Consultation to seek views on the new Substance Use Strategy for Northern Ireland – "Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use"

Consultation opened on Friday 30 October 2020.

Consultation closes on Friday 05 February 2021 at 17:00.

Summary

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

Consultation Description

The new Substance Use Strategy for Northern Ireland – **"Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use"** – was issued for public consultation on 30 October 2020:

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

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

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

Taking on board the outcomes from the review a pre-consultation exercise took place in 2019 on what should be contained within a new substance use strategy. This was followed by the development of the new strategy on a co-production basis with involvement from key stakeholders including; the community and voluntary sector; service users; health professionals; academics; and key government departments and agencies.

We are now seeking views from partners and the general public on the new strategy. We want your views on the vision, indicators, outcomes and targets set out in the new strategy. And we want your views on what should be prioritised, in the event that not all actions can be taken forward in the final published strategy.

Next Steps

Following this consultation, we will collate and analyse all views and inputs, and begin the process of developing the final strategy. This will need to be agreed by the Minister of Health and the NI Executive before being published. It is important to note that the NSD Phase 2 – and all the structures that support action and collaboration – will remain in place until any new strategy is put in place.

The Closing Date for responses is Friday 05 February 2021

Ways to respond: Respond Online

It may be easier for you to respond online, and you can do this by clicking on the Green Button "Respond Online" above – this will take you straight to the online questionnaire on the Citizen Space.

Alternatively, you can access the relevant documentation on the DoH website at:

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

or contact us using the details below:

Email: HDPB@health-ni.gov.uk

Write to: Health Development Policy Branch
Room C4.22
Castle Buildings
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INTRODUCTION	
	What is your name?
	Name: Adam Jones, Director of Public Affairs, Partnerships and Business Development
	What is your e-mail address? *If you enter your email address then you will automatically receive an acknowledgement email when you submit your response.*
	E-mail: ajones@drinkaware.co.uk
	Is your response being submitted on behalf of an organisation or as an individual? (*please tick below as appropriate*)
	X **Organisation** *Please use text box below to state the name of your organisation etc?* ☐ **Individual**
	[*text box*] **The Drinkaware Trust** The Drinkaware Trust is an independent charity, funded largely by voluntary and unrestricted donations from UK alcohol producers, retailers and supermarkets. The Trust was set up in 2006 through a Memorandum of Understanding with the then Department of Health, the Home Office, Scottish Executive, Welsh Assembly Government and the Northern Ireland Office, in partnership with The Portman Group as convenors of the UK alcohol industry. The Trust's purpose was to be "an independent, UK-wide, public-facing body with the objective of positively changing public behaviour and the national drinking culture to help reduce alcohol misuse and minimise alcohol-related harm". This purpose remains so today, and we seek to fulfil this remit through accessible, evidence-based public information; campaigns directly to those most at risk, and product innovation in self-help tools and educational materials to help people make better, more informed choices about alcohol. The Trust is governed independently by its Board of Trustees, the Chair of which is Sir Leigh Lewis, former Permanent Secretary at the Department for Work and Pensions. The Board is advised by an independent Medical Advisory Panel and Dr Fiona Sim, Drinkaware's Chief Medical Advisor. Representatives from the Department of Health and The Home Office attend board meetings as observers to the Board. Drinkaware is providing our response based on our rich insights into the public's drinking behaviour, methodological considerations on collecting data on drinking behaviour, experience of delivering interventions to reduce alcohol harm, and engagement in health promotion campaigns. While the consultation considers both the use of alcohol and other drugs, our response refers only to the alcohol strategy. Drinkaware acknowledges the World Health Organization (WHO) position of the three key influencers of alcohol consumption – price (affordability), ease of purchase (availability) and the social norms around its consumption (acceptability) – and within this alcohol education has a role to play in supporting behaviour change.

Equality/Good Relations and Rural Screening (Chapter 1)

Question 1a	**Have you any comments on either the Equality/Good Relations or Rural screening documents?** [*comments*] No comments
Question 1b	**Have you anything you believe we should be considering in future Equality/Good Relations or Rural screenings?** [*comments*] No comments

Vision, Outcomes, Values, Priorities and Target Groups (Chapter 5)

Question 2a	**Do you agree with the Vision?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 2b	**Do you agree with the Outcomes?** X Yes ☐ No If No, please provide further information. [*comments*]

Question 2c	**Do you agree with the Values?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 2d	**Do you agree with the Priorities?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 2e	**Do you agree with the Target Groups?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 2f	**Have you any further comments?** [*comments*] Drinkaware supports an alcohol strategy that is universal in scope with the specific targeting of groups most at risk of alcohol harm.

