Stakeholder Engagement Survey

The Public Health Agency (PHA) will be putting the Drug and Alcohol services that it funds out to tender next year.

To help us ensure the services meet the needs of the population, we are asking those who use the services, those who provide services and others affected by drug and alcohol issues for their views.

This will help the PHA to:

- Understand what services over the next 4-7 years will best meet the needs of service users and achieve the best outcomes possible with the funding available, and to understand how these services are best delivered;

- Identify the key issues around drugs and alcohol and consider the wider factors that affect these issues, so that we can agree what our priorities should be for the next 4 – 7 years;

- Gain a deeper understanding of the various needs and interests of those who will be affected by the services that we fund;

We are particularly interested in the views of those directly affected by the services we fund: those who use the services, or could benefit from using them;
friends and family of those affected by alcohol/drug use; those who deliver the services and/or related services (e.g. mental health services, homelessness services, etc.).

We are also keen to hear the views of the wider public and those living in communities affected by alcohol/drug related issues.

Please consider the background information and further reading available before completing the survey:

https://www.publichealth.hscni.net/about-us/consultations/current-consultations/public-healthagency-stakeholder-engagement-alcohol

There are two elements of focus within this engagement:

- Young People/Community Services; and
- Adult Services

You can complete one or both sections of the survey depending on which of the above areas you want to contribute to.

This survey must be returned no later than 18th November to alcoholdrugsengagement@hscni.net .

Feedback on Young People/Community Services

2. What are the gaps or barriers within the current service models?

Apparent lack of standardisation of services offered to children and young people (CYP) for Drugs and Alcohol across Trusts –

The Drug and Alcohol Services funded positions through PHA often sit within or alongside extant CEIS or CAMH services but, to our knowledge, the funding streams are separate – this can create a lack of clarity in terms of who does what – particularly in the area of substance misuse occurring comorbid with mental health disorders. Whereby Drug and Alcohol Services are, or are at risk of, becoming an 'add-on' rather than fully integrated with extant services.

There is variation as to how CYP availing of Drug and Alcohol Services avail of medical assessment and intervention necessary as a direct result of their substance misuse issue.

What is the difference between the interventions offered at so-called 'Drug and Alcohol Mental Health Services' ('DAMHS') versus those offered in the community and voluntary sector? 'DAMHS' is potentially an over-estimation of what is offered as often that 'service' is one or two practitioners, who may even be uni-disciplinary in terms of professional background.

3. What has worked well in the current service models?

We would estimate that the current service models work because of relationships that staff forge with allied teams and professionals.

4. What aspects of the current service models have not worked well, and how can these be addressed?

CYP known to Drug and Alcohol Services often present with significant behaviour issues and risks in terms of mental ill health or misadventure. These CYP need comprehensive multidisciplinary teams to oversee their care and out-reach as necessary as sometimes the CYP's motivation to change is at a pre-contemplation phase. Child and Adolescent Psychiatrists are often asked to interface with cases known to PHA Drug and Alcohol Services or 'DAMHS' even though this may not be their area of expertise nor captured within their work plan.

5. Are there links/connections between services that need to be strengthened? (Please explain)

The relationship between PHA funded Drug and Alcohol services, CEIS and CAMH services needs to be strengthened or more integrated. Relationships to adult services need to be clearer cut with a potential for consultation with down-reach to below 18 in some cases as that is where the CCT consultant expertise in substance misuse exists in NI.

10. Please use this space to add any additional points you would like to make to support your response.

As above

***Please continue to the next section on *'Adult Services'* or jump to *'Contact Details'*.**

Feedback on Adult Services

6. What are the gaps or barriers within the current service models?

1. The current separation between Tier 2 and Tier 3 addiction services is somewhat arbitrary and the terminology wrongly suggests that Tier 2 services do not deal with clients with complex needs or who are at high risk for an adverse outcome. Consideration should be given to changing the current Tier 2 and Tier 3 terminology.

2. It is increasingly the case that people who use drugs or alcohol have co-occurring mental health and alcohol and drug use conditions as well as housing, financial, childcare or forensic issues which require a multiagency response with ready access to appropriate services.

