identified by Public Health Services. In view of the sudden appearance of these four cases, Public Health Services were seriously concerned that community seeding of SARS-CoV-2 had occurred in Guernsey and the risk of uncontained onward transmission was a significant possibility. This could lead to the healthcare system, as well as the testing and contact tracing capacity, being overwhelmed and the need for urgent escalation was identified. These four cases of infection have now been identified as being caused by infection with the Kent' SARS-CoV-2 variant of concern – known as VOC-202012/01 (also known as lineage B.1.1.7, 20I/501Y.V1

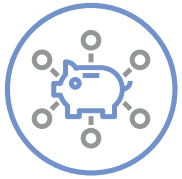
As a consequence of the identification of these four unexplained community cases of COVID-19 on 22nd January 2021, on 23rd January 2021 the CCA directed a full lockdown and, as of 12:00 noon on Saturday 23 January.

The consequences of the first lockdown, in relation to substance use, were measured in the Guernsey Community Survey Report (preliminary findings published in August 2020). A total of 3,699 people took part in this survey which equates to 7% of the Bailiwick population. The impact of lockdown, and the COVID-19 pandemic, on substance use is highlighted in this survey. Of the respondents, 12% said that their alcohol consumption in the first lockdown increased 'a lot' and 29% said that it increased 'a little'. Furthermore 5% said that their smoking or vaping increased 'a lot' and 7% said it increased 'a little'. However, further analysis of the 21% to whom the question on smoking and vaping was applicable, showed that 22% said that this had increased 'a lot' and 32% that it had increased 'a little'. Encouragingly, however, a small number of respondents reported that they had given up smoking or alcoholic drinks whilst in lockdown.[74]

Current Services

Information and data from services is, in some instances, lacking. Some services also report on very small numbers of service users. This was identified by stakeholders as an area for improvement.


Tier 1
Interventions include provision of advice, support, screening and referral to specialist treatment
Primary Care - Universal services who provide support, information and advice, screening and referral to specialist services
School based programmes including ASSIST (tobacco) and those run through PSHCE programme
Community and Voluntary Sector programmes e.g. Guernsey MIND
Services and information available though Secondary Care, including the Medical Specialist Group and Health & Social Care
Targeted health & safety campaigns
Dry January
Anti-drink driving
Stoptober
Information on recreational steroids use
Information and services available through the Health Improvement Commission
Alcoholics Anonymous
Signposting to UK online services and apps
Youth Commission
Public Health Services campaigns
Tier 2
Interventions include provision of information and advice, triage assessment, referral to structured treatment, brief psychosocial interventions, harm reduction and aftercare
In-dependence (formerly Drug Concern)
Support services
Needle exchange
Services and information available through Primary care including GPs, pharmacies and practice nurses
Quitline support smoking cessation
Guernsey Alcohol Advisory Service (GAAS)
Youth Justice and Guernsey Caring for Ex-Offenders
Community Care and Social Work
Action for Children Supporting children and young people with drug and alcohol concerns and substance use issues
Healthy Minds
Caritas Community Cafe
Emergency Department
Tier 3
Interventions include the provision of community-based specialised assessment and co-ordinated care-planned treatment and specialist liaison
Community Drug and Alcohol Team (CDAT)
Hepatitis C treatment programme
In-patient care at the Princess Elizabeth Hospital
Tier 4
Include the provision of residential specialised treatment, which is care-planned and care co-coordinated to ensure continuity of care and aftercare
Detox beds on Crevishon Ward in the Secondary Care Mental Health Services
Brockside Residential Units (alcohol detox)
Off-Island care placements
Detox at St Julian's Hostel in the Community



Funding

Currently the Drug and Alcohol Strategy and the Tobacco Strategy are funded.

Funding for Drug and Alcohol Strategy:

- Criminal Justice Treatment Services – Total £121,000
    - Prison/Community Substance Misuse Service – In-dependence
    - Criminal Justice Substance Misuse Service – In-dependence
    - These services are specialist treatment services designed to meet individual client needs within the Criminal Justice system
    - Community Treatment (predominantly adults) – Total £222,000
- Core Services (Information, skilled advice, support), service user engagement – In-dependence
    - Core Services (Information, skilled advice, support), service user engagement – GAAS
    - Clinical interventions, information, skilled advice, support, service user engagement – Community Drug and Alcohol Team (CDAT)
    - Promotion of a recovery community – All agencies
    - Treatment/Education Services for Young People and prevention/ awareness packages - £211,000
    - Drug & Alcohol Education Service in Junior, Secondary and 6th form schools and colleges – Action for Children (AfC)
    - Young People's Substance Misuse Service - AfC
    - Contribution to Young People's Outreach Service - AfC
    - Intervention and Prevention packages e.g. REACH, Social media initiatives, awareness /media campaigns: Drink Drive Campaign, Alcohol and the Brain – Public Awareness campaign

Funding for Tobacco Strategy:

- Tobacco Education Worker 40 weeks per year - £31,181
- Health Improvement Practitioner (Tobacco Control) - Part-time £26,607
- Advertising, marketing, travel, training - £8,000
- ASSIST(A Stop Smoking In Schools Trial) programme – licence plus training costs - £6,060
- Contribution towards salary for PSHCE Adviser - £25,000
- Quitline Smoking cessation service – staff salaries, training, advertising, new Pharmacy Outreach service - £106,000
- Nicotine Replacement Therapy - £25,000

Education

In schools there is a comprehensive Personal, Social, Health, and Citizenship Education programme (PSHCE) which runs throughout the five Key Stages. Lessons on drugs, alcohol and tobacco are taught by class teachers and specialised input is delivered by workers from local agencies at different stages of a child's schooling.

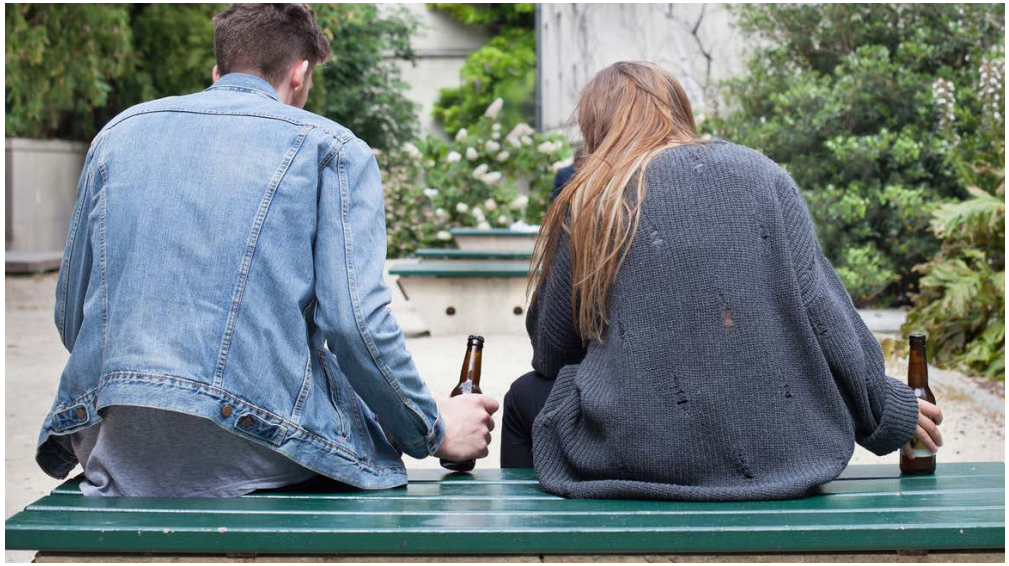
In upper primary and secondary schools, drugs and alcohol sessions are led by workers from Action for Children (see detail below). Tobacco education sessions are provided/commissioned by the Tobacco Education Worker who is currently employed by CfHSC but will in future be provided by The Health Improvement Commission. These include 1 lesson per class from Year 6 to Year 11. The lessons are overseen by the PSHCE Adviser who also runs the HSC funded ASSIST programme – a peer-led, school-based smoking prevention programme in several secondary schools. This is an evidence-based programme focusing on creating non-smoking social norms among young people by training 12–14 year old students to work as peer supporters.

The Bailiwick Drug and Alcohol Strategy commissions drug and alcohol education is delivered by Action for Children (AfC) within the PSCHE Programme. In 2018, 2650 students were involved, 721 of whom were in Primary Education and 1,929 in Secondary Education. Action for Children delivered an additional 25 sessions on drug and alcohol education at the College of Further Education. They were also supported by the Bailiwick Drug and Alcohol Strategy Coordinator in delivering drug and alcohol awareness training to professional organisations such as law enforcement and school nurses.

Services for Young People

Action for Children (AfC) provide the Young Peoples' Substance Misuse Service for people under the age of 25 years, with a primary focus on those post 16 years, together with more vulnerable groups. Referrals are accepted from health professionals and families of young people, with onward referral to structured treatment providers available.[63]

In 2018, 209 young people accessed the services provided by AfC. Of these, 101 (48%) reported drug and/or alcohol issues and more were male (59%). Referrals to AfC were from Criminal Justice Services, the Multi-Agency Support Hub (MASH), Looked After Children's Services, as well from family members and young people themselves.



Smoking Cessation Services

Stop Smoking Services are provided by Quitline, who operate from the Princess Elizabeth Hospital. Quitline is a free service which provides advice, information and support to people living in the Bailiwick of Guernsey who are thinking of stopping smoking.

