CONSULTATION RESPONSE WITH APPENDIXS

THE JOINT COMMISSIONING FRAMEWORK FOR DRUGS AND ALCOHOL

A CONSULTATION RESPONSE BY THE TRAUMATIC STRESS, ALCOHOL & DRUGS NORTHERN IRELAND BEST PRACTICE FORUM

Traumatic stress, Alcohol & Drugs Northern Ireland Best Practice Forum

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CONSULTATION RESPONSE

The Traumatic Stress, Alcohol and Drugs Northern Ireland Best Practice Forum

The Forum is the outcome from a cross-sectoral response to the past years work in research, public seminars and a pioneering information leaflet for individuals and families. The Forum's Aim as a Regional body (see enclosed Terms of Reference and Information, Appendix 1) is to focus on the sharing, development and widespread dissemination on Best Practice whilst providing a common vision and relevant guidance for all those concerned with the Co-Existing conditions of Trauma (of the 'Troubles'), Alcohol and Drugs (primarily prescription drugs) and every 2 months it rotates its main meetings which are hosted **in turn** to all the HSC Trust areas.

The Forums Objectives include**:**

- To explore how promising and evidence based best practice as a method or technique that has consistently shown results superior to those achieved with other means, and to benchmark this
- To develop a dialogue across Voluntary and Statutory bodies dealing with traumatic stress and Alcohol & Drugs, that begins to develop a process of shared understanding of Best Practice in this area of care, and consequently the delivery of high-quality care that promotes best outcomes
- To highlight the **Co existing** conditions of Traumatic Stress, Alcohol and Drugs and the learning in Best Practice that can be gained from local examples of such care
- Respond to the demand from service users and current research for a change in practice
- Address the problem,ie that many practitioners/professionals/trainers have not had the understanding of how Trauma experienced by people here in N.Ireland affects the physical, mental and social dimensions of health and their interrelations especially with Substance Misuse. The Forum's objective is to intensify (and diversify in) our collaboration by actively reaching out to and hearing from those in related fields and experiences
- To create resources towards recognising the aspirations of practitioners towards a more effective way of working and outcomes along the principles of Communication; Better Service User feedback and Best Practice around these Co-Existing Conditions
- To provide opportunities for members networking and to identify and disseminate through the Forum knowledge of good practice already taking place.

1.Response to Consultation

In general we view the document as promising with the background information and the research referencing many of the issues of concern and it was comprehensive in its assessment on the disparity of access to particular services. However it is imperative to draw your attention to some aspects of the document we do not endorse or has not been examined and we hope that the overall and specific comments and ideas expressed in this response will be considered.

The greatest aspect of concern we have for this Consultation document is that there is no mention of Trauma of the `troubles' in relation to alcohol and drugs despite the researched evidence and work done on this significant issue. Trauma and Post Traumatic Stress Disorder is a significant public health issue and it is the background to many of our chronic personal, social, health, institutional and economic problems.

2.Post Traumatic Stress Disorder

The DSM-IV refers to the fourth publication in 1999 that PTSD is defined as "the personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror." (American Psychiatric Association, 1994:424). Other emotional responses include guilt, shame, intense anger or emotional numbing (NICE 2005). As trauma affects the person physiologically, psychologically and socially, it has been described as a state of turbulence and complexity where symptoms present a vicious circle of intrusive experiences. Following a traumatic experience some people (adults and children) can develop one or more psychological disorders, such as depression, a panic disorder, general anxiety or PTSD. As Dass – Brailsford & Myrick (2010) stated that "..it is not unusual for individuals experiencing trauma to become involved in self destructive behaviours such as substance misuse or selfharm as a way to cope and manage unbearable distress".

PTSD is one of the most prevalent disorders in Northern Ireland, with an estimated 61% of the population have experienced a traumatic event in their lifetime and an estimated 8.8% of the adult population meet the criteria for PTSD at some point in their life, and these events associated with the conflict have been a major traumatic stressor for the population. On a gender note with relevance for this consultation, females had a higher conditional risk of PTSD following exposure to traumatic events and in relation to the experience of traumatic events (Ferry et al) females were significantly more likely than males to meet the criteria for lifetime and 12-month PTSD.