3. Services with alcohol or drug problems should be co-located and have a single point of referral.

4. The separation of funding between drug and alcohol services funded by PHA and those commissioned by HSCB undermines support in practice for a planned whole systems approach.

5. Relatively short funding cycles across Tier 2 do not support service development and can lead to poorer staff retention and morale.

6. Support for smoking cessation is barely mentioned within the current service model - yet smoking rates are high in individuals who use alcohol or drugs. Funding for smoking cessation service comes from PHA and is not commissioned through statutory addiction services with the result that smoking cessation is generally not addressed within Tier 3 services.

7. Alcohol and drug outreach services have a key role in engaging with individuals who were traditionally seen as "unmotivated" and have a shared conversation about what interventions, if any, would be helpful.

8. Services for women who are drinking alcohol in pregnancy but who are non-dependent are not discussed - this service had previously been available in some Trusts through CAWT (Co-operation and Working Together).

9. There is a role for Tier 2 services in supporting primary care in screening and delivering brief advice for individuals with non-dependent alcohol or drug use, including prescription drug use.

10. There is no discussion of treatment services for problem gamblers.

11. Opportunities to address alcohol and drug dependence as a healthcare problem rather than a criminal justice issue and to redirect funding from custodial care should be encouraged.

12. The challenges and opportunities of treating substance use disorders in custodial settings should be an important part of any new strategy.

13. The Impact Measurement Tool (IMT) for drug and alcohol services is used to assess the effectiveness of Tier 1 and Tier 2 drug & alcohol services, but it collects data in a way which is often difficult to interpret and an alternative outcome measure should be considered. Waiting times for treatment need to be routinely captured.

14. The effects of COVID-19 on access to treatment and how virtual technologies can be used to best effect needs attention.

15. A "Housing First" approach for individuals who are at risk of homelessness and who have drug or alcohol problems should be the norm. Having high numbers of people in hostel accommodation with drug and alcohol problems presents significant risks.

7. What has worked well in the current service models?

Links between Tier 2 and Tier 3 service have improved with joint referral meetings becoming the norm.

Access and delivery of Take Home Naloxone and Needle Exchange Services have generally been successful but need further expansion.

8. What aspects of the current service models have not worked well, and how can these be addressed?

(a) Delivering training, screening and brief interventions across a variety of healthcare setting

Tier 2 services can have an increased role in delivering training, screening and delivery of brief intervention for alcohol or drug problems across a wide variety of healthcare settings.
There are daily opportunities for staff working in Primary Care, mental health services, Emergency Departments/acute hospitals, community pharmacists, criminal justice services and other settings to have a meaningful conversation with individuals about the possible negative effects of alcohol or drug use, including prescription drug use. There are other groups who are likely to come into contact with young people or adults who may have substance use issues and who could help signpost people to support services. These groups include teachers, community workers, social workers, housing officers, services for looked after children, health visitors, sexual health, family planning services etc. The use of apps or online resources could support this approach.
This broad range of health and care professionals and indeed those working in criminal justice settings should be encouraged to develop the core skills to "make every contact count". Public Health England has provided "All Our Health" guidance to support non-specialist services to help people with alcohol or other substance use disorders.
Some individuals who use performance enhancing or image enhancing drugs or who engage in chemsex are unlikely to attend an addiction clinic and some thought should be given as to how best to engage with these groups.

References

1. *Alcohol: applying All Our Health Updated 07.02.18* https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health
2. *Misuse of illicit drugs and medicines: applying All Our Health 03.05.19* https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health/misuse-of-illicit-drugs-and-medicines-applying-all-our-health
3. *E-learning: A free e-learning aimed at supporting the Everyday Interactions* toolkit https://www.rsph.org.uk/our-work/policy/wider-public-health-workforce/measuring-public-health-impact/e-learning.html

(b) Services for people with co-occurring mental health and substance use disorder (COMHAD)

There are clear concerns that people are unable to access appropriate and timely services as they are falling between mental health and addiction services. Some mental health services use current substance use as exclusion criteria to offering an assessment. This is particularly problematic in the case of people with known or suspected alcohol related brain damage.

