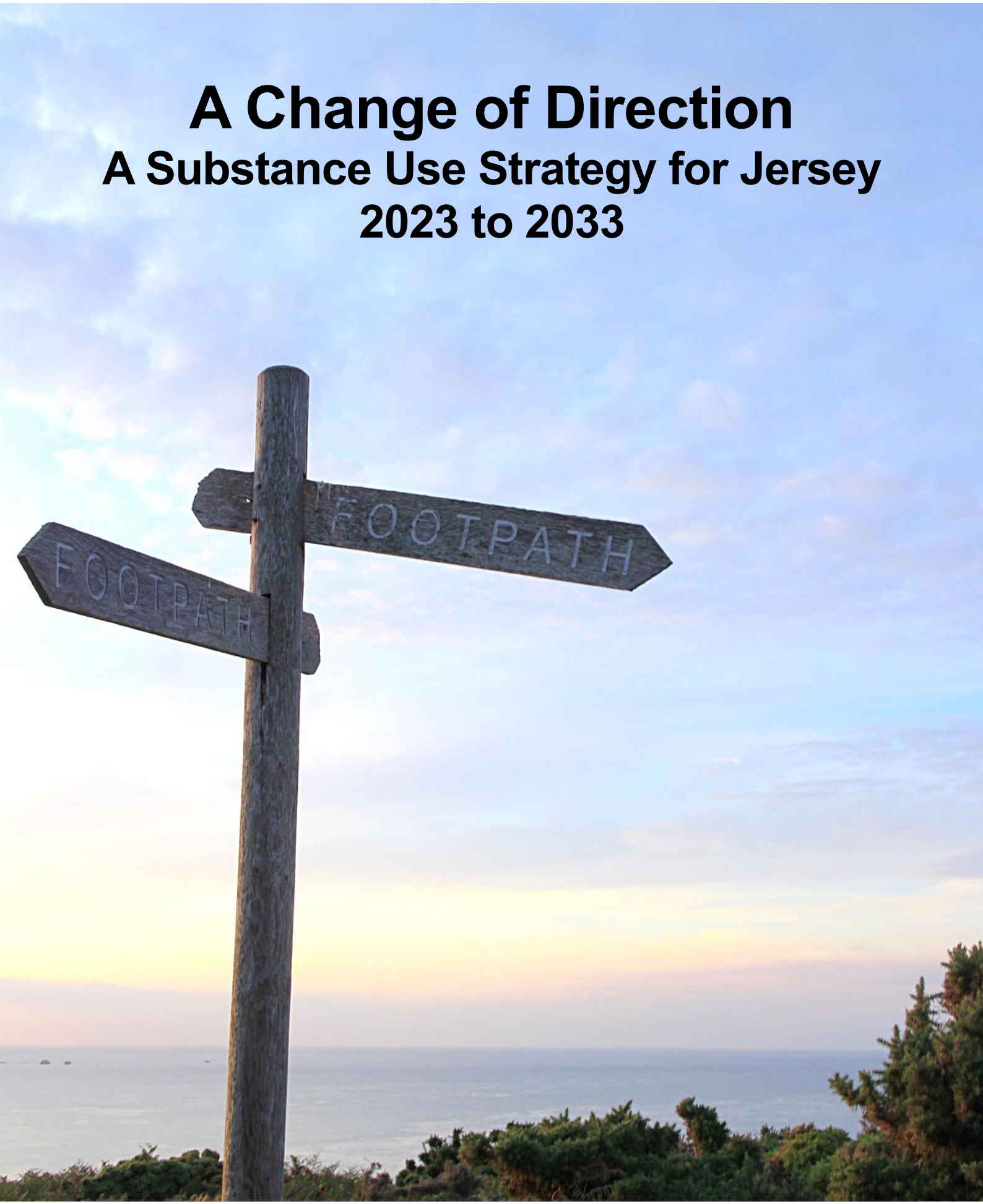
Public Health Jersey

A Change of Direction

A Substance Use Strategy for Jersey 2023 to 2033



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Public Health Jersey

Contents

With thanks to Government of Jersey departments, third sector stakeholders and Islanders with lived experience of substance use who helped produce this strategy.

Ministerial foreword

The use of substances (both drugs and alcohol) has a clear and direct impact on an individual's wellbeing here in Jersey. Over time many people have either destroyed or lost their lives by inappropriately using drugs or repeatedly consuming excessive amounts of alcohol.

Often characterised by family disintegration, criminal activity and violence the costs and risks attributed to the use of substances must be of concern to us all given the major significance and impact they have in people's lives.

Alcohol continues to be our Island's biggest problem, but the proliferation of substance use worldwide cannot be ignored as this too has a significant impact within our island community.

Our approach to addressing these issues must therefore change. This new strategy builds on previous work and marks a clear path for progress over the next ten years which is focused on delivering a public health response to this growing public health concern and has at its foundation an evidence-based approaches to prevention, harm reduction, access to support, and the improvement of health and wellbeing.

Deputy Karen Wilson

Minister for Health and Social Services

Introduction and background

Substance use is neither a medical condition nor a moral failing. The use of psychoactive substances is a normal human behaviour, occurring worldwide and its eradication in unachievable (1). For over 50 years there has been an unsuccessful war on drugs, which has attempted to achieve results through force rather than behaviour or social change. At international levels the war on drugs, and prohibitionist and zero tolerance approaches continue to be challenged from multiple angles (2) (3) (4) (5) (6) (7). In large this is due to the lack of success and unintended consequences of previous policies and approaches.

In 2016 the United Nations General Assembly (UNGASS) stressed the need for United Nation member states to adopt a public health, human rights and development-oriented approach to drug policy (3). Instead of continuing to promote punitive approaches, UNGASS urged UN member states to consider the proportionality and alternatives to criminal punishment for drug offences. This approach was something Jersey began exploring some 17 years ago, after seeing our own lack of success with strong punitive approaches (1).

Substance use includes legal substances such as alcohol and medicines which may or may not be used appropriately. A balance needs to be struck to ensure medicines are accessible to those who need them and restricted from those who do not.

Viewing alcohol and drug use separately can be counterproductive. The idea that drug use is immoral, dangerous or a social evil has led to heavy enforcement and eradication-focused policies (2). These policies in turn strengthen the incorrect assumption that drugs cause more harm than alcohol, to individuals and society (2). When ranking the harms caused by substance use, alcohol is shown to cause more harm than most illegal drugs (8).

Bringing all substance use together, along with the different types of use, into a single strategy allows us to address multiple problems at once. This can be achieved through targeting shared underlying risk factors and being aware of displacement effects where reduction in one substance can lead to rises in another. For many substances, long-term harms often go unmissed until they become significant problems later in life. It is therefore important to consider the use of different substances across the life course.

Focusing on evidence over ideology leads us towards a better understanding of substance use, the effects it can have, and how to respond successfully. This in turn will ensure we create a society which helps where help is needed.

Types of substances

Substances may be divided into psychoactive and non-psychoactive substances. Psychoactive substances are those which affect thoughts, feelings and behaviours in some way. Psychoactive substances can be grouped into seven distinct types based on their effects (9):

1. Stimulants
2. Empathogens
3. Psychedelics

4. Dissociatives
5. Depressants
6. Opioids
7. Cannabinoids

The only non-psychoactive substances included in this strategy are what are known as Image and Performance Enhancing Drugs. These are used to improve physical appearance, and to increase physical strength and ability (10). They include anabolic steroids, human growth hormone, human chorionic gonadotrophin and others that promote weight loss.

Patterns of substance use and why people use substances

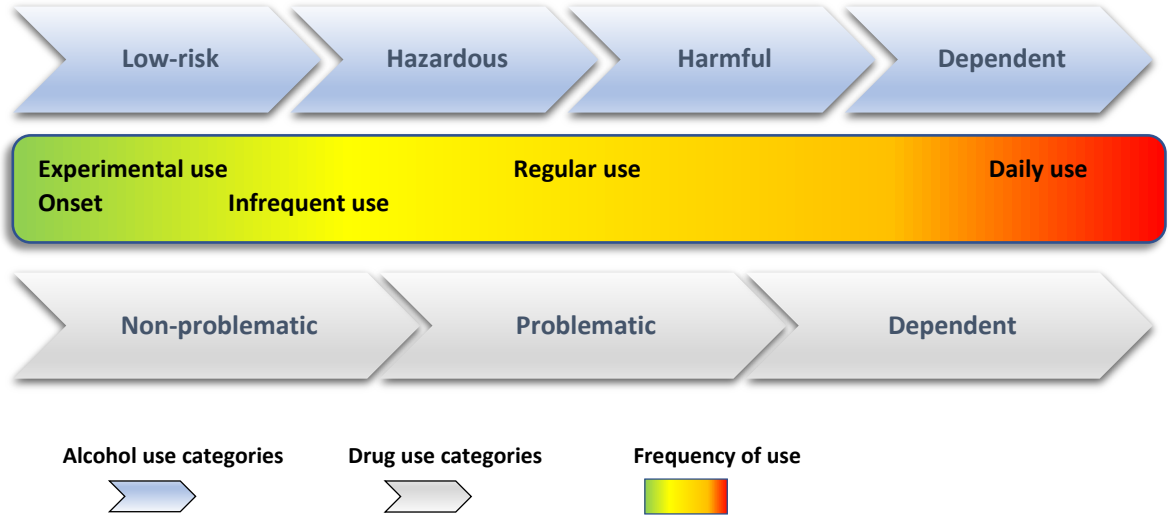
There is no single approach to defining patterns of substance use. Attempts to do so tend to vary depending on the substance, whether the focus is risk or behaviours, and whether it is to assess the individual or societal problem. Most methods do however tend to frame substance use as a spectrum in which harms can occur at any point, which is the approach taken in this strategy.

In Jersey, patterns of alcohol use are typically described as low risk, hazardous, harmful, or dependent, due to the categorisations used in population surveys and health settings.

Patterns of drug use are categorised as non-problematic, problematic, or dependent. This is largely due to the lack of pre-established risk limits with illegal drugs and the diverse effects of different drugs when trying to assess overall use. Instead, drug use is often assessed on the severity and impact of the problems caused to the individual. This categorisation system of non-problematic, problematic, or dependent use is therefore useful in describing all types of substance use.

In non-problematic use, sometimes called sporadic or recreational use, intake is moderate and sporadic, alongside other recreational and lifestyle activities. In problematic use, consumption intensifies, becoming more sustained and more frequent. As a direct effect of problematic use, social and personal function decreases and destabilises. Dependent use includes instances of substance use disorders, where substance-related activities are now the primary focus of the individual. A visualisation of this can be seen in Figure 1.