In 2019 an outreach Pharmacy-based service was introduced in Guernsey at selected pharmacies who opted to participate in the Stop Smoking Programme. Nicotine replacement therapy is also available through the pharmacy in Alderney.

In 2018 and 2019 data collection for this service has been compromised by the absence of IT support but data from 2017 showed that 494 new clients registered with the service and there were 1593 follow-up appointments.

Guernsey Alcohol Advisory Service (GAAS)

The core services provided by GAAS include the provision of Information, skilled advice and support to clients with regards to alcohol use.

During 2018 GAAS saw 80 clients, a 33% increase compared to 2017. Of these, 37 (49%) clients chose abstinence as the intervention/ therapeutic process and 38 (51%) clients chose controlled/reduced alcohol consumption. The majority (77%) of service users are male and between 30 and 50 years old.[63]

Community Drug and Alcohol Team

The Community Drug & Alcohol Team (CDAT) is part of Secondary Care Mental Health Services and provides clients in Guernsey and Alderney with clinical interventions which cannot be provided in Primary Care or by other treatment agencies. It is the only treatment service on the island which offers substitute prescribing. CDAT also provides an adult clinical and therapeutic treatment service provision to Alderney. Clients either travel to Guernsey or receive support via phone or video call dependent on need.[63]

The number of people entering the CDAT programme has remained consistent over the past two years with 102 clients in 2018 and 101 in 2017. Activity for 2018 is illustrated in Table 27 with the majority (71%) of clients being male. Furthermore the majority of new clients in 2018 used alcohol only (51%), followed by opiate use (38%).[63]

Table 27: Substance Use by Gender in New Clients attending the Community Drug and Alcohol Team in 2018

	Female N (%)	Male N (%)
Opiate user	8 (26%)	27 (38%)
Non-Opiate user	0 (0%)	1 (1%)
Non-Opiate/other with Alcohol	3 (10%)	7 (10%)
Alcohol only	20 (64%)	36 (51%)
Total	**31 (100%)**	**71 (100%)**

Further data showed that:

- people aged 35 years and under are more likely to access treatment for drug use;
- people over the age of 35 are more likely to access treatment for alcohol addiction.[22]

Since April 2019, CDAT has reversed its very long established trend of prescribing opioid substitute medications to increasing numbers of people. This has been facilitated by measures to restrict diversion and thereby, reduce numbers of new opioid users presenting for opioid prescribing and by shifting treatment emphasis toward recovery and rehabilitation.

From June 2019 to January 2021, the number of people in treatment on opioid substitute therapy with CDAT fell from 170 to 142. Phasing out unlicensed and unsupervisable Dihydrocodeine prescribing has been a priority for CDAT. In April 2019, the number of people prescribed Dihydrocodeine by CDAT was 69; as of January 2021, this number was 20 (71% reduction). During this period, the average dose of Dihydrocodeine prescribed by CDAT fell from 880mg daily to 426mg daily. The combination of fewer service users prescribed Dihydrocodeine and lower doses, means that over this 21 month period the total amount of Dihydrocodeine prescribed by CDAT decreased by 86%. Some people

have switched from Dihydrocodeine to Buprenorphine-based medications but, in the same period, Buprenorphine prescribing by CDAT increased by only 10%.

The changes in treatment philosophy that have enabled these achievements in opioid substitute therapy have also brought about a 40% reduction in benzodiazepine prescribing by CDAT.

In the context of the first Covid lockdown that began in March 2020, CDAT started to prescribe Buvidal (subcutaneous Buprenorphine depot), which prevents deviation from prescribed dose and diversion. It also makes pharmacy attendance unnecessary, so it reduces supervision. Minimising pharmacy visits was highly desirable in lockdown and Buvidal is also helpful given the limited capacity for supervision on Guernsey.

In late 2020, Methadone prescribing was approved by the Prescribing and Formulary Panel. CDAT is cautiously reintroducing Methadone prescribing. As of February 2021, two CDAT service users are prescribed Methadone.

In-dependence (formerly Drug Concern)

The primary aim of In-dependence is to help people whose lives are affected by drug or alcohol use by providing a confidential, non-judgemental service. They work with individuals and families; both those who are using and those who are affected by someone's drug or alcohol use.

In-dependence provides support services which are specifically designed to help people who are struggling to change behaviour.

Interventions include:

- Access to cognitive behavioural therapy sessions;
- Integrative counselling; and
- Self-management and recovery Training (both group and individual work).

The focus is on problem identification and management, motivational work in relation to reduction of drug and /or alcohol use and specific relapse prevention techniques for those who have already made changes to substance use. In-dependence also has a direct pathway with the police custody suite (Arrest Referral) and the Emergency Department.

In 2019, 251 assessments were completed with 173 offered treatment by the service; 81 from community, 44 from the Criminal Justice substance Service and 48 from the prison.

Outcomes are measured using the Clinical Outcomes in Routine Evaluation (CORE) which measures the client's distress, and includes subjective well-being, commonly experienced problems or symptoms, and life/social functioning. In addition, items on risk to self and to others are included. As these measures can be gathered at each appointment, any unplanned endings (mostly) still result with a measurable outcome.

CORE reports on both clinical change and reliable change.

- **Clinical change*** represents a shift from being in the clinical population (scoring above 10 on a scale of 0-40)** to being in the non-clinical population (scoring below 10), i.e. a reduction from a severe or moderate-to-severe, to a normal manageable level. This is useful data in the field of substance use specifically because substance use is considered as symptomatic of other underlying problems. If we can reduce psychological distress with our interventions, it is more likely that problematic substance use will be reduced.
- **Statistically reliable change** represents a change of 5 or more in the client's scores.

***A note on clinical change – If a client scores 10 or below upon entry into treatment, it is not possible for them to achieve clinical change. This is of significance for the CJSS treatment population, who, on the whole enter treatment with relatively low scores having already stabilised and implemented change.*

****CORE levels of distress: 0-10 low; 10-15 mild; 15-20 moderate;20-25 severe; 25-40 moderate to severe.*

The year 2019 was the first full year in which clinical outcomes were measured. Data was collected using CORE for a total of 112 clients.

Community clients: 45% of community clients experienced statistically reliable change. A further 33% experienced clinical change.

Criminal Justice Substance Service: The majority of clients on this service are seeking to maintain change, and this is demonstrated in the low levels of change reported using CORE. A measure of success for this client group relates to the number of orders breached within a 12 month-period. There were 19 completions during 2019, four of which were breaches. [63]

Prison: There is a need for further discussion regarding what measure(s) to use in a controlled environment such as the prison. The validity of using CORE has been the focus of discussion based on seemingly impressive scores that do not mirror observations of behaviour in the context of change. The use of core scores in the prison ceased in August 2019.

Needle Exchange

The needle exchange service is delivered specifically as a harm reduction measure. Its introduction was a response to concerns that a growing number of users were injecting drugs, often with used or shared injecting equipment thereby increasing the risk of transmission of blood borne viruses. This is particularly relevant with regard to the on-island transmission of the Hepatitis C virus.[19][64] Opening hours are set, however clients are able to call out of hours to see if a member of staff is available to provide the service.

Currently, needle exchange provision includes an initial screening assessment relating to harms and options to be referred on to The Orchard Centre. At each subsequent visit, key points are reiterated to service users. A small number of needle exchange clients go on to engage in optional talking therapies.

A fully functioning exchange will often provide paraphernalia including:

- Alcohol swabs;
- Saline solutions;
- Utensils used for preparation of controlled drugs (spoons, bowls, cups, dishes);
- Citric acid;
- Used needle containers;
- Foils; and
- Tourniquets.

Currently the needle exchange provides syringes, needles, citric acid, swabs and used needle containers. Legislative changes were made in 2020 to additionally enable the supply of swabs, utensils for the preparation of a controlled drugs, citric acid, filters, ampoules of water for injection and ascorbic acid, bringing local legislation in line with other jurisdictions.

Peer exchange is also available, and whilst this may be seen as controversial, the service is provided for a small number of clients who do not want to present at the exchange but may otherwise share equipment. This operates on the basis that the service user collects and distributes equipment to others. They are also provided with literature relating to best practices.

The majority of clients using the service in 2018 (as in previous years) are male and aged over 30 years. Encouragingly, 2018 saw an increase in the needle return rate (to 94%), from 89% in both 2016 and 2017. [64] The service can also gather information on trends in local drug use and, recently, has found an increasing number of people reporting to be using performance enhancing substances. [64]

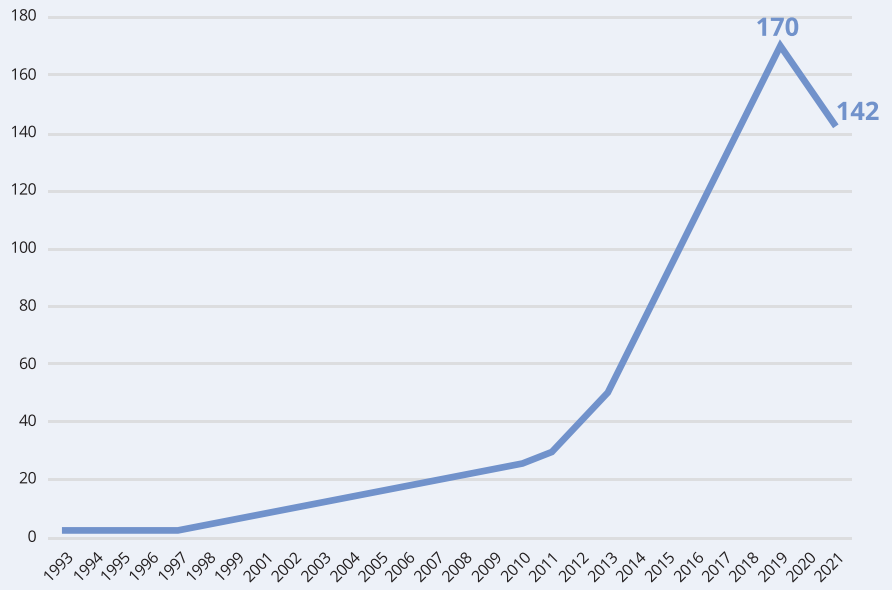
Opioid Substitution Treatment

Opioid dependence is a complex health condition that usually requires long-term treatment. OST can be used by individuals dependent on heroin or for those who have become addicted to opioids prescribed to them for pain. OST involves prescribing a long-acting 'clean' opioid to substitute the drug that is being used inappropriately, providing an opportunity to stabilise lives and address the social and psychological problems that tend to accompany this type of dependence.