Individuals with a "dual diagnosis" of co-occurring mental health and substance use disorder (COMHAD) have an increased risk of adverse outcomes. However it is very important to note that the incidence among people of mental health and alcohol and/or drug use conditions so commonly co-occurs that their care is "everyone's business" who works in mental health or addiction services [1,2,3]. Clinks[1] suggests "approximately three quarters of people who attend drug and/or alcohol misuse services will also have a mental health issue. Around a third of people using mental health services will have some form of drug and/or alcohol use condition(s)".

Not only do mental disorders and substance use disorders commonly co-occur but each is a risk factor for the other. People with more severe mental health disorders and a co-occurring substance use disorder should be under the care of mental health services while those with a substance use disorder and mild to moderate mental health disorders will be under the care of addiction services. Where appropriate clients/ patients should be jointly managed by both mental health and addiction services.

We would recommend that the Department of Health (NI) ensure that the mainstream mental health service here has the core competencies to assess individuals with COMHAD - who not infrequently have a past history of trauma - and also adopt the "no wrong door" approach which is supported by NICE and Public Health England.

It is a matter of regret that the challenge of developing competent and well-funded services to assess and treat people with co-occurring mental health and substance use disorders (COMHAD) was not discussed within the Department of Health Mental Health Action Plan May 2020.[4] It is hoped that this gap will be closed within the forthcoming Mental Health 10 Year Strategy.

Mental health and addiction services must work together to bridge the gaps in patient care for those with COMHAD.

All practitioners working in drug and alcohol services must have core skills in assessment of risk of self-harm and mental disorders.

Tier 2 addiction services need a clear pathway when engaging with people with a substance use disorder and who are having a mental health crisis.

References

1. *Capability Framework: Working effectively with people with co-occurring mental health and alcohol/drug use conditions CLINKS 2019*

   "Working with people who have co-occurring mental health and alcohol and/or drug use conditions (COMHAD) is everyone's business. This is because people with multiple needs often require help across many different agencies, including mental health, drug and/or alcohol misuse, health, housing, the criminal justice system and social services. It is also because these co-occurring conditions are very common.
   Approximately three quarters of people who attend drug and/or alcohol misuse services will also have a mental health issue. Around a third of people using mental health services will have some form of drug and/or alcohol use condition(s).

Therefore, all services and the workers within those services need to be equipped with the right values, knowledge and skills to be able to offer timely and effective advice and help.
In the UK, all services need to have an understanding of COMHAD conditions and be capable of providing an appropriate level of integrated care to meet individuals' needs. In order to achieve this goal, all workers in agencies that come into contact with individuals who have COMHAD issues will need some key capabilities related to values and compassion, engagement, working effectively with multiple agencies and coordination of care, as well as providing effective evidence-based treatments."
https://www.clinks.org/publication/capability-framework-working-effectively-people-co-occurring-mental-health-and

2. *Public Health England (2017) Better care for people with co-occurring mental health and alcohol/drug use conditions - A guide for commissioners and service providers*
"Two key principles
a. Everyone's job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
b. No wrong door. Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point."
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

3. *Coexisting severe mental illness and substance misuse Quality standard Published: 20 August 2019* www.nice.org.uk/guidance/qs188
"Mental health and substance misuse practitioners do not exclude people from a service because of severe mental illness or substance misuse. This applies at the **point** of referral and when people present to the service, even if they are severely intoxicated on presentation. Practitioners work with people with coexisting severe mental illness and substance misuse, and other services as needed, to ensure they provide the care and support required."