Figure 1. Categorisation of substance use



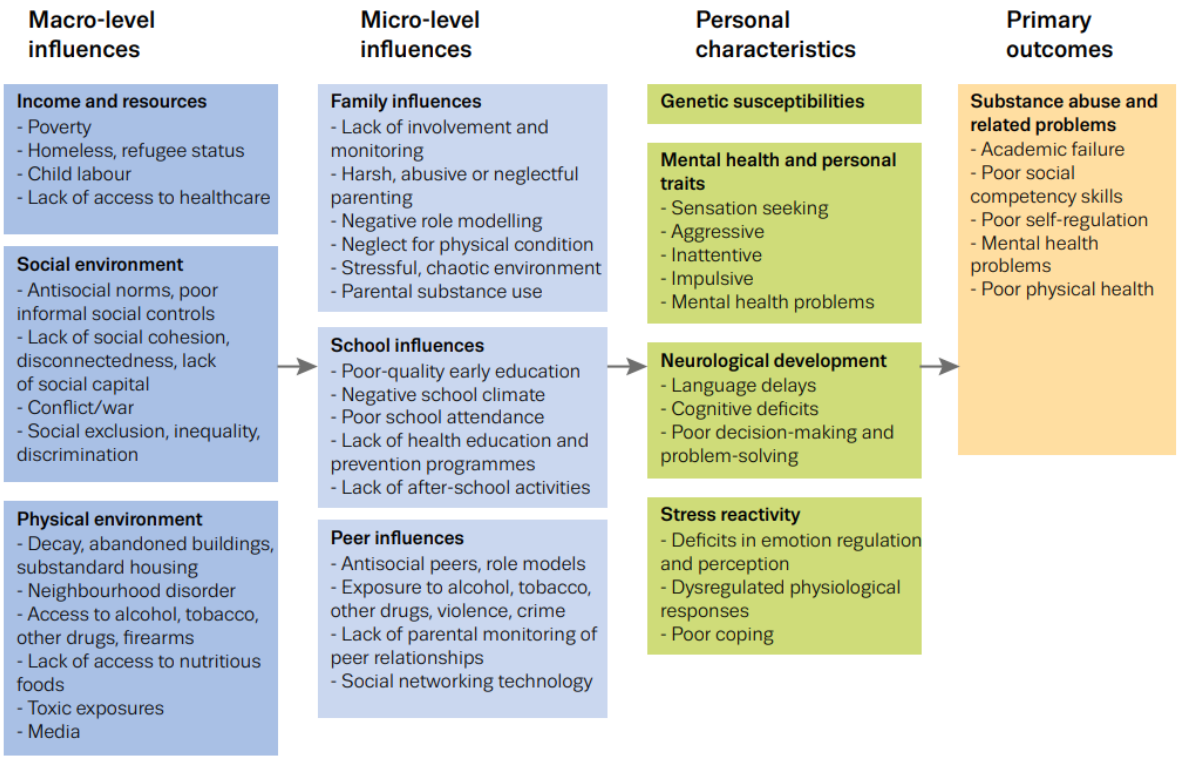
The more we understand the contexts of substance use and the associated risk factors, the

more successful responses will be. This is why it is unhelpful to think of all illegal drug use as abuse or misuse while paradoxically accepting alcohol and tobacco use. Such lack of distinction also makes it difficult to understand the factors that contribute to problematic, non-problematic and dependent use.

Risk factors for substance use and its progression

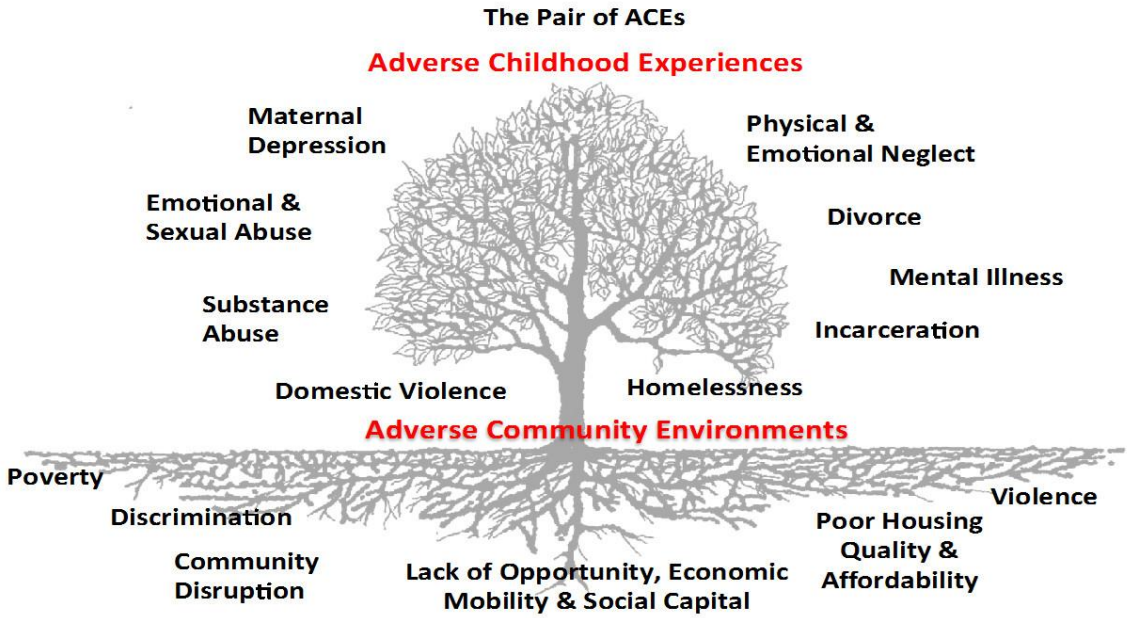
Substance use typically begins in late childhood or adolescence (11). Its onset is not driven by a single cause but by numerous interacting factors. These include personal characteristics, micro-level influences of social and interpersonal interactions, and macro-level environments including community, institutional and societal factors (11). The European Monitoring Centre for Drugs and Drug Addiction identifies a range of risk factors that can be reduced by preventive interventions (11). This is reproduced in Figure 2.

Figure 2. Risk factors that can be reduced by prevention interventions (11)



An overlapping framework already in use locally is the Pair of ACEs model (12), as demonstrated in the Children and Young People Emotional Wellbeing and Mental Health Strategy (13). A visual overview can be seen in Figure 3, which summarises Adverse Childhood Experiences and Adverse Community Environments. Adverse Childhood Experiences are potentially traumatic experiences occurring in those aged under 18; they are often grouped into abuse, neglect and household or social dysfunction. Experiencing four or more of these in childhood - compared to none - significantly increases the risk of health and social problems later in life, many of which are risk factors for the next generation (14). This includes higher rates of problematic and dependent alcohol and drug use. Preventing these experiences from occurring and supporting those with past trauma are key targets for sustainable prevention and improved Public Health. In addition, sources of resilience and strengthening risk factors have been shown to offset the harms from Adverse Childhood Experiences (15). Additionally, prevention efforts using these models result in other positive outcomes.

Figure 3. Pair of ACEs tree (12)

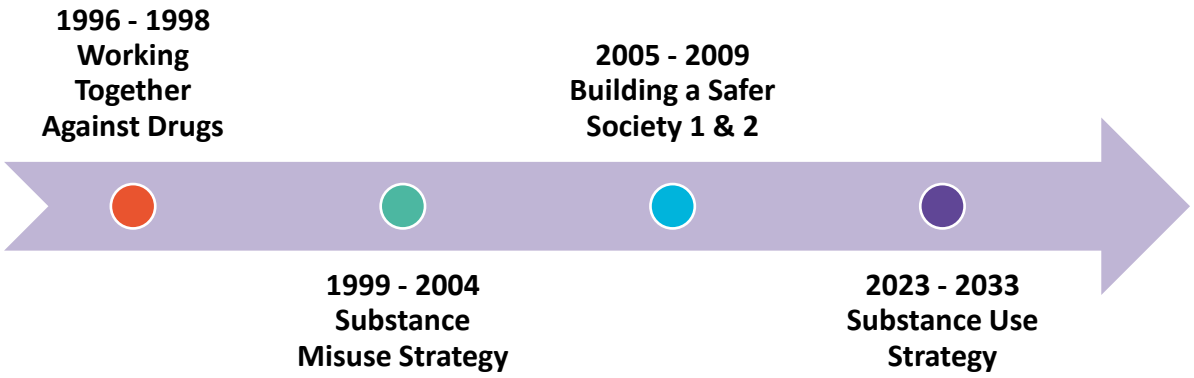


Adverse Community Environments represent systemic social factors that overlap with the wider determinants of health. When combined with Adverse Childhood Experiences, their negative effects are compounded. The sheer scale and breadth of risk factors presented so far reflect the complexity of this public health problem and the need for a broad and collaborative approach.

Previous strategies and recent progress

The Government of Jersey has always been committed to reducing illegal activity, reducing the harm caused by alcohol, drugs and crime. A chronology of previous strategies can be seen in Figure 4. In 1996 emphasis was placed on working collaboratively across government and with the third sector to reduce the harm cause by illegal drugs. By 1999 this approach was expanded to address the harms of alcohol, drugs, tobacco, prescribed medicines, solvents and anabolic steroids. During this time distinctions were made between people dependent on drugs in possession of personal amounts and people who trafficked drugs for profit for the first time. This distinction set the groundwork for a range of new interventions to divert people from the criminal justice system into the health system. In 2005, problematic substance use and community safety were combined for the first time in a strategy titled Building a Safer Society (BaSS) (16). Following its success, the strategy was relaunched in 2016 as BaSS 2 (17), with the intention of delivering an even wider range of interventions. Although largely successful, not all of the planned deliverables were fully realised. A lack of monitoring and disbanding of the overseeing strategic group impeded progression. The sudden onset of the COVID-19 pandemic added further delays to a wide range of workstreams across government, including the evaluation of BaSS 2 and its successor's development.

Figure 4. Chronology of substance use strategies in Jersey



In the hiatus since BaSS 2, stakeholders have continued to work collaboratively to increase public safety and reduce the harms caused by alcohol, drugs, and crime. This has resulted not just in the continuation of past commitments, but also delivery of the following interventions:

1. Expanding support for young people through a second young persons' substance misuse worker, to engage with young people at risk of harm from alcohol and drugs
2. Increased alcohol support and earlier intervention in the third sector
3. Community-based distribution of naloxone, which is a medication to reverse opiate overdoses and save lives
4. Delivery of a specialised trauma pathway to support Islanders with Adverse Childhood Experiences and other forms of trauma, including the Alcohol and Drug Service
5. Use of new buprenorphine formulations for opiate substitution therapy to prevent inappropriate use and diversion to the illicit market. This also includes a longer-acting depot injection which reduces the daily burden to both services and service users.
6. The introduction of Operation Shark, an initiative to disrupt the supply of drugs
7. The reintroduction of a pro-active Drug Squad to focus primarily on targeting organised drug crime
8. Revised Attorney General guidance for Centeniers regarding personal amounts of certain controlled drugs. Following arrest for drugs possession, this guidance is used to divert people away from court appearances and criminal records to Parish Hall Enquiries
9. Prison reform, including a new Seven Pathways approach to reduce reoffending by addressing the wider needs of prisoners through working across government
10. The Positive Steps project by Probation which gives young people the opportunity to learn a wide range of new skills through collaborative partnerships.

Despite the general success of previous strategies there is now a range of new government commitments which requires more than an extension of BaSS 2. A changing drug landscape and the advancement of drug policies globally also indicate the need for a fresh approach.

Towards a health and social based approach

The subtitle Substance Use Strategy was selected to reflect:

1. The range of legal and illegal substances the strategy encompasses
2. The reasons why people use alcohol and drugs while noting not all drug use is automatically misuse or abuse
3. The importance of addressing the ways in which substances are used as these behaviours are often more harmful than the substance itself
4. The different types of use

So called health and social based approaches to substance use are actions and interventions that address use and associated health and social harms as the main priority. These can prevent use, reduce deaths, disease, dependency and address wider social issues such as healthcare access, unemployment, homelessness and inequalities (18). This definition does not specifically include actions taken to enforce laws or to reduce the supply of drugs. This does not imply law enforcement is unimportant, but only that it is secondary to health.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines the key principles for health and social approaches (18) as follows:

1. Be respectful of human rights, including the right to the enjoyment of the highest attainable standard of physical and mental health, and the right of people who use drugs to give informed consent to treatment
2. Respect ethical principles, including informed consent, confidentiality, and equity of access
3. Promote service user and peer involvement in service design and delivery
4. Be based on an assessment of needs and tailored to the specific requirements of the target population
5. Respond to cultural and social characteristics, including gender issues and health inequalities
6. Be well designed, evidence-based, monitored, and evaluated

These key principles have influenced the planning and development of this strategy and they will be used to shape its ongoing delivery. Keeping the emphasis on health, this strategy has also been aligned to the Health and Wellbeing Framework (19) to achieve a systematic and collaborative approach to ensure sustainable wellbeing. To do so includes placing an emphasis on prevention and early intervention, reducing health risks and improving quality of life. This process includes evidence-driven action informed by a population needs assessment. Monitoring and evaluation of this strategy is linked to the Jersey Performance Framework and other key outcomes.

The development of the strategy has been aligned to guidance on health and social based approaches to substance use from:

1. The European Centre for Drugs and Drug Addiction (11) (18)
2. United Nations (3) (20) (21)
3. International Drug Policy Consortium (5) (22)
4. Global Commission on Drug Policy (4)
5. Johns Hopkins - Lancet Commission on Drug Policy and Health (2)
6. The Society for the Study of Addiction (6).