Outcome A – Fewer People are at risk of harm from the use of Alcohol and Other Drugs (Chapter 6)

Question 3a	**Do you agree these indicators help to demonstrate progress against this outcome of having fewer people at risk of harm?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 3b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. [*comments*] While Drinkaware broadly agrees with the proposed indicators, we offer two additional suggestions for consideration. **Triangulation with other data/datasets.** Survey data is only as reliable as the original source, and it has been estimated that surveys measuring individuals' self-reported alcohol consumption usually results in overall consumption figures which can be between 40-60% of supply-based estimates (i.e., data on the production and trade of alcohol).[1] This suggests individuals either underestimate their own consumption and/or that such surveys do not reach the people with the highest consumption. In either case, survey data can be considered an underestimation of alcohol consumption at a population level. Such biases can be accounted for or improved with triangulation with alternative data sources.[2] Ideally, adult alcohol consumption per capita (APC) would be measured and reported. Globally, APC is the main indicator of harmful alcohol use, as it is not only highly associated with harm, but is also reported for most countries on an annual basis (as it is largely derived from routinely collected statistics). Therefore, reductions in APC can also indicate harm prevention and reduction. While Northern Ireland figures are generally subsumed within data for the United Kingdom, if it is possible to disaggregate such figures for Northern Ireland, then this may provide an additional indicator of progress. In addition, expenditure (£) and/or weekly consumption of alcohol (ml) could be reported using the sub-national datasets of the Department for Environment, Food & Rural Affairs' (DEFRA) Family Food series to triangulate survey data.

[1] World Health Organization. (2019). *Global status report on alcohol and health 2018*. World Health Organization.
[2] Rehm, J., Kilian, C., Rovira, P., Shield, K. D., & Manthey, J. (2020). The elusiveness of representativeness in general population surveys for alcohol. *Drug and Alcohol Review*, dar.13148.

	Additional indicators *(1) % aware of CMO guidelines* Action A9 specifies that the PHA will promote and raise awareness of the UK Chief Medical Officers' low-risk drinking guidelines and understanding of alcohol units across the region. As such, it is recommended that level of awareness and understanding of the guidelines is also monitored as an indicator of progress. This indicator will also assist in evaluation of this aspect of the strategy. *(2) Alcohol-related hospital admissions (under 18s)* If available, it is also recommended that the Department of Health consider including alcohol-related hospital admissions among under 18s as an indicator of progress towards its prevention of harm outcome. This would not only demonstrate harm prevention, but also provide a means to triangulate the indicator on the proportion of young who get drunk, as admission episodes are correlated with consumption.[3]
Question 4a	**Will these actions achieve this outcome of having fewer people at risk of harm?** X Yes ☐ No If No, please provide further information. [*comments*] While the proposed actions will help to achieve the outcome of having fewer people at risk of harm, in two actions, Drinkaware offers some further considerations. **Action A3 - Updating the drugandalcoholni.info** Drinkaware would be happy to share our information and resources to support the PHA with this action. Each year, Drinkaware receives between six and 10 million unique visitors to our website, accessing our information, tools, and resources—of which, between 95,000--140,000 are from Northern Ireland (comprising approx. 2.2% of all website visitors). In 2019, our Drink Compare calculator (developed based on principles of Intervention and Brief Advice), had more than 250,000 tool completions, and our Self-Assessment Tool (a digitised version of the WHO's Alcohol Use Disorders Identification Test) had over 300,000 completions.[4] Drinkaware is able to offer these digital tools to the PHA. **Action A9 – Promote and raise awareness of the UK CMO guidelines and understanding of alcohol units.** As recognised in the consultation document, and evidenced by survey data,[5] awareness of the UK CMO guidelines is low. Therefore, efforts at improving this are supported.