4. *Department of Health Mental Health Action Plan May 2020"*
https://www.health-ni.gov.uk/publications/mental-health-action-plan

5. *DRUG AND ALCOHOL FINDINGS HOT TOPICS -The complexity and challenge of 'dual diagnosis'*
https://findings.org.uk/docs/dual_findings.pdf?s=eb&r=&c=&sf=fpd

6. *Mental Welfare Commission GOOD PRACTICE GUIDE (2019) Alcohol Related Bain Damage*
https://www.mwcscot.org.uk/sites/default/files/2019-06/arbd_gpg.pdf

7. *DH (2006) Dual diagnosis in mental health settings*
https://webarchive.nationalarchives.gov.uk/20130123191132/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649

(c) The need to improve outcome measures across Addiction Services

The lack of outcome measures across addiction services has been highlighted by the Northern Ireland Audit Office (2020) Addiction Services in Northern Ireland https://www.niauditoffice.gov.uk/sites/niao/files/media-files/235243%20NIAO%20Addictions%20Services%20Report__NEW%204.pdf
Unfortunately the quality of the data collection across addiction services has been problematic and a new and proven approach is required.
The National Drug Treatment Monitoring System (NDTMS) which is in place across England records a comprehensive range of outcome measures for drug and alcohol using a Core dataset, using information collected by practitioners (TREATMENT OUTCOME PROFILE and ALCOHOL OUTCOME RECORD). https://www.ndtms.net/
It should be understood that for some individuals, addiction will sadly become a chronic disorder and should be treated during exacerbations as one might treat diabetes or COPD. Abstinence from alcohol or other substances cannot be regarded as the only meaningful treatment outcome.
Most, if not all of this information is already being collected routinely in England through the National Drug Treatment Monitoring System. Information on parental status and safeguarding children has been added to the NDTMS
The Impact Measurement Tool (IMT) currently being used to monitor outcomes across Tier 1 and Tier 2 drug & alcohol services is commissioned by the Public Health Agency (PHA) but it collects data in a way which is difficult to interpret.
It is suggested that the existing N.I. alcohol and drug outcome data systems be discontinued and replaced with the NDTMS.

(d) Addressing nicotine addiction across addiction services

Over 60% of opioid dependent patients smoke tobacco products, yet this is not a focus for treatment in most addiction service.
The most effective pharmacological treatment to support quit attempts is Varenicline, yet it is rarely prescribed by addiction or mental health services. This is not surprising as smoking cessation services unfortunately sit outside of NI addiction services
This can result in situations where an individual may successfully stop drinking following a period of treatment - only to still die prematurely due to tobacco related diseases.
The burden of smoking related disease is now disproportionately falling on those with mental health conditions and those who are most socially disadvantaged:

- "People with mental health conditions die on average 10-20 years earlier than the general population and smoking is the single largest factor accounting for this difference"
- "Around one third of adult tobacco consumption is by people with a current mental health condition with smoking rates more than double that of the general population"
- "A third (33%) of people with mental health problems and more than two thirds (70%) of people in psychiatric units smoke tobacco. Reductions in smoking rates in the general population over the last 20 years have not been matched in these mental health populations."

Source; The Stolen Years- The Mental Health and Smoking Action Report ASH 2016 http://ash.org.uk/information-and-resources/reports-submissions/reports/the-stolen-years/
It is also suggested the PHA review its guidance on e-cigarettes and vaping as a harm reduction measure for those individuals who have not managed to stop burning tobacco products using conventional treatments.

Any concerns about the potential for harm associated with vaping are accepted by most experts to be less than for burning tobacco products. This is consistent with guidance from Public Health England (PHE), Action on Smoking and Health (ASH) and National Centre for Smoking Cessation and Training (NCSCT).
"Many people are choosing to use electronic cigarettes to help them quit smoking, even though they are not licensed as medicines. Regular electronic cigarette use is confined almost entirely to smokers and ex-smokers. Electronic cigarettes are now the most popular quitting aid, according to a survey in the Smoking Toolkit Study, and emerging evidence indicates they can be effective for this purpose.
Smokers who want to use electronic cigarettes to help them quit should seek the expert support of their local stop smoking service. Stop smoking services should provide them with the support they need to stop successfully. PHE encourages all electronic cigarette users to quit tobacco use. Important facts include:

- 2.6m adults use electronic cigarettes in Great Britain
- 3 in 5 electronic cigarette users are current smokers
- 2 in 5 electronic cigarette users are ex-smokers who have to vaping"

https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england (accessed 11.11.20)

Supporting smoking cessation should be a core skill and outcome across all addiction and indeed mental health services. Specialist smoking cessation nurses should be available, if necessary using virtual technology to support front line staff.
Varenicline should be readily available for individuals who have not benefitted from NRT as an aid to smoking cessation.
Vaping should be recognised as a reasonable choice for adults who have failed to stop using tobacco products using standard treatments.