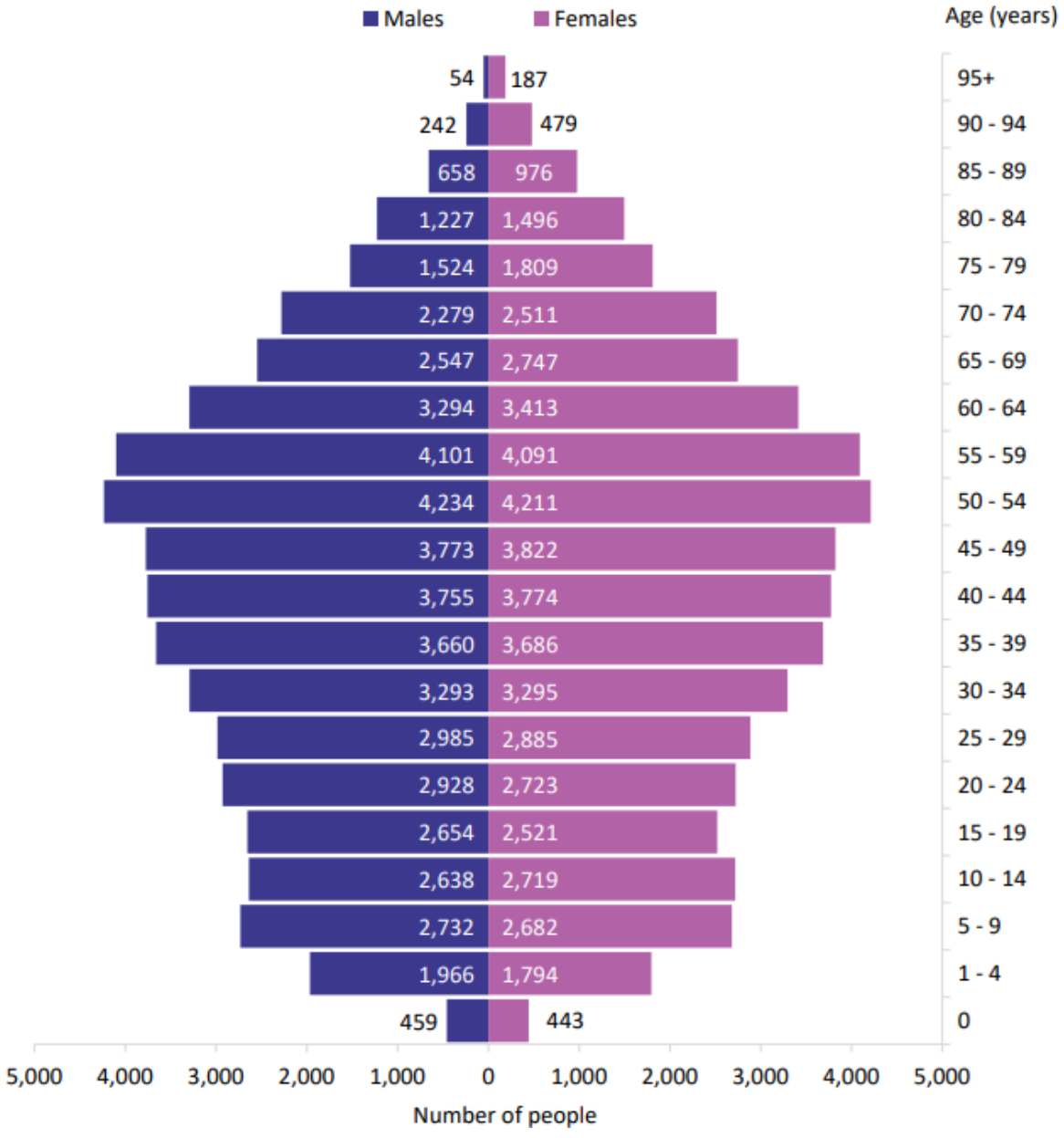
Substance use in Jersey

Population profile

On 21 March 2021, Jersey had a population of 103,267 (23). This represents an increase of 5,395 since 2011, most of which was driven by migration. Given differences in alcohol and drug consumption by nationality, the migration profile is a factor in the substance use landscape of Jersey.

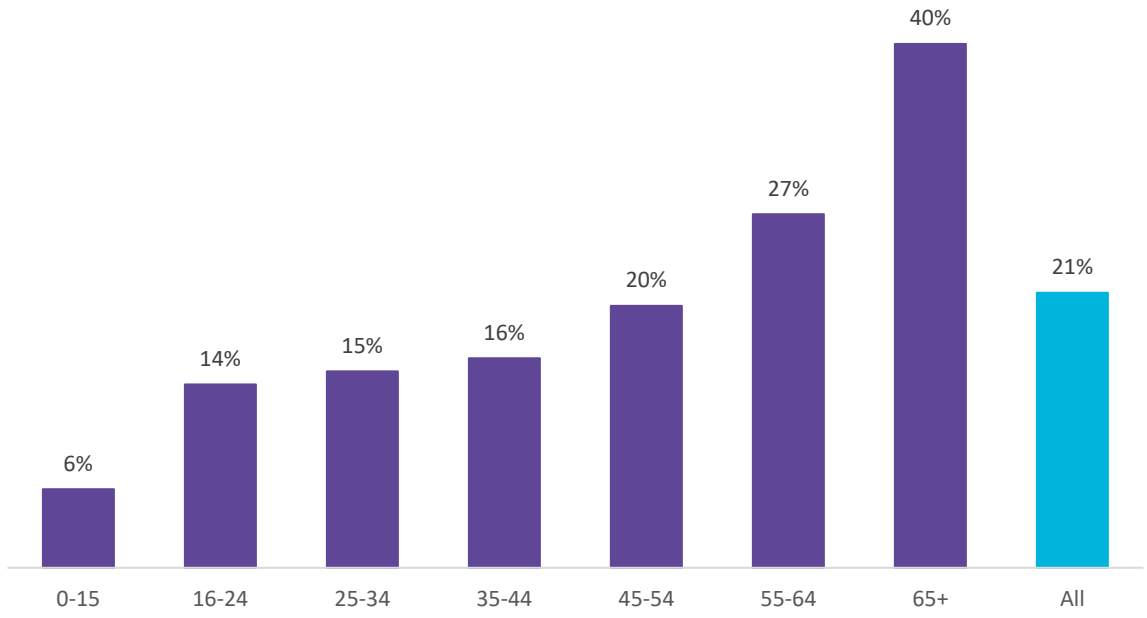
Jersey's population structure is balanced by sex but characterised by a large proportion of adults aged between 35 and 65 (Figure 5).

Figure 5. Population structure of Jersey in 2021 (23)



Around a fifth (21%) of Jersey's population have a longstanding physical or mental health condition or illness (24). The majority of this cohort are older adults, as shown in Figure 6. Considering Jersey's ageing population, this burden of disease may increase in the future. Alcohol and drug related health burdens may also increase, based on their bi-directional relationships with physical and mental health.

Figure 6. Proportion of Jersey's population in 2021 with longstanding physical or mental health conditions or illnesses, by age groups (24)



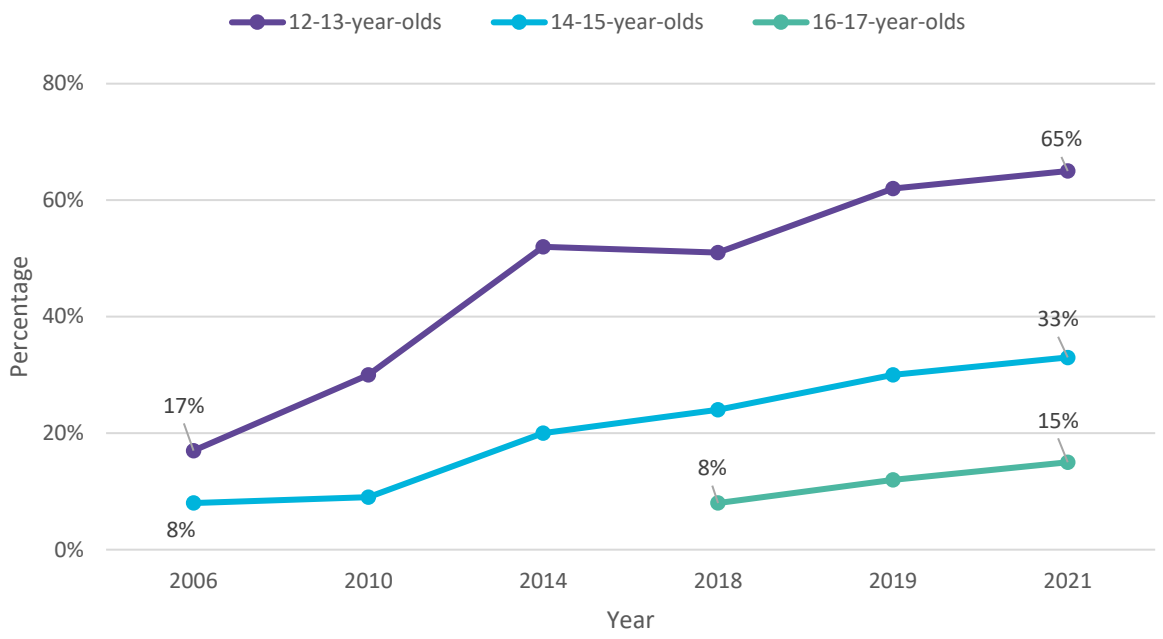
Alcohol

Prevalence of alcohol use in children and young people

The 2021 Jersey Children and Young People's Survey indicates more children are choosing not to drink alcohol (25). The percentage of 14-15-year-olds who report *never* drinking alcohol has increased from 8% in 2010 to 33% in 2021. A similar pattern can be seen in other age groups as shown in Figure 7.

The percentage of surveyed children that report drinking alcohol *regularly* or *occasionally* has trended downwards over the period 2018-2021, most notably amongst 15-16-year olds (26). However, the proportion of surveyed children reporting they drink alcohol *regularly* continues to increase sharply with age. Latest survey findings show this ranges from 4% of 14-15-year-olds, to 17% of 16-to-17-year-olds.

Figure 7. Percentage of young people reporting they have never drunk alcohol (26)



The reasons for these positive changes are unclear. Stakeholders have suggested these trends may be partly due to the influence of social media and the promotion of healthy lifestyles changing social norms. However, given the lack of data on occasional and regular drug use, a displacement effect from alcohol to drug use is possible and should not be discounted.

In April 2020, Minimum Unit Pricing (MUP) came into effect. This ensured alcohol sold in off-licences was no cheaper than 50 pence per unit. MUP is known to have more of an effect on cheaper alcohol. This includes spirits and ciders which were the most popular alcoholic drinks reported by children and young people in 2021 (25). The local impact of MUP on children and young people is not yet known due to the timescale involved and overlapping effects of the COVID-19 pandemic during MUP's introduction.

Prevalence of alcohol use in adults

In 2022 most adults in Jersey (87%) reported drinking alcohol in the previous year (26). While only 13% of adults in Jersey reported being abstinent compared to 21% in England. This is likely due to a number of demographic, socio-economic and alcohol policy differences. Reported past year abstinence amongst young people in Jersey (16-34 year olds) has changed the most dramatically in recent years. This has almost doubled from 8% in 2014 to 15% in 2022.

Latest available data on expectant mothers indicates that 75% report drinking alcohol to some extent before their pregnancy (26). On delivering a baby only 2% report drinking alcohol, of which most report drinking only small amounts or only occasionally. It can be difficult to accurately measure drinking in pregnancy as those doing so may feel guilt or stigma and be less likely to report it. In addition to more accurate measurements more work is required locally to fully understand the impact of alcohol use during pregnancy on an unborn child.