[3] Oldham, M., Holmes, J., Whitaker, V., Fairbrother, H., & Curtis, P. (2018). *Youth drinking in decline*. https://eprints.whiterose.ac.uk/136587/1/Oldham_Holmes_Youth_drinking_in_decline_FINAL.pdf

[4] Drinkaware. (2020). *Sharpening our focus. Impact Report 2019*. https://www.drinkaware.co.uk/media/dadpotkg/drinkaware-impact-report-2019-final.pdf

[5] Rosenberg, G., Bauld, L., Hooper, L., Buykx, P., Holmes, J., & Vohra, J. (2018). New national alcohol guidelines in the UK: Public awareness, understanding and behavioural intentions. *Journal of Public Health*, 40(3), 549–556. https://doi.org/10.1093/pubmed/fdx126

	However, evidence (in the UK and further afield) indicates that awareness of drinking guidelines does not result in changes in alcohol consumption.[6] In fact, a study of knowledge and use of the previous guidelines in England, found that despite such guidelines being in place for two decades, only one in four drinkers correctly identified these, with even fewer using the guidelines to monitor their drinking.[7] Instead, such studies suggest a need to engage more with how drinkers respond to and use the guidelines in practice. While population-wide messaging is important, Drinkaware has observed value in tailoring messages around alcohol consumption to different audiences. Some individuals may be motivated to drink within the guidelines once they are aware of them; others, however, may respond more to knowing the calorie content of alcoholic drinks. Indeed, our 2020 Drinkaware Monitor found that three in 10 (30%) drinkers agreed that they would change the amount they drink based on calorie content. Conversely, for other groups (e.g., men[8]), health messaging is a better approach to encourage a reduction in consumption (e.g., linking alcohol to cancer, hypertension, mental health, or obesity etc.). Indeed, research on the public understanding of the guidelines suggests that health messaging (and specifically, linking the guidelines to disease-specific evidence), may improve the salience and understanding of government advice on health behaviours.[9] Drinkaware's own data would indicate that more work needs to be done to increase awareness among the population on the impact of alcohol on specific health conditions. Data from our 2018 Drinkaware Monitor[10] found that although the link between alcohol and liver disease is well-recognised (92% prompted awareness), other health conditions such as high blood pressure (70% prompted awareness), heart problems (69% prompted awareness), and particularly cancer remains low. For example, despite evidence that alcohol causes at least seven types of cancer,[11] just 55% of respondents linked alcohol to cancer when prompted. As such, it is recommended that the Department of Health consider not only promoting the guidelines, but also link these to specific health conditions. Action A9 acknowledges that any promotion of the guidelines must be accompanied with education on how to understand and measure alcohol units. Indeed, individuals cannot track or assess their drinking against the guidelines, if they do not know how many units are in the drinks they consume. Drinkaware has an online unit calculator, and an App both of which aim to help individuals understand how much alcohol they are consuming in their drinks. With more than half a million unique visitors to our unit and calorie calculator in 2019,[12] there appears to be demand for this information.

[6] Holmes, J., Beard, E., Brown, J., Brennan, A., Meier, P. S., Michie, S., Stevely, A. K., Webster, L., & Buykx, P. F. (2020). Effects on alcohol consumption of announcing and implementing revised UK low-risk drinking guidelines: Findings from an interrupted time series analysis. *Journal of Epidemiology Community Health*, 74(11), 942–949. https://doi.org/10.1136/jech-2020-213820

[7] Buykx, P., Li, J., Gavens, L., Hooper, L., Gomes de Matos, E., & Holmes, J. (2018). Self-Reported Knowledge, Correct Knowledge and use of UK Drinking Guidelines Among a Representative Sample of the English Population. *Alcohol and Alcoholism*, 53(4), 453–460. https://doi.org/10.1093/alcalc/agx127

[8] Christmas, S., & Souter, A. (2016). *Midlife Male Drinking: Findings from research with men aged 45 to 60.* Drinkaware and YouGov. https://media.drinkaware.co.uk/media/pepfbt1p/midlife-male-drinking_v02-1.pdf?v=0.0.9

[9] Rosenberg, G., Bauld, L., Hooper, L., Buykx, P., Holmes, J., & Vohra, J. (2018). New national alcohol guidelines in the UK: Public awareness, understanding and behavioural intentions. *Journal of Public Health*, 40(3), 549–556. https://doi.org/10.1093/pubmed/fdx126

[10] Gunstone, B., Piggott, L., Butler, B., Appleton, A. and Larsen, J. (2018). *Drinking behaviours and moderation among UK adults: Findings from Drinkaware Monitor 2018*. London: YouGov and Drinkaware.