Community-supervised consumption describes the dispensing of drugs prescribed as part of OST and the direct observation of their consumption on a daily basis by a pharmacist. This supports drug users with their prescribing regime, allows monitoring of their response to medication and helps to improve retention and completion of treatment. It also ensures that each supervised dose is administered to whom it was prescribed, reducing the risk of diversion.

Currently, only six pharmacies (out of fifteen) facilitate supervised consumption of OST on Guernsey. This service is not available in Alderney. Even when prescribed in prolonged-release form, Dihydrocdeine is a twice daily medication, hence, it is, essentially, unsupervisable. The reduced level of Dihydrocodeine prescribing by CDAT has therefore helped to increase the proportion of people on opioid substitute therapy who are supervised. In April 2019, only 17 of 166 (10.2%) of CDAT clients receiving OST were supervised at a pharmacy; as of January 2021, the proportion was 44 of 142 (31%). Given that the main purpose of supervised consumption is to greatly reduce deviation from daily dose and diversion of medication, the total number of CDAT clients prescribed in ways that impose such restrictions include those on Buvidal (depot Buprenorphine); In January 2021, the total proportion of CDAT service users on OST who were on daily supervised consumption, or on Buvidal, was 60 of 142 (42.3%).

Figure 16: Number of people on OST with CDAT



Criminal Justice Substance Service

The Criminal Justice Substance Service (CJSS) is a partnership between In-dependence and the Probation Service which provides treatment for clients who are referred by a Probation Officer, or an Order from the Court Proceedings, where drug or alcohol use is considered as a contributing factor in their offending behaviour. The service aims to reduce their contact with the Criminal Justice System, criminal activity and their problematic substance use.

There were 37 referrals to the CJSS with 16 Court Orders granted in 2018. This was a 25% decrease from 2017. [64]

Prison Substance Misuse Service

The Prison Substance Misuse Service focuses on drug and alcohol use and acts as a conduit to the community-based services upon release. There were 44 new entrants into this service in 2018.

The Prison Service makes use of an evidence-based group recovery programme called 'Inside Out.' This considers the importance of motivation and how cravings and triggers to substance use can be better managed. It also focuses on how thoughts, feelings and behaviours can be modified to reduce the chance of relapsing into substance use. There is an emphasis on how living a balanced life is a key factor for maintaining change. A total of 25 prisoners completed the programme in 2018.

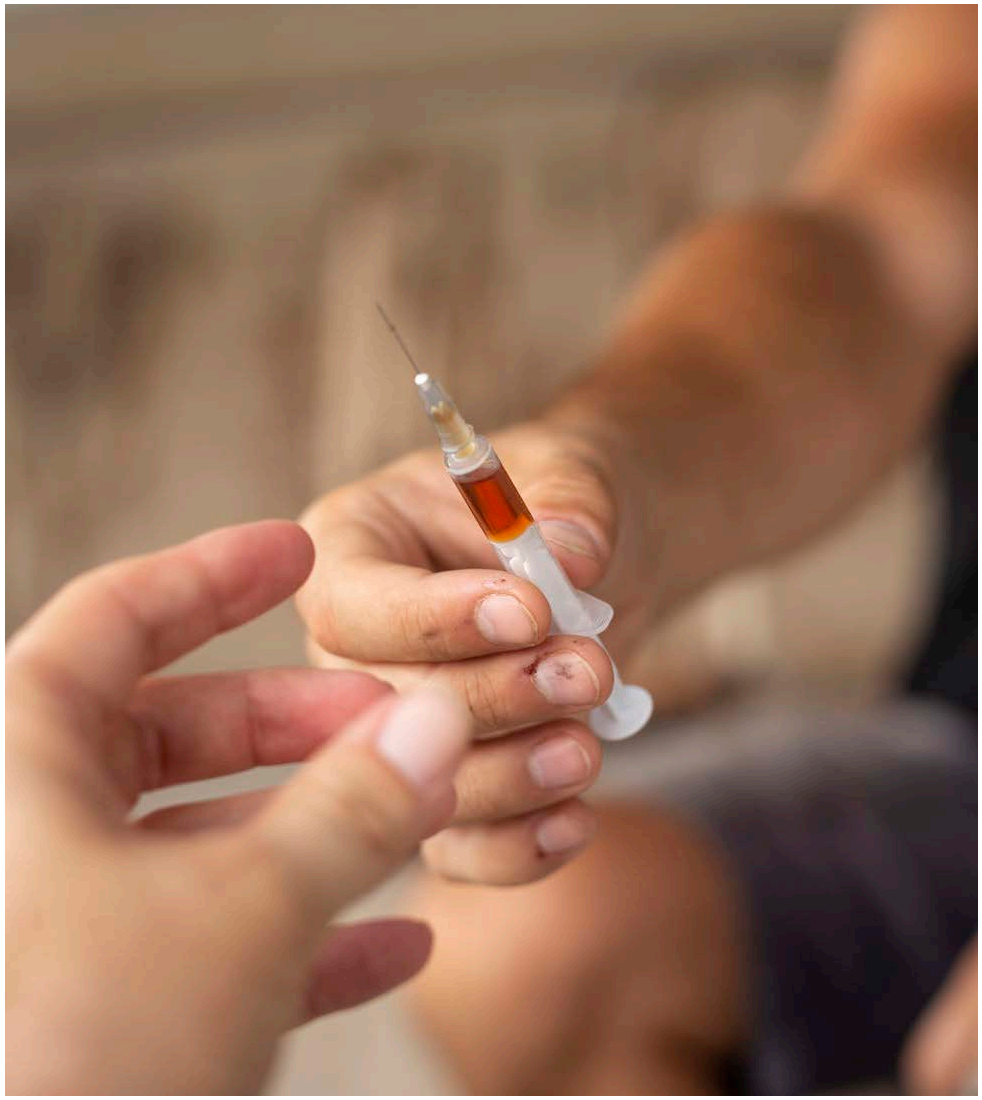
In addition to 'Inside Out', general support was offered to prisoners who were detoxing and unable to engage in any structured work. Individual recovery work was also provided for clients who wanted to refresh their recovery skills prior to release, or who were unable to participate in group programmes.

Management of Blood borne Viral Infections

Drug users who share needles when injecting drugs may contract a blood borne virus, such as HIV or Hepatitis C.

Currently there are around 100 people in Guernsey accessing the Orchard Centre for Hepatitis C treatment and around 40 for HIV treatment. To date, no cases of on-island transmission of HIV have been linked to injecting drug use. This contrasts to the situation with Hepatitis C where the overwhelming majority of infections (80%) have been linked to injecting drug use in Guernsey. People living with Hepatitis C in Guernsey report sharing needles, as well as the paraphernalia (spoons and water etc.) used with injecting drugs locally. **(19)**

The Orchard Centre is leading on a programme of elimination of Hepatitis C in the Bailiwick. The local availability of the new Hepatitis C treatments, which are both safe and effective, has made this programme possible. **(19)**



Qualitative Data

Qualitative Data

Individual and group interviews, together with focus groups were conducted and team meetings were attended to capture the views and experiences of service users and their families, health and care professionals, other States of Guernsey Committees and the community and voluntary sector. A full list of stakeholders can be found in Appendix B.

Notes were taken during these meetings and the main points were collated. Five themes were identified during the analysis and are presented below in Figure 16, below, and expanded upon further in this section.

Figure 17 Themes Identified in Stakeholder Engagement

Environment

Views of Service Users and their families

Service users and their families highlighted the importance of support being available post-treatment or on release from prison. Although there is good work being undertaken to provide life skills, it was felt that there was not always enough to help successful integration back into the community. It was highlighted that years, or in many cases a lifetime of using substances cannot simply be reversed in a matter of months. It was felt that this contributed significantly to relapse.

Providing an environment for recovery was considered to be important. Stakeholders expressed how living in Guernsey and Alderney can make it difficult for people to start afresh in the community, as their past may be known and recalled. This stigma was particularly pertinent to prisoners and ex-prisoners with drug-related convictions, where the implications of having a criminal record often makes it difficult to find employment. Creating an environment that fosters reintegration into society, rather than marginalisation which may occur as a result of having a criminal record, was thought to be important.

Prisoners with substance use problems may, upon release, lack supportive relationships, suitable accommodation and employment opportunities making it harder for them to adjust back to life in the community. If they had been detoxed from an OST prescription during their prison sentence, some reported that they would relapse on release and seek drugs through illicit channels.