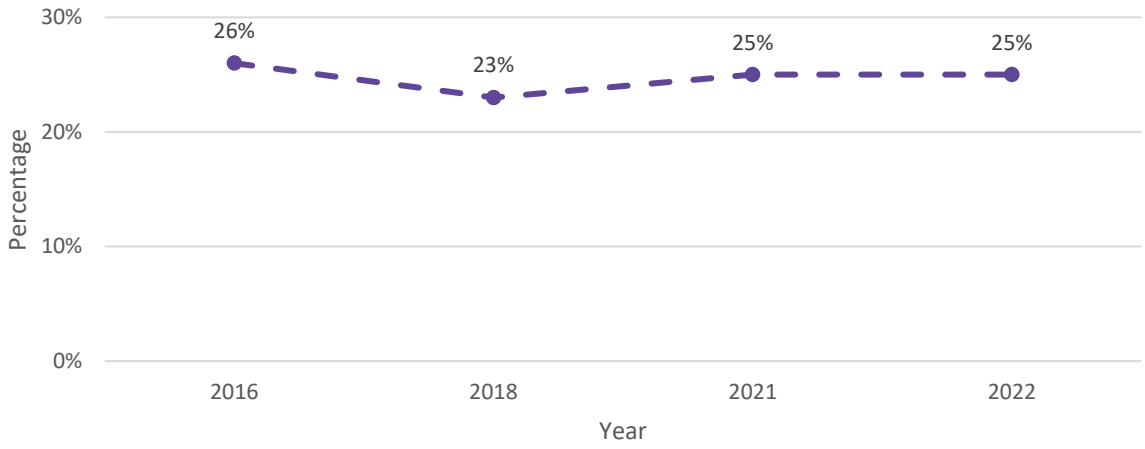
Binge drinking 8 or more units if male or 6 or more units if female at a frequency of monthly or more has stayed relatively constant from 2014 (34%) to 2022 (33%). Likewise the percentage of adults who report drinking more than 14 units of alcohol per week has

remained similar from 18% in 2016 to 20% in 2022 (26). Although this percentage did rise slightly in 2020 it has since returned to similar levels.

Latest data also shows data shows that 29% of males and 10% of females report drinking more than 14 units weekly (26). There were no significant differences between groups when stratified by household income, tenure or employment status. However, when stratified by age the percentage of adults reporting exceeding the recommended weekly intake was highest amongst 45-64-year-olds.

Of all adults that drink alcohol, it is estimated that one in four (25%) are doing so at hazardous or harmful levels (26), considered as problematic use. The rate of problematic use has been statistically similar since 2016, as shown in Figure 8. Increased rates of problematic alcohol use in turn increase the risk of alcohol related health and social harms. Levels of hazardous or harmful drinking are also higher in certain population groups (26). These include males aged 35 to 44, those in higher income groups and those living in qualified rental or socially rented accommodation. These findings have been relatively constant over time and reflect the importance of addressing the social determinants of health.

Figure 8. Adults in Jersey drinking at potentially hazardous or harmful levels over time (26)

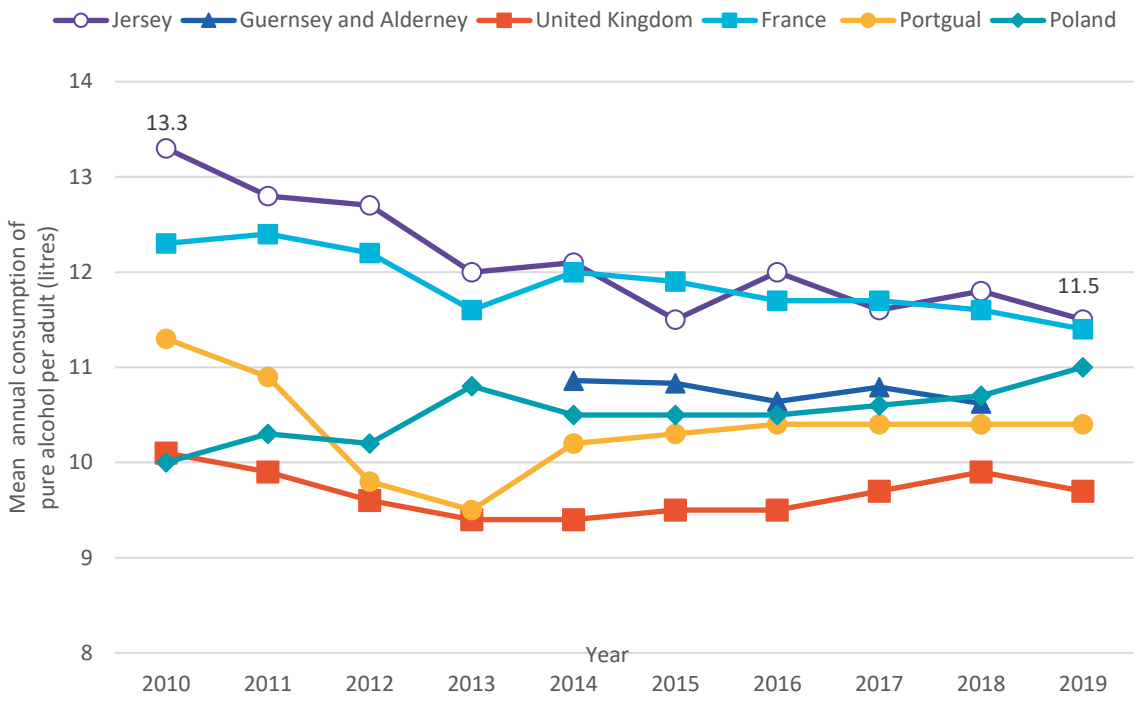


Of those who drink alcohol at potentially hazardous or harmful levels, only an estimated 3-4% drink dependently (27). Using latest population estimates (23) this equates to roughly 3,100 to 4,100 Islanders, although the true number could be higher. True prevalence of alcohol dependence is often difficult to ascertain. This can be due to stigma in that those who are dependent may be less likely to report their use truthfully when asked. It should also be noted that household surveys are not sent to residential institutions which typically house people with complex needs, such as alcohol dependency. This can in turn lead to the under-reporting of those who are alcohol dependent.

Overall population level consumption

In 2022, alcohol consumption per adult in Jersey was 12.0 litres of pure alcohol per year (26). This places Jersey as the second highest for alcohol consumption in OECD countries during 2022 using latest available data (26). This is equivalent to each Islander over the age of 15 drinking approximately 2.6 bottles of wine, 8.1 pints of strong beer or over half a bottle of spirits per week. From 2010 to 2019 Jersey's level of alcohol consumption was higher than other OECD countries which typically make up the majority of Jersey's population demographic (Figure 9).

Figure 9. Mean annual alcohol consumption per adult over time in Jersey and selected OECD countries (28) (29) (30)

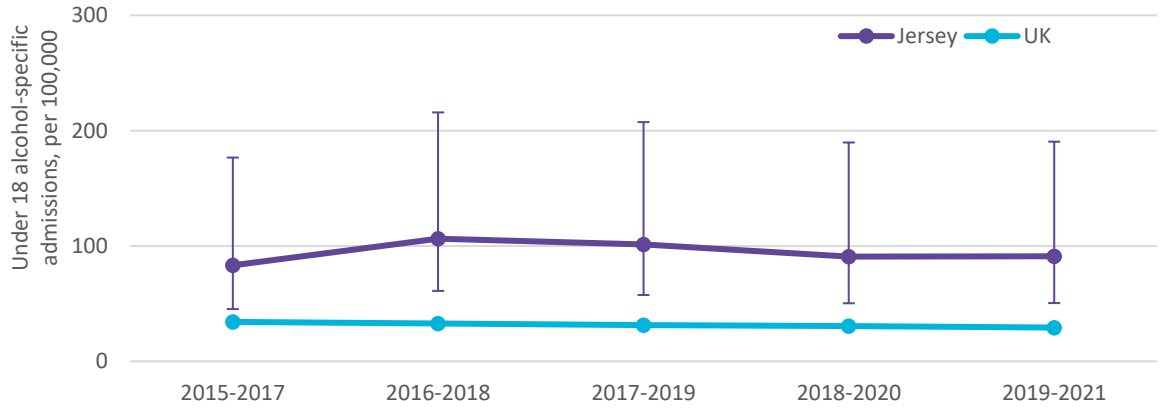


Harm related to alcohol use

Alcohol specific hospital admissions of under 18s

Over the three-year period 2019-2021, there were 51 admissions to hospital of under 18-year-olds with a primary or secondary diagnosis for an alcohol-specific condition (26). Over the same three-year period the crude rates for alcohol-specific hospital admissions of under 18s in Jersey overall were higher than in England. As Figure 10 shows these rates have remained similar since the 2015-2017 period. Historically in Jersey only a very small percentage of under 18-year-olds have multiple alcohol-specific hospital admissions each year.

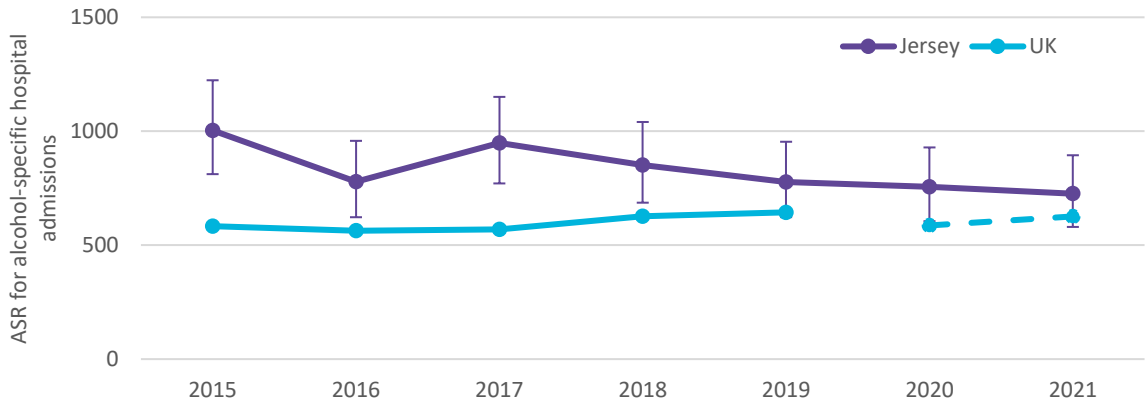
Figure 10. Under 18s alcohol-specific hospital admission rates (population age standardised) per three-year interval: England and Jersey (26)



Alcohol specific hospital admissions of whole population (age standardised rate)

In 2021, there were 765 hospital admissions specifically related to alcohol (26). This equates to an age-standardised rate of 725 episodes per 100,000 population. over the period 2015 to 2021, the age-standardised admission rate for males has reduced from 1,555 to 975 admissions per 100,000 population (26).

Figure 11. Age standardised rates of alcohol-specific hospital admission for Jersey and England (26)



Admissions data from Jersey General Hospital from 2015 to 2019 show a reduction in the number of hospital admissions due to alcohol withdrawal. Earlier community-based intervention efforts and expanded alcohol support provision through the Alcohol Pathway Team are likely to have contributed to this.

Deaths caused by alcohol

Alcohol-specific deaths

Around 2% of all deaths in Jersey annually are caused by alcohol (31). From 2019 to 2021 there were around 30 deaths directly due to the consumption of alcohol. Over the same three year period the age standardised rate of alcohol-specific deaths per 100,000 population in Jersey was 10.9, statistically similar to the rate in England in 2017-2019 of 10.9 per 100,000 population (26).

Alcohol-related deaths

In 2021, around 35 people died from alcohol-related causes such as fibrosis and cirrhosis of the liver. This equates to an age-standardised rate of 32.4 deaths per 100,000 population (26). Rates of both alcohol specific and related deaths were higher for males than females. The higher rate of per capita consumption and lower level of alcohol abstinence in Jersey is likely to be factors in this. Most deaths linked to alcohol are connected to the frequency and amount of alcohol consumed over time. As a modifiable behaviour, a population level reduction of alcohol consumption can lead to a reduction in mortality.

Crime related to alcohol use

Alcohol played a role in almost one in six (19%) of all crimes recorded in Jersey in 2022 (26). Around 3 in 10 (32%) assaults and serious assaults, one in nine (11%) of domestic assaults and almost one in four (23%) of offences in the St Helier night-time economy involved alcohol (26). The percentage of all crimes involving alcohol has trended downward from 23% in 2016 to 15% in 2022.