[11] Connor, J. (2017). Alcohol consumption as a cause of cancer. *Addiction*, *112*(2), 222-228.

[12] Drinkaware. (2020). *Sharpening our focus. Impact Report 2019.* https://www.drinkaware.co.uk/media/dadpotkg/drinkaware-impact-report-2019-final.pdf

	Finally, while it is important for the general population to be aware of the low-risk guidelines and alcohol units, it is also important to ensure such knowledge exists among health and care professionals, and particularly those who encounter targeted groups. Moreover, any effort at raising the awareness of the CMO guidelines should not only include the advice around regular drinking and single occasion drinking, but also the advice around drinking in pregnancy, which should be communicated as an important part of a prevention strategy. The 2016 CMO guidelines revised the advice for drinking alcohol during pregnancy, advising abstention. Given the change in advice, efforts to improve midwives' knowledge, skills, and clinical confidence to deliver alcohol advice should be considered[13,14]--such primary prevention in antenatal care is a World Health Organization priority. [15]
Question 4b	**Will these actions make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 4c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** [*comments*] Should not all actions be taken forward, Drinkaware would advocate prioritisation of actions targeting the most at-risk groups of harm.

Outcome B: Legislation and the Justice System support Preventing and Reducing the Harm related to Substance Use (Chapter 7)

Question 5a	**Do you agree these indicators help to demonstrate progress against this outcome of legislation and the justice system preventing and reducing harm?** ☐ Yes ☐ No

[13] Schölin, L., Watson, J., Dyson, J., & Smith, L. A. (2019). Alcohol guidelines for pregnant women: barriers and enablers for midwives to deliver advice. http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp37092019.pdf

[14] Schölin, L. (2016). *Prevention of harm caused by alcohol exposure in pregnancy: Rapid review and case studies from member states*. World Health Organization, Regional Office for Europe.

[15] World Health Organization. (2010). *Global strategy to reduce the harmful use of alcohol*. World Health Organization.

	If No, please provide further information. [*comments*]
Question 5b	**Are you aware of any other indicators that would demonstrate such progress?** ☐ Yes ☐ No If Yes, please provide further information. [*comments*] It is recommended that such indicators are reviewed following the outcomes of the Liquor Licensing Bill, consultation on MUP, and work with the UK Government on alcohol advertising.
Question 6a	**Will these actions achieve this outcome of legislation and the justice system preventing and reducing harm?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 6b	**Will they make positive impacts on the indicators?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 6c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** [*comments*]

Outcome C – Reduction in the Harm caused by Substance Use (Chapter 8)

Question 7a	**Do you agree these indicators help to demonstrate progress against this outcome of reducing harm?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 7b	**Are you aware of any other indicators that would demonstrate such progress?** X Yes ☐ No If Yes, please provide further information. [*comments*] **Broadening the CMO guideline indicator** While it is important to report on the proportion of individuals drinking above the UK CMO guidelines, it is recommended here that the Department of Health considers broadening the scope of this indicator to report the proportion of individuals drinking at increasing and higher risk levels as well. The National Institute for Health and Care Excellence (NICE) distinguish between three types of risk from drinking: 1) Lower risk drinking - Not regularly drinking more than 14 units of alcohol per week (both men and women). 2) Hazardous or increasing risk drinking - Drinking more than 14 units a week, but less than 35 units a week for women, or less than 50 units for men. 3) Harmful or higher risk drinking - Regularly consuming more than 50 units per week for men or over 35 units per week for women. Looking only at the proportion of adults drinking above the guidelines suggests that all harm above this level is the same. Yet, for many conditions, directly or partially attributable to alcohol, the risk of harm increases in either a dose-dependent manner,[16,17] or with chronic excessive consumption.[18]