Views of Professional Stakeholders

Professionals overwhelmingly agreed that the most widely used substance in Guernsey and Alderney is alcohol. They felt that alcohol consumption was widespread and many adults lacked awareness around the volume of alcohol that they actually consumed. Many believed that there was a significant group of functioning alcoholics among the working community, who were not on engaging with services. This group, or their peers did not consider themselves to be alcohol dependent, largely due to the perceived entrenched culture and acceptability of drinking alcohol that exists in our community.

Professional stakeholders highlighted the fact that alcohol use also contributes significantly to the health, social and economic costs of our community. This includes the impact on illness, injury, crime, violence and anti-social behaviour, as well as family and relationship breakdown. These broader environmental considerations need to be taken into account. Stakeholders were aware of alcohol-related harm related to physical health where there is unequivocal scientific evidence demonstrating the link between alcohol consumption and an increased risk of some cancers and other diseases. However, stakeholders also cited views that alcohol consumption also causes significant harm in the community impacting on mental health, crime, domestic abuse and the lives of children. They also considered that there needs to be a greater awareness of ACEs.

Many professionals were also of the view that appropriate legislative and fiscal controls are beneficial in creating an environment for health. They noted that whilst there is not, currently, a specific direction on the setting of excise duty on alcohol, the Policy & Resources Committee have consistently recommended an increase of 5% per annum. There was a recognition that while excise duties can go some way to creating an environment that discourages excessive consumption and may change individual choices, it is acknowledged that it can be somewhat of a blunt instrument when compared to more targeted fiscal policies such as MUP. MUP sets a minimum price below which a unit of alcohol cannot be sold. Evidence shows that as alcohol has become more affordable, alcohol-related harms have increased. [65]

With regards to social harms, it was acknowledged that alcohol consumption was associated with crimes, such as assaults and domestic abuse, and this impacted profoundly on the Emergency Services, and affected the health and wellbeing of the whole population.

There was consensus on the health harms of smoking and the negative influence of parental smoking on children and young people and an acknowledgement that these need to continue to be addressed. While the smoking prevalence had gone down in recent years, they felt that tobacco control measures should still be implemented to mitigate against smoking-related harm. Creating an environment where being smoke-free is the norm was thought to be important.

Stigma and discrimination were still considered to be an issue and may impact on people's willingness to seek help for substance use issues. These societal attitudes do not create an environment for recovery and improved health and wellbeing.

Stakeholders also highlighted the impact of the ageing demographic in Guernsey and Alderney which will bring with it complex additional health challenges. Older service users may present with complex co-morbidities both related and unrelated to drug, alcohol and tobacco use. These will present an on-going challenge to health and care services.

Guernsey's drug environment is considered unique. Stakeholders expressed the view that the limited ports of entry into Guernsey and Alderney, together with vigilant border controls, have made sourcing traditional recreational drugs difficult. Views were expressed that the above, together with the absence of the local availability of methadone and the wide use of dihydrocodeine as opiate substitution therapy has led to the diversion and illicit supply of medicines (DISM), commonly referred to as 'prescription diversion.' Prescription diversion is the transfer of a legally prescribed substance from the individual for whom it was prescribed to another person and is an illegal act.

There was support for the introduction of a methadone OST programme. Youth Workers expressed the view that, due to recent national news coverage concerning medicinal cannabis, many young people believe that there are no risks associated with the use of cannabis recreationally.

Training

Views of Professional Stakeholders

Training of frontline staff working in Health and Care, Education, as well as those working in relevant commissioned services, in Adverse Childhood Experiences (ACES) was advised, to enable identification of, and support for, children currently experiencing ACES.

There was some concern that the misuse of substances by children was often minimised and seen as adolescent experimentation. Professionals believed that there was a lack of understanding generally about the detrimental effects on brain development in young people. More awareness and education are required to ensure that both clients and professionals are aware of these potential harms.

Information

Views of Service Users and their families

Services users and their families expressed a wish for signposting to information sources to be available online. They also thought that clear treatment pathways across all services would be helpful for them to understand their treatment journey.

Views of Professional Stakeholders

The importance of signposting, clear and comprehensive data collection and appropriate data sharing was highlighted by professionals who felt this would enhance patient care.

There generally appeared to be an absence of referral and treatment pathways for drug and alcohol services, which may explain why many professionals were unsure of the provision of each service and relied upon certain helpful individuals with whom they had built a good working relationship.

'If I'm totally honest, I'm never really sure who does what.'
General Practitioner

Specifically some professionals were of the opinion that:

- In terms of drug use, it was accepted that the biggest problem in the community was addiction to prescription drugs, which was considered widespread. Some drug importations inevitably evaded the checks of the Guernsey Border Agency and found their way onto the street, but this was felt to be a lesser issue in comparison with drugs that had been prescribed and diverted locally. The Guernsey Border Agency had also encountered individuals sourcing controlled drugs via prescription from doctors in France.

- The use of dihydrocodeine for OST was not considered optimal for use in the OST Programme. Most health professionals were supportive of the introduction of methadone for OST. The use of dihydrocodeine in Opioid Substitution Treatment (OST) programmes was also criticised by most service users and for various reasons. Some had used methadone in treatment programmes in the UK and believed they were more stable on this compared to dihydrocodeine substitution treatment

Mental Health and Wellbeing

As previously discussed the link between mental health problems and substance use are well established. Most service users were explicit in their desire for more mental health input, to address the issues underlying their substance use.

Out of hours care (including emergency services): Service users held strong views about the absence of support available to them outside of standard (9am-5pm on Monday to Friday) working hours. This inevitably meant that there was a reliance on the Emergency Services and the Emergency Department. Emphasis was placed on the need for crisis support to provide further assistance outside of normal working hours. The Emergency Services and the Emergency Department believed that opportunities to help people who present to their services are lost, because they are not best placed to provide mental health and substance use interventions. The Emergency Services frequently cited loneliness and poor mental wellbeing as a trigger for substance use and the subsequent call out of their services. In-dependence does not provide crisis support but do provide appointments beyond 5pm and appointments for affected family members at weekends.

Some professionals agreed with service users about the absence of provision for mental health and substance use outside of normal working hours. They acknowledged that the psychiatric services were therefore often relied upon. However, a gap was identified where service users did not meet the criteria for admission to Secondary Mental Health Services.

The Stop Smoking Service, Quitline, was generally well known by professionals. They expressed the view that although Quitline provides some evening clinics it generally does not operate outside of office working hours. However nicotine addiction does not tend to trigger contact with the Emergency Services and a 24 hour service was not thought necessary. Out of hours support for hospital in-patients is accessed in the form of nicotine replacement therapy, through a Patient Group Directive on the wards.

Prevention and early intervention: Professionals expressed the view that we need to focus on changing attitudes and endorsing mental health promotion, stigma reduction, and substance misuse prevention. Raising awareness will enable people to initiate conversations, dispel myths, and make it easier for people to seek support.

The need for the greater use of ad-hoc Very Brief Advice (VBA) by health professionals was also highlighted by stakeholders. Very Brief Advice proactively raises awareness of a healthy lifestyle choices with a person. If a person responds positively to this a brief intervention may be useful, for example by giving simple advice on changes that may improve health and wellbeing. Some professionals felt frustrated as services were considered to be too reactive to acute problems. There was a desire for investment in preventative measures, particularly in regards to co-occurring substance use and mental health issues.

Drug and Alcohol Treatment Services

Dual Diagnosis: Service users expressed their preference for a service that provides support for both their mental health and their substance use issues, also known as a Dual Diagnosis Service.

Location of detox services: Service users frequently cited the structured routine of Crevichon Ward as an inappropriate place to undertake a detox programme. Whilst they were very honest about their own associated mental health issues, they felt that being on a ward with patients who required hospital admission for mental health reasons was difficult. Some professionals agreed that Crevichon Ward was an inappropriate location for service users undergoing detox, but no alternative venue was suggested by either service users or professionals.

Many healthcare professionals highlighted the need for access to more free counselling.

Across most services, a number of members of staff were frequently praised for going the extra mile. However, service users expressed the wish to have some services available online, including the ability to book appointments. It was felt that this would help overcome the lack of anonymity people face when accessing services in small communities like Guernsey and Alderney. General information and clearer signposting to services would also be helpful.