It is estimated that 80% of the adult population experienced their first time traumatic event before they reached the age of 29 years. There is evidence to suggest that exposure to traumatic events in childhood and adolescence in particular can have a substantial psychological impact in later life (Thabet et al.2003) with the consequences for those adults growing up as children throughout the troubles. Kessler and colleagues (2010) highlight the importance of childhood trauma in determining adult mental health outcomes. In their cross national study (including data from 21 countries) of the association of childhood adversities with adult psychopathology across 12 types of disorders across all countries the research has shown that the figures for PTSD lay in the upper range of international estimates compared to other countries including South Africa, Israel and Lebanon. Studies from the early days of the `troubles' did not detect any marked evidence of adverse mental health consequences and it is only as time has passed that any other studies began to pick up something of the distinctive mental health issues/needs linked to the violence, and one factor that might in part explain this being, with the end of the conflict people were better able to, and felt safer in articulating their experiences and needs.

The Trauma, Alcohol and Drugs Comorbidity report (see enclosed Appendix 2) concluded that interviewees had agreed that there was a great need for psycho-education both within the community; for family members and for individuals who were experiencing trauma and substance abuse in order to have more understanding of trauma in terms of how it affected the individual experiencing the trauma, what issues they could expect to be dealing with in the family and a sharing of coping mechanisms that families would find useful and this recommendation was quickly followed up with an Information/Resource Leaflet(see appendix 3, Traumatic Stress, Alcohol and Drugs Information leaflet for Individuals & their Families)
If the post-traumatic symptoms are not addressed then sufferers are in danger of descending into a spiral of disconnection with people, social isolation, loneliness, poor physical health, depression or other anxiety disorders and maladaptive coping mechanisms such as substance abuse. The use of alcohol, drugs, caffeine or nicotine in order to cope with their symptoms may, eventually lead to dependence on these substances. The most common coping strategy is to

use substances such as alcohol and prescribed drugs/medication to ease or numb the pain of the trauma and the associated symptoms.

2. Substance Disorders

These include alcohol abuse, alcohol dependence, drug abuse and drug dependence (including prescription).The research report (appendix 2) on Trauma, Alcohol and Drug Comorbidity (2011) concluded that the onset of traumatic stress disorder can typically precede the onset of substance abuse. There appears to be a suggestion that self-medication using prescription drugs, was prevalent during the 'troubles' when many people self-medicated in order to function. A majority of adults (84%) take sedatives, tranquillisers or anti-depressants daily or almost daily (DHSSPSNI 2002/03).

> *"During the 'troubles' many women developed addictions to prescribed medication like Valium to deal with the depression they suffered as a result of the men they lived with being killed. Men dealt with the 'troubles' more with alcohol".* (Witness at the Centre for Social Justice Policy hearing (2010)

The high prevalence of prescription drug misuse is specific to Northern Ireland, in contrast with the UK, and recent evidence suggests that this could be largely associated with the management of illnesses associated with the 'troubles'. The study by the mental health charity Threshold (2010) found that in NI there were 75% more prescriptions for tranquillisers than in the rest of the UK and that doctors in Northern Ireland also have the second highest prescribing rate of anti-depressants in Europe. A statement from the Central Health and Social Care Board, admitted that the figures were high and stated,"*Northern Ireland does have a higher usage of these drugs (tranquillisers and sleeping pills) which has been attributed partly to the legacy of the 'troubles'.*(Rainey,S Belfast Telegraph, 24/1/2011)

3. The Co-Existing Conditions of PTSD & Alcohol and/or Drugs

Throughout this response when mentioning Co-Existing Condtions this will be referring to the comorbidity of Traumatic Stress, Alcohol and Drugs (primarily prescription drugs).