[16] Bagnardi, V., Rota, M., Botteri, E., Tramacere, I., Islami, F., Fedirko, V., ... & La Vecchia, C. (2015). Alcohol consumption and site-specific cancer risk: a comprehensive dose–response meta-analysis. *British Journal of Cancer*, *112*(3), 580-593.
[17] Roerecke, M., Kaczorowski, J., Tobe, S. W., Gmel, G., Hasan, O. S., & Rehm, J. (2017). The effect of a reduction in alcohol consumption on blood pressure: a systematic review and meta-analysis. *The Lancet Public Health*, 2(2), e108-e120.
[18] Osna, N. A., Donohue Jr, T. M., & Kharbanda, K. K. (2017). Alcoholic liver disease: pathogenesis and current management. *Alcohol research: current reviews*, 38(2), 147.

As such, individuals drinking at higher risk levels and reducing the amount they drink to increasing risk levels can still indicate progress towards harm reduction—as acknowledged in point 8.14 in the consultation document. For example, evidence has demonstrated that a reduction in alcohol consumption lowers blood pressure in a dose-dependent manner.[19] As such, even if higher risk drinkers do not manage to reduce their drinking to within the guidelines, by reducing their level of consumption, they may lower their likelihood of developing some of the health impacts of alcohol.

In addition, any change observed in the proportion of adults drinking within or above the guidelines may reflect, primarily, those individuals who drink around the margins of that level of consumption and could potentially miss progress among individuals with the highest consumption.

Each year, Drinkaware commissions a large survey (Drinkaware Monitor) to track and understand the nation's drinking, including drinking behaviour in Northern Ireland. We have collected data on weekly unit consumption since the CMO guidelines were updated in 2016. This data indicates the following for Northern Ireland:

Risk level (weekly unit consumption)	*2017*	*2018*	*2020*
Lower risk* (0-14 units)	78%	78%	83%
Increasing risk (14.01–34.9 F; 14.01–49.9 M)	19%	17%	15%
Higher risk (35+ F; 50+ M)	3%	5%	3%
Base (n):	506	593	608

Note: 2019 Drinkaware Monitor had significantly smaller sample size (n=2,000).
*Includes non-weekly and never drinkers

While the above is not long-term data, it does indicate that increases in the 'lower risk' group have been primarily due to decreases in the 'increasing risk' category. Therefore, only reporting the 'lower risk' figure can potentially obscure change (or lack thereof) at higher levels.

As such, it is recommended that in addition to the proportion of adults drinking above and within the CMO guidelines, going forward the Department of Health also reports the proportion of individuals drinking at differing levels of risk above this.

Disease-specific indicators of alcohol harm
It is unclear from the current general indicators listed in this section whether the rate of alcohol deaths and hospital admissions will also report on disease-specific indicators (e.g., liver cirrhosis, alcohol-related liver cirrhosis, alcohol poisoning etc.). Such indicators would provide monitoring data on both chronic and acute disease consequences attributable to alcohol).[20] As such, if good data exists on alcohol-related disease, it is recommended that the Department of Health consider reporting on at least one chronic and one acute indicator.

Question 8a	**Will these actions achieve this outcome of reducing harm?**

[19] Roerecke, M., Kaczorowski, J., Tobe, S. W., Gmel, G., Hasan, O. S., & Rehm, J. (2017). The effect of a reduction in alcohol consumption on blood pressure: a systematic review and meta-analysis. *The Lancet Public Health*, 2(2), e108-e120.
[20] Rehm, J., & Scafato, E. (2011). Indicators of alcohol consumption and attributable harm for monitoring and surveillance in European Union countries. *Addiction*, 106, 4-10.