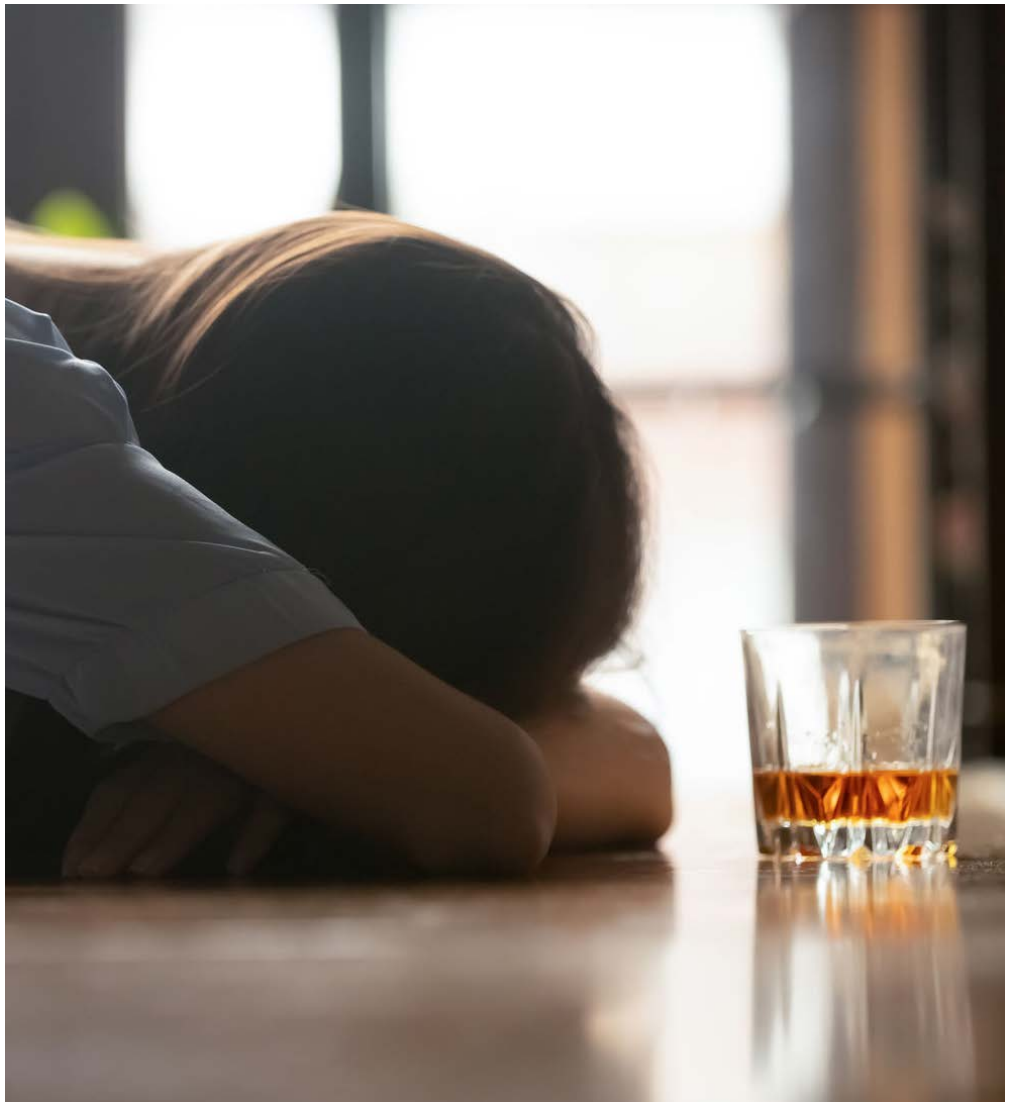
Health professionals in secondary care were often unsure of 'who does what' between CDAT and In-dependence, although the voluntary sector had a better awareness of their roles. In Primary Care, the absence of a GP Shared Care Arrangement with agreed care pathways was raised as a gap in service.

Healthcare professionals working in Primary Care expressed concerns that cost was a barrier for people seeking help for substance use problems highlighting a need to increase the awareness of health professionals' (outside of the substance use services) of the Guernsey Alcohol Advisory Service. There was also a concern that this impacts on the transfer of stable service users back to Primary Care from Secondary Care.

Health professionals outside of substance use services were generally unaware of the existence of the Guernsey Alcohol Advisory Service.

In prison: Some prisoners with substance use problems criticised the absence of support from the Community Drug and Alcohol Team within the prison, particularly by those who were under their care prior to sentencing. Some prisoners also expressed the view that there was a higher threshold needed to be met for prisoners to access psychological services compared to individuals in the community.

Some prisoners expressed frustration at delays in accessing some services, whilst others who used drugs were concerned about the illegality of the substance they were using. The latter was considered to be a possible barrier to accessing help.



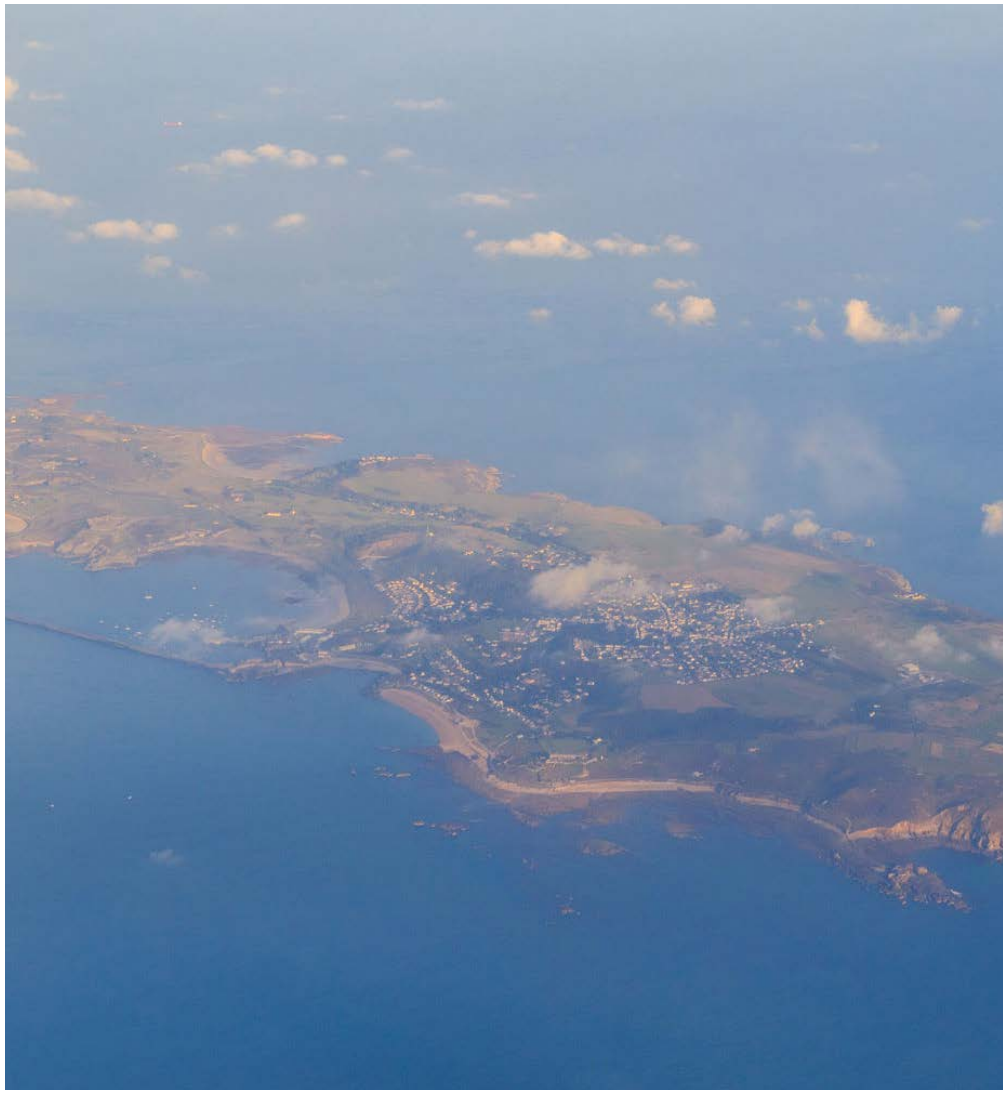
Alderney Specific

Data

Seventy-seven Alderney residents took part in the Wellbeing Survey 2018. While this represents a good level of participation for the islands' population it makes it difficult in statistical terms to be confident of drawing reliable conclusions about the health of people in Alderney as a stand-alone group. In a small population, the results from that group are more volatile and random variation is more evident than it would be in a larger sample from a bigger population. This gives us less certainty in the findings as it easier to mistake a chance variation for a real finding, association or difference. [2]

Bearing in mind the limitations discussed above, the comparison of results for the two islands showed no strong evidence that drug, alcohol or tobacco use were different between the Guernsey and Alderney respondents.

In 2020, there are 22 premises in Alderney that have liquor licences, an increase of four since 2019.[16] Information from the Mignot Memorial Hospital in Alderney showed that the alcohol or drug-related admission rate was 3.6% of admissions. [28] Health professionals consistently reported that alcohol use is an important concern in Alderney.
During 2018, students at St Anne's School in Alderney were surveyed to explore their relationship with drugs and alcohol, and their emotional health and wellbeing. A total of 39 young people completed the survey (66% female vs. 33% male) with ages ranging from 11 to 17 years old, representing nearly 50% of residents within this age range. [21] The results



showed that the majority of young people occasionally consumed alcohol, with most reporting that some or all of their friends also drank. A third of students knew family members who misused alcohol and 8% reported that their family was significantly affected by the use of alcohol. In Alderney, cannabis was the most frequently used drug by young people, particularly young men. A total of 30% of young people had tried drugs. [21]
A range of family concerns such as alcohol misuse, drug use and no supportive adult, and personal problems such as criminal activity, low self-esteem, unhappiness, self-harm and anxiety, were reported.

Treatment and Services

Primary Care Services in Alderney are provided by the Island Medical Centre which offers a diverse service to local people. There is a focus on acute care, but also on the need to have preventative services that improve the health of the population. General Practitioners working at the Island Medical Centre also provide medical services for the Mignot Memorial Hospital.

The Mignot Memorial Hospital provides a variety of services to the people of Alderney. This includes support for patients with health needs related to drug, alcohol and tobacco use. Other professionals visiting Alderney include a weekly visit from a Health Visitor and regular visits by a Social Worker from Guernsey. Regular visits are also made by a Community Mental Health Nurse.

In addition to this, the Youth Commission employs a resident Youth Worker in Alderney to provide advice and support for young people who are dealing with substance use issues. Targeted interventions are provided by Action for Children in Guernsey. A Stop Smoking Service is provided by the local pharmacy which is supported by Quitline. In-dependence also works with the Alderney pharmacy to provide a needle exchange.