Most of the USA research published data support a pathway whereby PTSD precedes substance misuse or dependence. Their preclinical work has led to the proposal that in PTSD, carticotropin-releasing hormone and noradrenergic systems may interact such that the stress response is progressively augmented and people may use alcohol and drugs in an effort to interrupt this progressive augmentation. Addiction involving alcohol is one of the most commonly-reported disorders among Vietnam War Veterans. Individuals whose brain development has been altered by stress are more sensitive to the effects of addictive substances and are more vulnerable to the development of addiction.

Alcohol abuse is the most prevalent Co-existing condition with post-traumatic stress disorder (Kessler 1995). At lower doses alcohol can act as a stimulant, may also lower anxiety and inhibit fear; therefore it is evident how this may, in the short-term assist the person suffering from post-traumatic stress disorder cope with a number of physical symptoms such as hyperarousal and provides ease for some social situations. However this relief is only temporary and the use of substances to reduce these symptoms is ultimately harmful to the individual, their relationships and wider circle, to be productive in work and life in general. At higher doses alcohol acts as a depressant and alcohol misuse or dependence may also be responsible for causing interpersonal problems or indeed exacerbating them. Specifically trauma survivors may self-medicate using stimulant or other drugs to maintain alertness and psychoactive drugs to try to block the distress of intrusive thoughts and traumatic memories (Dass-Brailford and Myrick). The presence of additional disorders indicates a more complex clinical presentation as this will have several targets for both assessment and treatment according to the literature. The Co-existence of post-traumatic stress disorder and substance abuse is described in literature as a 'downward

spiral' where trauma symptoms are common triggers of substance use, which in turn can heighten post-traumatic symptoms (Najavits, 1997). The literature substantiates the idea that Co-existence is a complex problem and that some individuals may 'present' with substance dependency or misuse problems or they may 'present' with symptoms relating to post-traumatic stress disorder. Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition and memory (Herman, 2001) and therefore it should not be unexpected that people 'present' in varying states of crisis and emotional turmoil. Traditionally, service users with Co-existing conditions were/are sent to one treatment setting or another to address their problems sequentially. They have been advised to "solve" their addiction problems before entering mental health treatment or stabilise their mental health problems before entering addiction treatment. It would be our belief based on available research and experience (national & international) that this has not been effective since each condition tends to exacerbate the other.

4. In terms of response to this Consultation an **Essential Programme Components and Principles for working with and treating service users (& their families) with Coexisting Conditions that we wish to see adopted by the consultation.**

A comprehensive assessment that would include an evaluation for Co-existence thereby determining what other disorders may be present, prioritising these and developing an appropriate treatment plan. It is further recommended that this be carried out by appropriately experienced staff (Foa et al., 2009; Herman, 2001; Wilson et al., 2001, NICE June 2010, Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence). Integrating addiction treatment and PTSD for these service users will no doubt increase retention and yield positive outcomes, including higher abstinence rates. We support and welcome the Consultations documents points on the inclusion of Service Users and intended format of future involvements however this could be strengthened with a link in with the Forum to help identify and evolve existing good practice through feedback from Forum practitioners in regard to their efficacy which could in turn redefine carepathways.

Women: A considerable body of evidence primarily form the USA demonstrates the importance of addressing gender differences in the treatment process, particularly for women with histories of trauma and those that are pregnant or parenting. Women are in a unique position when it comes to pregnancy and mothering, yet little attention is given in the Consultation document to the needs of mothers in the context of Co-existing conditions of substance use problems and trauma for women are twice as likely to develop PTSD after a traumatic event and their chronicity of symptoms persists up to 4 times longer than men. **Pregnant women** with Coexisting conditions require additional medical monitoring because pregnancy can aggravate certain symptoms of mental illness such as depression. Case management is particularly critical for pregnant women with addiction; this should include the assurance of standardised assessments, access to prenatal and paediatric care, mental health services, parenting classes, childcare and transportation services.