	X Yes ☐ No If No, please provide further information. [*comments*] Drinkaware offers two points for further consideration. **(1) Addition of a specific action for alcohol** While the proposed actions will help to achieve the outcome of harm reduction, Drinkaware would recommend an action specific to reducing harm from alcohol in this outcome. Specifically, it is recommended that the Department of Health consider including the 'Making Every Contact Count' (MECC) programme (listed as action (A6) in Outcome A), as an action in Outcome C as well. The National Institute of Health and Care Excellence recommends the use of Intervention and brief advice (IBA), or alcohol screening and brief interventions (SBI), as part of MECC. IBA is considered one of the most effective interventions to reduce alcohol consumption and have been demonstrated as having a positive impact on alcohol consumption, mortality, and morbidity.[21,22] However, recent evidence suggests that opportunities for intervention and brief advice are being missed during NHS Health Checks, with advice on alcohol consumption being provided less often than other lifestyle advice.[23] This may be due to a lack of health practitioners confidence in having those conversations about alcohol with their patients.[24,25] As such, efforts to improve implementation should be considered. **(2) Digital IBA delivery** While the majority of studies evaluating the effectiveness of IBA have been conducted in primary or emergency care settings, there is some evidence of the effectiveness of electronic IBA.[26] The societal restrictions imposed due to the COVID-19 pandemic has resulted in a rapid adoption of digital technology, and a surge in patients' uptake of remote health services (NHS App, NHS login and e-prescription services) has been reported.[27] While the full impacts of such a move are not yet known,[28] there is the potential to expand access to IBA, which may help in ensuring a new alcohol strategy reflects the 'universal' value outlined in the consultation document. Electronic IBA can reach a larger population than traditional face-to-face IBAs, may be more cost-effective, and has the potential to offer greater flexibility and anonymity for the individual. Drinkaware is pivoting its tools and interventions for a post-pandemic world and will be monitoring and evaluating such tools throughout

[21] Kaner, E. F., Dickinson, H. O., Beyer, F., Pienaar, E., Schlesinger, C., Campbell, F., ... & Heather, N. (2009). The effectiveness of brief alcohol interventions in primary care settings: a systematic review. *Drug and alcohol review*, 28(3), 301-323.
[22] Kaner, E. F., Beyer, F. R., Muirhead, C., Campbell, F., Pienaar, E. D., Bertholet, N., ... & Burnand, B. (2018). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane database of systematic reviews*, (2).
[23] Paxton, B., Mills, K., & Usher-Smith, J. A. (2020). Fidelity of the delivery of NHS Health Checks in general practice: an observational study. *BJGP open*, 4(4).
[24] World Health Organization. Regional Office for Europe. (2009*). Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: WHO Regional Office for Europe. https://apps.who.int/iris/handle/10665/107269.
[25] Beich, A., Gannik, D., & Malterud, K. (2002). Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. *Bmj*, *325*(7369), 870.
[26] Donoghue, K., Patton, R., Phillips, T., Deluca, P., & Drummond, C. (2014). The effectiveness of electronic screening and brief intervention for reducing levels of alcohol consumption: a systematic review and meta-analysis. *Journal of medical Internet research*, 16(6), e142.
[27] Hutchings, R. (2020). *The impact of Covid-19 on the use of digital technology in the NHS*. 23. https://www.nuffieldtrust.org.uk/files/2020-08/the-impact-of-covid-19-on-the-use-of-digital-technology-in-the-nhs-web-2.pdf
[28] Watts, G. (2020). COVID-19 and the digital divide in the UK. *The Lancet Digital Health*, 2(8), e395–e396.

	2021-22. Drinkaware would be happy to share insights with the Department of Health when we have them.
Question 8b	**Will they make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 8c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** [*comments*]

Outcome D – People access High Quality Treatment and Support Services to Reduce Harm and Empower Recovery (Chapter 9)

Question 9a	**Do you agree these indicators help to demonstrate progress against this outcome of accessing treatment?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 9b	**Are you aware of any other indicators that would demonstrate such progress?** ☐ Yes X No If Yes, please provide further information. [*comments*]
Question 10a	**Will these actions achieve this outcome of accessing treatment?** X Yes ☐ No If No, please provide further information. [*comments*] Action D2 states that the PHA and the HSCB will ensure that self-care advice and support is available through a range of sources, including online, via apps, etc. This is an important action. Broad information offers (such as the one Drinkaware provides) has an important role to play in help and information seeking behaviours as well as signposting people to treatment services. In addition, analysis of our Drinkaware app users indicate that a significant proportion are classified as increasing and higher risk drinkers (using the HSE classification, based on units consumed per week). Moreover, such users are more likely to engage with the app over a longer duration than lower risk drinkers. For example, increasing and higher risk drinkers comprise 40% of users in Week 1 and 61% at Week 10. We find similar findings with MyDrinkaware—our online tool to track drinking. This suggests that there are a

	number of individuals drinking at harmful levels who are actively seeking support, and Drinkaware's online and remote services are meeting a level of this need. Drinkaware remains happy to share its digital tools and/or the insights gained from them with the Department of Health.
Question 10b	**Will they make positive impacts on the indicators?** X Yes ☐ No If No, please provide further information. [*comments*]
Question 10c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** [*comments*]