WALL'S
Love ice Cream
LOUISE
QUAYSIDE
SORT SHOES
NEIRD FISH

What is working and what can be done?

Alcohol

The World Health Organization-led initiative 'SAFER' was launched in 2018 as an alcohol control initiative to prevent and reduce alcohol-related death and disability. SAFER provides five high-impact strategic actions that are prioritised for implementation to promote health and wellbeing. [66] These are:

- **S** Strengthen restrictions on alcohol availability
- **A** Advance and enforce drink driving counter measures
- **F** Facilitate access to screening, brief interventions and treatment
- **E** Enforce bans or comprehensive restrictions on advertising, sponsorship and promotion
- **R** Raise prices on alcohol through excise taxes and pricing policies

Looking at the components of SAFER in more detail in relation to Guernsey and Alderney – the programme includes the following:

Strengthen the restrictions on alcohol availability

In 2018 there were 269 alcohol licences issued to various establishments in Guernsey enabling them to sell alcohol. This would seem to be high for a jurisdiction the size of Guernsey. Data are not available from previous years to compare any difference or observe trends in the total number of alcohol licences and types issued. The licencing process allows for alcohol availability to be monitored.

The availability of alcohol and tobacco products for sale on States of Guernsey owned airlines needs to be considered.

Advance and enforce drink driving measures

The World Health Organization advises that drink driving increases both the risk of a road traffic accident and death or serious injury. The blood alcohol concentration (BAC) level above which motorists in Guernsey will be prosecuted for drink driving is 80mg per ml. In most other European countries, the BAC limit is lower. The current BAC limit in Guernsey is based on evidence from 1964. This has been superseded by research demonstrating that the risk of accident, death and serious injury increases significantly with a blood alcohol concentration (BAC) level of 50mg per ml of blood. [66]

Anti-drink driving campaigns are run at least annually and checks on motorists are routine work for Guernsey Police.

Facilitate screening, brief intervention and treatment

Brief interventions on alcohol describe opportunistic conversations with service users by members of staff, often but not limited to health care professionals. Brief interventions for alcohol are limited and inconsistent across services in Guernsey. Brief interventions make use of the interactions that organisations and people have with other people every day to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Programmes, such as Making Every Contact Count (MECC), provide a framework from which training can take place to support staff, to undertake brief interventions and to record, collect and monitor data to enable evaluation of outcomes. MECC is currently being considered for implementation in Guernsey and Alderney.

Enforce bans or comprehensive restrictions on advertising, restrictions, sponsorship and promotion.

In comparison with tobacco, there are few bans on the advertising, sponsorship and promotion of alcohol. Multi-buys and special offers are commonplace in retail outlets in both Guernsey and Alderney.

Raise prices on alcohol through excise taxes and pricing policies

The SAFER programme identifies price raising policies as a key action to reduce alcohol related harm [67] because evidence shows that as alcohol becomes more affordable, harm increases.

While it is recognised that excise duties can go some way to changing consumption and discouraging excessive drinking, it is acknowledged that it can be somewhat of a blunt instrument when compared to more targeted fiscal policies such as Minimum Unit Pricing (MUP).

MUP sets a minimum price below which a unit of alcohol cannot be sold. Evidence shows that, internationally, as alcohol has become more affordable, alcohol-related harms have increased. [61] A MUP policy is specifically targeted at addressing the cheapest alcohols, which are affordable options for some of the heaviest drinkers. It was implemented in Scotland at 50 pence per unit in May 2018 and is due to come into force in Wales in March 2020. [68]

A report published on the implementation of MUP in Scotland showed that, owing to the higher prices typically found in the on-trade sector (pubs, clubs and restaurants), these businesses had been largely unaffected by the implementation of MUP. However, encouragingly, assessment of the off-trade sector (convenience stores and supermarkets) was largely compliant with MUP legislation. This is a critical first stage in the

implementation. Early modelling suggested that a reduction in alcohol consumption in Scotland following the introduction of 50 pence per unit MUP would be around 3.5% for each drinker annually. This would correspond in the 20 years after implementation to more than 2,000 fewer deaths, and around 39,000 fewer hospital admissions for Scotland as a whole. However in Scotland, there was an observed reduction of up to 7.6% in purchases, which were more than double the modelling based estimates. This suggests that the health benefits could be substantially greater. [68]

A scoping project, examining the price of alcohol, has been undertaken in Guernsey. The study found that alcohol was generally more expensive in Guernsey than in the UK and for MUP to be effective, a floor price of at least 70p per unit of alcohol would be required. However the lowest price alcoholic drinks in Guernsey are those which are routinely on promotion, so regulation of promotions such as 'multi-buys' is an important policy consideration for the Bailiwick. MUP has been considered in Guernsey at a political level and a decision was made to await further findings of MUP implementation in Scotland. [69]

Tobacco

Legislation, Treaty and Policy

The World Health Organization's Framework Convention for Tobacco Control (FCTC) is the first world health treaty that addresses both the supply and demand of tobacco. The objectives of the framework are to improve public health outcomes related to the tobacco epidemic, but also to address the social, economic and environmental impacts of tobacco.

The FCTC is governed by the Conference of Parties, of which there are currently 181 parties, with Guernsey recently becoming a signatory to the United Kingdom party. Guernsey has demonstrated to the United Kingdom that it has met the minimum threshold of compliance with the three measures that are considered the most urgent for tobacco control policy. The three measures are:

- To prohibit misleading information on tobacco packaging;
- To prohibit advertising, promotion and sponsorship of tobacco; and
- To protect people from second-hand smoke.

The guiding ethos of the convention is to encourage implementation of measures beyond those required by the FCTC and its protocols. With this in mind, the United Kingdom has also implemented plain packaging. Plain packaging of tobacco, also known as standardised, generic or homogeneous packaging, refers to packaging that has had the attractive

promotional aspects of tobacco products removed and where the appearance of all tobacco packs is standardised. This means that there is no branding other than the product name in a standard font, size and colour. Plain packaging has been implemented in the United Kingdom and Australia because there is evidence to demonstrate that it is less attractive to young people, improves the effectiveness of health warnings, reduces mistaken beliefs that some brands are safer than others and is likely to reduce smoking uptake amongst children and young people.[70][71][72]

The Committee for Health & Social Care has agreed to the implementation of plain packaging in the Bailiwick to add to the comprehensive legislation that is already in place, namely:

- Tobacco Advertising (Guernsey) Law, 1997
- The Tobacco Advertising (Guernsey) Regulations, 2010; and
- Tobacco Advertising (Amendment) Regulations, 2010.

Broadly, these items of legislation ban advertising of tobacco products through point of sales promotions, by banning misleading messages on packaging and through graphic pictorial health warnings.

The following legislation is in place to protect residents in Guernsey and Alderney from the toxins emitted by second-hand smoke:

Guernsey

- Smoking (Prohibited Buildings and Vehicles) Ordinance 1971; Notice of Smoking in Public Places Ordinance, 2004;
- Smoking (Prohibition in Public Places and Workplaces) (Guernsey) Law, 2005;
- Smoking (Prohibition in Public Places and Workplaces) (Guernsey) Law, 2005 (Commencement) Ordinance, 2006;
- Smoking (Prohibition in Public Places and Workplaces) (Exemptions and Notices) (Guernsey) Ordinance, 2006; and
- Smoking (Prohibition in Public Places and Workplaces) (Exemptions and Notices) (Amendment) (Guernsey) Ordinance, 2013.

Alderney

- Smoking (Prohibition in Public Places and Workplaces) (Alderney) Law, 2008;
- Smoking (Prohibition in Public Places and Workplaces) (Alderney) Law, 2008 (Commencement) Ordinance, 2010; and
- Smoking (Prohibition in Public Places and Workplaces) (Exemptions and Notices) (Alderney) Ordinance, 2010.

Both Guernsey and Alderney have no legislation enacted to protect children from second-hand smoke inside private vehicles. In 2018, the CfHSC directed that an education campaign was preferred in the first instance prior to further consideration on whether to legislate or not. Given the success of other policy measures on the smoking rates, this direction should now be reconsidered. Smoking in vehicles carrying children is banned in the United Kingdom due to the high concentration levels of toxins in the confined space of a car and the increased vulnerability of children to the detrimental effects of second-hand smoke.

Through The Tobacco Products (Guernsey) Ordinance 2014, the Office of Environmental Health and Pollution Regulation (OEHPR) operate a tobacco licensing scheme. This scheme requires tobacco retailers to apply to OEHPR annually for a licence to sell tobacco. The tobacco licensing scheme allows officers to monitor and enforce the particulars of this ordinance, many of which are designed to reduce the availability of tobacco to children. No formal action against tobacco retailers has been required.

Tobacco is available to buy without duty applied at Guernsey's ports and on the commercial aircraft and vessels that operate from them. While there is no data to clearly evidence where smokers purchase their products, the availability of tobacco at a reduced price in the States of Guernsey-owned airline and other Government property contradicts efforts to reduce tobacco-related harm.

Fiscal measures

Increases in the price of tobacco products have helped to reduce the smoking prevalence in Guernsey and Alderney from over 30% in 1988 to 13% in 2018.