Coordinated treatment; recovery plans and Reintegration with the Community

- Access to addiction and regular trauma services through collaborating programmes
- Comprehensive support services to address issues such as housing, unemployment and trauma or dealing with the past issues
- Access to mutual support programming and
- Reintegration of the service user with their families and communities

5. Best Practice and Points of Consideration for the Consultation

By reference to Best Practices we mean: Systematically developed statements to assist practitioner and patient decisions about appropriate care for specific clinical circumstances

(Health Canada, 2001, p. 24) **or** Activities or programs that are in keeping with the best available evidence regarding what is effective (US Department of Health and Human Services, 2001, p.196)**. Evidence-based:** Programs or interventions that have undergone scientific evaluation and have proven to be effective.

With regard to this Consultation document the suggestion of Couples and Family therapy in terms of treatment is welcomed, as they aim to improve communication and support and reduce conflict between couples and within families and should be approached from a co-existence perspective. "Addiction is a family disease and you cannot treat an addict without brining in the family and children", (CEO Betty Ford Centre).

The emphasis in the Consultation document on interventions delivered as an integrated system is clearly a much needed priority. Yet again the central role of families in any approach is agreed as an important focus. In this regard the impact of **Trans generational** trauma on such families is a factor that needs to be more clearly understood for identified strategies to be effective. A holistic integrated approach to stabilise (Herman's first stage approach to trauma) such families before effective strategise can be implemented need to be understood by both statutory and voluntary agencies involved in any care pathways. It is apparent that broader social change is needed to allow the more particular work to be effective and at its hub is the strengthening of family functioning. This is well identified in the Consultation however it might be even more effective to suggest more positive outcomes such as; to identify key ex-users who would be active in an educational program. The recognition of the context of the drinking habits of the home background is very important however when you look at the report from the Commission for Victims and Survivors in October 2011 on the impact of civil conflict in Northern Ireland, we also get a picture of a community that leads the world in levels of PTSD per head of the population. Statistics in the report show the effect in the population in regard to higher levels of addiction in areas most influenced by the 'Troubles', which correlate closely to the most deprived areas in the community.

Whilst we would agree with many of the Consultation priorities however due to the impact of the 'Troubles' we would widen these to take in mental health needs that can be done if judged suitable in tandem with additions services. Service users with PTSD and Substance abuse can benefit from psychoscocial treatments as well as pharmacacotherap. We welcome the Consultations multi agency approach and this is both practical and welcome, however there is not enough common agreement about how to address Co-existing conditions on such a level. There is not enough communication between such agencies for client care and this results in fractured unclear pathways that can sometimes duplicate care or leave key elements of care out and this is something that the Forum can help clarify as in our practitioner consultation such gaps are identifies.

6. With regard to sections 8 – 11 (pages 40 to 100) we wish to make the following points of our response for your consideration

A Coordinated and Integrated Service System that the Forum can Assist in Developing:

The Forum can assist in developing firstly In terms of Assessments – an agreed cross-sectoral comprehensive assessment on trauma and substance misuse which will assist for effective treatment that is individualised and tailored to the service user. The need to provide coordinated and integrated services across service delivery systems for people living with a concurrent disorder is based on the understanding that substance use disorders and mental health disorders can occur together and each disorder should be considered primary. Best practices for the treatment of concurrent disorders can best be summed up as "one team with one plan for one person" (The California Department of Alcohol and Drug Programs, The California Department of Mental Health, 2004), but this team can be cross-sectoral and

agency. To put this in place at the system level requires developing enduring linkages between service providers or areas within a system, or across multiple systems, to facilitate the provision of service to individuals and families at the local level. It is important that those with PTSD and the coexisting conditions of substance abuse receive appropriate treatment (misuse and addiction) and that this is assessed, monitored and supported. Since co-existence is high, one might assume that it is also important that people with a substance misuse be evaluated appropriately for PTSD and we wish for the Consultation to adopt this priority.

- **Services and systems employ best practice models and interventions**, whether building on the strengths of the existing service system or developing new services and the Forum is in a unique position to help and support with this.
- **A continuum of coordinated and integrated services** including assertive outreach, screening, assessment and treatment planning, case management, early intervention, harm reduction, treatment, housing options and community reintegration services are available, accessible and provided over the long term at levels and intensities consistent with individual needs.