Crimes associated with the night-time economy (NTE) are those occurring between 8pm and 4am, in or outside of licensed premises, commercial premises or on the street within the parish of St Helier. Between 2020 and 2022, 23% of crimes in the NTE involved alcohol (26). This is a decline from 32% of crimes in the NTE involved alcohol reported in 2018 and 2020 (28). The two most common crimes in the NTE over the period 2020 to 2022 were common assault, of which 23% involved alcohol, and grave and criminal assaults of which 32% involved alcohol (26). Crime in the NTE in general reduced significantly during the pandemic but increased during 2021 (32). Offences in the NTE during 2020 were at their lowest annual level since offences were classified in this way. For the two lockdown months of April and December 2020, there were a total of four recorded offences in the NTE (33). Seated service as a mitigation for COVID-19 is thought to have had an unintended positive impact on reducing the level of intoxication and alcohol related incidents on licensed premises.

Alcohol policy

Alcohol is regulated under the Liquor Licensing Law (Jersey) 1971 and ensures only licence holders can supply alcohol. Liquor licences are issued by a Licensing Assembly consisting of the Attorney General, Bailiff and Jurats. The Attorney General issues robust licensing guidance on pricing and marketing, which includes:

1. Preventing on-licence price promotions such as happy hours, and buy one get one free deals
2. Limiting variation in alcohol prices to no more than 10% across on-licence establishments
3. Ensuring Seventh Category premises focus their advertising on entertainment
4. Ensuring off-licences – except duty-free retailers – sell alcoholic drinks at a price no lower than 50 pence per unit

This guidance, along with increases in *impôt* duty, reflect a shared desire to reduce alcohol-related harm using fiscal policies. Regulating both alcohol price and promotions is deemed an effective way for governments to reduce consumption and alcohol-related harm. This approach is recommended by the World Health Organisation (34).

In contrast to price regulation, limiting the accessibility of alcohol can be considered a less utilised intervention in Jersey. High alcohol outlet density, defined as having a high concentration of retail alcohol outlets in a small geographic area, is an environmental risk factor for excessive drinking and alcohol-related societal harms (35). With over 700 alcohol licences in Jersey, this could be considered high given population and geographic size. Reducing density and availability to under 18s and intoxicated people, through strict enforcement of licensing laws, are deemed beneficial (36). The benefits include reduced consumption, alcohol related harms, assaults, and vehicle accidents (36).

Alcohol licensing reform

Both the Government Plan 2021-2024 (37) and Government Plan 2022-2025 (38) made commitments to reduce harmful alcohol consumption. This includes considering financial and economic positions alongside advice from Public Health regarding excise duties on alcoholic drinks. Despite this, and earlier commitments towards Sustainable Wellbeing in which alcohol is considered a harm to health and children, alcohol and licensing policy have remained largely unresolved. Previous proposals for a new alcohol licensing strategy have been built around the following:

1. The Licensing (Jersey) Law 1974 being deemed ineffective and outdated

2. Policy responsibility is complex, spread between the government and a Licensing Assembly of the Governor, the Bailiff and Jurats, acting as the determining authority for liquor licence applications
3. Criticisms of the current system include legal complexities, inflexible licence categorisation, unfair fee structure, and its limited contribution to reducing problematic alcohol consumption

Previous proposals have included:

1. Producing a draft statement of alcohol licensing policy which as a minimum addresses price, availability, advertising, and promotion
2. Resolving licensing issues such as authority, categorisation, and fee structure
3. Facilitating the States Assembly to take a greater responsibility for developing evidence-based alcohol policy with support from Strategic Policy, Planning and Performance (SPPP), including Public Health, and Department for Economy

Previous draft liquor licensing law proposals have made several recommendations which are consistent with a health and social based approach. This includes five equally weighted statutory licensing objectives which aim to balance health, crime, and economic activity (39). These are:

1. To help reduce alcohol-related crime and disorder
2. To better secure public safety
3. To help prevent public nuisance
4. To help protect children from alcohol-related harm
5. To better protect and improve public health

It should be noted that these recommendations were developed prior to the relevant Government Plans, Sustainable Wellbeing, and this strategy.

Continuing work in this area is needed to resolve long-standing issues and balance the competing interests of licence holders and the economy, with the negative effects of alcohol.

Drugs

Less is known about drug use in Jersey. Data from the Jersey Children and Young People's Survey (25) and the States of Jersey Police Annual Reports (32) exists, along with information from a small number of other sources.

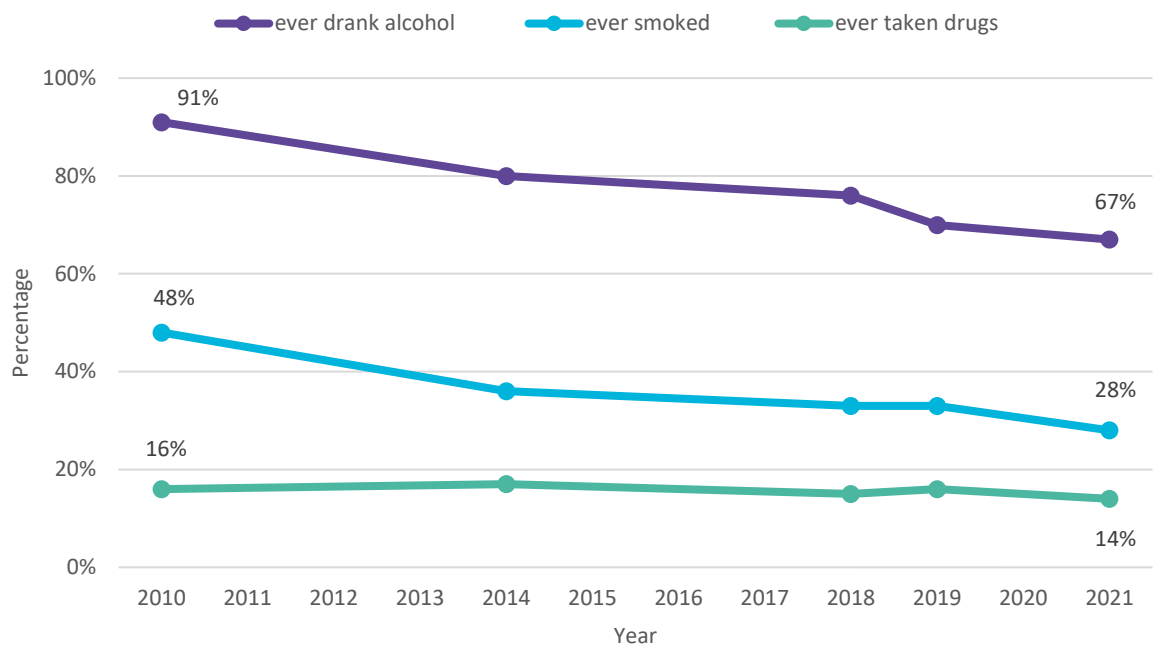
Prevalence of drug use in children and young people

In 2021, 28% of surveyed young people reported they knew someone that they thought took drugs (25). This fell from the 38% noted in the 2019 and 2018 surveys, perhaps due to lack of supply during the COVID-19 pandemic. The 2021 rate at which young people were offered cannabis (22%) and other drugs (11%) is relatively consistent with previous survey findings.

Results from the Children and Young People's Surveys show ever reported drug use has remained relatively stable in comparison to declining trends in alcohol and smoking (Figure 12).

Like alcohol use, ever reported drug use increases with age group. In 2021 this was 1% of 12-13-year-olds, 14% of 12-13-year-olds and 27% of 16-17-year-olds (25). Increased substance use with age is consistent with previous survey findings and is a common target in prevention science (11).

Figure 12. Reported substance use in 14-15-year-olds in Jersey over time (25)



It should be noted that alcohol, tobacco and vaping products are regulated substances which are amenable to the use of population level interventions to actively reduce use. These include MUP, legal age limits and the strict enforcement of ID checks at point of sale. Illicit substances lack these controls and the growth of online drug markets, including through social media, has increased children and young people's access to drugs. Drugs may also be sourced online in smaller quantities, making them more affordable. Online drug markets rely on payment up front which reduces the possibility of drug debts, allows greater anonymity and distances the buyer from locally known criminal networks.

When traditional offline drug markets are used by young people locally there is a risk of further exploitation. This can include trapping young people into drug debts and then using threatening behaviours to coerce young people into importing or supplying drugs to others to clear debts. The occurrence of this behaviour has been deemed rare by stakeholders, but of great concern.

Types of drugs taken by children and young people

Cannabis remains the most common illicit drug taken by young people (25). In 2021, 11% of 14-15-year-olds and 23% of 16-17-year-olds reported ever using cannabis (25). These rates were similar at 13% and 28% respectively in 2018. Although encouraging, there is evidence of displacement of cannabis by synthetic cannabinoids. During the 2018 to 2021 period, self-reported synthetic cannabinoid use increased. In 2018, 2% of 14-15-year-olds and 4% of 16-17-year-olds reported ever using synthetic cannabinoids; by 2021 this had risen to 13% and 25% respectively. Synthetic cannabinoids are generally stronger than natural cannabis and are linked to higher rates of addiction and psychosis, with deaths remaining a rare occurrence.

School survey data from 2018, 2019 and 2021, along with other government intelligence, suggests an increasing trend in past-month use of MDMA and LSD. Given the small numbers involved, the data quality and significance of these findings should be treated with caution. The inappropriate use of volatile solvents, such as lighter fluid, appears to be rare in

young people. Similarly, although there is evidence of nitrous oxide use in children in young people, this is not considered widespread.

Harms related to drug use

Adverse events related to substance use reported by young people

In 2019, 15% of 14-15-year-olds and 12% 16-17-year-olds reported ever experiencing an adverse drug event (40). Findings for boys and girls were similar. The most cited events included panic attacks, anxiety, loss of consciousness, paranoia and depression.

Deaths linked to drug use

Since 2010, drug specific deaths in Jersey have remained low, with five or less deaths occurring annually. Over the last 10-year period there has been a similar proportion of deaths between males and females and across different age groups. However, due to the low numbers involved and data quality issues it is difficult to infer meaningful trends.

MDMA was noted as being involved in the greatest number of drug related deaths in Jersey over the past 10 years. Deaths linked to drugs over the last 10 years have also often involved more than one substance, including alcohol and prescription medicines. This makes it difficult to ascertain the exact role of individual substances.

The relatively low number of drug related deaths in Jersey is likely due to the continued emphasis on harm reduction as a response to drug problems. Needle exchange services, opiate substitution therapy, early intervention with at-risk groups and self-referral to treatment services are all known to contribute towards reducing drug deaths. However, interventions targeting MDMA use and associated harms are lacking in comparison to other substances.

Crime related to illegal drugs

By virtue of being illegal to produce, import, possess and supply, drug related crime differs to that for alcohol. Cannabis is regularly the most frequent drug seized annually by both States of Jersey Police and Jersey Customs and Immigration Service. Unlike alcohol, cannabis and other drugs are not generally considered a significant contributing factor to crimes in the NTE, serious assaults, or domestic abuse. Possession of a controlled substance constituted 5% of all arrests in 2021 (32) and 6% of all crimes in 2020 (33).

Of all drug-related crimes from 2010 to 2019, at least 54% involved cannabis. Of the crimes involving cannabis, 9% were possession and supply offences. The number of drug related cases have reduced year on year from 138 in 2016, to 112 in 2018. Possible explanations include a reduction in drug demand and by extension activity and an increase in the number of undetected crimes. The latter appears to be on account of the launch of Operation Shark in 2020 and the reinstating of Drug Squad in 2021.

Inappropriate use of medicines

Stakeholders have reported that prescription medicines continue to be used inappropriately in Jersey. This includes exceeding prescribed doses, using medicines prescribed to others including medicines imported from the UK and Europe for illegal onward supply. These medicines commonly include opiates, benzodiazepines, gabapentinoids and - to a lesser extent - sleeping tablets. Over the counter medicines typically containing codeine are used at times when other opiates, illegal or prescription, are harder to source. This can be both for the effect of codeine itself, or to avoid opiate withdrawal.