Indeed, as part of the Guernsey and Alderney Tobacco Control Strategy 2015-2020, the States of Deliberation resolved

"to increase the rate of excise duty on cigarettes at a minimum of the Retail Price Index (X) plus 5% annually for the five years 2016 to 2020" and "to increase the rate of excise duty on other tobacco products at a minimum of Retail Price Index (X) plus 7.5% annually for the five years 2016 –2020, subject to the rate of excise duty on each tobacco product not exceeding the rate of excise duty on cigarettes."

Therefore in 2019, an increase in excise duty in respect of cigarettes of 7.4%, for cigars of 7.9% and for all other tobacco products of 9.9% was applied.

Stop Smoking Services

The data previously outlined reveals a need and opportunity to offer tailored smoking cessation advice and support to pregnant women and those they live with.

Drugs

The pillars of drug policy focus on:

1) reducing demand;
2) restricting supply; and
3) building recovery.

1) Reducing Demand

This requires:

- a cross-government approach;
- creating an environment for people to make healthy choices;
- the needs of vulnerable people to be taken into account across their lifespan; and
- that every opportunity is taken to identify risk factors known to be associated with the misuse of drugs.

This begins with professionals involved in maternity and services for children, with early identification of the children of parents who misuse drugs, to keep them safe and to build their resilience. The Multi Agency Support Hub (MASH) is a single point of entry to provide help and support for children, young people and their families, who have complex needs that require the support of more than one agency or professional. They meet daily and are made up of representatives from the following key statutory agencies:

- Police
- Child Health
- School Attendance Service
- Children's Social Care

Other agencies who attend regularly include: the Child and Adolescent Mental Health Service (CAMHS), the Community Drug and Alcohol Team (CDAT), Youth Justice, the Children's Convenor and Action for Children.

In schools across Guernsey and in Alderney, PSHCE (Personal, Social, Health and Citizenship Education) is delivered by various specialist educators, who teach young people about health risks and aim to build confidence and resilience in them, giving them the skills to help cope with, and recover from adversity. It is important to remember however, that PSHCE is a universal offer to school pupils and not designed to support children who may be experiencing trauma at home. Therefore, in addition to PSHCE, systems need to be in place to identify and further support these children, who may also have poor school attendance.

Many young people who are not in education, employment or training (NEETs) self-declare substance use. The Youth Commission provides a range of services to support children and young people up to the age of 25 years in their social, physical and emotional wellbeing. They operate from youth centres across Guernsey and in Alderney. Action for Children support the most vulnerable and neglected young people with the aim of keeping them safe, encouraging them to achieve, and equipping them with skills and resilience to increase their opportunities in life.

Professionals working in substance misuse areas have an opportunity to identify victims of domestic abuse and refer them to IDVAs (Independent Domestic Violence Advisors). In Guernsey, this service is provided by the charity Safer. It may be the case that perpetrators of domestic abuse are also in contact with substance misuse treatment services. There is a need for service providers to be able to refer people to programmes that may help reduce their propensity to abuse.

The vulnerability of prisoners on release from prison has already been discussed in this report. For the children of prisoners, it must be highlighted that having a parent incarcerated during childhood increases the likelihood of substance misuse. While there is no suggestion that serious offences should go unpunished, there is a need to carefully examine the validity of short sentences which undoubtedly cause great harm to children by impacting on their ability to access finance, education and employment.

To reduce demand, more work also needs to be done to understand and address the wider determinants of health so that people are less likely to turn to drugs in the first instance. This will require cross-governmental working and may also benefit from a Health in all Policies approach or post.

2) Restricting Supply

Restricting supply includes both a focus on prescription diversion as well as preventing the importation and cultivation of illegal drugs.

Prescription rates for opioids have decreased over the past five years, thus resulting in a supply of medicines that can be diverted illicitly. Further work is required to prevent 'leakage' of these substances.

The Guernsey Border Agency is tasked with protecting the Bailiwick's borders and works with UK Law Enforcement Agencies to ensure that the islands are safe places to live. One way in which this is achieved is through the seizure of illegal drugs where importation has been attempted via mail, on an individual externally or internally or on a vehicle or vessel.

3) Building Recovery

Many agencies are available to support drug users, including services supported by the States of Guernsey, as well as those provided by the community and voluntary sector. Furthermore, peer-led support is an important component of recovery and should be easily accessible before, during and after structured treatment programmes. This has not yet been established in Guernsey and Alderney to support those using drugs, although has been attempted both using the 12 step and SMART models. This is in contrast to the successful peer-led support provided by Alcoholics Anonymous.

Small communities present different challenges for residents in Guernsey, and more so in Alderney. The lack of anonymity makes it difficult for those in recovery to start anew due to the stigma of being known as a drug user within a small community. Service users expressed concerns that they were not able to truly isolate themselves from previous bad influences with the potential impact on their recovery. There is a need to reduce stigma and increase support in the community to support sustained recovery.

Opioid Substitution Treatment Programme

More details on the Opioid Substitution Programme are presented as this was identified as a specific treatment gap.

In 2018, a confidential Opioid Substitute Treatment (OST) Research Report for Guernsey was commissioned and the project was undertaken by Dr Jan Melichar, a Clinical Senior Lecturer in Psychopharmacology and Medical Director and Consultant in Addiction Psychiatry. This report was commissioned due to concerns about the current local OST programme. The report is not in the public domain but outlined the following issues which, if addressed, would bring Guernsey enhanced local services.

The wide abuse and diversion of dihydrocodeine, and robust sentencing rules which currently allow for the development of a young cohort of opioid-dependent patients.

- Guernsey is one of the few places with a young opioid-using cohort of patients, as it is easier to get illicit dihydrocodeine on the island than other illicit substances.

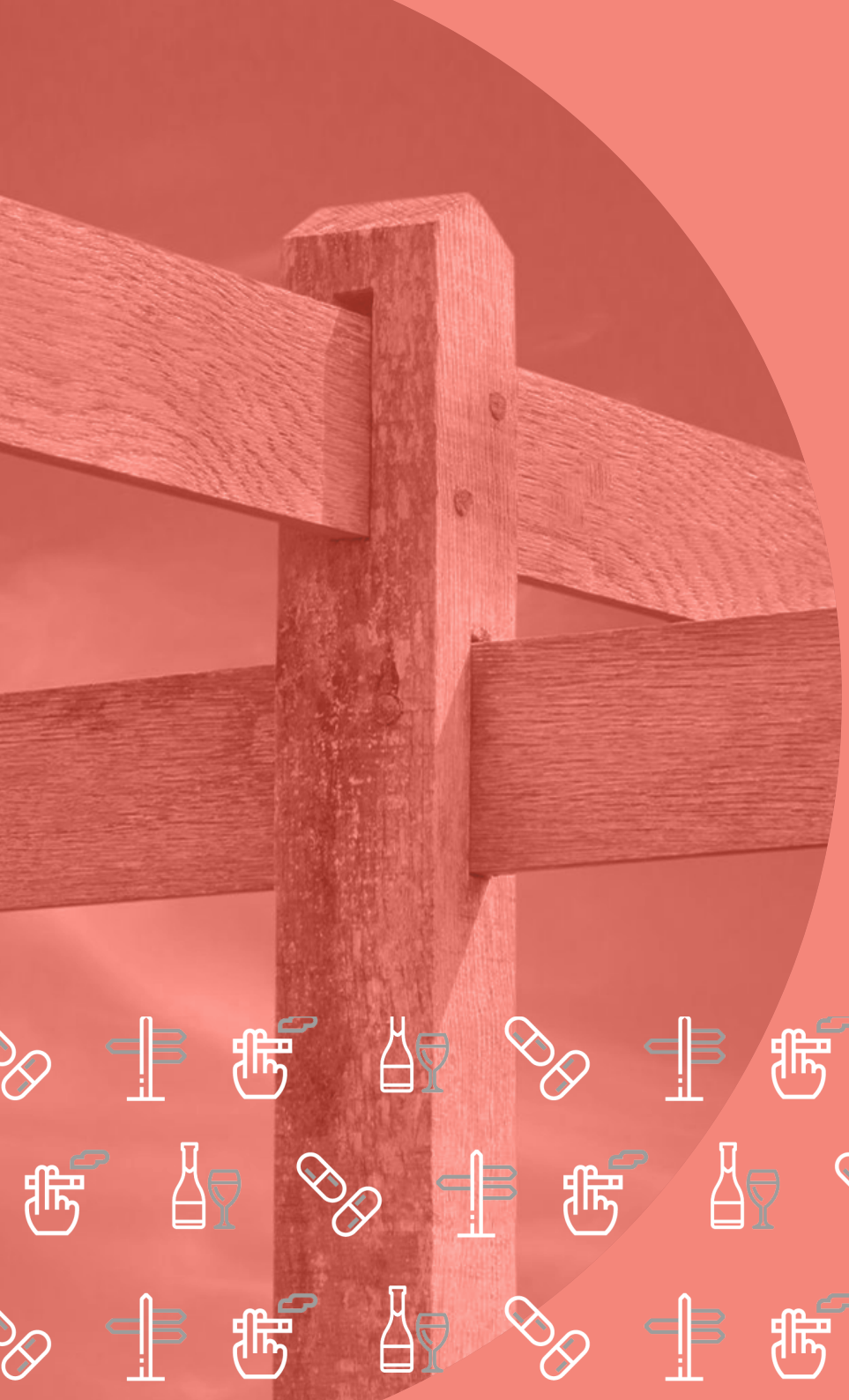
Methadone Programe

- In 2021 a methadone programme was reintroduced to the Bailiwick. This is currently being implemented involving small numbers of service users, with the aim of expanding this in the future.