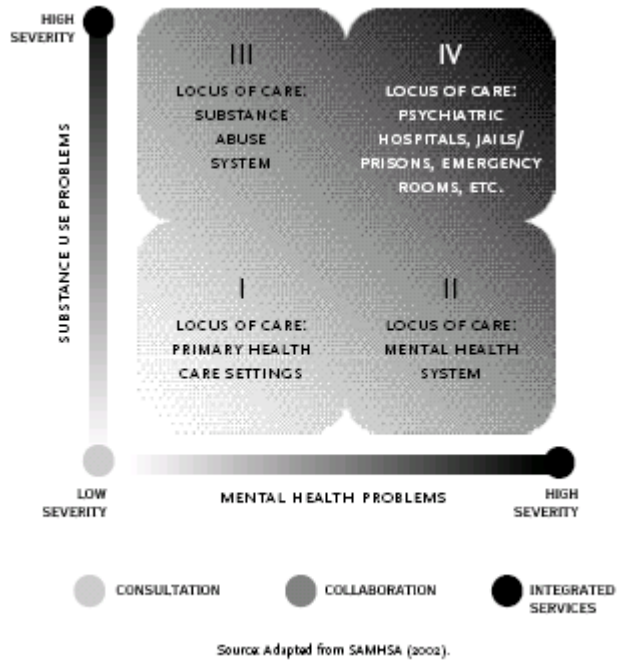
Positive working relationships are promoted across mental health and substance abuse services and systems and at all levels including opportunities for shared or cross training and other joining activities It would be useful here to be informed of such training and activities to help the Forum evaluate the learning from those attending to enrich our own body of evolving understanding. The emphasis on early intervention and sharing of resources across agencies to improve outcome are clear and important priorities. However little is said about the open access to such services to militate against the earlier identified disparity of access to services and it also challenges what is shared between voluntary and statutory bodies that are effective for good service user care and this is where the Forum can help facilitate the necessary ways forward.

Rarely is there only one obstacle to a person receiving needed treatment and as already outlined in this response there are many additional ones including lack of treatment referrals (primarily from the health care system but also from other agencies and voluntary organisations), negative public attitudes and behaviour towards those with addiction, privacy concerns, lack of information on how to get help especially on the co-existing conditions of PTSD and substance abuse (see first leaflet produced in 2011 on such support - appendix 3) and the Forum can be of assistance in raising awareness, pyschoeducation, training and support.

The Forum totally supports the need for a common assessment tool relevant to the patients need for engagement with the services however if this tool is not used in a thoughtful and sensitive way it may prove a bottleneck to access to services the patient needs rather than facilitating such access. It might be helpful in considering the need for review, development and co-ordination of a multiagency approach to consider the role of a Case Manager, trained for such a post to ensure people receive continuity of care across voluntary and statutory agencies working to identified protocols.
The priorities are agreed however because of the multiagency approach protocols might need to be basic then be gradually built on as we learn how to more effectively work across the statutory and voluntary bodies to the Service Users benefit. The priorities focus more on the statutory sector however the role of the voluntary agencies within these priorities needs to be looked at more carefully. The role and function of the voluntary agencies in care delivered needs to be more carefully thought out, to use their strengths in their community identity rather than use then as an add on to what is already in place if we are to have a more seamless and effective service.

7. Further Recommendations Put Forward to be considered by Consultation

The Four Quadrant Model below illustrates a continuum of problem severity and a corresponding level of service system co-ordination and integration. It is widely used in the United States and other jurisdictions to provide substance use and mental health providers with a common framework and language to make decisions about how the two systems will work together. .



Source: Adapted from SAMHSA (2002).

Assess each program's capacity to serve people living with a concurrent disorder and their families

In order to identify each planning areas current capacity, gaps and needs in providing a coordinated and integrated system of services for people living with a concurrent disorder and their families, it is important to assess the current capability of each program to provide concurrent disorder services with four levels of capacity:

- Basic program which can provide treatment for one disorder, but screens for the others and can access the necessary consultation.
- Intermediate program focuses primarily on one disorder, but also addresses some needs of the other disorder.
- Advanced program provides integrated substance use and Co-existing conditions by adding needed expertise and relevant interventions either internally or through collaboration with other services.
- Fully integrated program actively combines substance use and Co- Existing interventions.