Medication diversion, stockpiling, and over-prescribing have been identified by stakeholders as long-standing unaddressed problems. Both HMP La Moye and high-risk secure hospital wards noted a regular pattern of rebound prescribing, in which prescriptions were reduced or stopped entirely only to increase to similar or previous levels once a patient returned to a community prescriber. Reasons for this may include the mental health effects of institutional release, patient pressure on prescribers, lax prescribing practices, a lack of patient monitoring, and communication issues. At times under-prescribing, leading patients to use substances to supplement prescribed medication has been noted.

Cannabis based medicinal products (CBMPs)

In 2018 the legislation was changed to allow General Practitioners to prescribe unlicensed cannabis based medicinal products (CBMPs). Importation data and information from stakeholders suggests the use of unlicensed CBMPs such as oils and cannabis flower has increased steadily since 2020. Several medicinal cannabis clinics have been established in this period. Due to the private structure of the clinics, prescribing data is not centrally held or easily accessible by the Government of Jersey. There is however a requirement for all pharmacies to send the details of private prescriptions for controlled substances to the Chief Pharmacist on a monthly basis. This data is reviewed periodically by the Chief Pharmacist to ensure patients are not sourcing controlled drug prescriptions from multiple prescribers. The process includes – but is not limited to – CBMPs.

Importation data suggests there is more cannabis flower than oil being prescribed and used locally. Information from stakeholders indicates that more Islanders are using unlicensed CBMPs than licensed CBMPs being used off-licence.

Unlicensed CBMPs are subject to the manufacturing quality requirements as licensed medicines. This includes being manufactured in accordance with Good Manufacturing Practice by holders of a medicines manufacturing licence. However, as unlicensed medicines, these products have not been assessed by medicine regulators for safety, quality or efficacy in treating specific conditions.

The lack of regulation for and guidance around CBMPs has caused a range of concerns for stakeholders. A great deal of these concerns overlap the inappropriate use of medicines. Work on the medicinal cannabis agenda across government remains ongoing. This includes reviewing options to regulate cannabis clinics and the development of a consensus statement with guidance for professionals and the public.

Image and performance enhancing drugs

Image and performance enhancing drugs (IPEDs) cover a wide range of substances from classic anabolic steroids to human growth hormones and others (10). Jersey Customs and Immigration regularly intercept large quantities of IPEDs. Between 2017 and 2021 over 5,000 tablets and over 3 litres of IPEDs in liquid form were seized. Like all drugs, IPEDs carry both short and long-term risks, especially if injected. Anecdotal evidence indicates that some Islanders continue to inject steroids. Some local bodybuilding and contact sports competitions do not specifically ban or ask about IPED use. This may extend further to other types of sports and could be a missed opportunity to protect participants.

Impact of the COVID-19 pandemic

The COVID-19 pandemic has caused disruption to everyday life, both due to the disease itself and unintended consequences of mitigation measures. Evidence of this has been seen locally, as during the peak of the pandemic many Islanders saw their alcohol consumption increase (41). Support services described a pattern of many Islanders' drinking "moving up" a level. Some Islanders who previously drank harmfully began to drink hazardously, while those who drank hazardously began to drink dependently. As the COVID-19 pandemic subsided, these patterns appeared to return to pre-pandemic baselines. A rise in referrals to support services was also seen, but this too appears to have returned to baseline levels.

At points throughout the emergency COVID-19 pandemic phase, alcohol related crime fell. This was largely due to the closure of the NTE and differences in behaviour in the absence of stand-up drinking. It had also been noted that other crimes such as domestic abuse were reported in lower numbers during the emergency COVID-19 pandemic phase. This is significant as one third of domestic abuse cases typically involve alcohol (28).

The COVID-19 pandemic has had a noticeable effect on global drug markets, with reduced travel having a significant impact on international drug movements. At a local level customs data shows a significant reduction in drug seizures during 2020 and 2021 compared to pre-pandemic years. Before the pandemic, postal importation began increasing with air and boat importation reducing. Anecdotal evidence suggests an increase in regular but small-scale importation attempts for personal or social supply, likely linked to online drug markets.

Further evidence of a lack of supply can be inferred though the increased price of drugs in the Island during the pandemic. Intelligence suggests cannabis has exponentially increased in price from £12 to £15 per gram before the pandemic, to up to £40 a gram during its peak. Anecdotal evidence suggests a displacement effect that, during this time, the use of synthetic cannabinoids had begun to increase in younger Islanders, most likely due to lower prices and ease of sourcing when bought online. The high price of illicit cannabis is also likely to have led to increases of diverted medicinal cannabis being sold locally. In early 2022, despite a small decline in some drug prices locally, the price of illicit drugs in Jersey remained higher than in the UK. This makes the Jersey drug market an attractive target for organised crime.

Drug policy

Drug policy is best understood as a continuum (Figure 13). The common aim of criminalisation is to ensure possession of drugs, possession of paraphernalia, cultivation or production, and the supply of drugs is a criminal offence dealt with by the criminal justice system. Decriminalisation involves the removal of criminal penalties for selected activities, such as personal possession of drugs, paraphernalia and at times cultivation. Decriminalisation can also be considered *de facto* through guidance, or *de jure* through formal legislation. Legalisation is a process in which drug related activities such as possession, cultivation and supply are legal activities.

Figure 13. The Regulatory Continuum as outlined by the Canadian Centre on Substance Use and Addiction (42)

Jersey's current drug policy might be described as a kind of *de facto* decriminalisation. While the possession of drugs, paraphernalia, importation, cultivation, production and supply are offences under the Misuse of Drugs (Jersey) Law 1978, current practice allows for varying levels of diversion from the courts through the Parish Hall system. Centeniers can, under certain conditions, deal with possession of small quantities of controlled substances within the guidance issued by the Attorney General (43). This process does not lead to a criminal conviction.

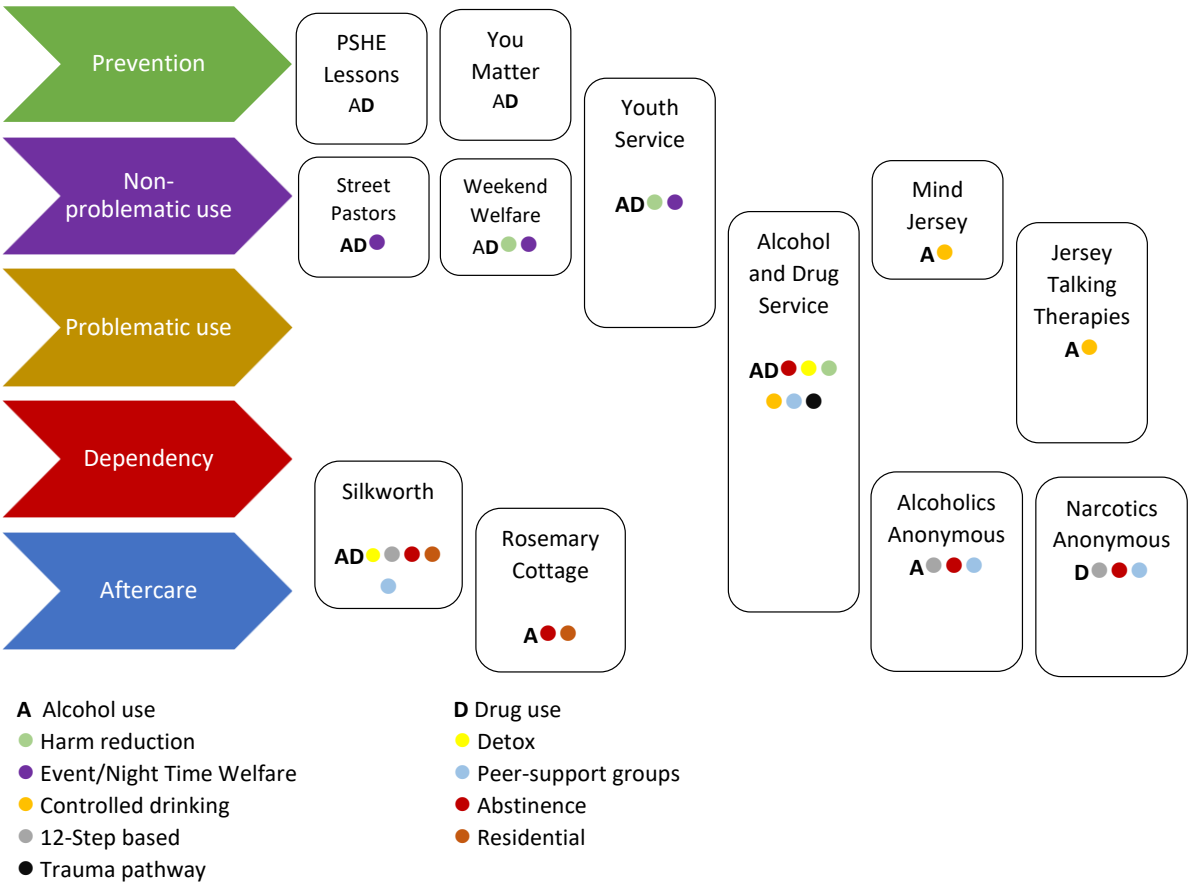
In addition, courts can also hand down community sentences utilising binding-over and probation-order treatment orders (BOTOs and POTOs). A BOTO or POTO typically involves referral to the Alcohol and Drug Service and is based on the premise of harm reduction. The treatment orders involve addressing alcohol or drug issues related to the offending behaviour.

The decriminalisation of personal drug use and the need to explore alternatives to criminalisation is becoming more widely recommended (4) (22) (6) (21) (44). At a local level there has been increased public and political interest in moving towards models of decriminalisation and legalisation.

Support service profile

There is a range of services in Jersey whose primary function is to support people who use or intend to use alcohol and other drugs. These services provide prevention and support with non-problematic use, problematic use, dependency, and longer-term aftercare. The specific interventions offered vary both between and within services and can include psycho-educational approaches, brief interventions, extended behaviour change interventions and more (Figure 14). While many of the services focus on a particular type of support, some span multiple areas. Across services there is some overlap, yet this is not necessarily negative as it provides variety and choice.

Figure 14 Map of publicly accessible support services in Jersey which primarily focus on alcohol or drug use



Islanders in the criminal justice system can also access support for alcohol and drug use at a number of points. An arrest referral worker from the Alcohol and Drug Service attends police custody regularly, and the Probation and Aftercare Service employs a specialist substance misuse worker. HMP La Moye provides alcohol and drug detoxes and employs a specialist substance misuse worker.

In addition to the above there are other community support services whose primary focus is not alcohol or drug use, but whose service users include those who use alcohol or drugs. These services generally work to support the wider needs of Islanders, such as physical and mental health, temporary and longer-term accommodation, and employment.

Stakeholder engagement

A range of methods to engage stakeholders was used to support the development of the strategy. These included holding workshops, small focus groups, meetings with service representatives, and joining meetings held by existing working groups. Paper-based “graffiti walls” and feedback sheets were used to collect insights from past and current service users.