- The previous switch away from methadone to an alternative opioid substitution therapy occurred in the 1990s. The report notes that the prescribing practice relating to methadone was poor and it was the process that was wrong, not the use of methadone *per se*. This made Guernsey one of the few places in the world that has a treatment programme that uses dihydrocodeine and does not have methadone OST.

Limited "Recovery Culture" on the island

- To the majority of patients, being stable meant being in treatment, on a prescribed opioid. This seemed to be due to their experience of previous unsuccessful "forced" detoxifications, which have reduced their confidence about successful drug-free living.[73]



Conclusions and next steps

Conclusions and Next Steps

This Joint Strategic Needs Assessment has been conducted to jointly consider drugs, alcohol and tobacco use. This forms part of the work mandated by the Partnership of Purpose which directed Public Health Services to conduct a suite of needs assessments to map the current and future needs of our population.[1]

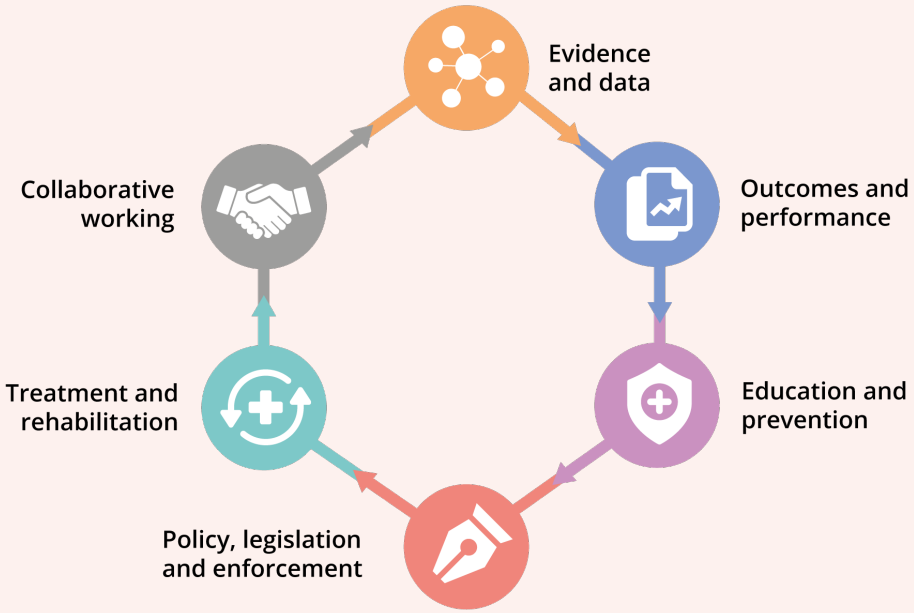
Specifically, this JSNA has considered:

- what we know, including an analysis of patterns and trends of substance use, including the identification of data gaps;
- who is at risk and why;
- current service provision and activity;
- evidence of what works; areas for strategic focus, including unmet needs and service gaps; and
- the impact of the wider determinants of health and wellbeing on substance use.

This JSNA has demonstrated that effective public health measures used to restrict supply, raise awareness and support people through treatment and recovery are applicable to alcohol, drugs and tobacco. However, it is vital to take a systems approach to prevention, early intervention and treatment which consider a multitude of risk and protective factors which do not function in isolation but interact, sometimes in unpredictable ways. As such, it is important to balance delivery of treatment services with actions which tackle the wider determinants of health and health behaviours to promote health and wellbeing amongst our populations in a holistic way.

It is possible that certain health-damaging behaviours (e.g. smoking and drinking) are used as ways of coping with adversity (of which stress is another sign). This has important implications for how we can encourage behaviour change at a population level. Simple health messaging exhorting people not to smoke, or drink to excess may not prove effective and could widen inequalities if the underlying, complex reasons why people do these activities in the first place are not addressed.[2]

Figure 18: Key areas for consideration for a combined Substance Use Strategy



The results of this JSNA will now inform the development of a Combined Substance Use Strategy which will define our goals in relation to substance use and map the provision of services for the next five years. Key areas of focus for inclusion in the Combined Substance Use Strategy as identified through this needs assessment, are illustrated in Figure 18.

Efforts to address the impact of substance use need to be equitable and focus on promoting health and wellbeing. There is a need to personalise the health and wellbeing services available to individuals, finding out what works for them. There needs to be an environment where islanders can live and thrive.

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Glossary of abbreviations and technical explanations

AUDIT: The Alcohol Use Disorders Identification Test

AUDIT was developed by the World Health Organisation (WHO) to support the identification of hazardous and harmful patterns of alcohol consumption. It consists of ten questions which measure the frequency and quantity of alcohol consumption and problems related to alcohol use.

Table 1: AUDIT categories	
Score	**Category**
0	Abstainer
1 to 7	Low-risk
8 to 15	Risky and hazardous
16 to 19	High-risk 1 / harmful
20 or more	High-risk 2 / possible dependence

Abbreviations

A&E - Accident and emergency (equivalent to Guernsey's Emergency Department)

ACES - Adverse Childhood Experiences

AfC - Action for Children

ASSIST - Alcohol, Smoking and Substance Involvement Screening Test

BAC - Blood Alcohol Concentration

CAMHS - Child and Adolescent Mental Health Services

CDAT - Community Drug and Alcohol Team

CfHSC - Committee for Health & Social Care

CJSS - Criminal Justice Substance Service

COPD - Chronic Obstructive Pulmonary Disease

CORE - Clinical Outcomes in Routine Evaluation

DISM - Diversion and Illicit Supply of Medicines

ENDS - Electronic Nicotine Delivery Systems

FCTC - Framework Convention for Tobacco Control

GAAS - Guernsey Alcohol Advisory Service

HBV - Hepatitis B Virus

HCV - Hepatitis C Virus

HIV - Human Immunodeficiency Virus

IARC - International Agency for Research on Cancer

ICD-10 - Tenth Revision of the International Classification of diseases

IDU - Injecting Drug Use

IDVAs - Independent Domestic Violence Advisors

INSIDE- OUT - Evidence-based group recovery programme run by Guernsey's Prison Service

IT - Information Technology

JSNA - Joint Strategic Needs Assessment

MARAC - Multi-agency Risk Assessment Conference

MASH - Multi-Agency Support Hub

MECC - Making Every Contact Count

MUP - Minimum Unit Pricing

NEETs - (Young People) Not in Education, Employment or Training

OEHPR - The Office of Environmental Health and Pollution Regulation

OST - Opioid Substitution Therapy

PHE - Public Health England

PSHCE - Personal, Social, Health, Citizenship Education

Safer - Guernsey-based charity supporting victims of domestic abuse

SAFER - WHO alcohol-control initiative

THC - Tetrahydrocannabinol

VBA - Very Brief Advice

WHO - World Health Organisation

YLL/YWLL - Years of Life Lost/Years of Working Life Lost

YPSMS - Young Peoples' Substance Misuse Service

Appendix A: Steering Group Members

Alex Hawkins-Drew
Head of Public Health Women and Children's Services

Amy Taylor
Public Health Practitioner and Programme Manager

Andrea Nightingale
Drug and Alcohol Strategy Co-ordinator,
The Health Improvement Commission

Andrea Tostevin
Quitline Manager

Andrew Hockey
Guernsey Police

Dr Gary Yarwood
Consultant Anaesthetist, Medical Specialist Group

Dr Hilary Holland
Consultant Anaesthetist, Medical Specialist Group

Dr Neil Wright
Consultant Psychiatrist, Substance Misuse

Dr Nicholas Shepherd
Consultant Anaesthetist, Medical Specialist Group

Dr Nicola Brink
Director of Public Health and Senior Responsible Officer

Dr Paul Williams
GP Guernsey

Dr Sally Simmonds
GP Alderney

Dr Simon Sebire
CEO, The Health Improvement Commission

Ed Freestone
Chief Pharmacist

Jane St Pier
Youth Commission

Michelle Aldridge
Service Manager, Community Drug and Alcohol Team

Peter Knee
Guernsey Border Agency

Rebecca Falla
Guernsey Border Agency

Tracey Rear
Service Manager, In-dependence

Yvonne le Page
Public Health Business Manager

Appendix B: Stakeholders

Action for Children

Adult Community Services

Alcoholics Anonymous

CAMHS

Children's Convenor

Children's Services

Choices

Community Drug and Alcohol Team

Domestic Abuse Strategy Co-ordinator

Drug Concern

Drug users

Education

Emergency Department

Families of drug users

Forensic Medical Examiner

Guernsey Alcohol Advisory Service

Guernsey College of Further Education

Guernsey Drug Strategy Campaign

Guernsey Police

Housing Department

In-dependence

Maternity services

Mental Health Nurse and Smoking Cessation Specialist

Mental Health Project Manager

Mental Health Services

MIND

Office for Environmental Health and Pollution

Pregnant smokers

Prescribing Advisor

Primary Care

Prison Governor

Prison Healthcare

Prisoners

Probation Service

Quitline

Resilient Bailiwick

Safeguarding

Social Security

St John Guernsey

The Orchard Centre

Youth Commission

Youth Justice

Alderney

Alderney Police

Community members

Hospital Matron

Mother & toddler group

Politicians

Youth group

Appendix C: Aknowledgements

The Committee for Health & Social Care and Public Health Services would like to thank all of the contributors who gave so generously of their time to conduct this Joint Strategic Needs Assessment focusing on Substance Misuse.

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Partnership of Purpose

States of Guernsey
Public Health Services