Develop and implement a training plan – Co-Existing Conditions

Ensuring that staff at all levels has the appropriate attitudes, knowledge and skills, consistent with each program's mandate within the system to provide services for people with living with a concurrent disorder and their families is integral to any strategy to improve the system of care. A system wide concurrent disorder service plan should ideally include a training plan

that identifies the current competencies and education and training required by staff at different levels and in different services settings.

Identify and Adopt Best Practice Guidelines

It is important that there is consensus on best practice principles and guidelines at the program/clinical level so that service providers are using agreed upon approaches for client care. Drake et al. (2001) have identified critical components of integrated programs as being: staged interventions, assertive outreach, motivational interventions, counselling, social support interventions, long term perspective, comprehensiveness, and cultural sensitivity and competence.

Develop partnership agreements to provide coordinated and integrated Co-Existing services

- In most planning areas, it will be necessary to develop protocols, shared care or partnership arrangements with other services in order to provide a continuum of services for people with concurrent disorders and their families. Formal agreements between agencies should describe the roles and responsibilities of partner agencies and how client referrals are made, admission and discharge criteria and responsibility of partner agencies for ensuring continuity of care.
- Examples include protocols for routine screening, integrated (joint) assessment and treatment planning and referral and/or single point of access for clients entering substance abuse and mental health service systems; regular case conferencing consultation and/or supervision across systems and services; mobile resource teams or person to provide expertise to a variety of services/locations; cross-system secondment or placement of clinical staff; interagency or blended service delivery teams; and co-location of substance use, gambling and mental health services in one physical location.

Develop a plan to monitor service system changes

The ultimate aim of is to improve identification, access, treatment and outcomes for people with living with Co-existing Conditions and their families, thus the regional and local plans should identify indicators at services and systems level that can be used to monitor these improvements. The treatment plan should include a discussion between the carer and the client about the possible effects of substance abuse problems on trauma related problems, including sleep, anger, anxiety, depression, and work on relationship difficulties. Treatment can include education, psychotherapy, and support groups that help the client address substance abuse problems in a manner acceptable to the client. Treatment for traumatisation and substance abuse problems should be designed as an overall plan that addresses both sources of difficulty and their interrelationships. Although there may be separate meetings or clinicians devoted primarily to traumatisation or to substance problems, all interventions should be carefully coordinated and integrated.
An integrated approach or Service that meets the needs of people suffering these Co-existing conditions is the most appropriate way to treat people. However the term ‘integrated’ needs to be defined. There are a number of interpretations of an integrated treatment approach could work in practice, for example in terms of client management and with parallel or integrated services verses referrals to existing community services. Some voluntary organisations felt that they were able to offer an integrated service as few already offered counselling services for trauma and addictions. As stated by one interviewee in the enclosed Trauma, Alcohol and Drugs Co-mobidity report:

“Social support is good for prevention and social support is good for recovery.”

Education and Prevention We welcome this document for outlining those points on restriction of access to alcohol and the importance of education on the issues. The recognition of the priority in deprived areas for such services is well noted, particularly the mention of fractured /unstable communities. This correlates with the identification of the areas most traumatised by our recent history. We also support the need for evidence based initiatives that are evaluated to evolve a more effective service The literature suggests that the family and friends may become bewildered, distressed and find difficulty in being supportive when a family member coping with trauma. If they are informed about the nature of Co-existing conditions and the likely symptoms, then the evidence is that are prepared and far more able to tolerate the disruptions in their lives.