Additional references
Smoking cessation and smokefree policies: Good practice for mental health services NCSCT (2018)
https://www.ncsct.co.uk/usr/pub/Smoking%20cessation%20and%20smokefree%20policies%20-%20Good%20practice%20for%20mental%20health%20services.pdf

Psychosis and schizophrenia in adults Quality standard [QS80] Published date: 12 February 2015 Quality statement 7: Promoting healthy eating, physical activity and smoking cessation
https://www.nice.org.uk/guidance/qs80/chapter/Quality-statement-7-Promoting-healthy-eating-physical-activity-and-smoking-cessation

(e) The unmet needs of pregnant drug or alcohol users

Pregnant women who misuse substances (alcohol and/or drugs) often have complex social factors, co-existing physical and mental health problems and may have experienced domestic violence during their lifetime (NICE 2010, 2014). They may find it difficult to actively engage with antenatal or other treatment services and they may be wary of involvement with Childcare Services.
Unfortunately, these vulnerable women are likely to find themselves excluded from specialist perinatal psychiatric services in the UK, except where substance use may co-exist with another mental disorder.
The current Royal College of Psychiatrists Report on Perinatal Mental Health Services (CR197), published in 2015 and due for revision in 2021, specifically stated that "this report does not cover the care of pregnant women with alcohol and substance misuse." The updated report will include a section on substance use in pregnancy.
Alcohol use in pregnancy can cause a variety of serious adverse outcomes but there are particular concerns about the life changing effects of Foetal Alcohol Syndrome or Foetal Alcohol Spectrum Disorders (FASD), conditions which are often misdiagnosed or not considered. The importance of avoiding alcohol use in pregnancy due to the

risk of FASD and obstetric complications has been highlighted by SIGN (2019)[1] and The Commission on Alcohol Harm (2020)[2]. NICE[3] completed a consultation on quality standards on Foetal Alcohol Spectrum Disorder during 2020 which will require an improvement in screening and treatment for women who use alcohol during pregnancy.
Each Trust should have at least one specialist midwife to support training in screening for alcohol or other substance use in pregnancy to other midwives, deliver brief interventions and liaise with addictions service in more complex cases. PHA currently fund specialist midwives to support smoking cessation during pregnancy. Their role should be reviewed and could include some responsibility for screening and addressing alcohol use in pregnancy.
All services for people with drug and alcohol problems need to have clear guidance on safeguarding both children and indeed vulnerable adults.

References

1.SIGN 156 Children and young people exposed prenatally to alcohol- A national clinical guideline Scottish Intercollegiate Guidelines Network January 2019
https://www.sign.ac.uk/assets/sign156.pdf
2. 'It's everywhere' – alcohol's public face and private harm (2020)- Report from The Commission on Alcohol Harm
https://ahauk.org/commission-on-alcohol-harm-report/
3. NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE Foetal alcohol spectrum disorder. NICE quality standard in development [GID-QS10139]
https://www.nice.org.uk/news/article/nice-extends-consultation-period-for-new-quality-standard-on-fetal-alcohol-spectrum-disorder
4.Royal College of Obstetricians and Gynaecologists (2019) Better for women

(f)The needs of homeless drug users and the lack of longer term drug and alcohol residential units or half-way houses in N. Ireland

Northern Ireland has an emerging problem with homeless or roofless drug users. Some are visible on our streets, while others are clustered in hostels, often with other addicts, while others revolve between short periods in prison or police custody before being released back to yet another hostel. Not all these individuals are ready to commit to abstinence, but they do need ready access to a range of healthcare service and outreach workers who can deliver harm reduction measures.
There is a glaring shortage of accommodation in Northern Ireland for young people with substance use disorders. Some of these young men and women would benefit from a placement in a drug or alcohol residential placement or a half-way house for 6 months or longer but this is not available in Northern Ireland. This needs to be addressed.
While drug outreach services provide valuable support to hostels and people who are in housing stress, the key priority is to access safe and secure housing. This is the "Housing First" approach:- .