Groups targeted throughout the stakeholder engagement process included:

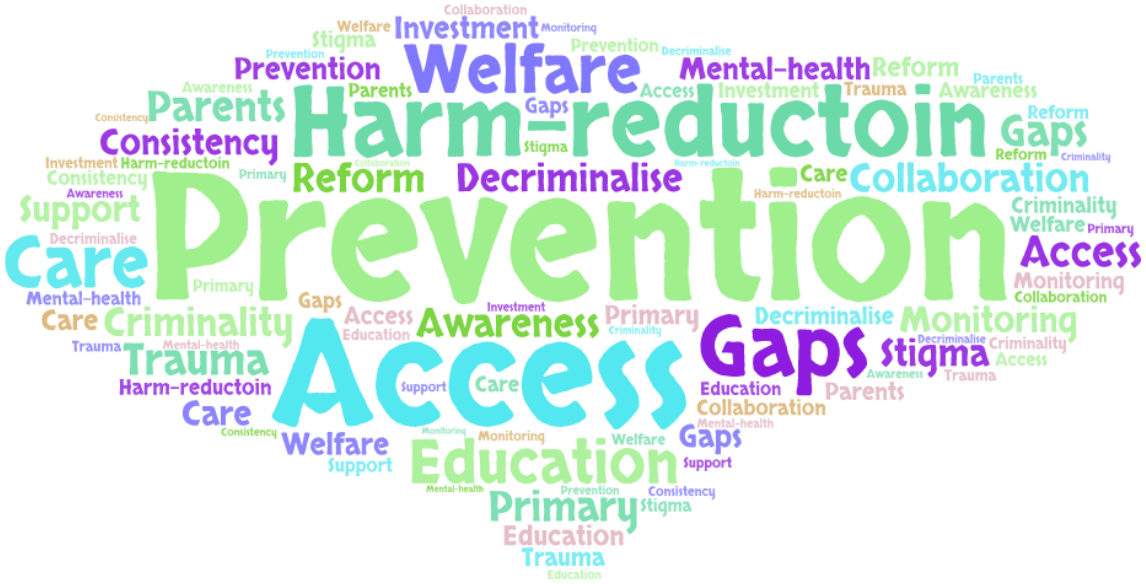
1. Young people with lived experience of substance use
2. Adults with lived experience of the criminal justice system and substance use
3. Internal Government of Jersey departments
4. Support and treatment services including third sector partners

Stakeholders who contributed to the development of the strategy included:

Advisory Council on Misuse of Drugs
Alcohol and Drug Service
Alcoholics Anonymous
Children Young People Education and Skills
Emergency Department
Jersey Customs and Immigration Service
Jersey Primary Care Body
Jersey Recovery College
Jersey Street Pastors
Jersey Talking Therapies
Jersey Youth Service
MIND Jersey
Orchard House
Probation and Aftercare Service
Sanctuary House
Shelter Trust
Silkworth Lodge
States of Jersey Police
States of Jersey Prison Service
Statistics Jersey
Strategic Policy, Planning and Performance

A word cloud showing the themes from the stakeholder engagement process can be seen in Figure 15. The key themes are then explored in detail, along with quotations (Figure 16-Figure 22).

Figure 15. Word cloud of themes identified by stakeholders



Prevention

Gaps in prevention, especially primary prevention, improving on past efforts and putting an emphasis on evidence-based prevention were commonly highlighted by stakeholders. This included moving away from fear-based tactics, the avoidance of passively giving information to young people and ensuring what was taught in education was consistent and relevant. Previous methods of alcohol and drug prevention in secondary schools were noted by several stakeholders as not being evidence based or having a demonstrated effect. Concerns were also raised about the lack of consistency in approaches and messages across past and current prevention efforts in secondary schools. No concerns were raised about alcohol and drug education and prevention in primary schools.

When discussing new approaches these typically included an emphasis on broader health and social based prevention and systemic approaches to include harm reduction, the roles of parents and professionals, and linking health and social intervention for those at higher risk. It was suggested that by preventing problematic use there would be a knock-on effect of reduced crime and health problems. Noted new approaches to explore included an emphasis on wider prevention systems, the Icelandic Prevention Model, also known as Planet Youth, social prescribing, overlapping substance use prevention with mental health, and addressing trauma and ACES in children and adults. The use of behavioural insights was also suggested as a useful tool for both prevention and harm reduction.

Figure 16. Stakeholder quotations on the theme of prevention

"We need evidence-based prevention that actually works"

"Replace risk taking behaviour via [alcohol and drug use] with managed risk in organised activities"

"[we should] adopt something like the Icelandic Model"

"[we need to] reduce and prevent Adverse Childhood Experiences - neglect, abuse, household and social factors"

"[we need a] whole systems approach"

"…it doesn't work [previous prevention efforts], if it did, we wouldn't be sat here now!"

"therapeutic work for young people using outdoor activities as a way to engage and educate"

"we need to focus on the addressing the causes of problematic use, to prevent health and crime problems. Otherwise we will keep going around in circles arresting and treating people"

Harm reduction

The need to improve harm reduction measures was a common theme. It was generally felt that the harms of substance use should be the priority over use itself within the new strategy. This was so much so that forced abstinence as an approach was only discussed as a factor that increases the risk of harm. A range of individual harm reduction measures were highlighted during discussions, some of which were missing locally. These included multi-agency drug checking services, which combine drug analysis and disposal with an individually tailored brief intervention. More generically it was a suggested MDMA harm reduction was a growing need. At times, harm reduction and health promotion interventions were possibly deemed unimplementable due to Jersey's Misuse of Drugs Law which prohibits possession of utensils for the purposes of committing an offence.

Figure 17. Stakeholder quotations on the theme of harm reduction

"Reducing harm should be the priority"

"Increase naloxone provision (put it in publicly accessible places)"

"Lack of education and harm reduction in schools"

"I went to [UK festival] last year and they had harm reduction and drug checking which makes sense as its where people use these drugs"

"Harm reduction and opiate maintenance is why our deaths are so low. This idea of forced abstinence only increases the risk of overdose and deaths as they have no tolerance and aren't ready to stop completely, we need to keep people alive and in contact with services"

"…the drugs law stops us from giving out anything other than needles due to being classes as drug paraphernalia, theres's so much more we could and should be doing"

"knowing dosage is important but we'd be encouraging someone to break the law if we recommended them buy scales"

Decriminalisation and negative effects of criminal records

The topic of decriminalisation of personal possession regularly surfaced. Common reasons were due to criminalisation being a barrier for accessing support, a cause of stigma, and a longer-lasting social harm than that of the substance itself. It was specifically suggested on more than one occasion that the harms of a criminal record be addressed, which in a small island were problems felt to be particularly damaging. Accessing higher education and professional training courses and gaining or maintaining employment were raised as impacts of a criminal record. Incarceration for non-violent drug offences such as drug trafficking was also suggested to disproportionately affect more females. Female prisoners were noted to have had traumatic backgrounds, problematic substance use and be victims of domestic violence. It was felt these factors made them more vulnerable to coercion into drug trafficking. It was noted that UK law allows protection and diversion from criminal justice system of people coerced into illegal drug activity, including young people.

The lack of acknowledgment of social supply. otherwise known as non-commercial drug supply, and personal importation within the Misuse of Drugs Law was seen as a concern. Personal importation and social supply were noted as normal behaviours among younger Islanders who use drugs. Discussions also included the Attorney General's Guidelines to Centeniers on personal amounts of certain controlled drugs. These guidelines were well supported in principle by stakeholders, but limited emphasis on health was highlighted. A discrepancy was that the guidelines favoured those with non-problematic use but were more likely to criminalise those with drug dependency. It was also noted how the guidelines were based on the legal classification of the substances and not the associated harms themselves. Perceived variability in how the guidelines were used by different parishes and Centeniers was also raised.

Figure 18. Stakeholder quotations on the theme of decriminalisation and negative effects of criminal records

"Not wanting to talk to people and be honest about use for fear of consequences"

"Criminalising addiction creates a vicious cycle"

"[there is a] fear of judgment and criminality if help sought"

"We need to reduce the negative impact on life chances. Criminal records should be considered a harm"

"The harms of a drug conviction can be worse than the drug itself"

"Legalising or regulating cannabis and maybe other drugs would decrease harm but also take control away from criminals and stop criminal markets. The main worry is what these criminals might go to next"

Access to support and treatment

Access to support was a regular theme. It included treatment for substance use and wider health needs, such as mental and physical health, housing and other social support. It was felt that both the public and professionals working outside of substance use were unaware of the support available. A particular lack of information around trends in substance use and services available was noted from those working in primary care. It was noted that onward referral from one service to another could be better. It was felt a forum for support services to come together would have multiple benefits, including greater awareness of what other services offer.

The physical health needs of those with dependencies were of concern. Stakeholders' experiences were that those dependent on alcohol or drugs often lacked access to primary care. This was at times due to cost, outstanding bills, no fixed abode, past behaviour, and stigma. The Health Access Scheme was considered unviable for some. Reasons for this included residential status, cost, and competing financial priorities including the purchase of substances.

Figure 19. Stakeholder quotations on the theme of access to support and treatment

"there is no understanding of support available [by pubic and professionals]"

"language barriers [lack of non-English speaking staff]"

"access and support needs to be easier"

"we need to take away stigma"

"wait times increase vulnerability to triggers in community"

"most people don't understand alcohol or drug use let alone know where, when and how to get holp"

"clients [who use alcohol or drugs] usually struggle to access other mental health services, they get pushed away easily and it's like a chicken and egg problem but we need to look at both problems together"

"the thresholds for social workers are too high and my clients only get worse before they can get better, it's not right"

Gaps and differences in support service provision

Throughout the stakeholder sessions various gaps in service provision were identified. Some of these arrived as suggestions to fit specific needs, others were noted simply as being on offer elsewhere. They included:

1. Dedicated harm reduction or club-drug clinic which focuses on drugs such as MDMA, ketamine, nitrous oxide and LSD
2. Drug checking services operating at local events or within the community, which engage harm reduction workers with missing populations
3. Dedicated support for people who engage in chemsex. Information from services suggested that although regular use is somewhat low, it is believed many Islanders travel off-Island to engage in chemsex in the UK
4. Recovery coaches, and other forms of peer-support not focused on 12-Step models
5. A blue-light project or similar which focuses on people who regularly use emergency and other public services.

Some services are actively exploring options to address these identified gaps.

Figure 20. Stakeholder quotations on the theme of gaps and differences in support service provision

"Services are great at changing behaviours but we need to maintain them too"

"Why don't we have drug checking, like at in the UK?"

"A Blue Light Scheme like in Scotland would help engage with that group that don't see support services"

"…don't just measure what's going wrong, measure what's going right"

"One size doesn't fit all, people need different options and more choice"

"…there's nothing for people that use drugs recreationally…"

"Some people engage in chemsex and have nowhere to go if things go wrong"

Welfare

Stakeholder workshops identified the NTE as both a priority area for policing and a missed opportunity for additional welfare and health promotion interventions. Qualitative workshops noted that alcohol related crime was often driven by level of intoxication and that interventions to reduce intoxication in the NTE should be considered. It was suggested that the level of intoxication could be decreased through behavioural modifications and stricter enforcement, to ensure people who are drunk are not served alcohol. It was raised that liquor licence holders, like gambling licence holders, have a level of social responsibility to look after the health, safety, and wellbeing of their customers.

Figure 21. Stakeholder quotations on the theme of welfare

"…licensed premises have a responsibility to keep their customers safe"

"why isn't there more welfare in town at the weekend just like we have at events?"

"welfare and safeguarding in nightclubs, free water, if someone is drunk how do you deal with it? is there a safe place for them to go?"

"[welfare] issues in town tie up police and other services, these usually aren't medical emergencies or crimes "

"most problems in town are caused by the level of intoxication, more should be done to stop people getting into that state"

Young people with lived experience of alcohol or drug use

In 2019 following the death of a young Islander, the young person's substance misuse worker used one of the regular drop-in groups as an opportunity for reflection. This included considerations on the education in school and alternatives based on their collective experiences. The group felt that scare tactics did not address the facts around drugs. Despite favouring in-person classroom-based discussions rather than assemblies, they felt the police may not be the best organisation to deliver what they deemed were health messages.

Suggestions for drug education included:

1. Delivery to Year 9 students and above
2. Using smaller groups to encourage interactive engagement
3. An hour-long lesson on each drug category to ensure adequate detail is covered
4. Delivery by younger people, to improve engagement

On reviewing the outputs of the session, the views of the young people typically echoed much of what was found in good-practice guidelines for prevention. With respect to the lessons, the suggested content covered a wide range of areas. Key themes included harm-reduction, including how drug-testing kits worked, the importance of having a sober friend during a drug experience, knowing what to look out for, clarifying that calling an ambulance will not result in being arrested and exploring wider elements of drug use rather than purely the short-term dangers.

Figure 22. Stakeholder quotations by young people with lived experience of alcohol or drug use

"Harm reduction, how to reduce risk if you are to use drugs"

"Using scare tactics that does not address the facts around drug use [is a bad idea]"

"if the message is important the person delivering should show the importance by addressing the message themselves, videos take away from the importance of the message"

"The message gets lost in large assemblies and often people are not listening"

"….how drug testing kits work and how they may help you to use drugs safely"

"…an additional element of the education could look at promoting the importance of having a sober friend during a drug experience and what dangers that person to look out for."