Transgenerational Trauma is the transfer of trauma as defined from the victims/survivor of the troubles to members of the family in the second and third generation experience and exhibit the same symptoms of trauma as the victim/survivor themselves. The emotional cost of living with a parent suffering from PTSD can lead to negative psychological consequences much later in life as these individuals develop more, behavioural and emotional problems than those who did not have parents with PTSD (Jacobsen, Sweeny & Racusin 1993). Those who are experiencing transgenerational issues often do not recognise that the `troubles' can be affecting their mental health and possibly co-existing conditions in the present. A lack of awareness on this by Service Providers and/or those making referrals and the affects for young people to the troubles related violence and intimidation that still continues. Bearing this in mind Treatment approaches for adolescents must be tailored to the profound neuro-chemical, physical, cognitive, emotional and social changes that take place during adolescent development and to the heightened influence of family and peers relative to adult service users. Because early initiation of substance use is related so strongly to the risk of addiction, interventions for young people demonstrating early signs of risky substance use and treatment for addiction against the backdrop of what has been noted on trauma is imperative. However Treatment approaches with a strong evidence base in adult populations are not necessarily applicable to the treatment needs of adolescents with addiction. The Forum would agree with the Consultation document that treatment programmes for adolescents should be developed appropriately and family orientated, however based on the outlined evidence in our response it would appear that a significant proportion of adolescents with addiction have histories of trauma and transgenerational trauma, compounded with adverse life experiences as well as co-existing conditions that must be addressed in prevention, treatment and support.

Importantly there is evidence that suggests that the person suffering from PTSD will benefit from treatment regardless of the time elapsed since the traumatic event (Gillespie et al, 2002).

Partnership: It would have been helpful if the Consultation had elaborated on defining within partnership across the community, voluntary and statutory sector**.** However we appreciate the detailed work that has gone into this Consultation document. We are particularly pleased that the issue of inclusivity has been emphasised throughout the work and that evidence based practice, the focus on the family and the identification of a multiagency approach have been identified as key strategic approaches. We feel however that the role of the voluntary/community agencies in the strategies pursued and developed, needs to be more clearly defined in tandem with their statutory co-workers. It may also help develop co-ordination to look at the role of Case Managers to help deliver a more consistent level of service to each Service User.

In our response we wish to emphasise greater support and resources Therapy for `Hidden Harm' and we support the consultations consideration of Family Therapy and other approaches to galvanise best practice and to overcome the great difficulties in this particular area of concern. The issues pertaining to Hidden Harm (debilitating patterns of parental care and routines, greater risk of neglect and abuse, negative interference to schooling/learning, deficient physical and mental health in later life), we feel are particularly

important regarding Trauma and the circumstances under which children and young people suffering in silence are affected by parental alcohol and drug misuse. We know that this impact is profound and enduring on their lives for many years and which may not emerge until later and beyond in their young adulthood. The Forum would be one of the linkway's for communicating to the various Community/Voluntary and Statutory organisations on collective issues and approaches with regard to Hidden Harm and bringing in the best practice relating to Transgenerational Trauma work as mentioned earlier in this response document.

Conclusion

In conclusion we welcome a number of the points laid out the document but as outlined we suggest that such a document to be relevant to Northern Ireland we need to address it within the context of the 'Troubles' in terms of Trauma. Treating coexisting conditions involves addressing not only the specific object of the addiction, but the antecedents, manifestations and consequences of addiction more generally. We have pointed out the issues and implications pertaining to the lack of attention to the understanding on how trauma can be central to the co-existence of mental health and substance misuse problems and the cost of this is significant for individuals, for families, for service systems and into the future of our society. Consequently we have put forward reasons for and solutions to the Integration at multi-levels – outreach and engagement, screening and assessment, resource coordination and advocacy, crisis intervention, mental health and substance use services, trauma specific services, parenting support and health care. This response document has given a lengthy analysis of Trauma of the Troubles (and trauma in general) to highlight why and how services outlined in the Consultation need to take into account knowledge and best practice on the impact of trauma and substance misuse as Co-existing conditions and integrate this knowledge into all aspects of the Statutory and Community/Voluntary sectors Service Delivery.

We have spent some time on the issue of Trauma in our response for these reasons and appreciate this opportunity to share this with you and look forward to the response process from the Consultation.