> "Housing is seen as a human right by Housing First services. There are no conditions around 'housing readiness' before providing someone with a home; rather, secure housing is viewed as a stable platform from which other issues can be addressed. Housing First is a different model because it provides housing 'first', as a matter of right, rather than 'last' or as a reward."
> *Source Homeless Link (2016) Housing First in England – The Principles*

A multiagency approach is required to address the complex needs of homeless people with drug or alcohol related problems, poor mental and physical health and little or no social network of support. A review should be undertaken to ensure the necessary agencies are able to address housing, social and care needs

The Queen's Nursing Institute, London. has published very helpful resources on the delivery of high quality healthcare to homeless people https://www.qni.org.uk/nursing-in-the-community/homeless-health-programme/homeless-health-resources/

(g) Encouraging Primary Care to become more actively engaged in the assessment and treatment of substance use disorders and raising awareness of addiction to prescribed medications

GPs have particular skills in the management of the complex comorbidities which are often present in individuals with substance use disorders but they are under severe pressure responding to the COVID-19 pandemic and other workload pressures.
The NHS Long Term Plan points to a service where the traditional boundaries between primary and secondary care are broken down and replaced with an integrated service where teams with a mix of skills are co-located and work in a truly collaborative manner. Such an integrated model holds the promise of better access to holistic care for individuals with alcohol or drug-related problems.
There is a key role also for Primary Care in the primary prevention of prescription drug misuse and early detection and treatment of substance misuse problems.
Efforts to encourage GPs to prescribe opioid substitute treatments across N. Ireland have had limited success.
Clearer guidance should be available to GPs on prescribing and deprescribing on medications with an abuse potential, such as benzodiazepines, z-drugs, opioids and gabapentinoids.
Tier 2 services based in primary care could offer screening and brief interventions for alcohol or drug problems in selected cases and also support planned reductions in prescribed medications.

(h) Services for problem gamblers should be included in the new strategy

The consultation document does not include any discussion about the care of problem gamblers despite the serious harms associated with gambling disorders including their increased risk of suicide.
This is a major oversight as additional services are required to address the growing threat of gambling disorders. At the time of writing the NI Assembly's All Party Group on Reducing Harm Related to Gambling has formed an Inquiry Call for Evidence related to this issue. This follows the closing of a Consultation on Regulation of Gambling in Northern Ireland held by the Department for Communities. The consultation showed considerable support for relaxing gambling legislation in NI which could result in an increase in gambling disorders.
At present Dunlewey Substance Advice Service offer community based treatment for problem gamblers.
A 12 week residential programme for problem gamblers is offered by Cuan Mhuire (NI) Limited, 200 Dublin Road, Newry, followed by a two year after care service.
Gamblers Anonymous are active in Northern Ireland but GAMCARE does not offer support to residents of Northern Ireland.
There is a pressing need to protect young people from the emergence of gambling via the internet, interactive television and mobile phone.
Addiction Psychiatrists may have a role in prescribing Naltrexone to problem gamblers, an opioid antagonist which is licensed to treat both opioid and alcohol dependence, although this is an off-license indication.
"Treatment services for problem gambling should have parity of esteem with other mental disorders, in particular alcohol, drug and tobacco addiction, and should be a core element of addictions treatment provision within the NHS". (Royal College of Psychiatrists)

Additional resources need to be put in place to address gambling disorders, including services for young people.