Outcome E – People are Empowered and Supported on their Recovery Journey (Chapter 10)

Question 11a	**Do you agree these indicators help to demonstrate progress against this outcome of empowering people?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 11b	**Are you aware of any other indicators that would demonstrate such progress?** ☐ Yes ☐ No

	If Yes, please provide further information. [*comments*]
Question 12a	**Will these actions achieve this outcome of empowering people?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 12b	**Will they make positive impacts on the indicators?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 12c	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** [*comments*]

Outcome F – Information, Evaluation and Research better supports Strategy Development, Implementation and Quality Improvement (Chapter 11)

Question 13a	**Will these actions achieve this outcome of better information, evaluation and research?** ☐ Yes

	☐ No If No, please provide further information. [*comments*]
Question 13b	**Which actions would you prioritise if they cannot all be taken forward, or are there other actions likely to have a bigger impact?** [*comments*]

Making it Happen – Governance and Structures (Chapter 12)

Question 14	**Do you agree with the proposal to review the role, function and membership of DACTs, and consider linkages with other local delivery structures?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 15	**Do you agree with the proposed governance structures?** ☐ Yes ☐ No If No, please provide further information. [*comments*]
Question 16	**Do you agree with the Timeframe proposed?** ☐ Yes ☐ No

	If No, please provide further information. [*comments*] The covid-19 pandemic, and the associated restrictions, has had significant impacts on drinking behaviour. Our research conducted in lockdown,[29,30] like many others,[31] reported a polarisation of change in behaviour, with a similar proportion of drinkers (between one-fifth and one-third of the population) drinking more than normal to those drinking less than normal. Moreover, certain subgroups have emerged as being more likely to have increased their drinking:[32] those whose mental health has been negatively affected, those whose have been furloughed or made redundant, and parents of young children. In addition, those more likely to be drinking more since lockdown began are most likely to be those who were already drinking at harmful levels pre-lockdown. While it is still unclear whether such changes in drinking behaviour will be sustained or not, given ten months of restrictions have past, for some, ingrained habits may have formed. Therefore, it may beneficial (before the Alcohol and Drug Strategy is finalised) to review the impact of the pandemic on alcohol use in Northern Ireland, to see if any further actions are needed.

[29] *Drinking habits in Lockdown—Part I* | Drinkaware. (2020, August). https://www.drinkaware.co.uk/research/research-and-evaluation-reports/drinking-habits-in-lockdown-part-i

[30] *Drinking habits in Lockdown—Part II* | Drinkaware. (2020, August). https://www.drinkaware.co.uk/research/research-and-evaluation-reports/drinking-habits-in-lockdown-part-ii

[31] Institute of Alcohol Studies. (2020). *Briefing. Alcohol consumption during the covid-19 lockdown. Summary of emerging evidence from the UK*.

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FINAL COMMENTS	
Question 17	**Have you any other comments you wish to make at this stage?** As an independent charity with significant consumer reach in Northern Ireland, we hope that Drinkaware could be a valuable partner to the PHA in supporting its efforts to prevent and reduce harm from alcohol. In particular, we would welcome sharing of our annual survey data on changing attitudes to alcohol and drinking behaviours, and insights about hazardous and harmful drinking amongst groups most at risk. Through independent evaluation of our public messaging and campaigns, we have developed a deep understanding of the potential of public messaging to engage consumers and to create a climate supportive of wider interventions to reduce harm and promote public health; and increasingly as higher-risk users access information and advice online, we are able to help users navigate advice services and signpost to sources of further help and support. We have a thorough understanding of how information seeking behaviours, online engagement and drinking behaviours are continuing to change in response to the global pandemic. In this context, key areas for our Research Programme include digital inclusion and the impact of online information and services on health inequalities, and the needs of 'forgotten' or overlooked audiences such as those in the LGBTQ community.

THIS IS THE END OF THE QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire.

Please submit your completed response via e-mail to:

HDPB@health-ni.gov.uk