"Looking at the role of intent in drug use, eg looking at the dangers of using drugs to manage emotions in developing addiction vs recreational use for fun"

"Educate that calling an ambulance may not result in police involvement or criminal charges"

How we will respond

Over the next 10 years we will work towards five key aims:

1. Delay the onset of use while preventing problematic use
2. Reduce the harm to individuals, families, and our Island
3. Ensure Islanders have access to support covering the spectrum of substance use
4. Improve wider health and wellbeing
5. Continue progress towards a sustainable health and social based approach

These aims have been devised from a comprehensive review of international guidance, the substance use profile in Jersey, and through stakeholder engagement. These aims are specific enough to resolve current problems and measure progress while being broad enough to ensure we can adapt to any future problems we may encounter. Within each aim will be number of objectives based on specific local needs. The first of these objectives can be seen in Tables 2 to 6 and reflect the actions we will take in the coming years.

Findings from the substance use profile and stakeholder engagement process both highlighted alcohol as the substance most associated with health and social harms. Alcohol and its harms were also identified as a priority area during the development of both the Public Health Strategy and Building a Safer Community framework. In response alcohol will be treated as a priority area upon strategy implementation and emphasised within these additional initiatives.

The Public Health Directorate will continue to support other government departments, strategies, and work areas which feature alcohol and other substance use. This includes working closely with Justice and Home Affairs to fulfil Ministerial priorities on refreshing community safety and substance use. Specific work in this area will ensure alignment between A Change of Direction, the Public Health Strategy, and the Building a Safer Community framework. Together these three initiatives will comprehensively address common problems through their individual and shared scopes of work. This will include collectively monitoring relevant harms caused to individuals, families and society.

A Substance Use Strategic Group will be formed to co-ordinate and deliver multi-agency working across health and criminal justice government departments. The group's responsibilities will be to:

1. Ensure current strategic aims and objectives are met
2. Monitor trends in substance use and its related harms
3. Identify, implement, and monitor appropriate responses to substance use problems
4. Monitor and evaluate overall progress and success of the strategy
5. Identify future aims and objectives

The Substance Use Strategic Group will also work closely with both the existing Advisory Council on the Misuse of Drugs and a newly formed Substance Use Service Forum. The Forum will bring together substance use services from government and the third sector. The Forum will improve information sharing, collaborative working and assist with problem solving. Service-level problems would likely be solvable within the forum while more complex systemic problems can be highlighted to either the Substance Use Strategic Group or Advisory Council on the Misuse of Drugs for actioning. Table 1 defines the acronyms used to designate the leadership for the objectives.

Table 1. Leadership acronyms

Acronym	**Service or group title**
ACMD	Advisory Council on the Misuse of Drugs
ADS	Alcohol and Drug Service
JCIS	Jersey Customs and Immigration Service
CYPES	Children Young People Education and Skills
DfE	Department for Economy
HCS	Health and Community Services
PH	Public Health
SOJP	States of Jersey Police
SPPP	Strategic Policy, Planning and Performance
SUSF	Substance Use Services' Forum
SUSG	Substance Use Strategic Group

Aim 1: Delay the onset of use while preventing problematic use

Table 2: Objectives for Aim 1

Objectives	Leadership
Produce key resources and lesson plan templates for secondary school PSHE lessons. These will be relevant to local needs, align to best practice and be consistent with messaging and approaches used in early intervention.	PH, ADS, CYPES
Develop a consistent and co-ordinated approach to substance use education with relevant stakeholders. This will include clearly defined roles, responsibilities, and production of a best practice guidance document relevant to local context.	PH, CYPES, SUSF
Explore the feasibility of options for delivering a data-driven, evidence-based universal primary prevention approach for young people. This could include community-based approaches like the Icelandic model and would aim to increase factors that promote wellbeing and reduce risk factors for substance use and other health harms.	PH, CYPES
Implement and deliver a prevention system spanning universal, selective, and indicated prevention. In addition, case identification will be included to ensure consistency with early intervention. The approaches used within the prevention system will be science-based, drawing on prevention science, behaviour change and driven by local data.	PH, SUSG
As part of a prevention system, prevent ACEs from occurring and support those who have experienced ACEs, including adults. This will include the use of trauma-informed and resilience -based approaches in addition to wider determinants of health.	PH, SUSG

Delaying the onset of substance use will be measured through**:**

1. Self-reported ever alcohol and drug use in young people, as measured by the Children and Young Persons' Survey

Preventing problematic use will be measured through**:**

1. Self-reported rate of occasional and regular alcohol and cannabis use in young people, as measured in the Children and Young Persons' Survey
2. Self-reported rates of hazardous and harmful drinking, as measured by the Opinions and Lifestyle Survey and monitored in the Jersey Performance Framework
3. Self-reported binge drinking as measured in the Opinions and Lifestyle Survey
4. Number of new referrals to the Alcohol and Drug Service requiring an alcohol or drug detox

Aim 2: Reduce the harm to individuals, families and our Island

Table 3. Objectives for Aim 2

Objective	Leadership
Increase harm reduction and health promotion work around noted gaps in the areas of: MDMA, club-drugs, IPEDs and chemsex. This will include a healthier weekends approach to address risky behaviours collectively.	PH, ADS, HCS, SUSF
Work to challenge and reduce the stigma of alcohol and drug use. Use similar methods to what has been done with mental health and wellbeing, including education and awareness.	PH, SUSF
Update Gov.je webpages on alcohol and drugs. This will include updated information on substances, their effects and harm reduction. In addition, raise awareness of what support services are available locally and how they can be accessed.	PH, ADS
Implement a co-ordinated early warning system to monitor the drug landscape and respond before harms occur.	PH
Target commercial drug trafficking and organised crime groups which have a negative effect on society.	SOJP, JCIS
Review new ways of working to reduce alcohol related crime and other health and social problems in the NTE.	SOJP, PH
Identify and support high-risk populations including domestic violence and households with children. This may overlap with targeted and indicated prevention efforts.	PH, SUSF

The effect of reduced harm to individuals will be measured through:

1. Self-reported rates of a bad experience due to drugs
2. Alcohol and drug specific admissions to hospital
3. Self-reported rates of hazardous and harmful drinking in adults
4. Post-arrest diversion from Courts to Parish Hall Enquiries
5. Deaths due to alcohol and drug use

The effect of reduced harm to families will be measured through:

1. Domestic abuse crimes involving alcohol
2. Community-based alternatives to incarceration, including parental incarceration
3. Safeguarding incidents involving alcohol and drug use

The effect of harm reduction interventions on our Island will be measured through:

1. Youth crime and antisocial behaviour linked to substance use
2. Rates of crime involving alcohol in the NTE
3. Successful completion of Probation Order Treatment Orders and Binding Over Treatment Orders and alcohol and drug related offence

Aim 3: Ensure Islanders have access to support covering the spectrum of substance use

Table 4. Objectives for Aim 3

Objectives	Leadership
Increase support options for those with family members using substances. As part of this, a SMART Family & Friends program will be delivered to support families with members who use substances problematically. Other work will include updating "A Parents' Guide to Drugs", producing similar age-appropriate resources for young people and improving signposting for families to access wider support services. Naloxone training will also be offered to family and household members of people who use opiates.	ADS, PH, SUSF
Set up a substance use services forum to improve partnership working and information sharing.	PH
Improve service access and quality for those with limited English proficiency by reducing language barriers. This will include increasing the number of bilingual staff and peer support workers where needed.	SUSF
Exploring missing service provisions and their suitability for local needs. This will include secondary health and social needs.	SUSF, SUSG
Increase service user and peer involvement in service design, delivery and strategy progression. This should be seen as an ongoing process allowing service users and peers to openly raise the problems they face for services or the Substance Use Strategic Group to address.	SUSF
Review evidence-based responses for those not in contact with treatment or support services who regularly use emergency and other public services. This will include supporting people whose alcohol use could be described as change resistant, and young people regularly linked to anti-social behaviour.	PH, ADS, SOJP, HCS, SUSF
Explore feasibility of creating a single point of contact for substance use needs. This could be an online portal which lists the services available and signposts based on identified needs.	SUSF
Explore opportunities to increase the number of opportunistic brief interventions for alcohol and other substances.	PH, SUSF, HCS
Ensure adequate training and support is available for service staff.	HCS, SUSF
Explore digital opportunities to encourage self-assessment, brief interventions, and self-monitoring for alcohol and drug use. This will include improving current gov.je provision and partnering with existing international entities. It may include promoting interactive tools developed by the Global Drug Survey.	PH, SUSG

Access to support will be measured through:

1. Inappropriate emergency service use by known groups and individuals
2. Implementation, monitoring, and evaluation of new service provision
3. Referrals to services, including from missing populations
4. Visits on relevant gov.je webpages
5. Brief interventions delivered in primary care settings

Aim 4: Improve wider health and wellbeing

Table 5. Objectives for Aim 4

Objective	Leadership
Work with support services to include, monitor and report on indicators which reflect improvements matched to sustainable wellbeing in the Jersey Performance Framework. This includes wider determinants of health such as indicators on housing, employment and quality of life.	PH, SUSF
Work to lower alcohol consumption across the Island, beginning by targeting interventions at those drinking the most.	PH, SUSF
Promote and normalise both moderation and abstinence as positive health and wellbeing lifestyle choices.	PH
Engage with people who use substances to identify the most common reasons for lapse and relapse into more harmful patterns of substance use. Once complete, these insights will shape necessary areas to better maintain healthy behaviours.	SUSF
As part of developing primary prevention, ensure young people have access to supervised recreational, leisure and sports activities which promote healthy lifestyles and reduce the impact of ACEs.	PH, CYPES
Improve social prescribing for adults who use substances to encourage healthier lifestyles and provide positive meaningful activity and experiences.	PH, HCS

Health and wellbeing will be measured through:

1. Sustainable wellbeing indicators within regular service evaluations
2. Social prescribing referrals
3. Number of young people involved in structured and supervised leisure activities
4. Number of adults reporting low risk drinking as reported in the Jersey Opinions and Lifestyle Survey

Aim 5: Continue progress towards a sustainable health and social based approach

Table 6. Objectives for Aim 5

Objective	Leadership
Improve the ongoing analysis of activity, research and intelligence to better monitor and understand illegal drug use. This will include reviewing methodologies and options to allow comparisons with other jurisdictions on an ongoing basis.	ACMD, SUSG
Develop a centralised monitoring system which includes indicators on substance use, harms and wider determinants of health.	SUSG, SUSF
Review how small quantities of controlled drugs are dealt with to ensure alignment with a health and social based approach. In addition, improve the Parish Hall Enquiry and Deferred Decision process to include elements of health and social based approaches. This includes a focus on identifying and responding to wider risk factors that influence substance use and offending behaviour.	PH, ACMD
Conduct a review of the Misuse of Drugs Law (Jersey) 1978 and Misuse of Drugs (General Provisions) (Jersey) Order 2009, to ensure they are fit for purpose. This will include ensuring the laws are workable within the current drug landscape, are based on sound scientific understanding, and are consistent with a health and social approach.	ACMD, SUSG
Continue progression away from criminalisation by reviewing and adopting specific policy options that fall under decriminalisation and legalisation aims. This will include ensuring alignment to existing government commitments on improving health and protecting children.	PH, SPPP, ACMD
Promote service user and peer involvement in the design and delivery of substance use services.	SUSF
Review legislation on discrimination and relevant government policies on education, employment and housing to ensure people who use, or are dependent on substances do not arbitrarily face discrimination or inequalities.	PH, SPPP
Review current regulatory models including an updated liquor licensing law and licensing assembly which includes commitments and considerations on health. Draft a statement of alcohol policy intent, to include protecting the health and wellbeing of the public as well as protecting children from harm, in alignment with government commitments.	PH, SPPP
Protect children, young people, and others at risk of exploitation by organised crime. This includes exploring legislation options to provide amnesty in cases of coercion.	JHA, SPPP
Work across government to ensure Jersey meets the threshold of compliance with the UNESCO Anti-Doping Convention. Part of this involves setting up a National Compliance Platform, to inform a Government of Jersey anti-doping policy.	DfE, ACMD

Progress towards a sustainable health and social based approach will be measured against external criteria as detailed in the Global Drug Policy Index (7).

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