References

1.Gambling with our health Chief Medical Officer for Wales Annual Report 2016/17
https://gov.wales/sites/default/files/publications/2019-03/gambling-with-our-health-chief-medical-officer-for-wales-annual-report-2016-17.pdf
2.Rapid evidence review of evidence-based treatment for gambling disorder in Britain. Dr Henrietta BOWDEN-JONES, Professor Colin Drummond Royal College of Psychiatrists 2016
https://www.rcpsych.ac.uk/docs/default-source/members/faculties/addictions-psychiatry/addictions-resources-for-specialists-rapid-evidence-for-gambling.pdf?sfvrsn=736e144a_2
3. HOUSE OF LORDS Select Committee on the Social and Economic Impact of the Gambling Industry Report of Session 2019–21 Gambling Harm— Time for Action (2020)

(i) Addiction Services - changing models of service delivery

Treatment guidelines for alcohol and drug related problems are now widely available which, if implemented, should improve outcomes for both service users and their families. However, the funding available in NI to address the harms caused by alcohol and substance use are tiny in proportion to their costs to society, despite evidence that delivering good quality care in a timely way for substance use disorders is cost effective. An injectable form of buprenorphine is now licensed in the UK as an opioid substitute treatment (OST), namely Buvidal®, which can be administered on a weekly or monthly basis; other injectable or implantable preparations will become available in due course. These products mean service users no longer need to attend a community pharmacy for supervision or dispensing of their OST.

There is evidence that an assertive community treatment for people with alcohol dependence which provided more intensive support and for a longer period than has been the case can provide better outcomes; this approach does make additional demand on staff time.

Drug and Alcohol Outreach Services are key services and should be enhanced. For individuals who are unable to stop drinking alcohol and who have no support network and are at risk of becoming homeless - a placement in a hostel which provides a managed alcohol programme is an appropriate option.

"Managed alcohol programs (MAPs) are reduction interventions that aim to reduce the harms of severe alcohol use, poverty and homelessness. MAPs typically provide accommodation, health and social supports alongside regularly administered sources of beverage alcohol to stabilize drinking patterns and replace use of non-beverage alcohol (NBA). Pauly et al (2019)

(j) Expanding access and delivery of Take Home Naloxone and Needle Exchange Services

Take Home Naloxone and Needle Exchange Services have generally been successful but need further expansion. The introduction of intranasal take home naloxone may reduce some barriers to its use. Take home naloxone should be available from an ED or prior to discharge from an acute hospital; it should also be offered to individuals who are being prescribed high doses of opioids for pain.

References

Drummond C, Gilburt H Burns T et al Assertive Community Treatment For People With Alcohol Dependence: A Pilot Randomized Controlled Trial Alcohol and Alcoholism, 2017, 52(2) 234–241
doi: 10.1093/alcalc/agw091

Pauly B, Brown M, Evans J. (2019) "There is a Place": impacts of managed alcohol programs for people experiencing severe alcohol dependence and homelessness Harm Reduction Journal (2019) 16:70
https://doi.org/10.1186/s12954-019-0332-4

9. Are there links/connections between services that need to be strengthened? (Please explain)

The current separation between Tier 2 and Tier 3 addiction services is somewhat arbitrary and closer integration and ideally co-location of these community services would be helpful in reducing duplication of services and in ensuring the best use of resources.

The interface between prison healthcare and addiction services at the point of release continues to cause concern and particularly when individuals are being prescribed an opioid substitute treatment. There remains a need for a Tier 2 drug treatment service that can work across the prison and community interface and ensure individuals with substance use disorders are given attention in order to reduce the risk of dropping out of treatment at a time when there is a high risk of drug overdose.

10. Please use this space to add any additional points you would like to make to support your response.

As above

Please note that the Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.
The College has approximately 400 members in Northern Ireland, including doctors in training. These doctors provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

The feedback on Young People/Community services has been provided by our Chair of Child and Adolescent Faculty Dr Mark Rodgers and the feedback on Adult services has been provided by our outgoing Addictions Faculty Chair Dr Billy Gregg.

Contact Details

11. We are keen to understand the context to any responses. To help us in doing so, we would appreciate if you could include contact details as below. Please note that you are assured of complete anonymity in any analysis or report originating from this stakeholder engagement exercise.

Name

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*** This survey must be returned no later than 18th November to alcoholdrugsengagement@hscni.net .**